

Clinical Policy: Hypoglycemia Treatments

Reference Number: PHW.PDL.744

Effective Date: 01/05/2021

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 & Wellness[®] that Hypoglycemia Treatments are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Hypoglycemia Treatments

1. Prescriptions That Require Prior Authorization

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

1. A non-preferred Hypoglycemia Treatment. See the Preferred Drug List (PDL) for the list of preferred Hypoglycemia Treatments at: <https://papdl.com/preferred-drug-list>.
2. A Hypoglycemia Treatment 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 Hypoglycemia Treatment, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Hypoglycemia Treatment, cannot use the preferred Hypoglycemia Treatments because of clinical reasons as documented by the prescriber; **AND**
2. If a prescription for a Hypoglycemia 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 Hypoglycemia 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
Q1 2021: policy created according to DHS effective 01/05/2021	11/2020
Q1 2022 annual review: no changes.	10/2021
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 annual review: no changes.	11/2025