

Clinical Policy: Antibiotics, Topical

Reference Number: PHW.PDL.114

Effective Date: 01/01/2020

Last Review Date: 07/2022

[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 PA Health & Wellness® that Antibiotics, Topical are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antibiotics, 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 an Antibiotic, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. Has a history of therapeutic failure of or a contraindication or an intolerance of the preferred Antibiotic, Topical.

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 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
Updated wording per DHS	07/2022