


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.114	Effective Date: 01/01/2020 Revision Date: 01/2021
Policy Name: Antibiotics, Topical	
<p>Type of Submission – <u>Check all that apply:</u></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>*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.</p> <p>Please provide any changes or clarifying information for the policy below:</p> <p>Q1 2021 annual review: no changes.</p>	
<p>Name of Authorized Individual (Please type or print):</p> <p>Auren Weinberg, MD</p>	<p>Signature of Authorized Individual:</p> 

Clinical Policy: Antibiotics, Topical

Reference Number: PHW.PDL.114

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 Topical Antibiotics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antibiotics, Topical (formerly Impetigo Agents, Topical)

A. Prescriptions That Require Prior Authorization

Prescriptions for Antibiotics, Topical that meet the following conditions must be prior authorized.

1. A prescription for a non-preferred Antibiotic, Topical.

B. Review of Documentation for Medical Necessity

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

1. Has a documented history of therapeutic failure, a contraindication to or intolerance of the preferred products

OR

2. 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 recipient.

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 the request for a prescription for a non-preferred Antibiotic, Topical. 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 recipient.

D. Approval Duration:

- **New request: duration of request or 6 months (whichever is less)**
- **Renewal request: duration of request or 12 months (whichever is less)**

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