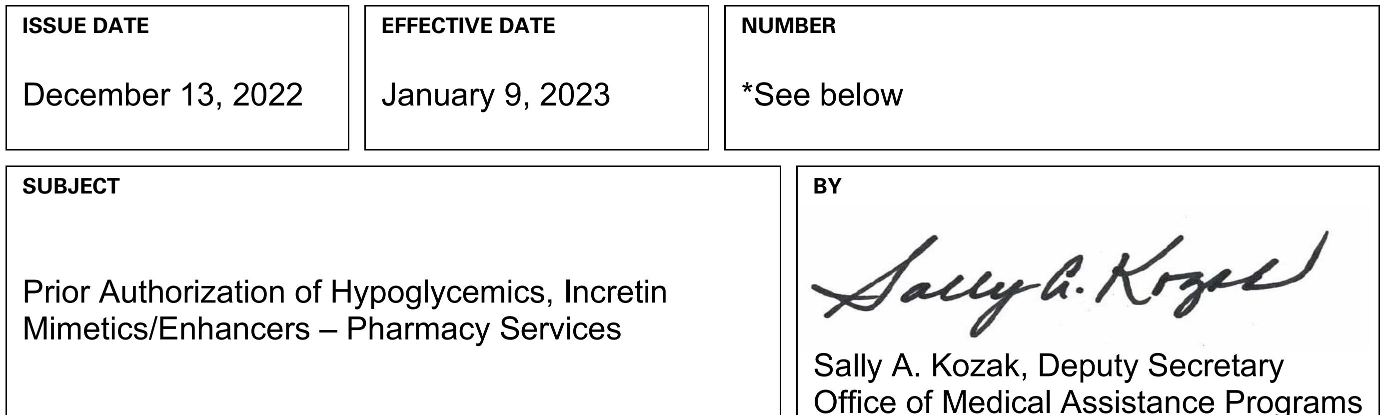
MEDICAL ASSISTANCE BULLETIN

pennsylvania
DEPARTMENT OF HUMAN SERVICES



ISSUE DATE	EFFECTIVE DATE	NUMBER
December 13, 2022	January 9, 2023	*See below

SUBJECT	BY
Prior Authorization of Hypoglycemics, Incretin Mimetics/Enhancers – Pharmacy Services	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: https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx.

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 Hypoglycemics, Incretin Mimetics/Enhancers submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Hypoglycemics, Incretin Mimetics/Enhancers will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Hypoglycemics, Incretin Mimetics/Enhancers to the appropriate managed care organization.

BACKGROUND:

*01-22-63	09-22-62	27-22-50	33-22-60
02-22-47	11-22-47	30-22-53	
03-22-46	14-22-47	31-22-66	
08-22-71	24-22-55	32-22-47	

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 website at https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx.

The Department of Human Services' (Department) Pharmacy and Therapeutics (P&T) Committee reviews published peer-reviewed medical literature and recommends the following:

- Preferred or non-preferred status for new drugs and products in therapeutic classes already included in the Preferred Drug List (PDL).
- Changes in the status of drugs and products on the PDL from preferred to non-preferred and non-preferred to preferred.
- New quantity limits.
- Therapeutic classes of drugs and products to be added to or deleted from the PDL.
- New guidelines or revisions to existing guidelines to evaluate the medical necessity of prescriptions submitted for prior authorization.

DISCUSSION:

During the September 14, 2022, meeting, the P&T Committee recommended the following revisions to the guidelines to determine medical necessity of prescriptions for Hypoglycemics, Incretin Mimetics/Enhancers:

- Removal of the requirement for prior authorization of preferred Hypoglycemics, Incretin Mimetics/Enhancers that are prescribed for a quantity that does not exceed the quantity limit and do not represent a therapeutic duplication.
- Removal of the guideline related to the beneficiary's diagnosis.
- Removal of the guidelines for glucagon-like peptide-1 receptor agonists and dipeptidyl peptidase-4 inhibitors for the treatment of type 2 diabetes.
- Revision of the guideline for non-preferred Hypoglycemics, Incretin Mimetics/Enhancers to consider the beneficiary's diagnosis.
- Removal of the guidelines for an amylin analog.
- Revision of the requirements for prior authorization of and corresponding medical necessity guidelines for Hypoglycemics, Incretin Mimetics/Enhancers that represent a therapeutic duplication.
- Removal of the section for automated prior authorization.

The revisions to the guidelines to determine medical necessity of prescriptions for Hypoglycemics, Incretin Mimetics/Enhancers submitted for prior authorization, 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 Hypoglycemics, Incretin Mimetics/Enhancers 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 Hypoglycemics, Incretin Mimetics/Enhancers) 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 and products 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
https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Pharmacy-Prior-Authorization-General-Requirements.aspx

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx

I. Requirements for Prior Authorization of Hypoglycemics, Incretin Mimetics/Enhancers

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, Incretin Mimetics/Enhancers that meet any of the following conditions must be prior authorized:

1. A non-preferred Hypoglycemic, Incretin Mimetic/Enhancer. See the Preferred Drug List (PDL) for the list of preferred Hypoglycemics, Incretin Mimetic/Enhancers at: https://papdl.com/preferred-drug-list.

2. A Hypoglycemic, Incretin Mimetic/Enhancer 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: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx.

3. A glucagon-like peptide-1 (GLP-1) receptor agonist when there is a record of a recent paid claim for another GLP-1 receptor agonist or a dipeptidyl peptidase 4 (DPP-4) inhibitor in the Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

4. A DPP-4 inhibitor when there is a record of a recent paid claim for another DPP-4 inhibitor or a GLP-1 receptor agonist in the 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 Hypoglycemic, Incretin Mimetic/Enhancer, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Hypoglycemic, Incretin Mimetic/Enhancer, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers with the same mechanism of action approved or medically accepted for the beneficiary's diagnosis; **AND**

2. For therapeutic duplication of a GLP-1 receptor agonist or a DPP-4 inhibitor, **one** of the following:

   a. Is being transitioned to or from another GLP-1 receptor agonist or DPP-4 inhibitor with the intent of discontinuing one of the medications
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines;

   AND

3. If a prescription for a Hypoglycemic, Incretin Mimetic/Enhancer is for 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 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 Hypoglycemic, Incretin Mimetic/Enhancer. If the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the applicable 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.