pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
June 27, 2019	July 8, 2019	*See below

SUBJECT

Prior Authorization of Immunomodulators, Atopic Dermatitis – Pharmacy Services

BY

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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.

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 Immunomodulators, Atopic Dermatitis 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 Immunomodulators, Atopic Dermatitis to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (DHS) Drug Utilization Review (DUR) Board meets semi-annually to review provider prescribing and dispensing practices for efficacy, safety, and

*01-19-17	09-19-16	27-19-13	33-19-16
02-19-12	11-19-12	30-19-12	
03-19-12	14-19-12	31-19-17	
08-19-18	24-19-14	32-19-12	

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

quality and to recommend interventions for prescribers and pharmacists through the DHS Prospective Drug Use Review and Retrospective Drug Use Review programs.

DISCUSSION:

During the March 21, 2019, DUR Board meeting, the DUR Board recommended that DHS require prior authorization of Dupixent (dupilumab) to ensure appropriate patient selection and drug utilization of Dupixent (dupilumab). Prior to the March 21, 2019, DUR Board meeting, Dupixent (dupilumab) was included in the Immunomodulators, Atopic Dermatitis Preferred Drug List class and guidelines to determine medical necessity were included in the Immunomodulators, Atopic Dermatitis handbook chapter. Recognizing that Dupixent (dupilumab) is now indicated for both asthma and atopic dermatitis, DHS is publishing handbook pages specific to Dupixent (dupilumab) and is removing the guidelines pertaining to Dupixent (dupilumab) from the medical necessity guidelines for Immunomodulators, Atopic Dermatitis. The new Dupixent (dupilumab) medical necessity guidelines include both the asthma and atopic dermatitis indications.

The revisions to the guidelines to determine medical necessity of Immunomodulators, Atopic Dermatitis were subject to public review and comment and subsequently approved for implementation by DHS.

PROCEDURE:

The procedures for prescribers to request prior authorization of Immunomodulators, Atopic Dermatitis are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. DHS 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 Immunomodulators, Atopic Dermatitis) 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

I. Requirements for Prior Authorization of Immunomodulators, Atopic Dermatitis

A. Prescriptions That Require Prior Authorization

Prescriptions for Immunomodulators, Atopic Dermatitis that meet the following conditions must be prior authorized.

1. A non-preferred Immunomodulator, Atopic Dermatitis. See Preferred Drug List (PDL) for the list of preferred Immunomodulators, Atopic Dermatitis at: https://papdl.com/preferred-drug-list.

2. A prescription for Eucrisa (crisaborole topical).

B. Review of Documentation for Medical Necessity

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

1. For Dupixent (dupilumab), see the provider handbook pages in the SECTION II chapter related to Dupixent (dupilumab); **OR**

2. For a non-preferred topical calcineurin inhibitor, has a documented history of therapeutic failure of, a contraindication to, or intolerance of the preferred topical calcineurin inhibitors;

   AND

3. For Eucrisa (crisaborole topical), **both** of the following:

   a. Has a documented history of therapeutic failure of, a contraindication to, or intolerance of a topical calcineurin inhibitor,
   b. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature.

   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 a prescription for an Immunomodulator, Atopic Dermatitis. 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. Automated Prior Authorization

Prior authorization of a prescription for Eucrisa (crisaborole topical) will be automatically approved when the DHS Point-of-Sale On-Line Claims Adjudication System verifies a record of a paid claim(s) within 90 days prior to the date of service that documents that the guidelines to determine medical necessity listed in Section B. have been met.