

20 - Pharmacy Services

The role of Health Plan of Nevada's (HPN) Pharmacy Services is to evaluate and determine the appropriateness of quality drug therapy while maintaining and improving therapeutic outcomes. Listed below are the functions performed by HPN's Pharmacy Services Department.

- Prior authorization of medications
- Call center for providers and pharmacies
- Maintenance of Preferred Drug Lists
- Drug member reimbursement/Coordination of Benefits
- Concurrent Drug Utilization Review
- Retrospective Drug Utilization Review

20.1 Prior Authorization of Prescription Drugs

The prior authorization process involves assessing and screening requests for prescription drug coverage from providers and members. A prior authorization is required for prescription drugs when it is indicated as a requirement per protocol guidelines, the drug is not on the members' formulary, or the request exceeds the plan's quantity limits. The screening process assists HPN in determining if the requested prescription drug is an appropriate therapy for the given diagnosis based on clinical information such as chart notes, lab reports and clinical rationale that is submitted by the provider, current Food and Drug Administration approved diagnosis, and HPN's protocols. The prior authorization process for our Commercial and Medicaid lines of businesses is handled locally by the HPN Pharmacy Services Department.

20.2 How to Obtain Prior Authorization or an Exception for Prescription Drug Coverage

The member, a member's appointed representative or prescribing physician can initiate a prior authorization or an exception request. Prior authorization is a process by which a drug must be approved for coverage before the plan will pay for it, whereas an exception is a request to obtain a non-preferred drug at a lower tier, or to obtain a drug not included in the formulary or the waiver of a utilization management requirement (e.g. step therapy, quantity limit, etc.). For both prior authorization and exception requests, it is the responsibility of the requesting provider to provide pertinent case specific clinical information to support the request for prescription drug coverage. The prior authorization form can be found in the **FREQUENTLY USED FORMS SECTION 24.8** and must be completely filled out.

Exception and Prior Authorization Requests

To submit a *prior authorization or exception request by phone*, call (702) 242-7050 #6 or (800) 443-8197 #6. Hours of operation are 8 a.m. - 5 p.m., Monday through Friday.

To submit a *prior authorization or exception request by fax*, fax (702) 242-6751 or (800)-997-9672. Hours of operation are 8 a.m. - 5 p.m., Monday through Friday.

To submit a *prior authorization exception request by mail*, mail to HPN - Pharmacy Services, Attn: Medical Necessity, P.O. Box 15645, Las Vegas, NV 89114-5645.

If you have questions on Commercial or Medicaid requests, need assistance filling out a form, or would like to inquire about the status of an exception or prior authorization request, call Pharmacy Services at (702) 242-7050 #6 or (800) 443-8197 #6, 8:00 a.m. – 5:00 p.m. Monday through Friday.

20.3 Prior Authorization Timeframes

Standard Requests:

Routine requests are reviewed with a determination rendered within 72 hours. If additional clinical information is needed to render a decision, the provider will be contacted by fax to supply the necessary information. We make every effort to complete all requests that include receipt of ALL necessary clinical information within the allotted timeframe.

Expedited Requests:

Expedited requests are for those services which are related to urgent prescription drug coverage that have the potential to become an emergency in the absence of treatment. Expedited requests are reviewed with a determination rendered within 24 hours. If additional clinical information is needed to render a decision, the provider will be contacted by fax to supply the necessary information. We make every effort to complete all requests that include receipt of ALL necessary clinical information within the allotted timeframe.

20.4 Denial/Appeal Process

Once a prior authorization request has been denied, the provider has the option to appeal the request. Only a Member, a member's appointed representative, or prescribing physician may request an appeal.

To request an appeal, a signed written request for an appeal with evidence and allegations of fact or law related to the issues in dispute must be submitted. This means, please write a letter *requesting an appeal* and provide any and all information that you wish to be reviewed.

The number of available appeals is limited. Please ensure you include all information you wish to be reviewed the first time.

Oral requests for an expedited appeal are accepted but must be followed by a written request within 24 hours.

Medicaid Members

Appeals must be submitted within 90 calendar days from the date of the coverage determination. Extensions may be provided for good cause.

Commercial Members

Appeals must be submitted within 180 calendar days from the date of the coverage determination notice.

To request an appeal, please see the contact information below.

