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: 11/2021**
Policy Number: PHW.PDL.037	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Bronchodilators, Beta Agonists	

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 2022: revised according to DHS revisions effective 01/03/2022

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Bronchodilators, Beta Agonists

Reference Number: PHW.PDL.037
Effective Date: 01/01/2020
Last Review Date: 10/2021

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 Agonist Bronchodilators are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Bronchodilators, Beta Agonists

A. Prescriptions That Require Prior Authorization

Prescriptions for Bronchodilators, Beta Agonists that meet any of the following conditions must be prior authorized:

1. A non-preferred Bronchodilator, Beta Agonist. See the Preferred Drug List (PDL) for the list of preferred Bronchodilators, Beta Agonists at: https://papdl.com/preferred-drug-list.

2. A Bronchodilator, Beta Agonist with a prescribed quantity that exceeds the quantity limit.

3. An inhaled long-acting Bronchodilator, Beta Agonist when there is a record of a recent paid claim for another agent that contains an inhaled long-acting beta agonist (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Bronchodilator, Beta Agonist, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. **One** of the following:

   a. For a non-preferred inhaled short-acting Bronchodilator, Beta Agonist, has a history of therapeutic failure, contraindication, or intolerance of the preferred inhaled short-acting Bronchodilators, Beta Agonists,
   b. For a non-preferred inhaled long-acting Bronchodilator, Beta Agonist, has a history of therapeutic failure, contraindication, or intolerance of the preferred inhaled long-acting Bronchodilators, Beta Agonists,
   c. For a non-preferred oral Bronchodilator, Beta Agonist, has a history of therapeutic failure, contraindication, or intolerance of the preferred inhaled

Bronchodilators, Beta Agonists approved or medically accepted for the member's diagnosis or indication;

AND

2. 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

3. If a prescription for a Bronchodilator, Beta Agonist 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 member 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 member, 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 Bronchodilator, Beta Agonist. 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 member.

D. **Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022: revised according to DHS revisions effective 01/03/2022	10/2021