Gateway Health It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Anticonvulsants

A. Prescriptions That Require Prior Authorization

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

1. A non-preferred Anticonvulsant. See the Preferred Drug List (PDL) for the list of preferred Anticonvulsants at: https://papdl.com/preferred-drug-list.

2. A prescription for a gabapentinoid (e.g., gabapentin, pregabalin) when there is a record of a recent paid claim for another gabapentinoid (therapeutic duplication).

3. A prescription for clonazepam when prescribed for a beneficiary under 21 years of age.

4. A prescription for clonazepam when there is a record of a recent paid claim for another benzodiazepine (excluding clobazam and benzodiazepines indicated for the acute treatment of increased seizure activity [e.g., rectal and nasal formulations])(therapeutic duplication).

5. A prescription for a clonazepam when there is a record of 2 or more paid claims for any benzodiazepine (excluding clobazam and benzodiazepines indicated for the acute treatment of increased seizure activity [e.g., rectal and nasal formulations]) within the past 30 days.

6. A prescription for clonazepam when a beneficiary has a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Anticonvulsant, **one** of the following:

   a. Has a current history (within the past 90 days) of being prescribed the same non-preferred Anticonvulsant (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)

   b. **All** of the following:

      i. Has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Anticonvulsants approved or medically accepted for the beneficiary's diagnosis (therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred)

ii. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

iii. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

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

AND

2. For clonazepam, **all** of the following:

   a. For a beneficiary under 21 years of age, **one** of the following:

      i. Has a diagnosis of **one** of the following:

         a) Seizure disorder,
         b) Chemotherapy induced nausea and vomiting,
         c) Cerebral palsy,
         d) Spastic disorder,
         e) Dystonia,
         f) Catatonia

      ii. Is receiving palliative care,

   b. For a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder, **both** of the following:

      i. Is prescribed the buprenorphine agent and clonazepam by the same prescriber or, if prescribed by different prescribers, all prescribers are aware of the other prescription(s)
      ii. Has an acute need for therapy with clonazepam,

   c. For therapeutic duplication of clonazepam with another benzodiazepine, **one** of the following:

      i. Is being titrated to or tapered from another benzodiazepine
      ii. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines,

   d. When there is a record of 2 or more paid claims for any benzodiazepine, **both** of the following:

      i. The multiple prescriptions are consistent with medically accepted prescribing practices and standards of care, including support from peer-reviewed medical literature or national treatment guidelines
      ii. The multiple prescriptions are written by the same prescriber or, if written by different prescribers, all prescribers are aware of the other prescription(s),

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e. **One** of the following:

i. Meets the guidelines in B.2.a.
ii. Has documentation that the prescriber or the prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the beneficiary's controlled substance prescription history;

AND

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

a. Is being titrated to or tapered from another gabapentinoid
b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines;

NOTE: If the beneficiary 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 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 an Anticonvulsant. 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 beneficiary.

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BENZODIAZEPINES PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Benzodiazepine requested:	Strength:	Dosage form (capsule, tablet, etc.):	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
If the requested benzodiazepine is non-preferred, did the beneficiary try and fail the preferred benzodiazepines approved or medically accepted for the treatment of their condition? *Refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred drugs.*		☐Yes – *Submit documentation.* ☐No	
Was a search of the Prescription Drug Monitoring Program (PDMP) completed by the prescribing office?		☐Yes ☐No	

Benzodiazepines (preferred and non-preferred) require prior authorization in the scenarios listed below. Check all options that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each.

☐The beneficiary is under 21 years of age and:
- ☐Has a diagnosis of: ☐seizure disorder ☐chemo-induced nausea/vomiting ☐cerebral palsy ☐spastic disorder ☐dystonia ☐catatonia
- ☐Is receiving palliative care
- ☐Does not have one of the diagnoses listed above and is not receiving palliative care and:
  - ☐Use of the requested benzodiazepine for a person <21 years of age is supported by national treatment guidelines or medical literature
  - ☐The beneficiary has tried other treatments for their condition – list: _____

☐The beneficiary is taking 2 or more different benzodiazepines concurrently (therapeutic duplication) and:
- ☐Concomitant use of the benzodiazepines is supported by national treatment guidelines or medical literature
- ☐Is being titrated to or tapered from one of the benzodiazepines

☐The beneficiary filled 2 or more prescriptions for any benzodiazepine in the past 30 days and:
- ☐The prescriptions are for the same benzodiazepine, strength, and directions
  - ☐Each prescription was filled for <30 days' supply
  - ☐Other reason for filling >1 benzodiazepine prescription in the past 30 days – specify: _____
- ☐The prescriptions were prescribed by the same prescriber
- ☐The prescriptions were prescribed by different prescribers
  - ☐All prescribers are aware of the other benzodiazepine prescriptions
- ☐The multiple prescriptions are consistent with medically accepted prescribing practices and standards of care

☐The beneficiary has a concurrent prescription for another controlled substance and:
- ☐The prescriptions were prescribed by the same prescriber
- ☐The prescriptions were prescribed by different prescribers
  - ☐All prescribers are aware of the other prescriptions
- ☐Has an acute need for the requested benzodiazepine – specify: _____

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date:

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NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM *(form effective 01/01/20)*

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

Please refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:		Dosage form:	Strength:
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Has the beneficiary taken the requested non-preferred medication in the past 90 days? *(submit documentation)*…… ☐Yes ☐No

Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. *Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.*

☐Treatment failure or inadequate response with preferred medication(s) *(include drug name, dose, and start/stop dates)*:

_____

_____

☐Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Contraindication to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Unique clinical or age-specific indications supported by FDA approval or medical literature *(describe)*:

_____

_____

☐Absence of preferred medication(s) with appropriate formulation *(list medical reason formulation is required)*:

_____

_____

☐Drug-drug interaction with preferred medication(s) *(describe)*:

_____

_____

☐Other medical reason(s) the beneficiary cannot use the preferred medication(s) *(describe)*:

_____

_____

☐For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: