Clinical Policy: H. Pylori Treatments

Reference Number: PHW.PDL.001
Effective Date: 01/01/2020
Last Review Date: 11/2024

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® H. Pylori Treatments are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of H. Pylori Treatments

A. Prescriptions That Require Prior Authorization

All prescriptions for a non-preferred H. Pylori Treatment must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred H. Pylori Treatment, the determination of whether the requested prescription is medically necessary will take into account whether:

1. The H. pylori treatment regimens recommended by the American College of Gastroenterology, taken as the individual components and in the same combination, dose, and frequency, cannot be used by the member because of clinical reasons as documented by the prescriber.

   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 H. Pylori 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: 6 months**

E. **References**

1. Chey WD, Leontiadis GI, Howden CW et al. ACG Clinical Guideline: Treatment of Helicobacter pylori Infection. Gastro 2017; 112:2:212-239.
2. Fallone CA, Chiba N, Van Zanteri et al. The Toronto Consensus for Treatment of Helicobacter pylori infection in Adults. Gastro 2016; 15:51.
3. Crowe SE. Helicobacter pylori Infection. N Engl J Med 2019; 380:1158.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
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