pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 4, 2021	January 3, 2022	*See below

SUBJECT

Prior Authorization of Antiparasitics, Topical – Pharmacy Services

BY

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Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Antiparasitics, Topical submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Antiparasitics, Topical will be utilized in the fee-for-service delivery system and by the MA managed care organizations (MCOs) in Physical Health HealthChoices and Community HealthChoices. Providers rendering services in the MA managed care delivery system should address any questions related to the prior authorization of Antiparasitics, Topical to the appropriate MCO.

BACKGROUND:

*01-21-20	09-21-19	27-21-10	33-21-19
02-21-07	11-21-09	30-21-14	
03-21-07	14-21-10	31-21-22	
08-21-21	24-21-17	32-21-07	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx.

The Department of Human Services' (Department) Pharmacy and Therapeutics (P&T) Committee reviews published peer-reviewed medical literature and recommends the following:

- Preferred or non-preferred status for new drugs in therapeutic classes already included in the Preferred Drug List (PDL);
- Changes in the status of drugs on the PDL from preferred to non-preferred and non-preferred to preferred;
- New quantity limits;
- Classes of drugs to be added to or deleted from the PDL; and
- New guidelines or revisions to existing guidelines to evaluate the medical necessity of prescriptions submitted for prior authorization.

DISCUSSION:

During the September 14, 2021, meeting, the P&T Committee recommended a revision to the guidelines to determine medical necessity of Antiparasitics, Topical to specify that requests for lindane and all other non-preferred Antiparasitics, Topicals will take into account the beneficiary's diagnosis.

The revisions to the guidelines to determine medical necessity of prescriptions for Antiparasitics, Topical submitted for prior authorization, as recommended by the P&T Committee, were subject to public review and comment and subsequently approved for implementation by the Department.

PROCEDURE:

The procedures for prescribers to request prior authorization of Antiparasitics, Topical are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Antiparasitics, Topical) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements

https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Pharmacy-Prior-Authorization-General-Requirements.aspx

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx

I. Requirements for Prior Authorization of Antiparasitics, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions for a non-preferred Antiparasitic, Topical must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Antiparasitics, Topical at: https://papdl.com/preferred-drug-list.

B. 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 beneficiary:

1. For lindane, **all** of the following:

    a. Has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Antiparasitic, Topicals approved or medically accepted for the beneficiary's diagnosis,
    b. Weighs ≥ 50 pounds,
    c. Does not take medication that may reduce the seizure threshold (such as but not limited to meperidine, cyclosporine, theophylline)

    AND

2. For all other non-preferred Antiparasitic, Topicals, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Antiparasitic, Topicals approved for medically accepted for the beneficiary's diagnosis.

    NOTE: If the beneficiary 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 beneficiary, the request for prior authorization will be approved.

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 an Antiparasitic, Topical. 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 services are medically necessary to meet the medical needs of the recipient.

D. Dose and Duration of Therapy

Requests for prior authorization of Antiparasitics, Topical will be approved for a dose and duration of therapy consistent with FDA-approved package labeling.

E. 5-Day Supply

In response to health and safety concerns, the Department of Human Services will not cover a 5-day supply of lindane pending approval of a request for prior authorization.

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
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. Pedatrics. 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.
9. Salavastru CM, Chosidow O, Janier M, Tiplica GS. European guideline for the management of pediculosis pubis. Journal of the European Academy of Dermatology and Venereology. September 2017: 31(9):1425-1428.
10. Goldstein AO, Goldstein BG. Pediculosis pubis and pediculosis ciliaris. UpToDate Inc. Updated March 24, 2021. Accessed August 11, 2021.