MedStar Family Choice

DISTRICT OF COLUMBIA

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**218.DC**	
Subject:	**Pharmacy Authorization Process**	
Section:	**Pharmacy**	
Initial Effective Date:	**10/01/2020**	
Revision Effective Date(s):	**07/21, 07/22, 9/22, 07/23, 07/24**	
Review Effective Date(s):		
Responsible Parties:	**Health Plan Pharmacist, P&T Committee**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**NCQA 2024: UM 5C:2,4,7,8; UM 7G-I; UM 11B:4, UM 11E DC Contract C.5.28.15**	
Approved:	**AVP Clinical Operations**	**Senior Medical Director (Chief Medical Officer-DC)**

Purpose: **To define a process to ensure that Enrollees receive medically necessary medication promptly if the medication is non-formulary or formulary with a prior authorization requirement.**

Scope: **MedStar Family Choice, District of Columbia (DC)**

Policy: **MedStar Family Choice, DC follows standard processes for evaluating requests for medications requiring prior authorization in a timely fashion, consistent with the DC Contract and NCQA standards.**

Definitions:

Request: When an Enrollee, prescriber, or dispensing pharmacy staff asks for coverage of a specific pharmaceutical product.

- Includes concurrent and pre-service requests as defined by NCQA 2024 standards.

Urgent Request: A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the Enrollee or others, due to the Enrollee's psychological state, or
- In the opinion of a practitioner with knowledge of the Enrollee's medical or behavioral condition, would subject the Enrollee to adverse health consequences without the care or treatment that is the subject of the request.

Retrospective or Post-Service Request: A request for coverage of pharmaceutical services that have been received, such as if an Enrollee paid out-of-pocket for a prescription and is now seeking reimbursement.

Medical Reviewer: Medical Director or Health Plan Pharmacist

Procedure:

1. The request for medication authorization may be initiated by a prescriber, Enrollee, or dispensing pharmacy staff via telephone, fax, or on the MedStar Family Choice DC website.
   - 1.1. Requests may be submitted by telephone or fax using the corresponding submission form (see 1.2).
     - 1.1.1. Fax number: 202-243-6258
     - 1.1.2. Phone number: 855-798-4244
   - 1.2. Forms are located on the MedStar Family Choice DC pharmacy webpage. (https://www.medstarfamilychoicedc.com/providers/pharmacy)
     - 1.2.1. Pharmacy Prior Authorization (PA)/Non-Formulary (NF) form
     - 1.2.2. Opioid PA form for requests for any opioid medication
   - 1.3. For phone requests, preauthorization staff will take the date and time of request initiation, Enrollee's name, telephone number, prescriber's name, and details about the medication being requested.
   - 1.4. Requests must include clinical documentation to show medical necessity.
   - 1.5. A preauthorization staff member and a medical reviewer are on-call to receive and process any after-hour pharmacy requests.
     - 1.5.1. Requests submitted outside of normal business hours (Monday through Friday, 8:00 am-5:30 pm) will be reviewed by the clinical staff on call.

2. Preauthorization staff enter all requests into the clinical software system and forward them to a Medical Reviewer to evaluate and render a decision. If needed, the preauthorization staff may:
   - 2.1. Contact the prescriber to request any incomplete or missing clinical information, when not included with the initial request;
     - 2.1.1. Preauthorization staff will make at least one attempt to request needed clinical information.
   - 2.2. For formulary medication requiring prior authorization (PA) or step therapy (ST):
     - 2.2.1. Capture the approval criteria of the requested medication from the "Prior Authorization and Step Therapy Table" within the request; and
     - 2.2.2. Collate any clinical information provided in the request that supports PA or ST requirements;
     - 2.2.3. If PA or ST criteria are not met, redirection to a formulary alternative option may only be done under the supervision of a Medical Reviewer.
   - 2.3. Document if a requested medication is non-formulary.
     - 2.3.1. Redirection to a formulary-preferred option is done under the supervision of a Medical Reviewer.
   - 2.4. Document if the request originated from a network or non-network provider;

2.5. Preauthorization staff may obtain additional clinical information using available electronic health information resources to provide the Medical Reviewer information needed to evaluate medical necessity. Resources may include but are not limited to:
    2.5.1. MedStar Family Choice's clinical software system;
    2.5.2. MedStar system EMR;
    2.5.3. PBM prescription claims database;
    2.5.4. Prescription Drug Monitoring Program (PDMP) – CRISP-DC;
2.6. Summarize associated clinical documentation, then forward the request to a Medical Reviewer for clinical evaluation and determination.

