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.154	**Effective Date: 01/01/2020** **Revision Date: 07/2022**
Policy Name: Antipsoriatics, Oral	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ✓ **Statewide PDL** - *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must 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): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Antipsoriatics, Oral

Reference Number: PHW.PDL.154
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 Oral Antipsoriatics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antipsoriatics, Oral

A. Prescriptions That Require Prior Authorization

A prescription for an Antipsoriatic, Oral that meets any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Antipsoriatic, Oral.

2. A prescription for an Antipsoriatic, Oral with a prescribed quantity that exceeds the quantity limit.

B. Clinical Review Guidelines and Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Antipsoriatic, Oral, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. For a non-preferred Antipsoriatics, Oral, has a history of therapeutic failure of or contraindication or an intolerance to the preferred Antipsoriatics, Oral;

AND

2. If a prescription for Antipsoriatics, Oral 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 the request for a prescription for an Antipsoriatic, Oral. 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 requests: duration of request or 6 months (whichever is less)**
   - **Renewal requests: duration of request or 12 months (whichever is less)**

Reviews, Revisions, and Approvals	Date
Policy created	09/01/2019
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Updated wording per DHS	07/2022