Clinical Policy: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Reference Number: PHW.PDL.059
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 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) is **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

A. Prescriptions That Require Prior Authorization

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

1. A non-preferred NSAID.

2. A prescription for oral or nasal ketorolac when more than a 5-day supply is prescribed in the past 90 days.

3. An NSAID with a prescribed quantity that exceeds the quantity limit.

4. An NSAID when there is a record of a recent paid claim for another NSAID (therapeutic duplication).

B. Review of Documentation for Medical Necessity

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

1. For oral or nasal ketorolac, **all** of the following:

   a. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   b. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   c. Is not concurrently taking aspirin or any other NSAIDs;

AND

2. For a non-preferred NSAID, **one** of the following:
   a. **Both** of the following:
      i. For a non-preferred oral NSAID, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred oral NSAIDs (excluding ketorolac),
      ii. For a non-preferred oral NSAID combination drug with more than one active ingredient (e.g., Duexis, Vimovo, etc.), has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently,
   b. For a non-preferred topical NSAID, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred topical NSAIDs,
   c. For non-preferred nasal ketorolac, has a clinical reason as documented by the prescriber why oral ketorolac cannot be used,
   d. For all other non-preferred non-oral NSAIDs, **one** of the following:
      i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred NSAIDs,
      ii. Has a clinical reason as documented by the prescriber why the routes of administration of the preferred NSAIDs cannot be used; **AND**

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

   a. Is being transitioned to another drug in the same class with the intent of discontinuing one of the medications
   b. Has a medical reason for concurrent use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

4. In addition**,** if a prescription for an NSAID 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 an NSAID. 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: 12 months**

E. References

1. Duexis Package Insert. Deerfield, IL: Horizon Medicines LLC.; April 2021.
2. Ketorolac tromethamine tablets Package Insert. Parsippany, NJ: Teva Pharmaceuticals; July 2021.
3. Sprix (ketorolac tromethamine) Nasal Spray Package Insert. Wayne, PA: Zyla Life Sciences US Inc. April 2021.
4. Vimovo Package Insert. Deerfield, IL; Horizon Medicines, LLC.; March 2022.

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
Q1 2026 annual review: no changes.	11/2025