


<b>ISSUE DATE</b>  October 25, 2019	<b>EFFECTIVE DATE</b>  January 1, 2020	<b>NUMBER</b>  *See below
<b>SUBJECT</b>  Prior Authorization of Ophthalmics, Glaucoma (Formerly Ophthalmic Agents for Glaucoma) – 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 Ophthalmics, Glaucoma 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 Ophthalmics, Glaucoma to the appropriate managed care organization.

**BACKGROUND/DISCUSSION:**

The Department of Human Services (Department) is changing the title of the Ophthalmic Agents for Glaucoma class of drugs to Ophthalmics, Glaucoma and is revising the medical necessity guidelines to clarify that contraindications will be taken into account when

*01-19-75	09-19-71	27-19-69	33-19-71
02-19-69	11-19-68	30-19-67	
03-19-68	14-19-67	31-19-74	
08-19-77	24-19-69	32-19-67	

<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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reviewing a request for prior authorization of a non-preferred Ophthalmic, Glaucoma. There are no other changes to the medical necessity guidelines.

**PROCEDURE:**

The procedures for prescribers to request prior authorization of Ophthalmics, Glaucoma 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 Ophthalmics, Glaucoma) 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 Ophthalmics, Glaucoma**

**A. Prescriptions That Require Prior Authorization**

Prescriptions for a non-preferred Ophthalmic, Glaucoma must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Ophthalmics, Glaucoma 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 a non-preferred Ophthalmic, Glaucoma, the determination of whether the requested prescription is medically necessary will take into account the whether the beneficiary:

1. Has a history of therapeutic failure, contraindication, or intolerance to the preferred Ophthalmics, Glaucoma.

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 a non-preferred Ophthalmic, Glaucoma. 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.