

I. Requirements for Prior Authorization of Skeletal Muscle Relaxants

A. Prescriptions That Require Prior Authorization

Prescriptions for Skeletal Muscle Relaxants that meet any of the following conditions must be prior authorized:

1. A non-preferred Skeletal Muscle Relaxant. See the Preferred Drug List (PDL) for the list of preferred Skeletal Muscle Relaxants at: <https://papdl.com/preferred-drug-list>.
2. A Skeletal Muscle Relaxant that is subject to the U.S. Drug Enforcement Agency Controlled Substances Act (i.e., controlled substance) when the beneficiary has a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Skeletal Muscle Relaxant, has a history of therapeutic failure, contraindication, or intolerance to the preferred Skeletal Muscle Relaxants approved or medically accepted for the beneficiary's diagnosis; **AND**
2. For a Skeletal Muscle Relaxant that is a controlled substance for a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder, **both** of the following:
 - a. Is prescribed the buprenorphine agent and the Skeletal Muscle Relaxant by the same prescriber or, if prescribed by different prescribers, all prescribers are aware of the other prescription(s)
 - b. Has an acute need for therapy with the Skeletal Muscle Relaxant;**AND**
3. For a Skeletal Muscle Relaxant that is a controlled substance, has documentation that the prescriber or the prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program for the beneficiary's controlled substance prescription history.

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 Skeletal Muscle Relaxant. 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.			
<input type="checkbox"/> Treatment failure or inadequate response with preferred medication(s) <i>(include drug name, dose, and start/stop dates)</i> :			

<input type="checkbox"/> Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) <i>(include description and drug name(s))</i> :			

<input type="checkbox"/> Contraindication to preferred medication(s) <i>(include description and drug name(s))</i> :			

<input type="checkbox"/> Unique clinical or age-specific indications supported by FDA approval or medical literature <i>(describe)</i> :			

<input type="checkbox"/> Absence of preferred medication(s) with appropriate formulation <i>(list medical reason formulation is required)</i> :			

<input type="checkbox"/> Drug-drug interaction with preferred medication(s) <i>(describe)</i> :			

<input type="checkbox"/> Other medical reason(s) the beneficiary cannot use the preferred medication(s) <i>(describe)</i> :			

<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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