nh healthy families

# POLICY AND PROCEDURE

| DEPARTMENT: Pharmacy Operations | DOCUMENT NAME: Pharmacy Prior Authorization and Medical Necessity Criteria |
|---|---|
| **PAGE:** 1 of 5 | **REPLACES DOCUMENT:** |
| **APPROVED DATE:** 04/07 | **RETIRED:** |
| **EFFECTIVE DATE:** 04/07 | **REVIEWED/REVISED:** 02/08, 02/09, 02/10, 02/11, 02/12, 11/12, 02/13, 02/14, 08/14, 08/16, 07/17, 12/17 |
| **PRODUCT TYPE:** Medicaid | **REFERENCE NUMBER:** NH.PHAR.08 |

**SCOPE:**
Centene Corporate Pharmacy, Health Plan Pharmacy Departments, and US Script.

**PURPOSE:**
The Prior Authorization (PA) and Medical Necessity (MN) criteria are developed to promote the most appropriate utilization of selected high risk and/or high cost medications. The criteria for approval have been established by the Corporate Pharmacy Department, in conjunction with the Centene Health Plans and Envolve Pharmacy Solutions, the designated pharmacy benefit manager, 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, Centene Health Plan representatives, and review of current available medical literature and professional standards of practice.

**POLICY:**
- The Centene Corporate and Health Plan P&T Committees will make the final decisions regarding which medications are included on the Preferred Drug List (PDL) and of these, which require PA for approval. Drugs requiring PA and certain highly prescribed drugs not positioned on the PDL will have criteria developed for approval. 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.
- All PA or MN policies will be reviewed and approved by New Hampshire Medicaid
- 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 hours when all necessary and requested information is supplied. Medications classified as "URGENT" are reviewed the same day the request is received. When a medication is approved or denied a notation is made in the Envolve Pharmacy Solutions claims processing system.
- In the event of a PA or MN denial, the prescriber will be faxed notification of the adverse determination, including the reason for the denial, along with a request for use of PDL alternatives (when appropriate). Envolve Pharmacy Solutions will provide the Centene Health Plans, on a daily basis, a completed member denial letter for each denial processed.
- The member denial letter will be mailed to the member by the Centene Health Plan upon receipt (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 the Centene 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 or the Centene Health Plan Medical Director. A record of all denials is maintained by Envolve Pharmacy Solutions and/or the 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 US Script 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). If a denial is issued the member letter will clearly specify the information that is missing so the member is aware of this in addition to the provider via the provider letter

**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 the Centene Health Plan Pharmacist and/or Medical Director.
- An outreach to the prescriber may be made by the Centene Health Plan Pharmacist or 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 Envolve Pharmacy Solutions application. 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 or the Centene Health Plan Pharmacist as allowed by State regulations 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

**ATTACHMENTS:**
Attachment A: US Script Medication Prior Authorization Request Form

**DEFINITIONS:** N/A

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| **PRODUCT TYPE:** Medicaid | **REFERENCE NUMBER:** NH.PHAR.08 |

**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 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”. | 02/08 |
| 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 | 02/09 |

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| Plans for final determination. | |
| 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 |
| Added the member letter will clearly specify the information that is missing so the member is aware of this in addition to the provider via the provider letter | 07/15 |
| Added all PA or MN policies will be reviewed and approved by New Hampshire Medicaid | 07/15 |
| Annual review, no changes | 08/16 |
| Annual Review, No changes | 07/17 |
| Changed US Script to Envolve Pharmacy Solutions. Updated "within one business day to within 24 hours" to comply with new regulations. | 12/17 |

**POLICY AND PROCEDURE APPROVAL**

Pharmacy & Therapeutics Committee: Approval on file

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| 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.*