POLICY AND PROCEDURE

DEPARTMENT: Pharmacy Operations	**REFERENCE NUMBER:** CC.PHAR.08
EFFECTIVE DATE: 04/07	**POLICY NAME:** Pharmacy Prior Authorization and Medical Necessity Criteria
REVIEWED/REVISED: 02/08, 02/09, 02/10, 02/11, 02/12, 11/12, 02/13, 02/14, 08/14, 08/15, 08/16, 09/16, 11/16, 11/17, 08/18, 05/19, 08/20, 11/20, 01/05/21, 08/21, 11/21, 05/22, 08/22, 02/23, 05/23, 08/23	**RETIRED DATE:** N/A
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SCOPE:
Health Plan Pharmacy Departments, Centene Pharmacy Services.

PURPOSE:
The Prior Authorization (PA) and Medical Necessity (MN) criteria are developed to promote clinically appropriate utilization of selected high risk and/or high cost medications and include consideration of program exception requests for medications not included on the Health Plans' Preferred Drug List (PDL). The criteria for approval have been established by the Clinical Pharmacy Advisory Committee (CPAC), in conjunction with the Centene Health Plans and are approved through the Corporate Pharmacy and Therapeutics (P&T) Committee. Decisions on PA and MN criteria content are coordinated with input from pharmacy and medical practitioners, Centene Health Plan representatives, and review of current available medical literature and professional standards of practice.

PA policies approved by CPAC that have not yet been presented at the Corporate P&T Committee are considered to be interim PA policies. Pharmacists reviewing PA requests use interim criteria as reference when evaluating coverage requests until the criteria are reviewed and approved at Corporate P&T.

POLICY:

A. PRIOR AUTHORIZATION AND MEDICAL NECESSITY CRITERIA
- Drug prior authorization policies will include objective, easily verifiable information rather than subjective information. Effective drug prior authorization policies allow for the timely review and approval of medically necessary therapies for members, and prevent unnecessary denials and time-consuming, costly appeals.
- Pharmacy Services shall follow the procedures outlined in policy CC.PHARM.31 (Creating and Revising Drug Prior Authorization Policies) when drafting drug prior authorization policies.
- The Centene Corporate P&T Committee makes the final decision regarding clinical appropriateness of medical necessity policies and utilization management recommendations. Criteria for all drugs are developed for approval by the Drug Information team, and reviewed at CPAC prior to presentation at P&T. The Corporate P&T Committee must approve the prior authorization and medical necessity guidelines before implementation.
- The Health Plan creates a state-specific criteria if any of the following apply:

1. State regulations or health plan needs necessitate different criteria than an existing corporate criteria;
2. The Health Plan has a need for clinical criteria that is not necessary at the corporate level (Note: confirm with corporate P&T Committee if there is a question about whether the criteria could apply at the corporate level);
3. Clinical criteria are currently housed in utilization management (UM) policy. Any clinical criteria a Health Plan follows must be removed from UM policies and documented in a criteria.

B. PRIOR AUTHORIZATION AND MEDICAL NECESSITY REVIEW PROCESS

- It is Pharmacy Services policy to handle all Medicaid PA requests in a manner and timeframe that complies with all Federal and State laws and regulations.
- Policy CC.PHARM.03A (Medicaid Prior Authorization Review Process) documents the prior authorization review process for Medicaid PA reviews, wherein Pharmacy Services reviews requests for medications designated as "PA required" on the plan's Preferred Drug List (also referred to as a formulary).
- In order for a PA or MN medication to be covered, the prescriber must submit information consistent with the developed criteria to obtain approval for the medication. A form for submission of a PA or MN request is posted on Health Plan websites (see Attachment A, Medication Prior Authorization Form). Use of this form is not a requirement but provided only as guidance on the information that may be necessary to assure prompt review of a PA or MN request.
- Centene or its subsidiaries does not discriminate on the basis of race, color, national origin, sex, age or disability, nor exclude from participation in, deny the benefits of, or otherwise subject to discrimination under any applicable Company health program or activity.

C. APPEAL PROCEDURE

- The member, member's authorized representative, prescriber, or a member of the prescriber's staff may call, write, or fax Pharmacy Services to request coverage authorization, request to appeal an adverse determination, decline the request to prescribe a PDL alternative therapy, and/or refuse to supply additional information supporting the original request for coverage.
- A Clinical Pharmacist reviews any disputed denial or appeal to ensure appropriateness and forwards appeals to the Centene Health Plan. The health plan follows its policy and process for appeal review.

