Protect®

RxBenefits®

FAQ: Prior Authorization

RxBenefits Protect™ is designed to provide our customers with comprehensive programs to improve the overall clinical value of their prescription benefit program while managing cost and access consistent with each client's goals.

Independent Clinical Reviews
Prior Authorization (PA)

PROGRAM OPERATIONS

What is prior authorization?
In order to ensure that a drug that has been prescribed is safe and effective manner, at the best possible cost, certain drugs are required to undergo a review before they're approved to be dispensed. Prior authorizations may include elements of quantity limits and step therapy protocols.

How is the prior authorization medication list determined?
A prior authorization listing is based on a variety of factors, including Food & Drug Administration (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 that can be replaced with a more effective, cheaper drug

How does prior authorization work?
During claim adjudication, any medication containing a National Drug Code (NDC) that is on the prior authorization list will automatically be reviewed electronically. The claim system will scan the member's claim payment history to determine whether a previous prior authorization was approved during the look-back period. Look-back periods can vary but are typically 120-180 days. If no prior authorization approval is identified, the claim will be denied.

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AT THE POINT OF SALE

What message is communicated to the dispensing pharmacist through the POS system?

If the claim system is unable to confirm the existence of a previous prior authorization, the pharmacist will be advised to alert the member that prior authorization approval is required before the prescribed medication can be dispensed.

REQUESTING A PRIOR AUTHORIZATION

If a claim is rejected for not having a prior authorization in place, can approval be requested?

Yes. In the case where a previous prior authorization has lapsed or is needed, a prior authorization request can be made. Through the point-of-sale system, the pharmacist will be provided a dedicated phone number that can be used by the patient, the pharmacy, or the prescriber to initiate the prior authorization request. RxBenefits manages the review process for any exceptions submitted by members. Prior authorization requests will require supporting documentation submitted via fax from the prescriber. Our clinical reviewers evaluate exception requests against specific clinical criteria and will resolve the request with one of four actions: deny, dismiss, withdraw, or approve.

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

The anticipated turnaround time is less than one business day, provided that all necessary information is submitted and available to conduct a complete review. All reviews will be completed within 72 hours.

REVIEW PROCESS

What criteria is used to evaluate prior authorization requests?

All claims that reject for needing prior authorization will be reviewed for indication and dosage, as approved by the FDA. 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 pertaining to dosing and diagnosis are 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 reviewer to contact the provider, but will not exceed three outbound 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 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 letter 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. Certain medications used for less than 12 months may be granted a shorter approval period.

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 decision (approved or denied). If denied, the member or prescriber may appeal the decision and submit supporting documentation to an internal appeals team. A second, different pharmacist reviewer will analyze the appeal. If denied again, the member or prescriber may appeal a final time, based on medical necessity, to a third-party Independent Review Organization for an external review. If denied a third time, there are no further appeals.

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If you have any questions, remember that 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.**