3. The Medical Reviewer evaluates requests received in the clinical software system for medical necessity and clinical appropriateness.
    3.1. If additional clinical information is needed for evaluation
        3.1.1. The Medical Reviewer may ask preauthorization staff to procure the needed information.
        3.1.2. The Medical Reviewer may contact the prescribing provider for additional information.
    3.2. For non-formulary medication requests, the Medical Reviewer determines medical necessity as described in pharmacy policy 205.DC Non-Formulary Medications, sections 6 and 7.
    3.3. The Medical Reviewer makes a final decision to approve, deny, or otherwise action any request deemed to require clinical review.
        3.3.1. The timeline for rendering a decision is described in section 6, Table 1.
        3.3.2. For cases where full information is not available, the Medical Reviewer evaluates available information to make a final decision.
        3.3.3. Requests may be redirected or voided, if deemed appropriate by the Medical Reviewer.
        3.3.4. If the Medical Reviewer successfully redirects a request to a formulary alternative that requires PA or ST, the initial request may be converted to a request for the redirected medication.
            3.3.4.1. Preauthorization staff will update the request, as needed.

4. The default length of the approval period is the duration requested by the provider.
    4.1. Approval durations may have drug-specific limitations.
        4.1.1. Maximum 6-month approval for controlled medications.
        4.1.2. Maximum 12-month approval for non-controlled medications.
        4.1.3. Length of the approval period may be shorter as identified on the PA and ST table.
    4.2. Approval periods may differ for initial versus renewal authorizations.
    4.3. Medical Reviewers may use their clinical judgement to render partial approvals or shorter approval duration when clinically appropriate.

5. Preauthorization staff process and complete notification for all completed requests.
    5.1. Notification of a decision complies with the timelines as described in section 6.
    5.2. Approved request processing:

5.2.1. Place an override in the pharmacy benefits management (PBM) claims system so the prescription will adjudicate for the approved duration.
5.2.2. Notify the dispensing pharmacy to reprocess the claim.
5.2.3. Communicate the approval to the requesting individual by phone or by fax.

5.3. Denied request processing:
5.3.1. Preauthorization staff notify the Enrollee and prescriber of the denial in writing. The denial letter includes:
5.3.1.1. The specific reason(s) for the denial, in easily understandable language.
5.3.1.2. A reference to the benefit provision, guideline, protocol, or other criterion upon which the denial decision is based.
5.3.1.3. Formulary alternatives, if applicable.
5.3.1.4. Directions to access the Formulary and/or PA & ST Table, if applicable.
5.3.1.5. Procedure for initiating an appeal.
5.3.1.6. Name and credentials of the Medical Reviewer.
5.3.1.7. Option to discuss the denial with the Medical Reviewer, if desired.
5.3.1.8. The process and timeline for initiating an appeal.
5.3.1.9. Any additional information needed for the appeal.
5.3.1.10. A statement that upon request, Enrollees can obtain a copy of the actual benefit provision, guideline, protocol, or other criterion on which the denial decision is based.
5.3.1.11. Any forms required.
5.3.2. The appeal process is described in Member Services policies:
5.3.2.1. 301.DC; Enrollee Appeals, and
5.3.2.2. 307.DC; Provider Disputes.

5.4. Partially approved request notification follows processes described in 5.2 and 5.3.

6. Pharmacy requests are processed in accordance with NCQA Standards and DC Contract requirements.
6.1. Timelines for decision-making and notification are described in Table 1 below.
6.2. Requests confirmed to be clinically urgent will be prioritized for processing, and notification of the decision will occur no more than 24 hours from the date of receipt.
6.3. Requesting prescribers may speak to a Medical Reviewer at any during request processing.
6.4. Enrollees may initiate a retrospective coverage request up to 180 calendar days after the date of service.
6.4.1. If request approval occurs within three (3) days of the date of service, the enrollee will be instructed to return to the pharmacy for a refund.
6.4.2. If request approval occurs three (3) or more days after the date of service, enrollees will be instructed to mail their pharmacy and cash register receipts as described in Appendix I.

6.5. Requests that are redirected to a formulary-preferred alternative, or otherwise determined to be void/canceled will be processed within 24 hours from the date of receipt.

Table 1. Pharmacy request timelines and notification processes.

