PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
CEPHALOSPORINS

Proposed Effective Date: January 1, 2020

Revisions are noted with a ~~strikethrough~~ for deletions and ~~**bold and underline**~~ for additions.

I. Requirements for Prior Authorization of Cephalosporins ~~and Related Agents (Formerly Cephalosporins)~~

A. Revisions to Prescriptions That Require Prior Authorization

~~Prescriptions for non-preferred Cephalosporins and Related Agents must be prior authorized. See the Preferred Drug List (PDL) for the list of preferred Cephalosporins and Related Agents at: www.providersynergies.com/services/documents/PAM_PDL.pdf~~

All prescriptions for non-preferred Cephalosporins must be prior authorized. See the Preferred Drug List (PDL) for the list of preferred Cephalosporins at: https://papdl.com/preferred-drug-list.

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Cephalosporin ~~and Related Agent~~, the determination of whether the requested prescription is medically necessary will take into account ~~the following~~ **whether the beneficiary**:

1. ~~Whether the recipient~~ **One of the following:**

   a. Has a history of therapeutic failure, intolerance, or contraindication of the preferred Cephalosporins ~~and Related Agents~~ ~~**AND**~~
   b. ~~Whether~~ **Has** culture and sensitivity test results documenting that only non-preferred Cephalosporins ~~and Related Agents~~ will be effective.

   ~~**OR**~~

2. ~~The recipient 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 recipient.~~

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement 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 ~~the request for~~ a prescription for a ~~non-preferred~~ Cephalosporin ~~and Related Agent~~. If ~~any of~~ the guidelines in Section B. ~~is~~ are met, the reviewer will prior authorize the prescription. If ~~none of~~ 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~~ beneficiary.