PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
VAGINAL **ANTI-INFECTIVES**

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 ~~Antibiotics,~~ Vaginal Anti-Infectives

A. Revisions to Prescriptions That Require Prior Authorization

All prescriptions for **a** non-preferred ~~Antibiotics,~~ Vaginal **Anti-Infective** must be prior authorized. ~~See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Antibiotics, Vaginal.~~ **See the Preferred Drug List (PDL) for the list of preferred Vaginal Anti-Infectives 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 ~~Antibiotic,~~ Vaginal **Anti-Infective**, the determination of whether the requested prescription is medically necessary will take into account ~~the following~~ **whether the beneficiary**:

1. ~~Whether the recipient h~~Has a documented history of therapeutic failure, ~~or~~ intolerance, **or contraindication** of the preferred ~~Antibiotics,~~ Vaginal **Anti-Infectives approved or medically accepted for the beneficiary's diagnosis.**

   ~~**OR**~~

2. ~~Whether the recipient does not meet the clinical review guidelines listed in B.1. 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. ~~1.~~ above to assess the medical necessity of ~~the request for~~ a prescription for a ~~non-preferred Antibiotic,~~ Vaginal **Anti-Infective**. If ~~either of~~ the guidelines in Section B ~~1. is~~ **are** met, the reviewer will prior authorize the prescription. If ~~neither of~~ the guidelines ~~is~~ **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**.