Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

Requirements for Prior Authorization of Antipsoriatics, Topical

A. Prescriptions That Require Prior Authorization

Prescriptions for Antipsoriatics, Topical that meet the following conditions must be prior authorized:

1. A non-preferred Antipsoriatic, Topical. See Preferred Drug List (PDL) for the list of preferred Antipsoriatics, Topical at: https://papdl.com/preferred-drug-list.
2. A topical aryl hydrocarbon (AhR) receptor agonist.
3. A topical phosphodiesterase type 4 (PDE4) inhibitor.

B. Review of Documentation for Medical Necessity

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

1. Is prescribed the Antipsoriatic, Topical for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
2. Is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature; **AND**
3. Does not have a contraindication to the prescribed medication; **AND**
4. For a topical AhR agonist, **both** of the following:
   a. Has a history of therapeutic failure of or a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
   b. Has a history of therapeutic failure of or a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis;

   AND
5. For a topical PDE4 inhibitor, **both** of the following:
   a. Has a history of therapeutic failure of or a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the treatment of the beneficiary's diagnosis
   b. Has a history of therapeutic failure of or a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor approved or medically accepted for the treatment of the beneficiary's diagnosis;

   AND
6. For all other non-preferred Antipsoriatics, Topical, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antipsoriatics, Topical approved or medically accepted for the treatment of 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 a prescription for an Antipsoriatic, 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 beneficiary.

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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:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ 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 *(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 HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	**Date**: