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POLICY AND PROCEDURE	
Policy # and TITLE: PH05 Prior Authorizations	
Primary Policy owner: Pharmacy	**POLICY #:** PH05
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☒Behavioral Health (BH) 3) ☐Benefits Administration (BA) 4) ☒Care Management (CM) 5) ☐Claims (CLMS) 6) ☐Community Marketplace & Member Engagement (MAR) 7) ☐Compliance (CMP/HPA) 8) ☐Configuration (CFG) 9) ☐Provider Contracting (CONT) 10) ☐Cultural & Linguistics (CL) 11) ☐Customer Service (CS)	12) ☐Facilities (FAC) 13) ☐Finance (FIN) 14) ☒Health Equity (HEQ) 15) ☐Human Resources (HR) 16) ☐Information Technology / Core Systems (IT) 17) ☒Pharmacy (PH) 18) ☐Provider Networks (PRO) 19) ☒Quality Management (QM/GRV/HE) 20) ☒ Utilization Management (UM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** Policy # and Policy Title

I. PURPOSE

To provide a structure on how physician administered drug prior authorization requests are to be handled.

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II. POLICY

Prior Authorization is used for physician administered drugs that pose potential efficacy, toxicity, or utilization problems to ensure members receive high quality, safe, and efficacious medication therapy.

III. PROCEDURE

1. Prior Authorization is used to promote cost effective and appropriate use of pharmaceuticals.
2. Drugs are considered for Prior Authorization when any of the following criteria are met:
    a. The drug has the potential to be used for cosmetic purposes.
    b. The drug has the potential to be used for indications that are not covered benefits.
    c. There is significant clinical concern about potential overuse of an agent.
    d. There is potential for significant use that is deemed not to be cost effective.
    e. There is significant concern about the potential for sub-optimal use.
3. Prior Authorization criteria fall into three main categories:
    a. Diagnostic criteria identify indications that constitute acceptable uses for a drug.
    b. Prescriber criteria identify those prescribing practitioners who are approved to use specific drugs or drug classes.
    c. Drug-specific criteria identify approved doses, frequency of administration, duration of therapy, or other aspects that are specific to use of a drug.

4. Prior Authorization criteria are based upon information from authoritative sources considered in light of the characteristics of HPSJ/MVHP 's member population and local practice conditions. Information

   sources considered in the development, revision and approval of Prior Authorization criteria include but are not limited to:

   a. Published scientific literature
   b. Facts and Comparison Formulary Services
   c. Micromedex
   d. Medical and pharmacy review services
   e. National Guidelines Clearinghouse of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services
   f. American Hospital Formulary Services
   g. Food and Drug Administration
   h. FDA-approved manufacturer labeling information
   i. Recommendations of medical and health care specialty and standard-setting organizations
   j. Recommendations of governmental health care, research, and regulatory bodies
   k. Provider network composition
   l. Membership characteristics

5. Upon P&T Committee approval of a Prior Authorization requirement for a physician administered drug, the Pharmacy Director:

   a. Verifies documentation of the Prior Authorization requirement in the P&T meeting minutes.
   b. Notifies individuals responsible for implementing the requirement of the Prior Authorization requirement and of the relevant restrictions (if any).

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c. Formally documents the Prior Authorization criteria.

d. Ensures that:

i. Providers are notified via a provider alert no less than forty-five (45) business days before the changes take effect.

ii. Member and Provider quarterly newsletters remind their recipients that the medical benefit has been updated and updates can be viewed on the organization's website.

6. The information needed, including relevant forms, to support a Prior Authorization request are on HPSJ/MVHP's website, and available by phone and in hard copy, upon request, from the Pharmacy Department.

7. Prior Authorization (PA) Review by HPSJ/MVHP Pharmacy Staff

a. All clinical prior authorization requests are reviewed by licensed Pharmacists or Physicians (i.e., Peer Reviewers).

b. Determinations available to Pharmacists and Peer Reviewers include:

i. **Approve** – The request is approved as requested.

ii. **Approve with Modification (Modify)** - Approval that is given is not based on the actual or original request but changed or adjusted to meet the medical review criteria of the Medi-Cal program or HPSJ/MVHP.

iii. **Deny –** Deny coverage for the requested drug or service.

c. Documentation of failed medication regimens must be available to HPSJ/MVHP in the form of prescription fill history (located within First CI, the HPSJ/MVHP care management system, or from pharmacy records), medical claims, or medical records and can include dose, duration, and time frame of therapy. Exceptions to this will be reviewed on a case-by-case basis.

d. Licensed pharmacy technicians may approve prior authorization requests if they meet specific predetermined criteria (i.e.,

protocol) for approval developed and validated by HPSJ/MVHP Pharmacists and/or Physicians.

e. Licensed pharmacy technicians may also perform administrative denials for the following reasons:

i. If requested services are not a covered Medi-Cal benefit.ii. If Health Plan of San Joaquin/ Mountain Valley Health Plan is not the primary coverage. iii. If the member's eligibility has been terminated.

f. PA requests will not impose quantity limits or non-quantitative limits more stringently on mental health and substance use disorder drugs as compared to medical/surgical drugs prescriptions in accordance with 42 CFR 438.900 et. seq.

