Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 12, 2024	January 6, 2025	*See below

SUBJECT

Prior Authorization of Pancreatic Enzymes – Pharmacy Services

BY

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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.pa.gov/en/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents.html.

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 Pancreatic Enzymes submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Pancreatic Enzymes will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Pancreatic Enzymes to the appropriate managed care organization.

BACKGROUND/DISCUSSION:

The Department of Human Services (Department) is updating the medical necessity guidelines for Pancreatic Enzymes to consider therapeutically equivalent brands and generics when evaluating a request for a non-preferred Pancreatic Enzyme. There are no other changes to the medical necessity guidelines.

The revisions to the guidelines to determine medical necessity of prescriptions for Pancreatic Enzymes

*01-25- 24	09-25-24	27-25-24	33-25-24
02-25-24	11-25-24	30-25-24	
03-25-24	14-25-24	31-25-24	
08-25-25	24-25-24	32-25-24	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/en/agencies/dhs/departments-offices/omap-info.html

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 Pancreatic Enzymes 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 Pancreatic Enzymes) 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 and products 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
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements.html

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/clinical-guidelines.html

I. Requirements for Prior Authorization of Pancreatic Enzymes

A. Prescriptions That Require Prior Authorization

Prescriptions for a non-preferred Pancreatic Enzyme must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Pancreatic Enzymes at: https://papdl.com/preferred-drug-list.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Pancreatic Enzyme, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Has **one** of the following:

    a. A history of therapeutic failure of or a contraindication or an intolerance to the preferred Pancreatic Enzymes
    b. A current history (within the past 90 days) of being prescribed the same non-preferred Pancreatic Enzyme (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred).

    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 non-preferred Pancreatic Enzyme. 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.