⫽ Upper Peninsula Health Plan ⫽
Policy & Procedure

Index #: 300-009 **Effective:** 02/16/05

Subject: Pharmacy Prior Authorization Process (NCQA Procedures for Pharmaceutical Management) **Revised:** 11/29/12; 03/11/14; 01/01/16; 08/22/17; 08/09/18

Authorized By: ____________________________ **Date:** ___________ **Title: CEO**

Product Type(s):

Product Type(s): ☐ **All Products** ☒ Medicaid ☒ Healthy Michigan Plan
☐ Medicare ☒ MIChild ☐ MI Health Link

Purpose

To outline the mechanism by which a provider submits a prior authorization for formulary agents requiring a prior authorization or the process by which they may request an exception for a medically necessary non-formulary/non-covered medication for a member.

Policy

Upper Peninsula Health Plan (UPHP) desires that providers prescribe within the formulary. Prior authorization and medical necessity requests should be generated at the prescriber level.

Prior authorization is required for the following medications:

- Non-formulary medications
- Medications prescribed outside of quantity limits, time limits, and/or age restrictions
- Medications prescribed outside of step therapy or preferred status
- DAW prescriptions when a generic equivalent is available

UPHP accepts medication necessity review for medications that are covered on the Michigan Department of Health and Human Services (MDHHS) Michigan Preferred Product List (MPPL) but not on the MDHHS Managed Care Plan Common Formulary via the prior authorization process.

The request for prior authorization forms are available on the website www.uphp.com. A provider not having access to the website may request that the form be mailed or faxed to them by calling UPHP Customer Service. A provider may utilize the *UPHP Prior Authorization Form* or the *Michigan Standard Prior Authorization Request Form For Prescription Drugs* (Form FIS 2288).

UPHP is obligated to maintain compliance with the MDHHS Managed Care Plan Common Formulary policies and procedures governing specific drug categories.

Procedure

1. Primary care physicians (PCPs), specialists, or their designated agents complete the *UPHP Request for Prior Authorization Form* (Attachment A) or other method. Prescribing physician and beneficiary information must be complete as well as the drug name, strength, administration schedule, length of therapy and quantity requested. The prescriber may complete the remaining information by submitting a dictation, clinic notes or a letter that contains the relevant information.

2. **The form is faxed to the Pharmacy Benefit Manager (PBM) at the number listed on the request for prior authorization form.** Forms are accepted by mail. In most cases the form will be processed within 24 business hours of receipt at the PBM. Prescribers may contact the PBM by telephone during regular business hours and verbally complete the request for prior authorization form if the situation is urgent or an emergency. A written form should follow. Any urgent request will be processed as soon as possible, but within regulatory and accrediting organization timelines. Every effort will be made to ensure urgent requests are answered on the same day of the request.

3. Upon receipt, the PBM will review the request for prior authorization; it is then processed by the PBM in one of three ways:
   - **Approved**:
     If the request meets with approved criteria as set forth by the MDHHS Managed Care Common Formulary and Pharmacy Clinical Advisory Committee (PCAC), an approval is entered into the computer system so a pharmacy claim will process at point of sale. If criteria are not met, the PBM may redirect the prescriber to another drug on the formulary that has similar efficaciousness that would meet the needs of the member. If the practitioner agrees, this is considered redirection and the member receives the agreed upon formulary medication. The provider is notified by fax of all redirections and/or approvals.
   - **Pending:**
     Requests will pend if more information is needed. The PBM will contact the prescriber to obtain all necessary information to complete review of the request.
   - **Forward the request to UPHP**:
     If the authorization or redirection cannot be authorized after the PBM pharmacist review, the request for prior authorization is forwarded via the applicable electronic Web-based password-protected system to UPHP with appropriate notes and/or comments, drug information support, claims history, letter or support, etc. The PBM cannot deny prior authorization requests.

