pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
September 3, 2019	January 1, 2020	*See below

SUBJECT

Prior Authorization of Intranasal Rhinitis Agents – 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 Intranasal Rhinitis Agents 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 Intranasal Rhinitis Agents 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:

*01-19-62	09-19-58	27-19-56	
02-19-56	11-19-55	30-19-54	
03-19-55	14-19-54	31-19-61	
08-19-64	24-19-56	32-19-54	33-19-58

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 the following revisions to the guidelines to determine medical necessity of Intranasal Rhinitis Agents:

- Addition of a guideline to require a medical necessity determination for prescriptions that exceed the quantity limits established by the Department;
- Addition of a guideline to require a medical necessity determination for therapeutic duplication of two or more concomitant prescriptions for Intranasal Rhinitis Agents with the same mechanism of action; and
- Addition of an exemption from prior authorization for triamcinolone acetonide nasal spray for beneficiaries under four years of age.

The revisions to the guidelines to determine medical necessity of Intranasal Rhinitis Agents, 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 Intranasal Rhinitis Agents 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 Intranasal Rhinitis Agents) 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

I. Requirements for Prior Authorization of Intranasal Rhinitis Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Intranasal Rhinitis Agents that meet the following conditions must be prior authorized:

1. A non-preferred Intranasal Rhinitis Agent. See the Preferred Drug List (PDL) for the list of preferred Intranasal Rhinitis Agents at: https://papdl.com/preferred-drug-list.

2. An Intranasal Rhinitis Agent 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.

3. An Intranasal Rhinitis Agent containing an antihistamine when there is a record of a recent paid claim for another Intranasal Rhinitis Agent containing an antihistamine in the Department's Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

4. An Intranasal Rhinitis Agent containing a steroid when there is a record of a recent paid claim for another Intranasal Rhinitis Agent containing a steroid in the Department's Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

EXEMPTION FROM PRIOR AUTHORIZATION: Triamcinolone acetonide nasal spray is exempt from prior authorization when prescribed for a child under four (4) years of age.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Intranasal Rhinitis Agent, has a history of therapeutic failure, contraindication, or intolerance of the preferred Intranasal Rhinitis Agents with the same mechanism of action; **AND**

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

   a. Is being titrated to or tapered from another Intranasal Rhinitis Agent containing an agent with the same mechanism of action
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

   AND

3. If a prescription for an Intranasal Rhinitis Agent 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 above but, in the professional judgement 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 Intranasal Rhinitis Agent. 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 a non-preferred Intranasal Rhinitis Agent with a prescribed quantity that does not exceed the quantity limit established by the Department will be automatically approved when the Point-of-Sale On-Line Claims Adjudication System verifies a record of a paid claim(s) within 365 days prior to the date of service that documents that the guidelines to determine medical necessity listed in Section B. have been met.