- An outreach to the prescriber may be made by the Centene Health Plan Pharmacist or Medical Director as deemed appropriate. The denial may be overturned at any time during the appeal review process and a pharmacy technician will enter an authorization for approval in the pharmacy claims processing system. Both member and provider are notified in the event that a denial has been overturned.
- A final determination for any appeal of denials is made by the Health Plan Medical Director or the Centene Health Plan Pharmacist as allowed by state regulations. The Health Plan Pharmacist can overturn the denial on appeal but only the Plan Medical Director, or other appropriate same-or-similar specialist reviewer, can uphold the denial on appeal. An appeal resolution letter is sent to both the prescriber and the member. Documentation of the appeal review, including all letters associated with the appeal, is kept on file by the Health Plan.

REFERENCES:
CC.COMP.42_ACA 1557 Nondiscrimination in Health Programs Activities
CC.PHARM.31 Creating and Revising Drug Prior Authorization Policies
CC.PHARM.03A Medicaid Prior Authorization Review Process

ATTACHMENTS:

Attachment A: Medication Prior Authorization Request Form

Attachment B: South Carolina Absolute Total Care Addendum

Attachment C: Kansas Sunflower Addendum

Attachment D: Georgia PSHP Addendum

Attachment E: Iowa Total Care Addendum

Attachment F: Arizona Medicaid Addendum

Attachment G: New Hampshire Addendum

Attachment H: Oregon Trillium Addendum

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Attachment I: North Carolina Addendum

Attachment J: Nebraska Total Care Addendum

DEFINITIONS: N/A

REVISION LOG

REVISION	DATE
Remove "clinical personnel, participating physicians, and network pharmacists" from "SCOPE" as those are external parties and are not to be included per template definition of "SCOPE".	05/07
Remove the following from "PURPOSE": "Some medications requiring Prior Authorization may not be included in the Preferred Drug List (PDL). Formulary guidelines may require that certain conditions be met before these PA medications can be authorized."	02/08
Replace the "formulary" with "Preferred Drug List (PDL)" throughout the document.	02/08
Replace the "PBM" with "US Script" throughout the document.	02/08
Replace "the member will be issued an NOA (Notice of Action) and a copy of the right to a State Hearing form. Subsequently a file of all denials will be documented by US Script, Inc. and the Centene Health Plan appeals and grievance coordinator, whom will be responsible to send a copy of each State Hearing Form to the State." with "US Script will provide the plans, on a daily basis, a completed member denial letter for each denial processed." in the fifth bullet point of the "PROCEDURE".	02/08
Add the following bullet to the "PROCEDURE": "The plans will send the denial letter to the member and notify them of their right to appeal the decision."	02/08
Replace "the NOA and State Hearing Forms provide the directions for requesting an appeal or a State Hearing." with "the denial letter contains all of the member's options for appeal including contact information directing the	02/08

appeal back to the plan or any applicable state agencies" after "In the event a patient disagrees with the decision..." under "PROCEDURE".	
Complete reworking of the Policy and Procedure, identifying responsibilities, development and approval of PA criteria, timeliness of reviews, provider and member notification of denials, the appeals process and referral of appeals to the Health Plans for final determination.	02/09
Revisions completed at this time were made to address clerical errors, align with NCQA standards and language, and represent the work processes in place at both the Plan level and at US Script.	02/10
Defined notification of member and prescriber if a denial is overturned. Other semantic language changes only.	02/11
No changes.	02/12
Added language to the description of the prescriber denial response to include the reason for the denial.	10/12
No changes deemed necessary.	02/13
No changes deemed necessary.	02/14
No changes deemed necessary.	08/14
Deleted from Scope and Purpose sections: "Corporate Pharmacy Department and US Script" and replaced with "Pharmacy Solutions Group".	08/15
Annual Review; added verbiage concerning states that do not allow pharmacists to deny a prior authorization request.	08/16
Updated the purpose to include program exceptions for drugs not on the Health Plan's PDL.	09/16
Changed US Script to Envolve Pharmacy Solutions.	11/16
Changed section of policy to state PA and MN requests are responded to within 24 calendar hours; removed reference to urgent requests since all requests are now responded to within 24 calendar hours; removed "Envolve Pharmacy Solutions" that preceded claims processing system to just state "pharmacy claims processing system"; changed "Envolve Pharmacy Solutions application" to "pharmacy claims processing system" under Appeal Procedure section in the 3rd bullet; under bullet 8 added: A request for reconsideration containing new or additional information will be processed by Envolve Pharmacy Solutions as a new request and tracked independently of the initial PA request; under Appeal Procedure section in bullet 4 added: The Health Plan Pharmacist can overturn	11/17

