Clinical Policy: Antiparkinson's Agents

Reference Number: PHW.PDL.015
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 Antiparkinson's Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antiparkinson's Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Antiparkinson's Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Antiparkinson's Agent.

2. An Antiparkinson's 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 a Antiparkinson's Agent, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Antiparkinson's Agent, one of the following:
   a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antiparkinson's Agents;
   b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antiparkinson's Agent (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred);

   AND

2. If a prescription for an Antiparkinson's Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines that are 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 Antiparkinson's 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
Updated wording per DHS	07/2022
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025: policy revised according to DHS revisions effective 01/06/2025.	11/2024
Q1 2026 annual review: no changes.	11/2025