

PA DEPARTMENT OF HUMAN SERVICES  
MAAC BRIEFING DOCUMENT  
ANTIPARASITICS, TOPICAL

**Proposed Effective Date:** January 5, 2026

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

**I. Requirements for Prior Authorization of Antiparasitics, Topical**

**A. Prescriptions That Require Prior Authorization**

Prescriptions for a non-preferred Antiparasitic, Topical must be prior authorized.

See the Preferred Drug List (PDL) for the list of preferred Antiparasitics, Topical 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 an Antiparasitic, Topical, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

~~1. For lindane, all of the following:~~

- ~~a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antiparasitics, Topical approved or medically accepted for the beneficiary's diagnosis,~~
- ~~b. Weighs  $\geq$ 50 kilograms,~~
- ~~c. Does not take medication that may reduce the seizure threshold (such as but not limited to meperidine, cyclosporine, theophylline)~~

**AND**

- ~~2. For all other non-preferred Antiparasitic, Topicals, h~~**Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antiparasitics, Topical approved or medically accepted for the beneficiary's diagnosis.**

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 the request for a prescription for an Antiparasitic, Topical. 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

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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.

D. Dose and Duration of Therapy

Requests for prior authorization of Antiparasitics, Topical will be approved for a dose and duration of therapy consistent with FDA-approved package labeling.

E. 5 Day Supplies

~~In response to health and safety concerns, the Department of Human Services will not cover a 5-day supply of lindane pending approval of a request for prior authorization.~~