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.019	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Intranasal Rhinitis Agents	

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: Intranasal Rhinitis Agents

Reference Number: PHW.PDL.019
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 Intranasal Rhinitis Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Intranasal Rhinitis Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Intranasal Rhinitis Agents that meet the following conditions must be prior authorized:

1. A non-preferred Intranasal Rhinitis Agent.

2. An Intranasal Rhinitis Agent with a prescribed quantity that exceeds the quantity limit.

3. An Intranasal Rhinitis Agent containing an antihistamine when there is a record of a recent paid claim for another Intranasal Rhinitis Agent containing an antihistamine (therapeutic duplication).

4. An Intranasal Rhinitis Agent containing a steroid when there is a record of a recent paid claim for another Intranasal Rhinitis Agent containing a steroid (therapeutic duplication).

EXEMPTION FROM PRIOR AUTHORIZATION: Triamcinolone acetonide nasal spray is exempt from prior authorization when prescribed for a child under four (4) years of age.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Intranasal Rhinitis Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Intranasal Rhinitis Agent, has a history of therapeutic failure, contraindication, or intolerance of the preferred Intranasal Rhinitis Agents with the same mechanism of action; **AND**

2. For therapeutic duplication, **one** of the following:

   a. Is being titrated to or tapered from another Intranasal Rhinitis Agent containing an agent with the same mechanism of action
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

   AND

3. If a prescription for an Intranasal Rhinitis Agent 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 beneficiary does not meet the clinical review guidelines above but, in the professional judgement 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 a prescription for an Intranasal Rhinitis Agent. 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 beneficiary.

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