# Clinical Policy: Fluoroquinolones, Oral

Reference Number: PHW.PDL.028
Effective Date: 01/01/2020
Last Review Date: 11/2023

Revision Log

**Policy/Criteria**
*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of PA Health and Wellness® that Oral Fluoroquinolones are **medically necessary** when the following criteria are met:

## I. Requirements for Prior Authorization of Fluoroquinolones, Oral

A. Prescriptions That Require Prior Authorization

All prescriptions for a non-preferred Fluoroquinolone, Oral must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Fluoroquinolone, Oral, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. **One** of the following:

    a. Has a history of therapeutic failure, intolerance, or contraindication to the preferred Fluoroquinolones, Oral approved or medically accepted for the beneficiary's diagnosis
    b. Has culture and sensitivity test results documenting that only non-preferred Fluoroquinolones, Oral will be effective.

    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 a non-preferred Fluoroquinolone, Oral. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization requestwill 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. **Approval Duration: 6 months**

| Reviews, Revisions, and Approvals | Date |
|---|---|
| Policy created | 01/01/2020 |
| Q3 2020 annual review: no changes. | 07/2020 |
| Q1 2021 annual review: no changes. | 01/2021 |
| Q1 2022 annual review: no changes. | 11/2021 |
| Q1 2023 annual review: no changes. | 11/2022 |
| Q1 2024 annual review: no changes. | 11/2023 |