



Medical Assistance BULLETIN

ISSUE DATE November 10, 2025	EFFECTIVE DATE January 5, 2026	NUMBER *See below
SUBJECT Prior Authorization of Hepatitis C Agents – 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 Hepatitis C Agents 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 Hepatitis C Agents 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 Hepatitis C Agents 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:

*01-26-22	09-26-22	27-26-22	33-26-22
02-26-22	11-26-22	30-26-22	
03-26-22	14-26-22	31-26-22	
08-26-22	24-26-22	32-26-22	

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 a revision to the medical necessity guidelines for Hepatitis C Agents to add a guideline for the medical necessity determination of non-preferred Hepatitis C Agents other than direct-acting antivirals.

The revisions to the guidelines to determine medical necessity of prescriptions for Hepatitis C Agents 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 Hepatitis C Agents 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 Hepatitis C Agents) 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>

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Hepatitis C Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Hepatitis C Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Hepatitis C Agent. See the Preferred Drug List (PDL) for the list of preferred Hepatitis C Agents at: <https://papdl.com/preferred-drug-list>.
2. A Hepatitis C Agent 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/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits>.
3. A direct-acting antiviral (DAA) Hepatitis C Agent when there is a record of a recent claim for another DAA Hepatitis C Agent in the point-of-sale online claims adjudication system (therapeutic duplication).

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred DAA Hepatitis C Agent, **all** of the following:
 - a. If genotyping is recommended by the American Association for the Study of Liver Diseases (AASLD), has documentation of genotype,
 - b. Is prescribed a drug regimen that is consistent with U.S. Food and Drug Administration (FDA)-approved labeling, nationally recognized compendia, or peer-reviewed medical literature,
 - c. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
 - d. Has a cirrhosis assessment documented by a recent noninvasive test (e.g., blood test or imaging, a Fibroscan, FIB-4 calculation, or findings on physical examination),
 - e. If the beneficiary has received prior treatment(s) for hepatitis C, has documentation of previous hepatitis C treatment regimens,
 - f. If resistance-associated substitution (RAS) testing is recommended by the AASLD, has documentation of recommended RAS testing and is prescribed an AASLD-

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recommended drug regimen based on the documented results of a NS5A RAS screening,

g. **One** of the following:

- i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hepatitis C Agents appropriate for the beneficiary's genotype according to peer-reviewed medical literature
- ii. Is currently receiving treatment with the same non-preferred Hepatitis C Agent (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);

AND

2. For all other non-preferred Hepatitis C Agents, all of the following:

- a. Is being treated for a diagnosis that is indicated in the FDA-approved package labeling OR a medically accepted indication,
- b. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
- c. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
- d. Has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines;

AND

3. For therapeutic duplication, has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed medical literature or national treatment guidelines; **AND**
4. If a prescription for a Hepatitis C Agent 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

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Hepatitis C Agent. 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

Approvals of requests for prior authorization of DAA Hepatitis C Agents will be for the full recommended duration of treatment based on package labeling or consensus treatment guidelines.

E. References

1. AASLD/IDSA/IAS-USA. Recommendations for Testing, Managing, and Treating Hepatitis C. www.hcvguidelines.org. Accessed June 24, 2022.