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 line of business is handled locally by the HPN Pharmacy Services Department. The prior authorization process for our Medicaid line of business is handled by the UHC Prior Authorization 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 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 by submitting a Pharmacy Medical Necessity Request Form. The **Commercial Pharmacy Medical Necessity Request Form** can be found at www.healthplanofnevada.com/provider/pharmacy-benefits or in Frequently Used Forms at the end of this section. Form must be completely filled out.

Exception and Prior Authorization Requests

- To submit a *prior authorization or exception request* online, go to Online Provider Center, and click on **RX Prior Authorizations**.
- 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 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 #1 or (800) 443-8197 #1, 8:00 a.m. – 5:00 p.m. Monday through Friday.

Medicaid Exception and Prior Authorization Requests

- To submit a *prior authorization or exception request* online, utilize tools within your EMR or visit CoverMyMeds for online submission.
- To submit a *prior authorization or exception request by fax*, fax 866-940-7328

If you have questions on Medicaid requests, call the OptumRx Prior Authorization Department at 800-310-6826.

20.3 Prior Authorization Timeframes

Please note: Required timelines are different for our various lines of businesses and formularies. Timelines are below are goals and normal operations for the Pharmacy Services Department. Actual timelines may differ slightly.

Standard Requests

Routine requests are normally 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. All Medicaid requests are reviewed within 24 hours.

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 normally 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 HPN Commercial Pharmacy Services Call Center

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

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

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

- Formulary alternatives
- Prior authorization status

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 #1**	**(702) 242-6751**
Toll Free	**(800) 443-8197 #1**	**(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 are transferred to the claims processing call center staff who can answer questions related to eligibility, and medication history.

20.7 Pharmacy and Therapeutics Committee

HPN utilizes the UnitedHealthcare P&T Committee to assist in the clinical management of the HPN Preferred Drug Lists. Other operational committees exist that make additional recommendations on tier placement and other clinical programs. HPN pharmacy leadership is present at these committee meetings.

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
- 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 healthplanofnevada.com/Provider or myhpnmedicaid.com/Provider, click on **Drug List** at the top of the page. Preferred Drug List updates are posted 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 New to Market Exclusions

HPN Commercial plans have a 12-month exclusion that may be exercised before new drugs introduced to the market will be reviewed for Preferred List inclusion or exclusion. This process 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 650334, Dallas, TX 75265-0334.**

HPN (Commercial)

HPN members can call (702) 242-7300 or 1-800-777-1840 and request a Direct Member Reimbursement Form or go online to **healthplanofnevada.com/member**, click on **I Need Help with**, Click on **Health Plan Forms** then click on **Pharmacy Reimbursement Claim Form** to print out the form**.**

Once the form has been filled out, please mail the form to:

OptumRx Claims Department
P.O. Box 650334
Dallas, TX 75265-0334

20.14 Drug Utilization Reviews

Drug utilization reviews (DUR) are performed periodically. These reviews monitor 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.

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 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.

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, the health plan reviews the results of the analysis 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.