Clinical Policy: Hypoglycemics, TZDs

Reference Number: PHW.PDL.009
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 & Wellness® that Thiazolidinedione (TZD) Hypoglycemics is **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Hypoglycemics, TZDs

A. Prescriptions That Require Prior Authorization

Prescriptions for Hypoglycemics, TZDs that meet any of the following conditions must be prior authorized:
1. A non-preferred Hypoglycemic, TZD.

2. A Hypoglycemic, TZD with a prescribed quantity that exceeds the quantity limit.

3. A Hypoglycemic, TZD when there is a record of a recent paid claim for another Hypoglycemic, TZD (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a preferred or non-preferred Hypoglycemics, TZD, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Hypoglycemics, TZD, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Hypoglycemics, TZDs. **AND**

2. For therapeutic duplication, one of the following:
   a. Is being transitioned to or from another Hypoglycemics, TZD with the intent of discontinuing one of the medications,
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines; **AND**

3. If a prescription for a Hypoglycemics, TZD 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 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 Hypoglycemics, TZD. 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 service is 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: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2023: policy revised according to DHS revisions effective 01/09/2023	10/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024