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

I. Requirements for Prior Authorization of Glucocorticoids, Inhaled

A. Prescriptions That Require Prior Authorization

Prescriptions for Glucocorticoids, Inhaled that meet any of the following conditions must be prior authorized:

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

2. A Glucocorticoid, Inhaled when there is a record of a recent paid claim for another agent that contains an inhaled glucocorticoid in the point-of-sale on-line claims adjudication system (therapeutic duplication).

3. An inhaled long-acting anticholinergic when there is a record of a recent paid claim for another inhaled long-acting anticholinergic in the point-of-sale on-line claims adjudication system (therapeutic duplication).

4. An inhaled long-acting beta agonist when there is a record of a recent paid claim for another agent that contains an inhaled long-acting beta agonist in the point-of-sale on-line claims adjudication system (therapeutic duplication).

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred single-ingredient Glucocorticoid, Inhaled (i.e., a product that contains only one active ingredient), has history of therapeutic failure of or a contraindication or an intolerance to the preferred single-ingredient Glucocorticoids, Inhaled approved or medically accepted for the beneficiary's diagnosis; **AND**

2. For a non-preferred Glucocorticoid, Inhaled combination agent (i.e., a product that contains more than one active ingredient), has history of therapeutic failure of or a contraindication or an intolerance to the preferred Glucocorticoid, Inhaled combination agents approved or medically accepted for the beneficiary's diagnosis; **AND**

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

    a. For an inhaled glucocorticoid, is being titrated to or tapered from another inhaled glucocorticoid,
    b. For an inhaled long-acting anticholinergic, is being titrated to or tapered from another inhaled long-acting anticholinergic,
    c. For an inhaled long-acting beta agonist, is being titrated to or tapered from another inhaled long-acting beta agonist,
    d. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

AND

4. If a prescription for a Glucocorticoid, Inhaled is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account **one** of the following:

   a. The criteria in the Quantity Limits policy

   b. For a Glucocorticoid, Inhaled containing a beta agonist for the treatment of asthma, **both** of the following:

      i. The beneficiary is using the requested drug as part of a therapy that is supported by consensus treatment guidelines (e.g., Single Maintenance and Reliever Therapy [SMART])
      ii. The prescribed dose is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

   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 a Glucocorticoid, Inhaled. 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:

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 WITH SUPPORTING CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: