POLICY AND PROCEDURE

DEPARTMENT: Pharmacy Operations	**REFERENCE NUMBER:** OH.PHAR.08
EFFECTIVE DATE: 04/07	**POLICY NAME:** Pharmacy Prior Authorization and Medical Necessity Criteria
REVIEWED/REVISED DATE: 02/08, 02/09, 02/10, 02/11, 02/12, 11/12, 02/13, 02/14, 08/14, 08/15, 08/16, 09/16, 11/16, 10/17, 07/18, 10/18	**RETIRED DATE:** N/A
PRODUCT TYPE: Medicaid	**PAGE:** 1 of 7

SCOPE:
Centene Corporate Pharmacy Solutions, Health Plan Pharmacy Departments, Envolve Pharmacy Solutions.

PURPOSE:
The Prior Authorization (PA) and Medical Necessity (MN) criteria are developed to promote clinically appropriate utilization of selected high risk and/or high cost medications and include consideration of program exception requests for medications not included on the Health Plans' Preferred Drug List (PDL). The criteria for approval have been established by the Clinical Pharmacy Advisory Committee (CPAC), in conjunction with the Buckeye Health Plan and are approved through both the Corporate and Health Plan Pharmacy and Therapeutics (P&T) Committees. Decisions on PA and MN criteria content are coordinated with input from pharmacy and medical practitioners, Buckeye Health Plan, Centene Health Plan representatives, and review of current available medical literature and professional standards of practice.

PA policies approved by CPAC that have not yet been presented at Buckeye Health Plan's P&T are considered to be interim PA policies. Prior authorization pharmacists use interim criteria as reference when evaluating coverage requests until the criteria are reviewed and approved at Buckeye Health Plan's P&T.

POLICY:
- The Centene Corporate and Health Plan P&T Committees will make the final decisions regarding which medications are included on the PDL and of these, which require PA for approval. Criteria for all drugs will be developed for approval by the CPAC. The respective approval criteria are labeled either PA or MN criteria. The Corporate and Health Plan P&T Committees must approve the prior authorization and medical necessity guidelines before implementation.
- In order for a PA or MN medication to be covered, the prescriber must submit information consistent with the developed criteria to obtain approval for the

medication. A form for submission of a PA or MN request is posted on Health Plan web sites (see Attachment A, Envolve Pharmacy Solutions Medication Prior Authorization Form). Use of this form is not a requirement but provided only as guidance on the information that may be necessary to assure prompt review of a PA or MN request.

- Initial PA and MN requests will be reviewed by a Certified Pharmacy Technician (CPT) or a licensed Clinical Pharmacist at Envolve Pharmacy Solutions for a determination of meeting criteria. For requests that meet initial screening criteria, an authorization for approval will be entered in the Envolve Pharmacy Solutions PBM application and the prescriber will be notified that approval has been granted.
- When a request does not meet criteria, it will be forwarded to a licensed Envolve Pharmacy Solutions Clinical Pharmacist for a final determination. Clinical Pharmacists will review all denials.
- PA and MN requests are responded to within 24 calendar hours when all necessary and requested information is supplied. If all necessary information to review the request is not received in a timely manner, the request will be reviewed with the available information and a decision rendered within 24 hours. When a medication is approved or denied a notation is made in the pharmacy claims processing system.In the event of a PA or MN denial, the prescriber will be faxed notification of the adverse determination within 24 hours, including the reason for the denial, along with a request for use of PDL alternatives (when appropriate). Envolve Pharmacy Solutions will provide Buckeye Health Plan, on a daily basis, a completed member denial letter for each denial processed.
- The member denial letter will be mailed to the member by Envolve Pharmacy Solutions (normally within 24 to 48 hours of the denial determination). Both the prescriber notification and the member denial letters include the reason for the denial and language notifying them of their rights for appeal of the decision, including contact information at both Buckeye Health PLan and any applicable state agencies, if required.

- The prescriber or the member may request reconsideration of any denial made by Envolve Pharmacy Solutions. A record of all denials is maintained by Envolve Pharmacy Solutions and/or Buckeye Health Plan as applicable.
- A 72 hour supply is available any time there is a delay in the review process.

NOTE: If the request does not contain sufficient information to make an informed decision, the Envolve Pharmacy Solutions reviewer will notify the prescriber and document the request for additional information. If additional information is not received within 24 hours, to allow the Envolve Pharmacy Solutions reviewer to make an informed decision, a denial notification will be processed in accordance with the process described above (see CC.PHAR.06_PBM Inquiry for Additional Information).

