Pharmacy Prior Authorization Policy

This document outlines the policy and procedure for review of requests for coverage of medications subject to prior authorization (PA). This helps ensure Anthem Blue Cross and Blue Shield Medicaid (Anthem) members receive appropriate drug therapy coverage with formulary medications requiring specialized monitoring.

Procedure:

I. Prior authorization: This process is designed to promote prescribing of safe and cost effective medications. PA is required for all non-formulary and/or non-preferred drugs, brand name medications with a generic equivalent, drugs excluded from the pharmacy benefit/plan design, and any drug that exceeds plan limitations for drugs requiring clinical criteria. The health plan requires the use of a preferred generic or therapeutic equivalent alternative as medically necessary (where applicable) prior to approval of non-formulary and/or non-preferred drugs. When or if there has been a failure, contraindication, or intolerance to the specified alternatives, providers must submit a PA request documenting the aforementioned events.

1) The prescriber or pharmacy contacts the Pharmacy Prior Authorization department or pharmacy benefit manager (PBM), where applicable, to request a PA by phone, by fax or via the web (in other words, electronic prior authorization [ePA]). For requests received by phone or fax, a Pharmacy customer care representative will enter the authorization request into the web-based PA system. A pharmacy technician reviews the request to ensure completeness and accuracy of information. The technician then screens the request, following a set of standardized criteria as defined in the clinical drug policy. All data is entered into the web-based PA system.

2) If the request is part of a transition of care plan, the technician provides an immediate override according to the transition of care contract requirements.

3) If the PA request screening indicates the request meets clinical criteria, the coverage request is approved and the provider is notified.

4) The authorization is entered into the pharmacy claims processing system. The authorization takes into consideration all refills that will occur during the time period of the authorization.

5) If the request does not meet criteria or there is a question about the request, it will be forwarded to a clinical pharmacist for further review.

6) If the clinical pharmacist approves the coverage request after review and/or clinical discussion with the prescribing physician, proceed with step three above.

7) If the clinical pharmacist determines the request does not meet coverage criteria after review or after speaking with the provider, the request will be denied by a clinical pharmacist (in states where licensed pharmacist can deny) or sent to a medical director, who will issue the denial.

- **a.** If sent to the health plan medical director and the request is approved, proceed with step three above.
- **b.** If the health plan medical director or pharmacist denies the request, the denial is entered into the web-based PA system. The provider is notified of coverage approvals by fax. The provider is notified of a denial by fax and letter. The member is notified of a denial by letter.

8) If the health plan medical director or clinical pharmacist denies the request, the denial is entered into the web-based PA system. The provider is notified of the determination by both fax and mailed letter. The member is notified of a denial by letter.

9) Coverage denial letters are generated and faxed to the provider within 24 hours. Member and providers will also be sent a denial notification within 24 hours of the case being closed. The denial letter will

AKYPEC-2330-20 February 2020

contain the applicable language regarding the reason for coverage denial, formulary alternatives and appeal/administrative review procedures, and if applicable, state fair hearing forms.

10) PA coverage requests are processed within 24 hours of receipt unless otherwise stated in a specific state contract.

11) If additional clinical information is needed to make a determination, the Pharmacy department will fax the provider, noting the specific information required. If the provider's office has not responded within 24 hours of receipt of the original PA request, the request will be forwarded to a pharmacist for review.

12) The Pharmacy department monitors this turnaround time (TAT) via hourly audit reports.

13) Members and providers shall not be penalized financially or otherwise for PA requests.

14) The health plan does not arbitrarily deny or reduce the amount, duration, or scope of prescription coverage based solely on diagnosis, type of illness, or condition.

