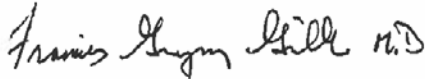


Prior Authorization Review Panel

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.122	Effective Date: 01/01/2020 Revision Date: 09/01/2019
Policy Name: Antiparasitics, Topical	
<p>Type of Submission – <u>Check all that apply:</u></p> <p> <input type="checkbox"/> New Policy <input type="checkbox"/> Revised Policy* <input type="checkbox"/> Annual Review - No Revisions <input checked="" type="checkbox"/> Statewide PDL - <i>Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.</i> </p>	
<p>*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.</p> <p>Please provide any changes or clarifying information for the policy below:</p> <p style="text-align: center;">New Policy created.</p>	
Name of Authorized Individual (Please type or print):	Signature of Authorized Individual:
Francis G. Grillo, MD	

Clinical Policy: Antiparasitics, Topical

Reference Number: PHW.PDL.122

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 Topical Antiparasitics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antiparasitics, Topical

A. Prescriptions That Require Prior Authorization

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

1. All prescriptions for non-preferred Antiparasitics, Topical.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Antiparasitic, Topical, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred product(s)

AND

2. For Lindane:

- a. Has a documented history of therapeutic failure, contraindication, or intolerance of each of the preferred products

AND

- b. Weighs \geq 50 pounds

AND

- c. Does not take medication that may reduce the seizure threshold (such as but not limited to; Meperidine, Cyclosporine, Theophylline)

OR

3. Does not meet the clinical review guidelines listed above, but in the professional judgment of the physician reviewer, the therapy is medically necessary to meet the medical needs of the recipient

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 an Antiparasitic, Topical. 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 recipient.

D. **Approval Duration:**

PA Health & Wellness will limit authorization to the U.S. Food and Drug Administration (FDA) maximum recommended therapeutic dose and duration for the Antiparasitic, Topical.

E. References:

1. Lindane Lotion/Shampoo [package insert]. Livonia, MI: Major; 2003
2. Eurax [package insert]. Buffalo, NY: Bristol Myers Squibb; May 1991
3. Permethrin Cream [package insert]. Bronx, NY: Clay-Park Labs; October 2002
4. Nix Lice Treatment [package insert]. New York, NY: Pfizer Consumer; 2003
5. Ovide Lotion [package insert]. Hawthorne, NY: TaroPharma U.S.A.,Inc.; 2005
6. Frankowski BL, Weiner LB, American Academy of Pediatrics. Head Lice. Pediatrics. 2002; 110:638-643.
7. Lebwohl M, Clark L, Levitt J. Therapy for head lice based on life cycle, resistance, and safety considerations. Pediatrics. 2007;119(5):965-974.
8. Rauch AE, Kowalsky SF, Lesar TS, Sauerbier GA et al. Lindane(Kwell)-induced aplastic anemia. Arch Intern Med. 1990 Nov;150(11):2393-5.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020