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.

Plan: PA Health & Wellness	**Submission Date: 11/2020**
Policy Number: PHW.PDL.059	**Effective Date: 01/05/2021** **Revision Date: 11/2020**
Policy Name: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ✓ **Statewide PDL** - *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q1 2021: policy revised according to DHS revisions effective 01/05/2021.

Name of Authorized Individual (Please type or print): **Auren Weinberg, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Reference Number: PHW.PDL.059
Effective Date: 01/01/2020
Last Review Date: 11/2020

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 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) is **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

A. Prescriptions That Require Prior Authorization

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

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

2. A prescription for oral or nasal ketorolac when more than a 5-day supply is prescribed in the past 90 days.

3. An NSAID with a prescribed quantity that exceeds the quantity limit.

4. An NSAID when there is a record of a recent paid claim for another NSAID (therapeutic duplication).

B. Review of Documentation for Medical Necessity

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

1. For oral or nasal ketorolac, **all** of the following:

   a. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

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

c. Is not concomitantly taking aspirin or any other NSAIDs;

AND

2. For a non-preferred NSAID, has a history of therapeutic failure, contraindication, or intolerance of the preferred NSAIDs (excluding ketorolac) with the same route of administration; **AND**

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

   a. Is being transitioned to another drug in the same class with the intent of discontinuing one of the medications
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

4. In addition**,** if a prescription for an NSAID is in 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 PA.CP.PMN.59 Quantity Limit Override.

   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 an NSAID. 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**

E. References

1. Ketorolac tromethamine tablets prescribing information. Teva Pharmaceuticals USA, Inc., North Wales, PA; July 2015.
2. Sprix (ketorolac tromethamine) Nasal Spray prescribing information. Egalet US Inc. Wayne, PA; January 2018.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021.	11/2020