




<b>ISSUE DATE</b>  July 31, 2019	<b>EFFECTIVE DATE</b>  January 1, 2020	<b>NUMBER</b>  *See below	
<b>SUBJECT</b>  Prior Authorization of Antimalarials – Pharmacy Services		<b>BY</b>    Sally A. Kozak, Deputy Secretary 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:  
[http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S\\_001994](http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994).

**PURPOSE:**

The purpose of this bulletin is to:

1. Inform providers of the addition of the Antimalarials class of drugs to the Preferred Drug List (PDL).
2. Issue new handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Antimalarials submitted for prior authorization.

**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 delivery system. Providers rendering services in the MA managed care delivery system should address any questions related to Antimalarials to the appropriate managed care organization.

*01-19-38	09-19-36	27-19-34	33-19-36
02-19-33	11-19-32	30-19-32	
03-19-32	14-19-32	31-19-38	
08-19-41	24-19-34	32-19-32	

<p><b>COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:</b></p> <p>The appropriate toll-free number for your provider type</p> <p>Visit the Office of Medical Assistance Programs Web site at  <a href="http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm">http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm</a></p>
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**BACKGROUND:**

The Department of Human Services' (Department) Pharmacy and Therapeutics (P&T) Committee reviews published peer-reviewed clinical literature and makes recommendations relating to the following:

- Preferred or non-preferred status for new drugs in therapeutic classes already included in the 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 requests for prior authorization of prescriptions for medical necessity.

**DISCUSSION:**

During the May 15, 2019, meeting, the P&T Committee recommended that the Department add the Antimalarials class of drugs to the PDL and proposed guidelines to determine medical necessity of Antimalarials. The requirement for prior authorization and guidelines to determine medical necessity of Antimalarials, 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 Antimalarials 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 Antimalarials) 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

<http://www.dhs.pa.gov/provider/pharmacieservices/pharmacypriorauthorizationgeneralrequirements/index.htm>

Prior Authorization of Pharmaceutical Services Handbook – SECTION II  
Pharmacy Prior Authorization Guidelines

<http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**I. Requirements for Prior Authorization of Antimalarials**

A. Prescriptions That Require Prior Authorization

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

1. A non-preferred Antimalarial. See the Preferred Drug List (PDL) for the list of preferred Antimalarials at: <https://papdl.com/preferred-drug-list>.
2. An Antimalarial with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at:  
<http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Antimalarial, **all** of the following:
  - a. Is prescribed the Antimalarial for an indication included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,
  - b. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
  - c. **One** of the following:
    - i. For treatment of malaria, has a history of therapeutic failure, contraindication, or intolerance of the preferred Antimalarials for the beneficiary's diagnosis
    - ii. For prevention of malaria, has a contraindication or intolerance of the preferred Antimalarials for the beneficiary's indication;

**AND**

2. If a prescription for an Antimalarial 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.

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

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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 a prescription for an Antimalarial. 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 beneficiary.

D. Dose and Duration of Therapy

The Department of Human Services will limit authorization of prescriptions for Antimalarials consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

E. References

1. Centers for Disease Control and Prevention. Guidelines for Treatment of Malaria in the United States. <https://www.cdc.gov/malaria/resources/pdf/treatmenttable.pdf>. Accessed April 30, 2019.
2. Centers for Disease Control and Prevention. Choosing a Drug to Prevent Malaria. <https://www.cdc.gov/malaria/travelers/drugs.html>. Accessed April 30, 2019.