the denial on appeal but only the Plan Medical Director can uphold the denial on appeal; under bullet 5 of Policy section, "delegate" changed to "other appropriate reviewer"; under bullet 8 of Policy section, removed "normally within 24 to 48 hours of the denial determination"; under bullet 3 of Appeal Procedure, added that a pharmacy technician will enter the authorization in the claims processing system; in 2nd bullet on Appeal Procedure added, "The health plan will use its policy and process for appeal review"; Added discrimination statement; Updated references; Added to Purpose: PA policies approved by CPAC that have not yet been presented at Corporate P&T are considered to be interim PA policies. Prior authorization pharmacists use interim criteria as reference when evaluating coverage requests until the criteria are reviewed and approved at Corporate P&T.	
Added under bullet 6 - If all necessary information to review the request is not received in a timely manner, the request will be reviewed with the available information by the medical director and a decision rendered within 24 hours; Added under bullet 6 that for a PA or MN denial, the prescriber will be faxed notification of the adverse determination within 24 hours.	08/18
Changed legacy PBM application to prior authorization system. Specified that providers are notified of Prior Authorization decisions via fax. Updated Appeal Procedure to allow members to request an appeal. Minor grammatical changes. Updated Attachment A to the current Envolve Pharmacy Solutions PA Request form. Added Addendum for Peach State Health Plan as Attachment B to the Attachments section. Changed "adverse coverage determination" to "adverse determination" in the first bullet of the APPEAL PROCEDURE section (pg 3).	05/19
Annual review. Added Addendum for South Carolina Absolute Total Care.	08/19
Added two policies to References section: EPS.PHARM.31 Creating and Revising Drug Prior Authorization Policies and EPS.PHARM.03A Medicaid Prior Authorization Review Process. Revised section that said when a medication is approved or denied a notation is made in the pharmacy claims processing system to say in the PA processing system. Revised the section that describes member denial letters being sent by EPS to all Centene healthplans on a daily basis. Member denial letters are only provided to the health plans daily if they are requested.	08/20

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Added Addendum for Kansas Sunflower.	11/20
Added Georgia Peach State Addendum back, which was inadvertently removed.	01/05/21
Annual Review- Minor grammatical updates. Updated to new EPS PA Request Form for Attachment A. Added to prescriber notification of denial: language notifying of right to appeal the decision, a description of appeal rights, explanation of the appeal process and expedited appeal process, reference to the criteria on which the decision was based and a statement that a copy of the criteria used can be obtained, upon request. Added to member denial letter: description of the expedited appeal process, notification of an external review process, a reference to the criteria on which the decision was based and a statement that a copy of the criteria used can be obtained, upon request. Added Addendum for Iowa.	08/21
South Carolina Addendum was updated.	11/21
Added section regarding when health plans create state-specific PA or MN criteria. Changed Certified Pharmacy Technician to licensed Pharmacy Technician. Changed Envolve Pharmacy solutions to Centene Pharmacy Services. Georgia PSHP Addendum was updated. South Carolina ATC Addendum was updated. Medicaid PA Request Form Attachment was updated. Removed Centene Corporate Pharmacy Solutions. Added addendum for Arizona. Iowa Addendum was updated.	05/22
Annual Review- Georgia Addendum was updated.	08/22
Added Addendum for New Hampshire. Georgia Addendum was updated.	02/23
Addendums added for Oregon and North Carolina.	05/23
Annual Review- Removed references to Health Plan P&T Committees. Updated policy to direct to CC.PHARM.31 (Creating and Revising Drug Prior Authorization Policies) and CC.PHARM.03A (Medicaid Prior Authorization Review Process) for specific process details.	08/23

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Removed specific details of the PA Department review process since we are now directing to the PA Department team's Policy CC.PHARM.03 Addendum added for Nebraska Total Care.	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.