

I. Requirements for Prior Authorization of Antianginal Agents

A. Prescriptions That Require Prior Authorization

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

1. A non-preferred Antianginal Agent. See the Preferred Drug List (PDL) for the list of preferred Antianginal Agents 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 Antianginal Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Antianginal Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antianginal Agents

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 Antianginal Agent. 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.

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.

☐ 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 HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date:
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