Clinical Policy: Macrolides

Reference Number: PHW.PDL.018
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 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 member:

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 member's diagnosis
    b. Has culture and sensitivity test results documenting that only non-preferred Macrolide will be effective.

NOTE: If the member 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 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 non-preferred Macrolide. 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.

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	11/2021
Q1 2023 annual review: no changes	11/2022
Q1 2024 annual review: no changes	11/2023
Q1 2025 annual review: no changes	11/2024