

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Antiparasitics, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions that meet any of the following conditions must be prior authorized:

1. All prescriptions for non-preferred Antiparasitics, Topical. See the Preferred Drug List (PDL) for the list of preferred Antiparasitics, Topical at:
www.providersynergies.com/services/documents/PAM_PDL.pdf

2. Prescriptions for Natroba (spinosad)

B. Emergency Supplies

Due to the toxicity of Lindane and the one-time application of the medication, the emergency five (5) day supply without prior authorization does not apply as it may jeopardize the health and safety of the recipient.

C. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antiparasitic, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. For a non-preferred Antiparasitic, Topical, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred product(s)

AND

2. For Lindane:

- a. Has a documented history of therapeutic failure, contraindication, or intolerance of each of the preferred products

AND

- b. Weighs \geq 50 kilograms

AND

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- c. Does not take medication that may reduce the seizure threshold (such as but not limited to: Meperidine, Cyclosporine, Theophylline)
3. For Natroba (spinosad), has a documented history of therapeutic failure, contraindication, or intolerance to a preferred pyrethroid agent (permethrin or pyrethrin/piperonyl butoxide)

OR

4. Does not meet the clinical review guidelines listed above, but in the professional judgment of the physician reviewer, the therapy is medically necessary to meet the medical needs of the recipient

D. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section C above to assess the medical necessity of the request for a prescription for an Antiparasitic, Topical. If the guidelines in Section C 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 services are medically necessary to meet the medical needs of the recipient.

E. Dose and Therapy Duration

The Department will limit authorization to the U.S. Food and Drug Administration (FDA) maximum recommended therapeutic dose for the Antiparasitic, Topical.

F. References:

1. Lindane Lotion/Shampoo [package insert]. Livonia, MI: Major; 2003
2. Eurax [package insert]. Buffalo, NY: Bristol Myers Squibb; May 1991
3. Permethrin Cream [package insert]. Bronx, NY: Clay-Park Labs; October 2002
4. Nix Lice Treatment [package insert]. New York, NY: Pfizer Consumer; 2003
5. Ovide Lotion [package insert]. Hawthorne, NY: TaroPharma U.S.A.,Inc.; 2005

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6. Frankowski BL, Weiner LB, American Academy of Pediatrics. Head Lice. Pediatrics. 2002; 110:638-643.
7. Lebwohl M, Clark L, Levitt J. Therapy for head lice based on life cycle, resistance, and safety considerations. Pediatrics. 2007;119(5):965-974.
8. Rauch AE, Kowalsky SF, Lesar TS, Sauerbier GA et al. Lindane(Kwell)-induced aplastic anemia. Arch Intern Med. 1990 Nov;150(11):2393-5