

<b>ISSUE DATE</b>  October 16, 2019	<b>EFFECTIVE DATE</b>  January 1, 2020	<b>NUMBER</b>  *See below
<b>SUBJECT</b>  Prior Authorization of Glucocorticoids, Inhaled – 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 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 Glucocorticoids, Inhaled 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 Glucocorticoids, Inhaled to the appropriate managed care organization.

**BACKGROUND/DISCUSSION:**

During a previous Department of Human Services’ (Department) Drug Utilization Review Board meeting, the board identified potential health and safety risks when two or more drugs within the same therapeutic class are used concurrently (therapeutic duplication). The

*01-19-79	09-19-75	27-19-73	33-19-75
02-19-73	11-19-72	30-19-71	
03-19-72	14-19-71	31-19-78	
08-19-81	24-19-73	32-19-71	

<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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board recommended that the Department require prior authorization of these drugs when the Department's online claims adjudication system determines that there is a record of a recent paid claim for a different drug within the same therapeutic class. The Department is updating the prior authorization guidelines for Glucocorticoids, Inhaled to include a requirement for prior authorization of prescriptions for agents that contain an inhaled glucocorticoid that may represent a therapeutic duplication.

The Department is also updating the medical necessity guidelines for Glucocorticoids, Inhaled to:

- Clarify that review of a request for a single-ingredient Glucocorticoid, Inhaled (i.e., a product that contains only one active ingredient) that is non-preferred on the MA Preferred Drug List will take into account a history of therapeutic failure, contraindication, or intolerance of the preferred single-ingredient Glucocorticoids, Inhaled. Prior authorization of a non-preferred Glucocorticoid, Inhaled combination agent will take into account a history of therapeutic failure, contraindication, or intolerance of the preferred Glucocorticoid, Inhaled combination agents; and
- Allow for the determination of medical necessity of prescriptions for agents in this class that exceed the quantity limits established by the Department.

The revisions to the guidelines to determine medical necessity of Glucocorticoids, Inhaled 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 Glucocorticoids, Inhaled 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 Glucocorticoids, Inhaled) 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/pharmacyservices/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 Glucocorticoids, Inhaled**

**A. Prescriptions That Require Prior Authorization**

Prescriptions for Glucocorticoids, Inhaled that meet any of the following conditions must be prior authorized:

1. A non-preferred Glucocorticoid, Inhaled. See the Preferred Drug List (PDL) for the list of preferred Glucocorticoids, Inhaled at: <https://papdl.com/preferred-drug-list>.
2. A Glucocorticoid, Inhaled 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>.
3. A Glucocorticoid, Inhaled when there is a record of a recent paid claim for another agent that contains an inhaled glucocorticoid in the Department of Human Services' Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

**B. Review of Documentation for Medical Necessity**

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

1. For a non-preferred single-ingredient Glucocorticoid, Inhaled (i.e., a product that contains only one active ingredient), has a history of therapeutic failure, contraindication, or intolerance of the preferred single-ingredient Glucocorticoids, Inhaled; **AND**
2. For a non-preferred Glucocorticoid, Inhaled combination agent (i.e., a product that contains more than one active ingredient), has a history of therapeutic failure, contraindication, or intolerance of the preferred Glucocorticoid, Inhaled combination agents; **AND**
3. For therapeutic duplication, **one** of the following:
  - a. Is being titrated to or tapered from another agent that contains an inhaled glucocorticoid
  - b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

**AND**

4. If a prescription for a Glucocorticoid, Inhaled 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

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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 a prescription for a Glucocorticoid, Inhaled. 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.