

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

Requirements for Prior Authorization of Hypoglycemics, TZDs

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, TZDs that meet any of the following conditions must be prior authorized:

1. A prescription for a preferred or non-preferred Hypoglycemic, TZD regardless of the quantity prescribed. See Preferred Drug List (PDL) for the list of preferred Hypoglycemics, TZDs at:
www.providersynergies.com/services/documents/PAM_PDL.pdf
2. See Quantity Limits for the list of drugs with quantity limits at:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_002077.pdf

GRANDFATHER PROVISION – The Department will grandfather prescriptions for pioglitazone within quantity limits when the PROMISe Point-Of-Sale On-Line Claims Adjudication System verifies that the recipient has a record of a paid claim for pioglitazone within the past 90 days from the date of service of the new claim. If the recipient has a record of a paid claim for pioglitazone, a prescription or a refill for pioglitazone within the quantity limits will be automatically approved.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a preferred or non-preferred Hypoglycemic, TZD, the determination of whether the requested prescription is medically necessary will take into account the following:

1. Whether the recipient has a documented history of
 - a. Failure to achieve glycemic control as evidenced by the recipient's HbA1c values using maximum tolerated doses of metformin in combination with maximum tolerated doses of a sulfonylurea

OR

- b. A contraindication or intolerance to metformin and sulfonylureas

AND

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2. Does not have a HbA1c greater than or equal to 12% in absence of ketosis

AND

3. Does not have a documented history of contraindication to the requested medication

AND

4. Has no evidence of heart failure, renal insufficiency, or bladder cancer

AND

5. For a non-preferred Hypoglycemic, TZD, whether the recipient has a documented history of therapeutic failure, contraindication or intolerance of the preferred Hypoglycemics, TZDs
6. In addition, if a prescription for either a preferred or non-preferred Hypoglycemic, TZD is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

OR

7. The recipient does not meet the clinical review guidelines listed above but in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Hypoglycemic, TZD. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the service is medically necessary to meet the medical needs of the recipient.

References:

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1. Inzucchi, S.E, et.al. "Management of hyperglycemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Diabetes Association (EASD)"Diabetes Care. June 2012; 35 (1364-1379).