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: N/A**
Policy Number: PHW.PDL.070	**Effective Date: 01/01/2020** **Revision Date: 01/2021**
Policy Name: Beta Blockers	

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 annual review: no changes.

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

Clinical Policy: Beta Blockers

Reference Number: PHW.PDL.070
Effective Date: 01/01/2020
Last Review Date: 01/2021

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 Beta Blockers are **medically necessary** when the following criteria are met:

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.

2. A Beta Blocker with a prescribed quantity that exceeds the quantity limit.

3. A Beta Blocker when there is a record of a recent paid claim for another Beta Blocker (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 clinical 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 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.

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. **Approval Duration: 12 months**

E. 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.

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