15) Telephone requests received outside of normal business hours (Monday through Friday 8 a.m. to 8 p.m. and Saturday 10 a.m. to 2 p.m. ET) are routed to the Nurse Helpline. The 24/7 NurseLine will do the following:

- **a.** Assess urgency of request.
- **b.** If not urgent, have the provider call back during regular business hours.
- **c.** If urgent, the nurse will remind the requesting prescribing physician and/or pharmacist to provide the member with a 72-hour supply of the requested drug. The nurse will then email the request to the Pharmacy department for follow-up during the next business day.
- **d.** If the 24/7 NurseLine nurse is unable to resolve the prescriber/pharmacy's issue or if the prescriber/pharmacy needs additional assistance, the case will be referred to the on-call pharmacy technician. The pharmacy technician will attempt to resolve the issue and document the outcome of the call in the web-based PA system the next business day.
- **e.** If the on-call pharmacy technician is unable to resolve the prescriber/pharmacy's issue or the prescriber/pharmacy needs additional assistance, the case will be referred to the on-call clinical pharmacist. The clinical pharmacist will attempt to resolve the issue and will document the outcome of the call in the web-based PA system the next business day.
- **f.** If the on-call clinical pharmacist is unable to resolve the prescriber/pharmacy's issue or the provider/pharmacy needs additional assistance, the case will be referred to the on-call plan medical director. The medical director will attempt to resolve the issue and will document the outcome of the call in the web-based PA system the next business day.

16) During a state-recognized potential or actual disaster, the Regulatory Services department will notify the Corporate Pharmacy department's Account team of the state declaration of potential or actual disaster and state-defined emergency prescription refill period. The Corporate Pharmacy department's Account team will direct the PBM to immediately institute an early prescription refill waiver for the state-defined period and will notify the Regulatory Services department of the execution of the emergency waiver. The Pharmacy account director (RPh) will notify the state and health plan of the emergency waiver implementation.

17) Reports of PA requests will be reported to health plans and applicable state agencies as appropriate under the contract. A reporting tool should be developed to accommodate the aforementioned.

18) All appeals are coordinated through the health plan's standard appeals process. Pharmacy utilization management (UM) letters utilize the approved appeal and grievance attachment provided by the health plan.

19) All received PHI is documented and protected according to HIPAA regulations and standards.

20) All pharmacy PAs have a 24-hour TAT. Medical PA's have a 72-hour TAT for urgent requests and a 14-day TAT for non-urgent requests.

II. Benefit coverage, limitations and exclusions

Anthem does not impose quantitative limit (QTL) or non-quantitative limit (NQTL) more stringently on mental health and substance use disorder drugs as compared to medical/surgical drugs prescriptions in accordance with *42 CFR 438.900 et. Sq*. Depending upon market-specific *Preferred Drug List (PDL)*/formulary coverage and PA criteria, the following topics may apply:

1) Criteria for coverage of brand medication when equivalent generics are available

