

I. Requirements for Prior Authorization of Antiparasitics, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions for a non-preferred Antiparasitic, Topical must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Antiparasitics, Topical at:
<https://papdl.com/preferred-drug-list>.

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 beneficiary:

1. For lindane, **all of the following:**

- a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antiparasitics, Topical approved or medically accepted for the beneficiary's diagnosis,
- b. Weighs ≥ 50 kilograms,
- c. Does not take medication that may reduce the seizure threshold (such as but not limited to meperidine, cyclosporine, theophylline)

AND

- 2. For all other non-preferred Antiparasitic, Topicals, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antiparasitics, Topical approved or medically accepted for the beneficiary's diagnosis.

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 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. Dose and Duration of Therapy

Requests for prior authorization of Antiparasitics, Topical will be approved for a dose and duration of therapy consistent with FDA-approved package labeling.

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

<input type="checkbox"/> New request <input type="checkbox"/> 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:	
Medication will be billed via: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medical (Jcode: _____)			Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's Office <input type="checkbox"/> Home <input type="checkbox"/> Other	

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 <i>(submit documentation)</i> :		Dx code <i>(required)</i> :	
Has the beneficiary taken the requested non-preferred medication in the past 90 days? <i>(submit documentation)</i> <input type="checkbox"/> Yes <input type="checkbox"/> 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.			
<input type="checkbox"/> Treatment failure or inadequate response with preferred medication(s) <i>(include drug name, dose, and start/stop dates)</i> : <hr/> <hr/>			
<input type="checkbox"/> Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) <i>(include description and drug name(s))</i> : <hr/> <hr/>			
<input type="checkbox"/> Contraindication to preferred medication(s) <i>(include description and drug name(s))</i> : <hr/> <hr/>			
<input type="checkbox"/> Unique clinical or age-specific indications supported by FDA approval or medical literature <i>(describe)</i> : <hr/> <hr/>			
<input type="checkbox"/> Absence of preferred medication(s) with appropriate formulation <i>(list medical reason formulation is required)</i> : <hr/> <hr/>			
<input type="checkbox"/> Drug-drug interaction with preferred medication(s) <i>(describe)</i> : <hr/> <hr/>			
<input type="checkbox"/> Other medical reason(s) the beneficiary cannot use the preferred medication(s) <i>(describe)</i> : <hr/> <hr/>			
<input type="checkbox"/> For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.			

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date:
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