

## **Clinical Policy: Antianginal Agents**

Reference Number: PHW.PDL.217

Effective Date: 01/01/2020

Last Review Date: 11/2024

### **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 PA Health & Wellness® that Antianginal Agents are **medically necessary** when the following criteria are met:

### **I. Requirements for Prior Authorization of Antianginal Agents**

#### **A. Prescriptions That Require Prior Authorization**

Prescriptions for Antianginal Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Antianginal Agent.
2. An Antianginal Agent 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 Antianginal Agent, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Antianginal Agent, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Antianginal Agents; **AND**
2. If a prescription for an Antianginal Agent 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 an Antianginal Agent. 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
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	11/2021
Q1 2023: policy revised according to DHS revisions effective 01/09/2023.	10/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024