4. When the request for prior authorization is received at UPHP it is reviewed by an appropriate professional. If a prescriber does not accept redirection to formulary alternatives and wishes to pursue the request, it is processed based on a medical necessity determination along with supporting documentation using some or all, but not limited to the following criteria:

- MDHHS Managed Care Common Formulary and UPHP formulary guidelines
- Food and Drug Administration (FDA)-approved indications for the medication requested
- The member's diagnosis and/or the indication for use
- Previous drug treatment for the member's diagnosis
- Compliance with previous drug treatment(s)
- Previous therapy failure using formulary alternatives

5. If after review by the appropriate professional at UPHP a request is approved, notification is sent to the PBM via secure email to the prior authorization department. The approval should include:
    - Member Episode of Coverage (EOC)
    - Member name, identification number and date of birth
    - Name of person approving the authorization

    The UPHP pharmacist will:
    - Notify the provider of the approval via phone or fax
    - Notify the pharmacy via phone
    - Document the approval in applicable electronic data systems
    - Enter authorization in the PBM claims system

6. Requests for prior authorizations/medical necessity that are denied are processed in accordance with Utilization Management (UM) Process (300-005) the Member Appeals Related to UM Adverse Determinations Policy (300-024) and National Committee for Quality Assurance (NCQA) and MDHHS standards for timeliness and notification. Notifications completed prior to 11 a.m. are mailed on the same business day.

7. UPHP annually evaluates the consistency with which UM pharmacy reviewers apply criteria in decision making and acts on opportunities for improvement, if applicable. The UPHP Pharmacy Administrative Assistant or designee conducts an inter-rater reliability (IRR) review and analysis, at least annually and as warranted, on all staff responsible for making UM pharmacy determinations.

    The annual IRR study consists of conducting a review and analysis of a consistent number of cases (NCQA 8/30 methodology) for each professional staff responsible for making UM determinations, which includes the UPHP Medical Director and pharmacists. The expected IRR concurrence rate is 80 percent or greater. If the analysis indicates the concurrence rate is less than 80 percent, a corrective action plan is formulated and implemented as opportunities for improvement are identified.

    After the IRR review and analysis is complete, the UPHP Pharmacy Director, UPHP Medical Director and pharmacist review the results and analyze any case which lacked consistent determinations. The report is presented to the PCAC for approval. The report is also reviewed annually by the UPHP Management Committee.

Attachments

Attachment A: *UPHP Request for Prior Authorization Form*

Exception to this policy may be made with the approval of the
Chief Executive Officer or an authorized designee.

⫽ END OF POLICY & PROCEDURE ⫽

UPHP HEALTH PLAN REQUEST FOR PRIOR AUTHORIZATION

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

PRESCRIBING PHYSICIAN:

Name:______________________________
First Last

Direct Phone #: (_ _ _) - _ _ _ - _ _ _ _

Fax #: (_ _ _) - _ _ _ - _ _ _ _

Physician specialty: _______________

BENEFICIARY:

Name:______________________________
First Last

Medicaid ID #: ______________________

Date of Birth: _ _ - _ _ - _ _ _ _

Sex: ☐ Female ☐ Male

Name and title of person completing form (please print): ______________________________

Drug name: Strength: Administration Schedule: Length of Therapy: Quantity Requested:

a) ______________________________

b) ______________________________

c) ______________________________

Patient's diagnosis for use of this medication: ______________________________

1. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:

   ____

2. Has the patient been seen by any other provider for this condition? ☐ Yes ☐ No

   If so, what was the prescriber's specialty? ______________________________

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
________	________	_ _ / _ _ / _ _ _ _
________	________	_ _ / _ _ / _ _ _ _
________	________	_ _ / _ _ / _ _ _ _

4. Pertinent laboratory test or procedure: (if applicable)

Procedure:	Findings:	Date:
________	________	_ _ / _ _ / _ _ _ _
________	________	_ _ / _ _ / _ _ _ _
________	________	_ _ / _ _ / _ _ _ _

5. Other Information:

   ____

   ____

   ____

Submit Requests to:
MagellanRx Management Systems
2520 Industrial Row Drive
Troy, Mi. 48084
Phone: (248) 540-6686 Fax: (248) 341-8133

MRx PA COMMENTS:______________________________

DT REC:__________ TIME REC:__________
GCN: a)________ b)________ c)________
EC: a)________ b)________ c)________
Qty:a)________ b)________ c)________
Appd :a)________ b)________ c)________
R.Ph:__________ DATE:__________
Entrd by: __________ DATE:__________
Auth # a)______________________
b)______________________
c)______________________

Effective March 2017