Clinical Policy: Antiparasitics, Topical

Reference Number: PHW.PDL.122
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 Topical Antiparasitics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antiparasitics, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions for non-preferred Antiparasitics, Topical must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Antiparasitics, Topical at: https://papdl.com/preferred-drug-list

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antiparasitic, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Has a history of therapeutic failure, contraindication, or intolerance of the preferred Antiparasitics, Topical approved for medically accepted for the member's diagnosis.

   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 the request for a prescription for an Antiparasitic, 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 member.

D. **Approval Duration**:

Requests for prior authorization of Antiparasitics, Topical will be approved for a dose and duration of therapy consistent with FDA-approved package labeling.

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: policy revised according to DHS revisions effective 01/03/2022	10/2021
Q1 2023 annual review: no changes.	11/2022
Q3 2023: policy revised according to DHS revisions effective 07/10/2023	07/2023
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025