MedStar Family Choice

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**218**	
Subject:	**Pharmacy Authorization Process**	
Section:	**Pharmacy**	
Initial Effective Date:	**01/01/2018**	
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Responsible Parties:	**Health Plan Pharmacist, P&T Committee**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**MDH Standards and Reporting Requirements of Drug Use Management Programs for MCOs March 2025 version, 2.12, 3.0. COMAR 10.67.09.04 I (d), COMAR 10.67.09.04(A)(3) NCQA 2025:UM 5C: 2, 4, 7, 8, and Extension Conditions, UM 7G-I, UM 11B(4), UM 11E**	
Approved:	**AVP Clinical Operations**	**Chief Medical Officer**

Purpose: **To define a process to ensure that members receive medically necessary medication promptly when the medication(s) are non-formulary or formulary with a prior authorization requirement.**

Scope: **MedStar Family Choice – Maryland**

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

Definitions:

Request: When a member, 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 member or others, due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Decision Extension: A one-time extension, by up to 14 calendar days may be granted, under the following conditions:

- The member requests an extension, or
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information
- Medical reviewer has determined that the information provided is insufficient to render a decision

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

Medical Reviewer: Medical Director or Health Plan Pharmacist

Procedure:

1. A request for a medication authorization may be initiated by the prescriber, member, or the dispensing pharmacy staff via telephone, fax or on the MedStar Family Choice website.
   - 1.1. Requests may be submitted by telephone or fax using the corresponding submission form (see 1.2).
     - 1.1.1. Fax numbers: 410-933-2274, 410-350-7492, or
     - 1.1.2. Phone to 410-933-2200 or 800-905-1722
   - 1.2. Forms are located on the MedStar Family Choice pharmacy website: https://www.medstarfamilychoice.com/maryland-providers/pharmacy-prescription-information
     - 1.2.1. General Medication Prior Authorization form
     - 1.2.2. Hepatitis C Medication Prior Authorization form
     - 1.2.3. Opioid Prior Authorization form
     - 1.2.4. Wegovy Prior Authorization form
   - 1.3. For phone requests, preauthorization staff will record the date and time of the request, the member's name, telephone number, prescriber's name, details about the medication being requested.
   - 1.4. Requests must include clinical documentation to support medical necessity.
   - 1.5. After-hour pharmacy requests:
     - 1.5.1. Requests submitted outside of the normal business hours of Monday through Friday, 8:30 am to 5 pm, will be reviewed by the on-call Medical Reviewer.
     - 1.5.2. A preauthorization staff member is also on-call to receive requests, enter the data into the clinical software system, and forward them to a Medical Reviewer to

evaluate for a decision. The preauthorization staff will process Medical Reviewer decisions by entering any needed overrides into the PBM system and communicating the decision to the requestor, member, and/or pharmacy as needed.

2. Preauthorization staff will enter all requests into the clinical software system and forward them to a Medical Reviewer to evaluate and render a decision.
   2.1. Categorize the reason for the request, e.g. non-formulary exception, prior authorization required, early refill or vacation request, quantity limits exceeded, etc.
   2.2. Document the formulary status of the requested product.
   2.3. Specify if requested product appears on the High Cost Medications list.
   2.4. Collate any clinical documentation that supports the request.
   2.5. Document if the prescriber is a network or non-network provider.
   2.6. Summarize associated clinical documentation.
   2.7. Forward preliminary request to Medical Reviewer (at this time).
   2.8. If additional information is needed to supplement the request, the preauthorization staff may obtain the resources, which may include, but are not limited to:
      2.8.1.1. Direct provider outreach,
      2.8.1.2. MedStar Family Choice's clinical software system,
      2.8.1.3. MedStar system EMR,
      2.8.1.4. LabCorp data
      2.8.1.5. PBM Claims reporting database.
   2.9. Documentation of all provider outreach attempts must be recorded in the clinical software system and include:
      2.9.1. Date and Timestamp of outreach attempt.
      2.9.2. Type of outreach (e.g. fax, phone, email, etc.).
      2.9.3. Contact details (e.g. fax, phone or email address) used for outreach and name of recipient.
      2.9.4. Description of information requested.

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 at least one attempt to obtain that information will occur within the first 24-hours of request receipt.
      3.1.1. The Medical Reviewer may ask preauthorization staff to procure the needed information.
      3.1.2. The Medical Reviewer may contact the prescriber for additional information.
      3.1.3. The Medical Reviewer may access the Chesapeake Regional Information System (CRISP), *excluding* the of the Prescription Drug Monitoring Portal (PDMP) portion of the data base.
   3.2. For non-formulary medication requests, the Medical Reviewer determines the medical necessity as described in pharmacy Policy 205: Non-Formulary Medications, Sections 6 and 7.
   3.3. The Medical Reviewer makes a 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 of this policy.

3.3.2. For cases where the full information is not available, the Medical Reviewer evaluates available information to make a decision.
3.3.3. Requests may be redirected by the Medical Reviewer or withdrawn if original requestor agrees.
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 may update the request when the Medical Reviewer has successfully redirected the request.

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.
4.4. MedStar Family Choice reserves the right to discontinue an existing authorization when the new authorization would create a duplication of therapy; this may result when the prescriber has discontinued the previously authorized medication.

