


**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.240</b>	<b>Effective Date: 01/01/2020</b> <b>Revision Date: 01/2021</b>
<b>Policy Name: Antibiotics, Inhaled</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>Q1 2021 annual review: no changes.</p>	
<p><b>Name of Authorized Individual (Please type or print):</b></p> <p><b>Auren Weinberg, MD</b></p>	<p><b>Signature of Authorized Individual:</b></p> 

## Clinical Policy: Antibiotics, Inhaled

Reference Number: PHW.PDL.240

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<sup>®</sup> that Inhaled Antibiotics are **medically necessary** when the following criteria are met:

### I. Requirements for Prior Authorization of Antibiotics, Inhaled

#### A. Prescriptions That Require Prior Authorization

Prescriptions for Antibiotics, Inhaled that meet any of the following conditions must be prior authorized:

1. A non-preferred Antibiotic, Inhaled.
2. An Antibiotic, Inhaled with a prescribed quantity that exceeds the quantity limit.

#### B. Review of Documentation for Medical Necessity

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

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. 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**
4. For a non-preferred Antibiotic, Inhaled, **one** of the following:
  - a. Has a history of therapeutic failure, contraindication, or intolerance to the preferred Antibiotics, Inhaled approved for the beneficiary's diagnosis

- b. Has culture and sensitivity test results that document that only a non-preferred Antibiotic, Inhaled will be effective;

**AND**

- 5. If a prescription for an Antibiotic, Inhaled 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 Antibiotic, Inhaled. 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:

- o **New request: 6 months**
- o **Renewal request: 12 months**

<b>Reviews, Revisions, and Approvals</b>	<b>Date</b>
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021