APPEAL PROCEDURE:

- The prescriber or a member of the prescriber's staff may call, write, or fax the Envolve Pharmacy Solutions Clinical Pharmacy Department to request coverage authorization, request to appeal an adverse coverage determination, decline the request to prescribe a PDL alternative therapy, and/or refuse to supply additional information supporting the original request for coverage.
- An Envolve Pharmacy Solutions Clinical Pharmacist will review any disputed denial or appeal to ensure appropriateness and will forward appeals to Buckeye Health Plan.
- An outreach to the prescriber may be made by the Buckeye Health Plan Medical Director as deemed appropriate. The denial may be overturned at any time during the appeal review process and an authorization for approval will be entered in the pharmacy claims processing system. Both member and provider are notified in the event that a denial has been overturned.
- A final determination for any appeal of denials will be made by the Health Plan Medical Director and an appeal denial letter will be forwarded to both the prescriber and the member. Documentation of the review and the generation of appeal denial letters is kept by the Health Plan.

REFERENCES: N/A

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ATTACHMENTS:
Attachment A: Envolve Pharmacy Solutions Medication Prior Authorization Request Form

DEFINITIONS: N/A

REVISION LOG

REVISION	DATE
Remove "clinical personnel, participating physicians, and network pharmacists" from "SCOPE" as those are external parties and are not to be included per template definition of "SCOPE".	05/07
Remove the following from "PURPOSE": "Some medications requiring Prior Authorization may not be included in the Preferred Drug List (PDL). Formulary guidelines may require that certain conditions be met before these PA medications can be authorized."	02/08
Replace the "formulary" with "Preferred Drug List (PDL)" throughout the document.	02/08
Replace the "PBM" with "US Script" throughout the document.	02/08
Replace "the member will be issued an NOA (Notice of Action) and a copy of the right to a State Hearing form. Subsequently a file of all denials will be documented by US Script, Inc. and the Centene Health Plan appeals and grievance coordinator, whom will be responsible to send a copy of each State Hearing Form to the State." with "US Script will provide the plans, on a daily basis, a completed member denial letter for each denial processed." in the fifth bullet point of the "PROCEDURE".	02/08
Add the following bullet to the "PROCEDURE": "The plans will send the denial letter to the member and notify them of their right to appeal the decision."	02/08
Replace "the NOA and State Hearing Forms provide the directions for requesting an appeal or a State Hearing." with "the	02/08

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denial letter contains all of the member's options for appeal including contact information directing the appeal back to the plan or any applicable state agencies" after "In the event a patient disagrees with the decision..." under "PROCEDURE".	
Complete reworking of the Policy and Procedure, identifying responsibilities, development and approval of PA criteria, timeliness of reviews, provider and member notification of denials, the appeals process and referral of appeals to the Health Plans for final determination.	02/09
Revisions completed at this time were made to address clerical errors, align with NCQA standards and language, and represent the work processes in place at both the Plan level and at US Script.	02/10
Defined notification of member and prescriber if a denial is overturned. Other semantic language changes only.	02/11
No changes.	02/12
Added language to the description of the prescriber denial response to include the reason for the denial.	10/12
No changes deemed necessary.	02/13
No changes deemed necessary.	02/14
No changes deemed necessary.	08/14
Deleted from Scope and Purpose sections: "Corporate Pharmacy Department and US Script" and replaced with "Pharmacy Solutions Group".	08/15
Annual Review; added verbiage concerning states that do not allow pharmacists to deny a prior authorization request.	08/16
Updated the purpose to include program exceptions for drugs not on the Health Plan's PDL.	09/16
Changed US Script to Envolve Pharmacy Solutions.	11/16
Changed section of policy to state PA and MN requests are responded to within 24 calendar hours; removed reference to urgent requests since all requests are now responded to within 24 calendar hours; removed "Envolve Pharmacy Solutions" that	10/17

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preceded claims processing system to just state "pharmacy claims processing system"; changed "Envolve Pharmacy Solutions application" to "pharmacy claims processing system" under Appeal Procedure section in the 3rd bullet.	
Added under bullet 6 - If all necessary information to review the request is not received in a timely manner, the request will be reviewed with the available information by the medical director and a decision rendered within 24 hours; Added under bullet 6 that for a PA or MN denial, the prescriber will be faxed notification of the adverse determination within 24 hours.	07/18
Replaced references to "the Centene Health Plan" with Buckeye Health Plan; added statement regarding interim policies; removed section referencing steps for States that do not allow pharmacists to deny prior authorization requests; clarified that member denial letters will be mailed by Envolve, not the health plan; in Appeals section – indicated appeals will be forwarded to Buckeye Health Plan, and indicated final appeal determinations will be made by Buckeye Medical Director and not a health plan pharmacist.	10/18

POLICY AND PROCEDURE APPROVAL

Pharmacy & Therapeutics Committee: Approval on file

V.P., Pharmacy Operations: Approval on file

Sr. V.P., Chief Medical Officer: Approval on file

NOTE: The electronic approval is retained in Compliance 360.

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