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 7 of this policy.
5.2. Approved request processing:
5.2.1. Preauthorization staff will enter an override in the Pharmacy Benefits Management (PBM) claims system so the prescription will adjudicate for the approved duration, and
5.2.2. Notify the dispensing pharmacy to reprocess the claim, and
5.2.3. Communicate the approval to the requestor by phone, fax, or electronic portal.
5.3. Denied request processing:
5.3.1. Preauthorization staff notify the member and prescriber of the denial in writing. The denial letter includes:
5.3.1.1. The specific reason(s) for the denial, in easily understood 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. Name and credentials of the Medical Reviewer.
5.3.1.6. Option to discuss the denial with the Medical Reviewer, if desired.
5.3.1.7. The process and timeline for initiating an appeal.
5.3.1.8. Any additional information needed for the appeal.

5.3.1.9. A statement that Members may obtain, upon request, a copy of the actual benefit provision, guideline, protocol, or other criterion on which the denial decision is based.

5.3.1.10. Any forms required e.g., if requesting a Brand medication and a MedWatch form is required for approval, MedStar Family Choice will include the form with the denial.

5.3.2. The appeal process is described in Member Services policies:

5.3.2.1. Policy 301: Member Appeals; and

5.3.2.2. Policy 307: Provider Appeals.

5.4. Partially approved request notification follows processes described in Section 6.2 and Section 6.3 of this policy.

6. Pharmacy requests are processed in accordance with NCQA Standards, the Maryland Department of Health Standards and Reporting Requirements for Drug Use Management Programs for MCOs, and the Code of Maryland Regulations (COMAR).

6.1.1. 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 time during request processing.

6.4. Members 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 member will be instructed to return to the pharmacy for a refund.

6.4.2. If request approval occurs more than three (3) days after the date of service, members will be instructed to mail their pharmacy and cash register receipts using the form and instructions described in Appendix I.

6.5. Requests that are redirected to a formulary-preferred alternative, or otherwise determined to be withdrawn 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 or Post-service • Non-Urgent Preservice Requests • Urgent Requests* • Urgent concurrent requests	Within 24 hours of the receipt date of the Request for Authorization. MedStar Family Choice MD will approve, deny, or request further information. If further clinical information is not received: a decision is made	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 -Member or Member's authorized representative

	within 24 hours of the date of receipt.			
Retrospective/ Post-Service Pharmacy Requests	Within 30 calendar days of the receipt date of the request.	Electronic or written within 30 calendar days of the initial receipt date of the request.	Electronic or written	-Member or Member'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:	**07/25:** • Updated all NCQA, MCO Standards, and COMAR references to current year. • Added Decision Extension section. • Added section 1.2.4-to include Wegovy PA form • Section 2 Added Clarification to categorize the reason for the request • Section 2.8 added the avenues the team may reach out to the providers and receive documentation • Section 3.1 added clarification on one attempt within the first 24 hours. • Section 3.2-specified for Non-formulary medication request • Section 3.3 removed "final" **07/24:** • Moved P&T Committee listing from "Responsible Department" to "Responsible Parties" section. • Reformatted font and procedure to improve readability. • Updated all NCQA, MCO Standards, and COMAR to current year references. • Updated policy Approver titles and removed individual names. • Incorporated Policy 212: Pharmacy Prior Authorization • Reworded the Purpose statement for clarity and to remove references to policies that cite this policy as a reference. • Clarified the process for redirecting to formulary preferred alternative medications, with emphasis that this may be done only by a Medical Reviewer or under the direct supervision of a Medical Reviewer. • Added additional fax number for initiating an authorization request.

	• Removed obsolete references to the 2017 Hepatitis-C PA timeline and all references, obsolete. • Added Appendix I: Prescription Reimbursement Claim Form **07/23:** • Responsible Parties changed to Health Plan Pharmacist • Health Plan Pharmacist added with Medical Director throughout Policy • Updated regulatory reference MDH Standards to March 2023 • Updated NCQA reference to 2023 Standards • Updated Approved by to: Dr. Wills and C. Attia • Updated COMAR references • Removed Table: Medication Request from Patient, Prescriber or Pharmacy **07/22** • Responsible Parties changed to Dr. Gregory Dohmeier • Removed from Responsible Parties: Dr. Gerry and Dr. Toye • Updated Regulatory Reference to April 2022 MDH Standards • Updated NCQA Reference to 2022 Standards • Updated tables to reflect changes to UM5C for pharmacy 24-hour response time • Embedded MDH Memorandum 12/07/2017 expanded and concatenated to pdf **07/21:** • Updated NCQA Reference to reflect 2021 Standards. • Added Maryland to Scope. • Changed Case Management to Clinical Operations in Responsible Departments. **07/20:** • Updated Regulatory References to reflect COMAR recodification and 2020 NCQA Standards. • Added the following COMAR references found in Procedure Section to Regulatory References COMAR 10.67.11.04, COMAR 10.67.09.04(A)(3). • Revised timeline for Urgent Concurrent requests from 72 hours to 24 hours, regardless of the presence or absence of complete clinical information. **07/19:** • Updated NCQA Reference to reflect 2019 Standards. • Removed “Maryland” from scope. • Removed “A” from any policy reference, as applicable. • Updated Urgent Concurrent timeframe to 72 hours from previous 24 hours. **07/18:** • Procedure 1. Updated to reflect methods of making requests (MFC PA form and MFC Non-Formulary Request form).

	• Procedure 2. Requests are sent to the medical director via the clinical software system. • Notification methods and who must be notified updated for all urgent timeframes. • Urgent pre-service and non-urgent notifications were revised to say that decision will occur within 24 hours of complete clinical. • Added “MDH Memorandum dated 12/07/2017: Re: Hepatitis C Medication Approval Timeline” as a reference and embedded it at end of policy. • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. **01/18:** • 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