



Prior Authorization

RxBenefits' Protect independent clinical management helps optimize your pharmacy benefits by improving your safety, lowering overall drug costs, and helping you make the most of your prescription drug coverage.

Independent Clinical Prior Authorization Reviews

Overview

What is a prior authorization?

A prior authorization (PA) is when your benefit plan requires approval of a prescription before it is covered, to ensure it is being used safely and appropriately as approved by the U.S. Food and Drug Administration (FDA). PA reviews may also be needed based on the medication dose (quantity limits) or prior therapy requirements (step therapy).

How is the PA medication list determined?

The determination of which drugs require a PA review is based on a variety of factors, including FDA-approved guidelines, standards of practice, dosing schedule, method of administration, and cost.

A PA review may be required for:

- Drugs that have dangerous side effects
- Drugs that are harmful when used in combination with other drugs
- Drugs with limited indications
- Drugs that are subject to abuse and misuse
- High-cost drugs with clinically equivalent, lower-cost alternatives available

How does a PA work?

During claim processing, any medication with a National Drug Code (NDC) on the PA list is automatically reviewed electronically. The claim system scans the member's claim history to determine whether the member has an active PA.

If no active PA is found, the claim will be rejected as not covered because a PA is required.

At the Point of Sale

What message is communicated to the dispensing pharmacist through the point-of-sale system?

If the claim system is unable to confirm an active PA, the pharmacist is advised to alert the member that approval is required before the prescribed medication can be dispensed by the pharmacy.

Submitting a PA

If a claim is rejected for not having a PA in place, can the member request approval?

Yes. In instances where a previous PA has lapsed or was not in place, the member can request one. The pharmacist is provided a dedicated phone number that the pharmacy or prescriber can use to initiate a PA request. RxBenefits manages the PA review process for any exceptions submitted by members. PA requests require supporting documentation to be submitted by your prescriber. Our clinical reviewers evaluate requests against specific clinical criteria to determine whether to approve or deny the request.

What is the RxBenefits' turnaround time for completing a PA Request?

An initial PA request is usually processed within one to three business days if all necessary information has been submitted.

Review Process

What are the criteria to evaluate PA requests?

All claims that require a PA approval for coverage are reviewed using established clinical criteria for coverage to ensure safe and appropriate use of the medication.

What happens if all the necessary information to complete the review is not provided with the initial request?

If additional information is required to complete the review, a request for additional information (RFI) is sent by fax to the provider noted on the request. If no response is received, our review team will continue to make reasonable efforts to contact the provider, including up to three attempts over three business days.

What happens when additional information is required but cannot be obtained?

If additional information is required but not obtained after three outbound attempts over three business days, the request is closed due to a lack of information. At this point, a notification stating that additional information is needed is mailed to the member and faxed or mailed to the prescriber.

Approval Notification

Who is notified if a PA request is approved, and how is notification provided?

If a PA is approved, a notification letter is mailed to the member and faxed or mailed to the prescriber.

How long will a prior authorization approval be granted?

Most PA approvals are for one year. However, the duration of approval varies based on the medication requested. The dates for which all PAs are approved are included on the approval notification sent to the member and their prescriber.

Appeals Process

What is the appeals process if a PA request is denied?

If a PA request is denied, the member or prescriber can submit an appeal. All appeals are reviewed by a different reviewer, who makes a determination to overturn or uphold a prior denial based on all previously and newly provided information for the request. If an initial appeal is denied, the member or prescriber may appeal the decision for a second internal appeal for medical necessity. If the second appeal is denied, the member or prescriber may appeal the denial a third and final time. At this point, the request is reviewed by a third-party independent review organization (IRO) for an external review. The determination made on a third appeal is final and binding and cannot be appealed further.

We are here to help

Chat: With a live agent via the RxBenefits member portal at Member.RxBenefits.com, Monday-Friday, 9:00 a.m. to 6:00 p.m. Central

Email: CustomerCare@RxBenefits.com, Monday-Friday, 7:00 a.m. to 8:00 p.m. Central

Call: RxBenefits Member Services at 1-800-334-8134, Monday-Friday, 7:00 a.m. to 8:00 p.m. Central



Access your pharmacy benefits information 24/7 from any device by registering on the My RxBenefits member portal at **Member.RxBenefits.com**. Once registered, you can view and download your ID card, set up your communication preferences, access up to 18 months of claims history, chat with a live agent, so much more.