Member Services	Member Services Phone	Member Services Fax (appeals)
Medicaid	(702) 242-7317 / (800) 962-8074	(702) 242-9431
Commercial	(702) 242-7300 / (800) 777-1840	(702) 242-9431

20.5 Pharmacy Services Call Center

Available for Commercial and Medicaid lines of business only.

The Pharmacy Services call center is a dedicated help desk for pharmacies and providers only. Call center representatives are able to assist **retail, hospital, and long term care facility pharmacies** with the following:

- Adjudicating claims online
- Providing eligibility information
- Checking the status of prior authorization

Call center representatives are also able to assist **providers and their staff** with the following:

- Formulary alternatives
- Prior authorization status
- Expedited phone prior authorizations

Pharmacy Services Representatives are available from Monday – Friday from 8:00 a.m. – 5: 00 p.m. (Pacific Standard Time)

	Telephone Number	Fax Number
Las Vegas Area	(702) 242-7050 #6	(702) 242-6751
Toll Free	(800) 443-8197 #6	(800) 997-9672

20.6 After Hours Call Center

From **5:00 p.m. to 8:00 a.m. PST Monday through Friday and all day Saturday and Sunday**, all telephone calls from pharmacists, providers, and health plan Member Services staff members are transferred to the claims processing call center staff who then handle all of the telephone calls. Since the claims processors house the claims processing system for HPN/SHL, call center staff members have access to information needed to handle the calls appropriately, such as eligibility, medication history, and length of health plan enrollment.

20.7 Pharmacy and Therapeutics Committee

HPN utilizes the UnitedHealthcare Enterprise P&T Committee to assist in the clinical management of the HPN custom Preferred Drug Lists. Additional operational committees exist that make additional recommendations on tier placement and other clinical programs. HPN pharmacy leadership is represented on these committees.

20.8 Changes to the Preferred Drug List

The P&T committee reviews requests for the addition or deletion of a drug from the Preferred Drug List and reviews the entire Preferred Drug List at least annually to maintain a clinically sound drug benefit. The P&T Committee may review drugs in response to:

- Provider requests,
- Member requests,
- Updated guidelines for disease treatment,
- New drug entities added to the market,
- Generic formulations added to the market,
- Products removed from the market due to safety or other concerns, and
- New Food and Drug Administration-approved indications or labeling changes.

Decisions to add or remove a drug from the Preferred Drug List are based on Food and Drug Administration-approved indications, efficacy, adverse effect profile, patient monitoring requirements, patient dosage and administration guidelines, impact on total healthcare costs, and comparison to other preferred agents.

20.9 Published Preferred Drug List

The HPN Preferred Drug List is updated regularly and is available on our web site at www.healthplanofnevada.com/provider/Pharmacy-Benefits, click on **Prescription Drug Lists**. Preferred Drug List updates are sent via fax as needed throughout the year. Practitioners are encouraged to use the HPN Preferred Drug List to select the appropriate medications for the members' treatment. Printed copies of the PDL can be made available to members by calling member services.

Upon notification of a drug being withdrawn from the market for safety or other concerns, a notification letter will be sent to affected members and providers within 14 days of a Class I recall and 30 days for a Class II recall informing them of the market change.

20.10 Moratorium

HPN Commercial plans have a 12-month moratorium that may be exercised before new drugs introduced to the market will be reviewed for Preferred List inclusion or exclusion. This will exclude the coverage of new drugs on the market for less than 12 months and allows for additional safety and clinical data to become available.

20.11 Incentives

HPN **does not** provide incentives to members, providers, or pharmacists for the use of preferred medications. However, the member's co-pay is lower with the use of preferred medications included on the Preferred Drug List. HPN may institute quantity limits on medications if there is no data to support the continued high usage of the quantity/dosage being prescribed.

20.12 Generic Substitution for Commercial Plans

HPN has a mandatory generic substitution policy that requires the dispensing of the generic equivalent when available. A significant cost saving can be achieved through the use of safe, therapeutically equivalent generic drugs. If you or the member chooses the brand-name product when a generic equivalent is available the member is responsible to pay the difference between the cost of the generic and brand name product in addition to the generic co-payment.

20.13 Direct Member Reimbursement of Prescription Drugs

HPN will reimburse a patient for a prescription medication that was paid for in cash if the patient meets the criteria for prescription drug coverage.

