

Clinical Policy: Leukotriene Modifiers

Reference Number: PHW.PDL.042

Effective Date: 01/01/2020

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 Leukotriene Modifiers are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Leukotriene Modifiers

A. Prescriptions That Require Prior Authorization

Prescriptions for Leukotriene Modifiers that meet any of the following conditions must be prior authorized:

1. For non-preferred Leukotriene Modifier.
2. A Leukotriene Modifier with a prescribed quantity that exceeds the quantity limit.
3. A Leukotriene Modifier when there is a record of a recent paid claim for another Leukotriene Modifier (therapeutic duplication).

EXEMPTION FROM PRIOR AUTHORIZATION: Montelukast pediatric granules are exempt from prior authorization when prescribed for a child under 2 years of age.

B. Clinical Review Guidelines and Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Leukotriene Modifier, the determination of whether the prescription is medically necessary will take into account whether the member:

1. For a non-preferred Leukotriene Modifiers, has a history of therapeutic failure of or a contraindication or an intolerance of the preferred Leukotriene Modifiers; **AND**
2. For therapeutic duplication, **one** of the following:
 - a. Is being transitioned to or from another Leukotriene Modifiers 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 Leukotriene Modifier 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 the request for a prescription for a Leukotriene Modifier. 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.

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
Q3 2022: Updated wording per DHS	07/2022
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