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.707	**Effective Date: 01/01/2020** **Revision Date: 01/2021**
Policy Name: Thalidomide and Derivatives	

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: Thalidomide and Derivatives

Reference Number: PHW.PDL.707
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 Bone Density Regulators are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Thalidomide and Derivatives

A. Prescriptions That Require Prior Authorization

All prescriptions for Thalidomide and Derivatives must be prior authorized.

B. Review of Documentation for Medical Necessity

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

1. Is prescribed the Thalidomide and Derivative by or in consultation with an appropriate specialist (i.e., hematologist/oncologist); **AND**

2. Is prescribed the Thalidomide and Derivative for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **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 Thalidomide and Derivative**, one** of the following:

   a. Has a documented history of therapeutic failure, contraindication, or intolerance to the preferred Thalidomide and Derivatives approved or medically accepted for the beneficiary's diagnosis
   b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Thalidomide and Derivative

   AND

5. If a prescription for a Thalidomide and Derivative 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 above but, in the professional judgement 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 PRESCRIPITONS FOR THALIDOMIDE AND DERIVATIVES: The determination of medical necessity of a request for prior authorization for a Thalidomide and Derivative that was previously approved will take into account whether the beneficiary:

1. Has documentation from the prescriber of tolerability and a positive clinical response to the medication; **AND**

2. Is prescribed the Thalidomide and Derivative by or in consultation with an appropriate specialist (i.e., hematologist/oncologist); **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. If a prescription for a Thalidomide and Derivative 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 a Thalidomide and Derivative. 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:**
- **New Request: 6 months**

- **Renewal Request: 12 months**

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