Upper Peninsula Health Plan
Policy & Procedure

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Title: Pharmacy Prior Authorization Process

Scope: Pharmacy, Customer Service

Revised: 2/16/05, 2/12/07, 11/3/10, 11/29/12, 3/11/14, 12/9/14, 1/1/16, 8/22/17, 8/9/18, 12/11/19, 1/30/20, 11/1/21, 10/28/22

Reviewed:

Authorized By: _____ Date: 11/3/22 Title: CEO

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 request 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
  - Dispense as Written (DAW) prescriptions when a generic equivalent is available

UPHP is obligated to maintain compliance with the Michigan Department of Health and Human Services (MDHHS) Managed Care Plan Common Formulary policies and procedures governing specific drug categories.

UPHP accepts medical necessity review for medications that are covered on the MDHHS Michigan Preferred Product List (MPPL) but not on the MDHHS Managed Care Organization Common Formulary via the Prior Authorization Process

The *Request for Prior Authorization* forms are available on the UPHP website at *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 or the Pharmacy Benefit Manager Customer Service. A provider may utilize UPHP's prior authorization form or the Michigan Standard Prior Authorization Request Form for Prescription Drugs (Form FIS 2288).

Professionals Making Pharmacy Prior Authorization Determinations

The following are the various levels of reviewers and the decisions permitted at each level using approved explicit criteria who have expertise in addressing the member's medication needs.

- Certified Pharmacy Technician (CPhT): Responsible for initial review of PA requests and approval of requests meeting clinical criteria.
- Licensed Clinical Pharmacist: Responsible for initial or second level review for change in therapy and approval of requests meeting clinical criteria.
- Physician Advisor: Responsible for final review in cases not meeting clinical criteria per requirements.

Procedure

1) Prescriber, or their designated agent, completes the UPHP *Request for Prior Authorization* available on the UPHP website. Prescriber and beneficiary information must be complete as well as the drug name, strength, administration schedule, length of therapy and quantity requested. The remaining information may be submitted through a dictation, clinic notes or a letter that contains the requested relevant information.

2) The form is faxed to the Pharmacy Benefit Manager (PBM) at the number listed on the *UPHP Request for Prior Authorization* form. Requests are accepted by fax 24 hours a day, 7 days a week. Forms are also accepted by mail. In most cases the request will be processed within 24 calendar hours of receipt by 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.

3) When the Request for Authorization is received by the PBM, it is reviewed by an appropriate professional (certified pharmacy technician, licensed clinical pharmacist or physician advisor). Requests with supporting documentation are processed using some or all, but not limited to, the following:
    - MDHHS Managed Care Organization Common Formulary Criteria
    - UPHP formulary guidelines
    - 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
- Medical necessity (all medical necessity requests are reviewed by a licensed clinical pharmacist)

4) Per Michigan Social Security Act (42 CF 438.3(s) the PBM shall provide a response on a prior authorization request within 24 hours of valid receipt. Decisions may be tolled if there has been an attempt to receive additional, necessary documentation.

5) For requests that meet criteria, an authorization for approval will be entered by the Magellan clinical reviewer in the Magellan Pharmacy Benefit Management (PBM) applicable application.
   a) The provider will be notified that approval has been granted by mail and fax.
   b) The member will also be notified in writing of the decision.

6) When a request does not meet criteria, the clinical pharmacist, or physician, will enter a denial decision is rendered in the system with applicable decision notes.
   a) The prescriber is notified of the decision and that the member will be receiving a written notification letter.
   b) Both the prescriber and the member denial letters include language regarding the member's appeal rights
      i) The prescriber/provider on behalf of the member; or
      ii) The member/their representative may request an appeal.

7) A record of all non-certifications and appeals is maintained by the PBM.

8) When a PA determination is rendered, the determination notes are documented in the PBM application system.

9) If the request does not contain sufficient information to make an informed decision, the reviewer may notify the prescriber and document the request for additional information.
   a) For pended requests, if additional information is not received within State/Federal regulatory timeframes or the client's contractual designated time period, the PBM reviewer will render a determination decision based on the available evidence prior to the end of the review timeframe.
   b) If the decision is a denial, a denial notification will be processed in accordance with the process described above.
   c) The following need to be documented in clinical notes or work log notes. Each client is different and may utilize either locations, as long as a location is consistent for the client to obtain this information.

Requests for Prior Authorizations and Medical Necessity Reviews for the Medicaid pharmacy benefit that are denied are processed in accordance with Utilization Management 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 6 pm EST. Monday through Friday and prior to 11:00 am on Saturday and Sunday are mailed on the same business day. The processes most advantageous to the member will apply.

The PBM quarterly evaluates the consistency with which UM Pharmacy Reviewers apply criteria in decision making and acts on opportunities for improvement, if applicable.

The quarterly IRR study consists of 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 PBM. The expected IRR concurrence rate is 80% or greater. If the analysis indicates the concurrence rate is less than 80%, a corrective action plan is formulated and implemented as opportunities for improvement are identified.

After the IRR review and analysis is complete, the results are reviewed with the PBM leadership team, and cases which lacked consistent determinations are reviewed.

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

END OF POLICY & PROCEDURE