pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
July 5, 2016	July 11, 2016	*See below

SUBJECT

Prior Authorization of Antifungals, Topical - Pharmacy Services

BY

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Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate their MA enrollment every 5 years. Providers should log into PROMISe to check their revalidation date and submit a revalidation application at least 60 days prior. Enrollment (revalidation) applications may be found at http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994. Providers who enrolled on or before SEPTEMBER 25, 2011 must complete the revalidation process as soon as possible. DHS must complete the revalidation for all providers enrolled on or before September 25, 2011 by September 25, 2016.

PURPOSE:

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

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program and providing services in the fee-for-service (FFS) delivery system, including pharmacy services to residents of long term care facilities.

BACKGROUND/DISCUSSION:

The Department of Human Services (Department) is removing the reference to Itraconazole in the guideline "Whether the recipient has a history of a contraindication, intolerance to, or therapeutic failure of oral Terbinafine and Itraconazole". The Department determined that a history of a contraindication, intolerance to, or therapeutic failure of oral Terbinafine is sufficient for the determination of medical necessity.

*01-16-21	09-16-19	27-16-19	
02-16-18	11-16-18	30-16-18	
03-16-18	14-16-19	31-16-23	
08-16-19	24-16-21	32-16-17	33-16-18

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 Web site at
http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm

PROCEDURE:

The procedures for prescribers to request prior authorization of Antifungals, 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 Antifungals, 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

SECTION II
Antifungals, Topical

I. Requirements for Prior Authorization of Topical Antifungals

A. Prescriptions That Require Prior Authorization

A prescription for a non-preferred Topical Antifungal must be prior authorized. See Preferred Drug List (PDL) for the list of preferred Topical Antifungals at: www.papdl.com

B. Review of Documentation for Medical Necessity

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

1. For a solution for the treatment of onychomycosis, whether the recipient:

   a. Is age-appropriate according to package labeling

   AND

   b. Has a diagnosis of onychomycosis that causes a medical problem and is confirmed by culture

   AND

   c. Has a history of a contraindication, intolerance to, or therapeutic failure of oral Terbinafine.

2. For all other non-preferred Topical Antifungals, whether the recipient has a history of a contraindication, intolerance to, or therapeutic failure of the preferred Topical Antifungals.

   OR

3. 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 guideline in Section B. above, to assess the medical necessity of the request for a prescription for a non-preferred Topical Antifungal. If the guideline in Section B is met, the reviewer will prior authorize the prescription. If the guideline is 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. References:

1. UpToDate – "Onychomycosis" accessed 04/24/15
2. Ciclopirox prescribing information.
3. Jublia prescribing information. Valeant Pharmaceuticals North America LLC. February 2015
4. Kerydin prescribing information. Anacor Pharmaceuticals, Inc. July 2014.