Gateway Health
It's Wholecare.

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

# I. Requirements for Prior Authorization of Leukotriene Modifiers

A. Prescriptions That Require Prior Authorization

Prescriptions for Leukotriene Modifiers that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Leukotriene Modifier, regardless of the quantity prescribed. See Preferred Drug List (PDL) for the list of preferred Leukotriene Modifiers at: https://papdl.com/preferred-drug-list.

2. A prescription for a Leukotriene Modifier when there is a record of a recent paid claim for another Leukotriene Modifier (therapeutic duplication)

EXEMPTION FROM PRIOR AUTHORIZATION: Montelukast pediatric granules are exempt from prior authorization when prescribed for a child under 2 years of age.

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

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

1. Has a documented history of therapeutic failure, intolerance, or contraindication of the preferred Leukotriene Modifiers.

**OR**

2. For therapeutic duplication, whether:

   a. The recipient is being titrated to, or tapered from, another Leukotriene Modifier; **OR**
   b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested

**OR**

3. Does not meet the clinical review guidelines 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 a Leukotriene Modifier. 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 *(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 GATEWAY – PHARMACY DIVISION

| | |
|---|---|
| Prescriber Signature: | Date: |