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

I. Requirements for Prior Authorization of Methotrexate

A. Prescriptions That Require Prior Authorization

The following prescriptions for Methotrexate require prior authorization:

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

B. Clinical Review Guidelines and Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a nonpreferred Methotrexate, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. Has a documented history of therapeutic failure, a contraindication to or intolerance of the preferred products

OR

2. Does not meet the clinical review guideline listed above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

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 Methotrexate. 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.

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NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM

☐ **FOR ONCOLOGY USE**

☐ New request ☐ Renewal request	# of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	Office NPI:
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 GATEWAY – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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