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.018	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Macrolides	

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: Macrolides

Reference Number: PHW.PDL.018
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 Macrolides are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Macrolides

A. Prescriptions That Require Prior Authorization

All prescriptions for a non-preferred Macrolide must be prior authorized.

B. Review of Documentation for Medical Necessity

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

1. **One** of the following:

   a. Has a history of therapeutic failure, intolerance, or contraindication to the preferred Macrolides approved or medically accepted for the beneficiary's diagnosis
   b. Has culture and sensitivity test results documenting that only non-preferred Macrolide will be effective.

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 a non-preferred Macrolide~~/Ketolide~~. 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: 6 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