




ISSUE DATE September 16, 2019	EFFECTIVE DATE January 1, 2020	NUMBER *See below
SUBJECT Prior Authorization of Hypoglycemics, Meglitinides – Pharmacy Services		BY  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.

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, Meglitinides 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 Hypoglycemics, Meglitinides to the appropriate managed care organization.

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:

*01-19-63	09-19-59	27-19-57	33-19-59
02-19-57	11-19-56	30-19-55	
03-19-56	14-19-55	31-19-62	
08-19-65	24-19-57	32-19-55	

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>

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

DISCUSSION:

During the June 21, 2019, meeting, the P&T Committee recommended removing the grandfathering provision for Prandin (repaglinide). Repaglinide is a preferred agent in this PDL drug class and does not require prior authorization. There are no other changes to the prior authorization guidelines for Hypoglycemics, Meglitinides.

The revisions to the guidelines to determine medical necessity of Hypoglycemics, Meglitinides, 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, Meglitinides 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, Meglitinides) 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 Hypoglycemics, Meglitinides

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, Meglitinides that meet any of the following conditions must be prior authorized:

1. A non-preferred Hypoglycemic, Meglitinide. See the Preferred Drug List (PDL) for the list of preferred Hypoglycemics, Meglitinides at: <https://papdl.com/preferred-drug-list>.
2. A Hypoglycemic, Meglitinide 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 a Hypoglycemic, Meglitinide, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Hypoglycemic, Meglitinide, has history of therapeutic failure, contraindication, or intolerance to the preferred Hypoglycemic, Meglitinides; **AND**
2. If a prescription for a Hypoglycemic, Meglitinide 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, Meglitinide. 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.