Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 13, 2025	January 5, 2026	*See below

SUBJECT

Prior Authorization of Glucocorticoids, Oral – Pharmacy Services

BY

Sally 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.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 Glucocorticoids, Oral 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 Glucocorticoids, Oral 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 Glucocorticoids, Oral to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (Department) Pharmacy and Therapeutics (P&T) Committee reviews published peer-reviewed medical literature and recommends the following:

*01-26-20	09-26-20	27-26-20	33-26-20
02-26-20	11-26-20	30-26-20	
03-26-20	14-26-20	31-26-20	
08-26-20	24-26-20	32-26-20	

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

- Preferred or non-preferred status for new drugs and products in therapeutic classes already included on the Statewide Preferred Drug List (PDL).
- Changes to the statuses of drugs and products on the Statewide PDL from preferred to non-preferred and non-preferred to preferred.
- Therapeutic classes of drugs and products to be added to or deleted from the Statewide PDL.
- New quantity limits.
- New guidelines or revisions to existing guidelines to evaluate the medical necessity of prescriptions submitted for prior authorization.

DISCUSSION:

During the September 24, 2025, meeting, the P&T Committee recommended the following revisions to the medical necessity guidelines for Glucocorticoids, Oral:

- Addition of guidelines for the treatment of eosinophilic esophagitis.
- Addition of guidelines for the treatment of primary immunoglobulin A nephropathy.
- Addition of guidelines for the dose and duration of therapy for requests for Eohilia (budesonide) suspension and Tarpeyo (budesonide delayed-release) capsule.

The revisions to the guidelines to determine medical necessity of prescriptions for Glucocorticoids, Oral submitted for prior authorization, as recommended by the P&T Committee, 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 Glucocorticoids, Oral 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 Glucocorticoids, Oral) 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 Glucocorticoids, Oral

A. Prescriptions That Require Prior Authorization

Prescriptions for Glucocorticoids, Oral that meet any of the following conditions must be prior authorized:

1. A non-preferred Glucocorticoid, Oral. See the Preferred Drug List (PDL) for the list of preferred Glucocorticoids, Oral at: https://papdl.com/preferred-drug-list.

2. A Glucocorticoid, Oral 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.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Glucocorticoid, Oral, **all** of the following:

   a. Is prescribed the Glucocorticoid, Oral for a diagnosis that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

   b. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   c. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Glucocorticoids, Oral approved or medically accepted for the beneficiary's diagnosis,

   d. For a diagnosis of eosinophilic esophagitis, has a history of therapeutic failure of or a contraindication or an intolerance to inhaled fluticasone propionate,

   e. For a diagnosis of primary immunoglobulin A nephropathy (IgAN), **all** of the following:

      i. Has a diagnosis of primary IgAN that is confirmed by a kidney biopsy,
      ii. Is prescribed the requested drug by or in consultation with a nephrologist,

iii. Is at very high risk[1] for progressive disease or already has progressive disease despite at least three to six months of maximally tolerated doses of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker based on current consensus guidelines,
iv. Has an estimated glomerular filtration rate greater than or equal to 35 mL/min/1.73 m^2;

AND

2. If a prescription for a Glucocorticoid, Oral is for 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 Glucocorticoid, Oral. 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. Dose and Duration of Therapy

Requests for prior authorization of Eohilia (budesonide oral suspension) and Tarpeyo (budesonide delayed-release capsules) will be approved for a dose and duration of therapy consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

E. References

1. Bonis PA, Gupta SK. Treatment of eosinophilic esophagitis (EoE). In: UpToDate [internet

[1] In patients with IgAN, patients who present with three or more of the following features are considered to be at very high risk for progressive disease or to already have progressive disease:
- Persistent proteinuria ≥1 g/day on at least two separate tests.
- Persistent moderate microscopic hematuria/hemoglobinuria (arbitrarily defined as 1+ or greater on urine dipstick or >10 red blood cells [RBCs]/high-power field [hpf] on at least two separate tests, in the absence of another possible cause).
- Progressive decline in kidney function (eg, documented or inferred by an estimated glomerular filtration rate [eGFR] <60 mL/min/1.73 m2 or a decrease in eGFR >3 mL/min/1.73 m2 per year) considered to be due to active IgAN.
- Evidence of one or more active lesions on recent kidney biopsy (eg, Oxford classification M1, E1, or C1 or C2 scores [particularly crescents involving >10 percent of glomeruli]) or an S1 lesion with podocyte hypertrophy [6].

database]. Talley NJ, Meyer C, eds. Waltham, MA: UpToDate Inc. Updated June 5,2025. Accessed July 31, 2025.
2. Dellon ES, Muir AB, Katzka DA, et al. ACG Clinical Guideline: Diagnosis and Management of Eosinophilic Esophagitis. The American Journal of Gastroenterology 120(1):p 31-59, January 2025.
3. Cattran DC, Appel GB, Coppo R. IgA nephropathy: Treatment and prognosis. In: UpToDate [internet database]. Glassock RJ, Fervenza FC, eds. Waltham, MA: UpToDate Inc. Updated September 19, 2025. Accessed October 8, 2025.
4. Kidney Disease: Improving Global Outcomes (KDIGO) ADPKD Work Group. KDIGO 2025 Clinical Practice Guideline for the Management of Immunoglobulin A Nephropathy (IgAN) and Immunoglobulin A Vasculitis (IgAV). Kidney Int. 2025;108(4S):S1–S71.