2) Coverage for doses or regimens not approved by the FDA as safe or effective — requests for dosing above FDA-approved doses will require clinical rationale and documentation of literature to support the dose being requested.
3) Duplicate therapy — prescribers must provide clinical rationale as to why a member requires treatment with agents from the same class.
4) Medications/products for cosmetic purposes — medications prescribed for cosmetic use are considered benefit exclusion.
5) Non-FDA approved age-coverage for medication that the FDA has not determined safe or effective for use in individuals of a certain age will require clinical rationale and literature to support the use of the requested medication in the non-FDA approved age group.
6) Coverage for combination products — the same or similar medicines, given as separate drugs, are preferred and should be utilized first. **Please note**: Non-compliance does not meet requirements of medical necessity for use of a combination product.
7) Convenience dosing — coverage of long-acting medications that have immediate release formulations available are non-preferred. Providers must provide clinical rationale as to why the member cannot use the preferred immediate release formulation. **Please note**: Non-compliance does not meet requirements of medical necessity for use of a non-preferred long-acting medication.
8) Other health insurance — the health plan will be considered as secondary payer when other health insurance is identified. However, PA may still be required.
9) Early refills — prescribers or pharmacies requesting early fills of medication must provide rationale for early fill, or for lost or stolen medications. **Please note**: The health plan is not responsible for emergency or nonemergency services provided outside the U.S. and its territories.
10) Budesonide respules are covered for members through age 4. For coverage of budesonide respules over age 4, prescribers must provide clinical rationale and documentation as to why the member cannot use preferred inhaled corticosteroid inhaler with spacer device.
11) Back-dating — prescribers are required to obtain a PA for non-preferred medications prior to the administration of the medication. Back-dated requests will not be approved.
12) Cannot swallow — prescribers are required to provide documentation of medical necessity that member cannot swallow **any** oral tablets **or** that the member has exhibited intolerance to at least two different preferred agents prior to coverage of certain dosage forms.
13) Carve-out
14) Max dollar amount exceeded — the health plan allows coverage of the following:
    a. Specialty claims up to $4,999
    b. Compound claims up to $200
    c. Regular (non-specialty/compound) claims up to $4,999.99
    d. A clinical pharmacist will review requests that exceeded one of the above limits for appropriateness.
15) Benefit exclusions — the following drug/drug classes (as well as drugs that are covered under the medical benefit or carved out of the pharmacy benefit) are not eligible for a 72-hour emergency supply at the pharmacy and are excluded from coverage by the health plan:
    a. Drugs when used for anorexia, weight loss or weight gain (Alli has some exception)
    b. Drugs when used to promote fertility
    c. Drugs when used for cosmetic purposes or hair growth
    d. Drugs used for symptomatic relief of cough and cold —the health plan allows for coverage of these products in members < age 21 (see the health plan *PDL*/formulary)
    e. Drugs used for the treatment of erectile dysfunction
    f. Prescription vitamins and mineral products — the health plan allows for coverage of some vitamins and minerals (please see the health plan *PDL*/formulary)
    g. Nonprescription /over-the-counter (OTC) drugs — the health plan allows for coverage of some OTC products with a written prescription from a prescriber (see the health plan *PDL*/formulary)

Notes:

1) Members are entitled to receive coverage of up to a 72-hour supply of medication while awaiting a PA determination. This does not apply to medications that are excluded from the pharmacy benefit or from coverage by Medicaid.

2) Pharmacies are expected to dispense up to a 72-hour supply of formulary or non-formulary and/or non-preferred medications at any time, without the need for a PA. This is done by the pharmacy entering an override code while processing the prescription. The 72-hour supply override also serves to accommodate requests during any emergency situation as determined by the dispensing pharmacy and/or member, or when a member needs to continue therapy while awaiting a PA.

3) In the event the prescription is for a non-preferred drug and the pharmacist cannot reach the prescribing physician, the contractor or its agent for approval (and the pharmacist deems it necessary), a 72-hour emergency supply shall be provided. If the physician prescribed an amount of the drug that is less than a 72-hour supply but is packaged so that it must be dispensed intact, the pharmacist may dispense the packaged drug and the contractor shall pay for it (even if it exceeds 72-hour supply. The contractor shall instruct pharmacy providers how to perform the override in the National Council for Prescription Drug Programs environment of the point-of-service pharmacy claims processing system.

4) In accordance with the *Omnibus Budget Reconciliation Act of 1990*, the contractor shall process a PA request within 24-hours of initial request, including weekends.

5) The health plan allows coverage of the following:

- Kentucky (specialty) claims up to $4,999.99 excluded from cost exceeds max limits
- Kentucky compound claims $200
- Kentucky regular (non-specialty/non-compound) claims up to $4,999.99

References:

- *42 CFR 438.210 et Sq.*
- *42 CFR 438.900 et Sq.*
- 2012 *HP Standards and Guidelines*, Utilization Management 7-Element C
- Academy of Managed Care Pharmacy. *Concepts in Managed Care Pharmacy-Prior Authorization*. **http://www.amcp.org/prior_authorization** (accessed July 20, 2012)
- Academy of Managed Care Pharmacy, *Principles of a Sound Drug Formulary System*
- CMS *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act*
- *Social Security Act Title XIX, Section 1927 (d)*