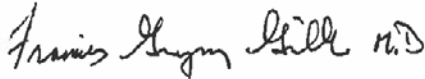


**Prior Authorization Review Panel**

**CHC-MCO Policy Submission**

A separate copy of this form must accompany each policy submitted for review.  
Policies submitted without this form will not be considered for review.

<b>Plan: PA Health &amp; Wellness</b>	<b>Submission Date: N/A</b>
<b>Policy Number: PHW.PDL.108</b>	<b>Effective Date: 01/01/2020</b> <b>Revision Date: 07/2020</b>
<b>Policy Name: Pancreatic Enzymes</b>	
<p><b>Type of Submission – <u>Check all that apply:</u></b></p> <p> <input type="checkbox"/> New Policy  <input type="checkbox"/> Revised Policy*  <input checked="" type="checkbox"/> Annual Review - No Revisions  <input checked="" type="checkbox"/> Statewide PDL - <i>Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.</i> </p>	
<p><b>*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.</b></p> <p><b>Please provide any changes or clarifying information for the policy below:</b></p> <p>Q3 2020 annual review: no changes.</p>	
<b>Name of Authorized Individual (Please type or print):</b>  Francis G. Grillo, MD	<b>Signature of Authorized Individual:</b>  

## Clinical Policy: Pancreatic Enzymes

Reference Number: PHW.PDL.108

Effective Date: 01/01/2020

Last Review Date: 07/2020

[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 health plans affiliated with PA Health and Wellness® that Pancreatic Enzymes are **medically necessary** when the following criteria are met:

### I. Requirements for Prior Authorization of Pancreatic Enzymes

#### A. Prescriptions That Require Prior Authorization

All prescriptions for non-preferred Pancreatic Enzymes 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 Pancreatic Enzyme, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Has **one** of the following:

- a. A documented history of therapeutic failure, contraindication, or intolerance of the preferred Pancreatic Enzymes
- b. A current history (within the past 90 days) of being prescribed the same non-preferred Pancreatic Enzyme.

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 non-preferred Pancreatic Enzyme. 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. **Approval Duration:** 12 months

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020