Clinical Policy: Pancreatic Enzymes

Reference Number: PHW.PDL.108
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 and Wellness® that Pancreatic Enzymes are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Pancreatic Enzymes

A. Prescriptions That Require Prior Authorization

All prescriptions for non-preferred Pancreatic Enzymes 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 Pancreatic Enzyme, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Has **one** of the following:

   a. A documented history of therapeutic failure, contraindication, or intolerance of the preferred Pancreatic Enzymes
   b. A current history (within the past 90 days) of being prescribed the same non-preferred Pancreatic Enzyme (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred).

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 a non-preferred Pancreatic Enzyme. 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**

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: policy revised according to DHS revisions effective 01/06/2025.	11/2024
Q1 2026 annual review: no changes.	11/2025