RxBenefits®
Protect™

FAQ: Prior Authorization

__RxBenefits Protect™__ helps members get the right medication at the right time by providing clinical management of your prescriptions. Part of that management includes requiring a prior authorization for certain medications to ensure they're used as approved by the U.S. Food and Drug Administration (FDA) and that they're safe, effective, appropriate, and more affordable.

Independent Clinical Reviews
Prior Authorization (PA)

PROGRAM OVERVIEW

What is prior authorization?
Certain medications must undergo a clinical review to ensure they're safe and effective before being approved for coverage. Prior authorizations may include quantity limits and/or step therapy, which requires a lower-cost drug to treat a condition before “stepping up” to a similar-acting, but more expensive drug. These procedures help identify the most clinically appropriate and cost-effective drug available.

How is the prior authorization medication list determined?
A prior authorization listing is based on a variety of factors, including FDA-approved guidelines, standards of practice, dosing schedule, method of administration, and cost.

Examples of medication subject to prior authorization include:

- 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
- Drugs with an excessive cost compared to equally effective, lower cost alternatives

How does prior authorization work?
During the prescription claim review process (claims adjudication), any medication on the prior authorization list will be rejected for coverage with a note that a prior authorization is needed, unless an approved prior authorization is active and on file for the member and medication. A prior authorization request must be submitted for review prior to coverage.

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AT THE POINT OF SALE

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

If the claims system is unable to confirm the existence of an active, approved prior authorization, the pharmacist will receive an alert that the medication requires a prior authorization for coverage and will advise the member of this requirement.

REQUESTING A PRIOR AUTHORIZATION

If a claim is rejected when a prior authorization is required, can approval be requested?

Yes. In the case where a prior authorization is needed, a request can be made. Through the point-of-sale system, the pharmacist will receive contact information that can be used by the patient, the pharmacy, or the prescriber to initiate the prior authorization request. RxBenefits manages the review of prior authorization requests from members or their providers via fax or through the online portal. Our clinical reviewers evaluate prior authorization requests against specific clinical criteria and will will make a coverage determination.

What is the turnaround time for completing a prior authorization request?

Standard turnaround times are 24 hours (urgent) and 72 hours (standard) if all necessary information is submitted and available to conduct a complete review.

REVIEW PROCESS

What criteria is used to evaluate prior authorization requests?

All claims requiring a prior authorization will be reviewed against clinical criteria for coverage and/or appropriate use based on the indication and dosage requested. Additional information regarding medical necessity will be reviewed on a case-by-case basis.

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

If additional information is required, a request for additional information (RFI) will be sent by fax to the prescriber noted on the request. Reasonable efforts will be made by the review team to contact the provider, but will not exceed three outbound attempts.

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

If additional information is required but isn't obtained after three outbound attempts, the request will be denied due to lack of information. A denial letter will be mailed to the member and faxed or mailed to the prescriber.

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APPROVAL NOTIFICATION

If a prior authorization request is approved, how will notification be provided and to which parties?

If approved, a notification is sent to both the member and prescriber.

How long will a prior authorization approval be granted?

Approvals are granted for one year for most requests. However, some medications may be approved for shorter or longer durations, based on coverage criteria and clinical appropriateness.

APPEAL PROCESS

If a prior authorization request is denied, what is the appeal process?

A pharmacist reviewer will evaluate the exception request and make a coverage determination. If denied, the member or prescriber may appeal the decision and submit supporting documentation to an internal appeals team. A different reviewer will evaluate the request for reconsideration. If denied for reconsideration, a second appeal may be submitted and reviewed as an exception request for medical necessity. If the second appeal is denied, the member or their prescriber may request a third and final appeal, which will be reviewed by a third-party Independent Review Organization for external review. If the final appeal is denied, no further appeals are available.

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If you have any questions, the RxBenefits Member Services team is here to help Monday – Friday from 7:00 a.m. to 8:00 p.m. CT at **800.334.8134** or **CustomerCare@rxbenefits.com.** You can also access your pharmacy benefits information 24/7/365 with the My RxBenefits member portal at **Member.RxBenefits.com**