Clinical Policy: Glucocorticoids, Oral

Reference Number: PHW.PDL.168
Effective Date: 01/01/2020
Last Review Date: 11/2023

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 Glucocorticoids are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Glucocorticoids, Oral

A. Prescriptions That Require Prior Authorization

Prescriptions for Glucocorticoids, Oral that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Glucocorticoids, Oral, regardless of the quantity prescribed.

2. A prescription for a preferred Glucocorticoid, 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 Glucocorticoid, Oral, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. For a non-preferred Glucocorticoid, Oral, all of the following:

   a. Is prescribed the Glucocorticoid, Oral for a diagnosis that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

   b. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   c. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Glucocorticoids, Oral approved or medically accepted for the beneficiary's diagnosis;

OR

2. In addition, if a prescription for either a preferred or non-preferred Glucocorticoid, 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 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 the request for a prescription for a Glucocorticoid, 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: duration of request or 12 months (whichever is less)**

E. **References**:

1. TARPEYO [package insert]. Stockholm, Sweden: Calliditas Therapeutics AB.; December 2021.
2. Cattran DC, Appel GB, Coppo R. IgA nephropathy: Treatment and prognosis. In: UpToDate [internet database]. Glassock RJ, Fervenza FC, eds. Waltham, MA: UpToDate Inc. Updated July 25,2022. Accessed July 28, 2022.
3. Fellström BC, Barratt J, Cook H, et al. Targeted-release budesonide versus placebo in patients with IgA nephropathy (NEFIGAN): a double-blind, randomized, placebo controlled phase 2b trial. Lancet 2017.

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 2023: policy revised according to DHS revisions effective 01/09/2023.	10/2022
Q1 2024 annual review: no changes.	11/2023