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: N/A**
Policy Number: PHW.PDL.062	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Hypoglycemics, Alpha-Glucosidase Inhibitors	

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:

Q1 2022 annual review: no changes.

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Hypoglycemics, Alpha-Glucosidase Inhibitors

Reference Number: PHW.PDL.062
Effective Date: 01/01/2020
Last Review Date: 10/2021

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 health plans affiliated with PA Health and Wellness® that Alpha-Glucosidase Inhibitors are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Hypoglycemics, Alpha-Glucosidase Inhibitors

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, Alpha-Glucosidase Inhibitors that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Hypoglycemic, Alpha-Glucosidase Inhibitor.

2. A prescription for a preferred Hypoglycemic, Alpha-Glucosidase Inhibitor 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 non-preferred Hypoglycemic, Alpha-Glucosidase Inhibitor, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. Has a documented history of therapeutic failure, intolerance, or contraindication of the preferred Hypoglycemics, Alpha-Glucosidase Inhibitors

OR

2. 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 recipient

3. In addition, if a prescription for either a preferred or non-preferred Hypoglycemic, Alpha-Glucosidase Inhibitor 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.

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 Hypoglycemic, Alpha-Glucosidase Inhibitor. 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: 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.	10/2021