HPN (Medicaid)

The member can call (702) 242-7317 or (800) 962-8074 and request a Direct Member Reimbursement Form or go to the health plan website at www.myhpnmedicaid.com.

Once the form has been filled out, please mail the form to: **Claims Department, P.O. Box 15645, Las Vegas, NV 89114.**

HPN (Commercial)

The member can call (702) 242-7300 or 1-800-777-1840 and request a Direct Member Reimbursement Form or go online to www.healthplanofnevada.com/Member then click on **I need help with**, then click on **Pharmacy Reimbursement Claim Form** to print out form.

Once the form has been filled out, please mail the form to: **OptumRx Claims Department, P.O. Box 29044, Hot Springs, AR 71903.**

20.14 Drug Utilization Reviews

Drug utilization reviews are performed periodically. These reviews monitor the members' medication usage and report any outliers to normal prescription therapy. Comparisons of provider prescribing patterns are made to other providers within the same specialty. Reports are sent to the prescribing provider and the Medical Director.

Concurrent Drug Review

HPN has systems, policies, and procedures in place to ensure concurrent drug utilization review prior to each prescription being dispensed to a health plan member at the point of sale. The pharmacy management system edits provide alerts and warning messages to pharmacists when medications that have been ordered may need prior authorization or must meet initial step therapy requirements before specific drugs are dispensed. In addition, other system edits alert pharmacists to potential duplicate drug therapy, possible drug to drug interactions, gender and/or age related contraindications, ordering of incorrect drug or dosages, possible misuse/abuse and over utilization, and underutilization for medications that are prescribed at levels less than the therapeutic recommended minimums.

Retrospective Utilization Review

Retrospective DUR activities are implemented after medications have been dispensed to health plan members. While not as effective as the real-time system edits that are in place in the health plan's pharmacy management system at the point of dispensing, retrospective DUR conducted by HPN Pharmacy Services staff can address specific medication management issues at the population level. The results of these activities can help further educate health plan management, members, practitioners, and/or pharmacists about important drug management issues.

2020 HPN Provider Summary Guide

To conduct retrospective DUR activities, Pharmacy Services staff request that data be extracted from the organization-wide Corporate Reporting Database, the health plan's data warehouse. Periodic DUR is conducted in response to identified medication management or quality issues may focus on:

- Drug-drug interactions
- Medication overuse and potential abuse
- Duplicate therapy

Once initial data analysis on the identified medication management issue has been completed, health plan Pharmacy Service management reviews the results of the analysis and work with Clinical Pharmacists to determine appropriate interventions that may include sending letters to affected members, prescribing physicians, and pharmacists. These letters educate the affected parties about the issue at hand and offer recommendations for change, as necessary.

20.15 Frequently Used Forms

- Medical Necessity Request Form (HPN Commercial and Medicaid)
- MedWatch- For the most updated form, go to:
<http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm>



Medical Necessity Request Form

[Applicable for HPN/SHL Commercial/Medicaid members only]

Member Name: _____ Date of Request _____

Primary Cardholder #: _____ M / F DOB: _____

Documented Allergies: _____

Physician Information - COMPLETE INFORMATION IS REQUIRED TO RECEIVE RESPONSE

Physician Name (please print clearly): _____

Physician Signature: _____ DEA No.: _____

Phone: _____ FAX: _____

Address: _____

Office Contact Person _____

Requested Medication

Drug name, strength, quantity and duration of treatment: _____

One drug request per form please

Additional Information: The following information must be included or request will be returned. (Please, when available, attach copies of office notes documenting prior therapy, diagnosis, lab results, etc.)

Diagnosis: _____

Medication History for this Diagnosis:

Drug	Daily Dose	Started	Stopped	Reason for discontinuing medication:
_____	_____	/	/	_____
_____	_____	/	/	_____
_____	_____	/	/	_____
_____	_____	/	/	_____

Clinical Rationale/Supporting Documentation: Why do you feel this drug is superior to current Preferred Drug(s)? (documented efficacy in this patient, documented failure or allergy of preferred meds, etc.)

PHONE: (702) 242-7050, option #6
(800) 443-8197, option #6
FAX to: (702) 242-6751 or (800) 997-9672

OR Mail to: HPN/SHL - PHARMACY SERVICES
Attn: Medical Necessity
P.O. Box 15645
Las Vegas, NV 89114-5645