


<b>ISSUE DATE</b> December 5, 2019	<b>EFFECTIVE DATE</b> January 1, 2020	<b>NUMBER</b> *See below
<b>SUBJECT</b>  Prior Authorization of Antidepressants, Other – Pharmacy Services		<b>BY</b>    Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs

**IMPORTANT REMINDER:** All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>.

**PURPOSE:**

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Antidepressants, Other submitted for prior authorization.

**SCOPE:**

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program and providing services in the fee-for-service delivery system. Providers rendering services in the MA managed care delivery system should address any questions related to Antidepressants, Other to the appropriate managed care organization.

**BACKGROUND:**

The Department of Human Services' (Department) Drug Utilization Review (DUR) Board meets semi-annually to review provider prescribing and dispensing practices for efficacy, safety, and quality and to recommend interventions for prescribers and pharmacists

*01-19-98	09-19-94	27-19-93	33-19-95
02-19-92	11-19-91	30-19-90	
03-19-91	14-19-90	31-19-98	
08-19-101	24-19-93	32-19-90	

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

The appropriate toll-free number for your provider type

Visit the Office of Medical Assistance Programs Web site at  
<https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx>.

through the Department's Prospective Drug Use Review and Retrospective Drug Use Review programs.

**DISCUSSION:**

During the September 13, 2019, meeting, the DUR Board recommended the following revisions to the guidelines to determine medical necessity of Antidepressants, Other:

- Addition of guidelines that the beneficiary's diagnosis, age, and prescribed dose and frequency are consistent with FDA-approved labeling or medical literature;
- Addition of a guideline that the beneficiary does not have a history of a contraindication to the prescribed medication;
- Revision of the guidelines for non-preferred Antidepressants, Other;
- Addition of guidelines for Spravato (esketamine); and
- Addition of renewal guidelines.

The revisions to the guidelines to determine medical necessity of Antidepressants, Other, as recommended by the DUR Board, were subject to public review and comment and subsequently approved for implementation by the Department.

**PROCEDURE:**

The procedures for prescribers to request prior authorization of Antidepressants, Other are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Antidepressants, Other) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs that require prior authorization.

**ATTACHMENTS:**

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

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**I. Requirements for Prior Authorization of Antidepressants, Other**

**A. Prescriptions That Require Prior Authorization**

Prescriptions for Antidepressants, Other that meet any of the following conditions must be prior authorized:

1. A non-preferred Antidepressant, Other. See the Preferred Drug List (PDL) for the list of preferred Antidepressants, Other at: <https://papdl.com/preferred-drug-list>.
2. An Antidepressant, Other with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx>.

**B. Review of Documentation for Medical Necessity**

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

1. Is prescribed the Antidepressant, Other 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, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Is prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
4. Does not have a history of a contraindication to the prescribed medication; **AND**
5. For Spravato (esketamine), **all** of the following:
  - a. Is prescribed Spravato (esketamine) by or in consultation with a psychiatrist,
  - b. Has a documented diagnosis of treatment-resistant moderate-to-severe major depressive disorder,
  - c. Is prescribed Spravato (esketamine) in conjunction with a therapeutic dose of an oral antidepressant,
  - d. Does not have severe hepatic impairment (Child-Pugh class C);

**AND**

6. For a non-preferred Antidepressant, Other, **one** of the following:

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- a. At least **two** of the following:
  - i. Has a history of therapeutic failure, contraindication, or intolerance of the preferred Antidepressants, Other approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of  $\geq 6$  weeks,
  - ii. Has a history of therapeutic failure, contraindication, or intolerance of the Antidepressants, SSRIs approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of  $\geq 6$  weeks,
  - iii. Has a history of therapeutic failure, contraindication, or intolerance of augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of  $\geq 6$  weeks;
- b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antidepressant, Other;

**AND**

7. If a prescription for an Antidepressant, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

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.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANTIDEPRESSANTS, OTHER: The determination of medical necessity of a request for renewal of a prior authorization for an Antidepressant, Other that was previously approved will take into account whether the beneficiary:

1. Is prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
2. Does not have a history of a contraindication to the prescribed medication; **AND**
3. For Spravato (esketamine), **all** of the following:
  - a. Is prescribed Spravato (esketamine) by or in consultation with a psychiatrist,
  - b. Is prescribed Spravato (esketamine) in conjunction with a therapeutic dose of an oral antidepressant,
  - c. Has documentation of improvement in disease severity since initiating treatment,
  - d. Does not have severe hepatic impairment (Child-Pugh class C);

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**AND**

4. If a prescription for an Antidepressant, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

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 Antidepressant, Other. 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.