Request Type	Timeline for UM Decision Making	Timeline for Notification	Notification Method	Who Must Be Notified
All Requests other than retrospective/post-service • Enrollee Exception Requests • Non-Urgent Requests • Urgent Requests*	Within 24 hours of the receipt date of the Request for Authorization. MedStar Family Choice DC will approve, deny, or request further information. If further clinical information is not received: a decision is made within 24 hours of the date of receipt.	Notification of the decision within 24 hours of the receipt date. A decision is made within 24 hours of the receipt date regardless of whether clinical information is received	Notice by telephone or another telecommunication device. Electronic or written (required for denials)	Telephone or Other Telecommunication Device (required): - Requesting practitioner/provider Written (required for denials): - Requesting facility - Requesting physician or clinician - PCP -Enrollee or Enrollee's authorized representative
Retrospective/ Post-Service Pharmacy Requests	Within 14 calendar days of the receipt date of the request.	Electronic or written within 14 calendar days of the initial receipt date of the request.	Electronic or written	- Enrollee or Enrollee's representative (verbal approval or written denial) -Treating physician or clinician or requesting provider - PCP (denial only)

*Urgent requests will be processed as expediently as feasible, not to exceed 24 hours from date of receipt.

Summary of Changes:	**07/24** • P&T Committee changed from Responsible Department to Responsible Parties • Updated Approver names and titles • Updated NCQA reference to 2024 Standards • Reworded the Purpose statement for clarity and to remove references to policies that cite this policy as a reference. • Incorporated content from pharmacy policy 212.DC Prior Authorization • Reformatted procedures to improve readability and minimize redundancy. • Removed duplicative content captured in both policy 218.DC and retired policy 212.DC

	• Clarified the process for identifying and redirecting to formulary-preferred alternative medications. • Added section about duration of approval (section 4) • Added Appendix: Prescription Reimbursement Claim Form **07/23** • Responsible Parties changed to Health Plan Pharmacist • Health Plan Pharmacist added with Medical Director throughout Policy • Updated NCQA reference to 2023 Standards • Removed Prior Auth Medication Form. **09/22:** • Updated the contact information and provided a link to the documents on the MedStar Family Choice DC Web site. • Combines all requests into Pre-Service and Post-Service. **07/22:** • Updated Responsible Parties to Plan Pharmacist. • Changed Approved from Patryce Toye, MD CMO to Raymond Tu, MD Senior Medical Director (CMO). • Updated NCQA Reference to 2022 Standards. • Updated tables to reflect changes to UM5C for pharmacy 24-hour response time. **07/21:** • Changed Case Management to Clinical Operations in Responsible Departments. • Changed responsible parties from Dr. Patryce Toye & Dr. Danielle Gerry to Raymond Tu, MD & Seema Kazmi, PharmD. **10/20:** • New policy.

Appendix I. Prescription reimbursement claim form.

CVS caremark

14423-STANDARD-0816

Prescription Reimbursement Claim Form

Important!

- Always allow up to 30 days from the time you receive the response to allow for mail time plus claims processing.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your prescription card)

Group Number/Group Name

Last Name

First Name MI

Address

Address 2

City

State Zip Country

Patient Information–Use a separate claim form for each patient

Last Name

First Name MI

Date of Birth Male Female Phone Number

Relationship to Primary Member
Member Spouse Child Other

Pharmacy Information

Pharmacy Name

Address

City State Zip

REQUIRED: Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (tape receipts or itemized bills on the back)

Reason I am filing this form is:

- ☐ Out of the country
- ☐ Pharmacy does not accept insurance
- ☐ Compound
- ☐ No insurance coverage at the time
- ☐ Other–provide reason below

☐ Medication purchased outside of the United States (tape receipts or itemized bills on the back)

PLEASE INDICATE:

Country: _____

Currency used: _____

Other Insurance Information

Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury? ☐YES ☐NO

Is the medicine covered under any other group insurance? ☐YES ☐NO

If YES, is other coverage:
☐PRIMARY ☐SECONDARY
☐MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company: _____

ID#: _____

Continued

Pharmacy Information Continued

Phone Number

Is this an on-site nursing home pharmacy? YES NO

NCPDP/NPI Required

x _____

Signature of Pharmacist or Representative (REQUIRED)

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x _____

Signature of Plan Participant (REQUIRED) Date

STEP 2 Submission Requirements

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will ONLY be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC Number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

A valid Prescribing Physician's NPI (National Provider Identification) number is required, please provide: _____

Prescribing physician's information (all fields required):

Name: _____

Address: _____

City, state, zip: _____

Phone: _____

Additional comments: _____

STEP 3 Mail completed forms with receipts to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER–To avoid having to submit a paper claim form:

- Always have your card available at time of purchase.
- Use medication from your formulary list.
- Always use pharmacies within your network.
- If problems are encountered at the pharmacy, call the number on the back of your card.