pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
December 4, 2019	January 1, 2020	*See below

SUBJECT

Prior Authorization of Beta Blockers – Pharmacy Services

BY

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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 Beta Blockers 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 Beta Blockers to the appropriate managed care organization.

BACKGROUND:

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

*01-19-104	09-19-100	27-19-99	33-19-101
02-19-98	11-19-97	30-19-96	
03-19-97	14-19-96	31-19-104	
08-19-107	24-19-99	32-19-96	

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

through the Department's Prospective Drug Use Review and Retrospective Drug Use Review programs.

DISCUSSION:

During the September 13, 2019, meeting, the DUR Board recommended the following: adding a requirement for prior authorization for prescriptions for Beta Blockers that may represent therapeutic duplication and prescriptions for Beta Blockers that exceed the quantity limits established by the Department; removing the guidelines specific to non-preferred Coreg CR (carvedilol phosphate extended-release capsule); adding a prior authorization requirement for preferred Hemangeol (propranolol hydrochloride oral solution) due to its limited FDA-approved indication and place in therapy; and revising the guideline for non-preferred Beta Blockers to consider the beneficiary's contraindications or intolerances to the preferred Beta Blockers and the beneficiary's diagnosis.

The revisions to the guidelines to determine medical necessity of Beta Blockers, as recommended by the DUR Board, 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 Beta Blockers 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 Beta Blockers) 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 Beta Blockers

A. Prescriptions That Require Prior Authorization

Prescriptions for Beta Blockers that meet any of the following conditions must be prior authorized:

1. A non-preferred Beta Blocker. See the Preferred Drug List (PDL) for the list of preferred Beta Blockers at: https://papdl.com/preferred-drug-list.

2. A Beta Blocker 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 Beta Blocker when there is a record of a recent paid claim for another Beta Blocker in the Department of Human Services' Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

4. A prescription for Hemangeol (propranolol hydrochloride oral solution).

B. Review of Documentation for Medical Necessity

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

1. For Hemangeol (propranolol hydrochloride oral solution), **all** of the following:

   a. Is prescribed Hemangeol (propranolol hydrochloride oral solution) for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling,
   b. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   c. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   d. Is prescribed Hemangeol (propranolol hydrochloride oral solution) by or in consultation with an appropriate specialist (e.g., pediatric dermatologist, hematologist, or oncologist);

   AND

2. For a non-preferred Beta Blocker, has a history of therapeutic failure, contraindication, or intolerance of the preferred Beta Blockers approved or medically accepted for the beneficiary's diagnosis; **AND**

3. For therapeutic duplication, **one** of the following:

a. Is being titrated to or tapered from a drug in the same class
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 Beta Blocker 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.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR HEMANGEOL (PROPRANOLOL HYDROCHLORIDE ORAL SOLUTION): The determination of medical necessity of a request for renewal of a prior authorization for Hemangeol (propranolol hydrochloride oral solution) that was previously approved will take into account whether the beneficiary:

1. Has documentation of improvement in disease severity since initiating treatment with Hemangeol (propranolol hydrochloride oral solution); **AND**

2. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed Hemangeol (propranolol hydrochloride oral solution) by or in consultation with an appropriate specialist (e.g., pediatric dermatologist, hematologist, or oncologist).

   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 Beta Blocker. 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. References

1. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure: executive summary: a report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines. Circulation 2013; 128:1810.
2. Hemangeol [package insert]. Parsippany, NJ. Pierre Fabre Pharmaceuticals, Inc. January 2015.
3. Krowchuk DP, Frieden IJ, Mancini AJ, et al. Clinical Practice Guideline for the Management of Infantile Hemangiomas. Pediatrics 2019;143.