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: 09/01/2019**
Policy Number: PHW.PDL.059	**Effective Date: 01/01/2020** **Revision Date: 09/01/2019**
Policy Name: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	

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:

New Policy created.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:**

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

Reference Number: PHW.PDL.059
Effective Date: 01/01/2020
Last Review Date: 09/01/2019

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 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, regardless of the quantity prescribed.

2. A preferred NSAID with a prescribed quantity that exceeds the quantity limit.

3. 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 a non-preferred NSAID, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For oral ketorolac (Toradol) – Whether the beneficiary:

   a. Is being prescribed ketorolac for ≤5 days in a 90 day period

      AND

   b. Is being prescribed oral Ketorolac in a dose not to exceed 40 mg in a 24 hour period

      AND

   c. Is at least sixteen (16) years of age or older

AND

d. Is not taking aspirin or any other NSAIDs.

2. For nasal ketorolac (Sprix) – Whether the beneficiary:

   a. Has a history of therapeutic failure, intolerance, or contraindication to oral ketorolac

   AND

   b. Is being prescribed ketorolac for ≤ 5 days in a 90 day period

   AND

   c. Is being prescribed nasal ketorolac in a dose not to exceed the following:

      i. For beneficiaries < 65 years of age, 126 mg/day
      ii. For beneficiaries ≥ 65 years of age, or who weigh less than 50 kg, or who are renally impaired, 63 mg/day

   AND

   d. Is at least eighteen (18) years of age or older

   AND

   e. Is not taking aspirin or any other NSAIDs.

3. For injectable ketorolac (Toradol) – Whether the beneficiary:

   a. Is being prescribed ketorolac for ≤ 5 days in a 90 day period

   AND

   b. Is not being prescribed ketorolac for self-administration

   AND

   c. Has a dosage that is limited to a single injectable dose if the beneficiary is a child age 2 years to 16 years

   AND

   d. Is not taking aspirin or any other NSAIDs.

4. For Topical NSAIDs – Whether the beneficiary has a documented history of:

    a. Therapeutic failure of at least two (2) preferred oral generic NSAIDs, contraindication, or intolerance of the preferred oral generic NSAIDs

    AND

    b. Support for the transdermal formulation as the medically necessary route of administration

    AND

    c. Therapeutic failure or contraindication of the preferred topical NSAID analgesic.

5. For all other non-preferred NSAIDs, whether the beneficiary has a history of therapeutic failure, intolerance, or contraindication to the preferred NSAIDs.

6. For therapeutic duplication, whether:

    a. The beneficiary is being titrated to, or tapered from, a drug in the same class

    OR

    b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested.

7. In addition**,** if a prescription for either a preferred or non-preferred 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: As described in Section C, if the beneficiary does not meet the clinical review guidelines and/or the quantity limit guidelines listed above, but in the professional judgment 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 NSAID. For all prescriptions for NSAIDs that require prior authorization, if the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. In any of the applicable 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