8. Decision Timeliness and Notification of Action Letters for Physician Administered Drug Prior Authorization Requests

a. The processes outlined in policy UM 01, Authorization and Referral Review, and policy UM 07, Notice of Action for Delayed, Denied, Modified, or Terminated Services, are followed in making determinations and submitting notification letters to members and providers.

b. Specific Notification Timeframe details can be found in table 1 below.

c. The Appeals process described in policy QM 65 Member Appeals Policy, is available for any non-authorization determination.

IV. ATTACHMENT(S)

1. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
2. Glossary of Terms Link
3. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

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V. REFERENCES

1. DHCS - APL 20-020 – Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
2. DHCS Contract, Exhibit A, Attachment 5, #2 & 3
3. Health & Safety Code, §1363.01, 1367.20, 1367.22, and 1367.24 4. NCQA Standard UM13 – Procedures for Pharmaceutical Management
5. SSA 1927(d)(5)
6. Title 22, CCR, §53914
7. Title 28, CCR, §1300.68
8. Title 28, CCR, §1300.67.214
9. UM01 – Authorization/Referral Process
10. UM07 – Notice of Action for Delayed, Denied, Modified, or Terminated Services
11. W & I Code 14185(a)(1)

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
000	07/08, 09/08, 11/10, 06/12, 11/14, 05/15, 09/16, 09/17, 02/18, 12/18, 07/19, 12/19, 07/20, 06/21, 12/21, 09/22	N/A
001	Moved PH05 to new template. Updated to ensure similar verbiage to PH18 and referencing Pharmacist reviewers and medical claims.	06/16/2023
002		
Initial Effective Date: 01/01/1999		

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VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	05/18/2023
☐ Privacy & Security Oversight Committee (PSOC)		
☐ Risk Management		
☐ Delegation Oversight		
☐ Policy Review	001	04/19/2023
Quality and Utilization Management		
☐ Quality Operations Committee		
☐ Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manger	001	12/30/2022
Department of Managed Care (DMHC)			

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IX. Approval *signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy

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Table 1. Decision and Notification Timeframes			
Type of Request	**Decision**	**Initial Notification from HPSJ/MVHP to Practitioner (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service All necessary information received at time of initial request	**Within 5 working days of receipt of all information reasonably necessary to render a decision** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such. • In this situation, the member has the right to request an appeal with HPSJ/MVHP and HPSJ/MVHP must send the member written notice of all appeal rights.	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision.
Routine (Non-urgent) Pre-Service ***– Extension Needed*** ***Additional clinical information*** • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	**Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request** • The decision may be deferred, and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

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	additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered **Additional information received** • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service **Additional information incomplete or not received** • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall make a decision with available information. • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such. • In this situation, the member has the right to request an appeal with HPSJ/MVHP and HPSJ/MVHP must send the member written notice of all appeal rights.		

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Expedited Authorization (Pre-Service) Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. All necessary information received at time of initial request	**Within 72 hours of receipt of the request a decision shall be made in a timely fashion appropriate for the nature of the enrollee s condition, not to exceed 72 hours** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such. • In this situation, the member has the right to request an appeal with HPSJ/MVHP and HPSJ/MVHP must send the member written notice of all appeal rights.	Practitioner: Within 24 hours of making the decision Member: None Specified	Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service
Expedited Authorization (Pre-Service) - Extension Needed Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. Additional clinical information required	**Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest	Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

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	Additional information received • If requested information is received, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such. • In this situation, the member has the right to request an appeal with HPSJ/MVHP and HPSJ/MVHP must send the member written notice of all appeal rights.		
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. CA H&SC 1367.01 (h)(3)	Within 5 working days or less, consistent with urgency of Member's medical condition NOTE: When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination (CA H&SC 1367.01 (h)(2))	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 24 hours of making the decision Member: Within 2 working days of making the decision

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	• Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such. • In this situation, the member has the right to request an appeal with HPSJ/MVHP and HPSJ/MVHP must send the member written notice of all appeal rights.		
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request
Post-Service ***- Extension Needed*** ***Additional clinical information required***	Additional clinical information required (AKA: deferral) • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request Additional information received • If requested information is received, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination

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Hospice - Inpatient Care	**Additional information incomplete or not received** • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

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