


<b>ISSUE DATE</b>  September 4, 2019	<b>EFFECTIVE DATE</b>  January 1, 2020	<b>NUMBER</b>  *See below
<b>SUBJECT</b>  Prior Authorization of Bronchodilators, Beta Agonists – 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:  
[http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S\\_001994](http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994).

**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 Bronchodilators, Beta Agonists 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 Bronchodilators, Beta Agonists to the appropriate managed care organization.

**BACKGROUND/DISCUSSION:**

The Department of Human Services (Department) is updating the medical necessity guidelines for Bronchodilators, Beta Agonists to allow for the determination of medical

*01-19-49	09-19-45	27-19-43	
02-19-43	11-19-42	30-19-41	
03-19-42	14-19-41	31-19-48	
08-19-51	24-19-43	32-19-41	33-19-45

<p><b>COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:</b></p> <p>The appropriate toll-free number for your provider type</p> <p>Visit the Office of Medical Assistance Programs Web site at  <a href="http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm">http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm</a></p>
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necessity of prescriptions for agents in this class that exceed the quantity limits established by the Department. The Department is also clarifying that therapeutic duplication of Bronchodilators, Beta Agonists is reviewed based on the route of administration and duration of action. Prior authorization for therapeutic duplication of an inhaled long-acting beta-agonist only takes into account whether the beneficiary has one or more recent paid claim(s) for a different inhaled long-acting beta agonist, and prior authorization for therapeutic duplication of an inhaled short-acting beta-agonist only takes into account whether the beneficiary has one or more recent paid claim(s) for a different inhaled short-acting beta-agonist. There are no other changes to the medical necessity guidelines.

The revisions to the guidelines to determine medical necessity of Bronchodilators, Beta Agonists 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 Bronchodilators, Beta Agonists 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 Bronchodilators, Beta Agonists) 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

### **RESOURCES:**

Prior Authorization of Pharmaceutical Services Handbook – SECTION I  
Pharmacy Prior Authorization General Requirements

<http://www.dhs.pa.gov/provider/pharmacyservices/pharmacypriorauthorizationgeneralrequirements/index.htm>

Prior Authorization of Pharmaceutical Services Handbook – SECTION II  
Pharmacy Prior Authorization Guidelines

<http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**I. Requirements for Prior Authorization of Bronchodilators, Beta Agonists**

**A. Prescriptions That Require Prior Authorization**

Prescriptions for Bronchodilators, Beta Agonists that meet any of the following conditions must be prior authorized:

1. A non-preferred Bronchodilator, Beta Agonist. See the Preferred Drug List (PDL) for the list of preferred Bronchodilators, Beta Agonists at: <https://papdl.com/preferred-drug-list>.
2. A Bronchodilator, Beta Agonist 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: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>.
3. A single-ingredient inhaled long-acting Bronchodilator, Beta Agonist.
4. An inhaled long-acting Bronchodilator, 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 Department of Human Services' (Department) Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).
5. An inhaled short-acting Bronchodilator, Beta Agonist when there is a record of a recent paid claim for another agent that contains an inhaled short-acting beta agonist in the Departments' 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 Bronchodilator, Beta Agonist, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. **One** of the following:
  - a. For a non-preferred inhaled short-acting Bronchodilator, Beta Agonist, has a history of therapeutic failure, contraindication, or intolerance of the preferred inhaled short-acting Bronchodilators, Beta Agonists,
  - b. For a non-preferred inhaled long-acting Bronchodilator, Beta Agonist, has a history of therapeutic failure, contraindication, or intolerance of the preferred inhaled long-acting Bronchodilators, Beta Agonists,
  - c. For a non-preferred oral Bronchodilator, Beta Agonist, has a history of therapeutic failure, contraindication, or intolerance of the preferred inhaled Bronchodilators, Beta Agonists approved or medically accepted for the beneficiary's diagnosis or indication;

**AND**

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2. For a single-ingredient inhaled long-acting Bronchodilator, Beta Agonist, **one** of the following:
  - a. Does not have a diagnosis of asthma
  - b. **Both** of the following:
    - i. Has a diagnosis of asthma
    - ii. Has a concomitant prescription for an inhaled steroid;

**AND**

3. For therapeutic duplication, **one** of the following:
  - a. Is being titrated to or tapered from a drug in the same class
  - b. Has a clinical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

**AND**

4. If a prescription for a Bronchodilator, Beta Agonist 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 a Bronchodilator, Beta Agonist. 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.

D. Automated Prior Authorization

Prior authorization of a prescription for a non-preferred inhaled short-acting Bronchodilator, Beta Agonist with a prescribed quantity that does not exceed the quantity limit established by the Department will be automatically approved when the Point-of-Sale On-Line Claims Adjudication System verifies a record of a paid claim(s) within 60 days prior to the date of

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service that documents that the guidelines to determine medical necessity listed in Section B. have been met.

Prior authorization of a prescription for a preferred single-ingredient inhaled long-acting Bronchodilator, Beta Agonist with a prescribed quantity that does not exceed the quantity limit established by the Department will be automatically approved when the Point-of-Sale On-Line Claims Adjudication System verifies a record of a paid claim(s) within 180 days prior to the date of service that documents that the guidelines to determine medical necessity listed in Section B. have been met.