Clinical Policy: BPH (Benign Prostatic Hyperplasia) Treatments

Reference Number: PHW.PDL.003
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 and Wellness® that BPH (Benign Prostatic Hyperplasia) Treatments are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of BPH (Benign Prostatic Hyperplasia) Treatments

A. Prescriptions That Require Prior Authorization

Prescriptions for BPH Treatments that meet any of the following conditions must be prior authorized:

1. A non-preferred BPH Treatment.
2. A BPH Treatment with a prescribed quantity that exceeds the quantity limit.
3. An alpha blocker when there is a record of a recent paid claim for another alpha-blocker (therapeutic duplication).
4. A 5-alpha reductase inhibitor when there is a record of a recent paid claim for another 5- alpha reductase inhibitor (therapeutic duplication).

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred BPH Treatment, has a history of therapeutic failure, contraindication, or intolerance to the preferred BPH Treatments; **AND**

2. For a phosphodiesterase 5 (PDE5) inhibitor (e.g., tadalafil), both of the following**:**

   a. Has a diagnosis of BPH**;**
   b. Is prescribed a dose that is consistent with U.S. Food and Drug Administration-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

AND

3. For therapeutic duplication, **one** of the following:

a. Is being titrated to or tapered from another BPH Treatment with the same mechanism of action
b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed literature or national treatment guidelines;

AND

4. If a prescription for a BPH Treatment 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 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 a BPH Treatment. 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
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
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