

# **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: 08/01/2022	
Policy Number: PHW.PDL.015	Effective Date: 01/01/2020 Revision Date: 07/2022	
Policy Name: Antiparkinson's Agents		
Type of Submission – <u>Check all that apply</u> :		
<ul> <li>□ New Policy</li> <li>□ Revised Policy*</li> <li>✓ Annual Review - No Revisions</li> <li>✓ Statewide PDL - Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.</li> </ul>		
*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.		
Please provide any changes or clarifying information for the policy below:		
Updated wording per DHS		
Name of Authorized Individual (Please type or print):SVenkateswara R. Davuluri, MD	Signature of Authorized Individual:	



# **Clinical Policy: Antiparkinson's Agents**

Reference Number: PHW.PDL.015 Effective Date: 01/01/2020 Last Review Date: 07/2022

# Policy/Criteria

**Revision Log** 

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<sup>®</sup> 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 beneficiary:

- 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 nonpreferred Antiparkinson's Agent;

## 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 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 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 beneficiary.

## D. Approval Duration: Length of Benefit

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