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	**RETIRED DATE:** N/A
PRODUCT TYPE: Medicaid	**PAGE:** Page 1 of 8

SCOPE:
Centene Corporate Pharmacy Solutions, Health Plan Pharmacy Departments, Envolve Pharmacy Solutions.

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 both the Corporate and Health Plan Pharmacy and Therapeutics (P&T) Committees. 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:
- The Centene Corporate and Health Plan P&T Committees make the final decisions regarding which medications are included on the PDL and of these, which require PA for approval. Criteria for all drugs are developed for approval by the CPAC. The respective approval criteria are labeled either PA or MN criteria. The Corporate and Health Plan P&T Committees must approve the prior authorization and medical necessity guidelines before implementation.
- 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 web sites (see Attachment A, Envolve Pharmacy Solutions 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.
- Initial PA and MN requests are reviewed by a Certified Pharmacy Technician (CPhT) or a licensed Clinical Pharmacist at Envolve Pharmacy Solutions for a determination of meeting criteria. For requests that meet initial screening criteria, an authorization for approval is

entered in the Envolve Pharmacy Solutions prior authorization system and the prescriber is notified via fax that approval has been granted.

- When a request does not meet criteria, it is forwarded to a licensed Envolve Pharmacy Solutions Clinical Pharmacist for a final determination. Clinical Pharmacists review all denials.
- For clients that reside in a state that does not allow pharmacists to deny a prior authorization request, the requesting prescriber is notified via fax that the request will be forwarded to the health plan or other appropriate reviewer for further review, evaluation and a decision, for requests that cannot be approved.
- PA and MN requests are responded to within 24 hours. 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 reviewer and a decision rendered within 24 hours. NOTE: If the request does not contain sufficient information to make an informed decision, the Envolve Pharmacy Solutions reviewer notifies the prescriber via fax and documents the request for additional information. If additional information is not received within the original 24 hour timeframe to allow the Envolve Pharmacy Solutions reviewer to make an informed decision, a denial notification is completed in accordance with the process described above (see CC.PHAR.06_PBM Inquiry for Additional Information).
- When a medication is approved or denied a notation is made in the PA processing system. In the event of a PA or MN denial, the prescriber is faxed notification of the adverse determination within 24 hours, including the reason for the 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, along with a request for use of PDL alternatives (when appropriate).
- The member denial letter is mailed to the member by Envolve Pharmacy Solutions or the Centene Health Plan upon receipt. Both the prescriber notification and the member denial letters include the reason for the denial and language notifying of the right for appeal of the decision, 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, including contact information at both the Centene Health Plan and any applicable state agencies, if required. Upon request by the Centene Health Plan, Envolve Pharmacy Solutions will provide copies of all member denial letters on a daily basis, for the previous day, via an automated process.
- The prescriber or the member / (member`s authorized representative) may request reconsideration of any denial made by Envolve Pharmacy Solutions or the Centene Health

Plan Medical Director. A record of all denials is maintained by Envolve Pharmacy Solutions and/or the Health Plan as applicable. A request for reconsideration containing new or additional information is processed by Envolve Pharmacy Solutions as a new request and tracked independently of the initial PA request. A 72 hour supply is available any time there is a delay in the review process.

- 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.

APPEAL PROCEDURE:

- The member, member`s authorized representative, prescriber, or a member of the prescriber's staff may call, write, or fax the Envolve Pharmacy Solutions Clinical Pharmacy Department 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.
- An Envolve Pharmacy Solutions 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
EPS.PHARM.31 Creating and Revising Drug Prior Authorization Policies
EPS.PHARM.03A Medicaid Prior Authorization Review Process

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ATTACHMENTS:

Attachment A: Envolve Pharmacy Solutions Medication Prior Authorization Request Form

CC.PHAR.08_Attachment A_EPS PA Requ

Attachment B: South Carolina Absolute Total Care Addendum

CC.PHAR.08_Attachment B_SC Addendu

Attachment C: Kansas Sunflower Addendum

CC.PHAR.08_Attachment C_KS Sunflowe

Attachment D: Georgia PSHP Addendum

CC.PHAR.08_Attachment D_Georgia PSH

Attachment E: Iowa Total Care Addendum

CC.PHAR.08_Attachment E_Iowa Addend

DEFINITIONS: N/A

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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 appeal back to the plan or any applicable state agencies" after "In the event a patient disagrees with the decision..." under "PROCEDURE".	02/08
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	02/11

semantic language changes only.	
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 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	11/17

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
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	08/21

the decision was based and a statement that a copy of the criteria used can be obtained, upon request. Added Addendum for Iowa.	
South Carolina Addendum was updated.	11/21

POLICY AND PROCEDURE APPROVAL

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