


| HEALTH PLAN OF SAN JOAQUIN | | |
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| Subject: Formulary & Pre-Authorization Process | | |
| Department: Medical Management - Pharmacy | | Policy #: UM 25 |
| Applies to: Medi-cal, Healthy Families, Commercial | | Scope: |
| Effective Date: 1/11/99 | Revised Date: 11/1/10 | Approved by:  Medical Director |

POLICY:

- A. The Health Plan of San Joaquin (HPSJ) maintains a formulary of preferred medications for the treatment of its members. When medications other than those listed on HPSJ's formulary represent a more appropriate method of treatment, the physician or pharmacist may initiate a prior authorization (PA) request for drug approval. Prior authorizations shall be reviewed by the Director of Pharmacy or Plan Pharmacist (a licensed pharmacist) and will be acted upon within twenty-four (24) hours of receipt (during normal business hours). Denials will be made by the Medical Director, physician designee, Director of Pharmacy or Plan Pharmacist. Letters for denied, or modified requests shall be signed by the Medical Director, physician designee, Director of Pharmacy or Plan Pharmacist, with clear instructions for appeal, and mailed within 24 hours of the decision.

PROCEDURES:

- A. Prior Authorizations for Formulary Medications.
1. Those medications listed on the formulary as needing prior authorization will be submitted to the Health Plan's Director of Pharmacy or Plan Pharmacist for review.
 2. The Director of Pharmacy or Plan Pharmacist will evaluate the drug against the Health Plan's criteria approved by the P&T Committee.
 - a. If the criteria is met, a prior authorization will be issued.
 - c. If the criteria is not met, the Director of Pharmacy or Plan Pharmacist will deny the request, or modify the request by recommending an alternative drug, under the general oversight of the Medical Director, or physician designee.
 - b. The provider and pharmacy are notified by fax. In addition, if the request is denied or modified, a denial or modify letter will be mailed to the member and to the provider within 24 hours of the decision, explaining the reason for the denial or modification. The Medical Director, physician designee, Director of Pharmacy or Plan Pharmacist will sign and date all denial or modify letters.

B. Prior Authorizations for Non-Formulary Medications

1. Physicians are required to use HPSJ's formulary in the treatment of members unless the physician determines that the formulary medication is medically inappropriate.
2. Physicians must request a prior authorization when prescribing non-formulary medications, and must indicate the medical reason for substituting a non-formulary drug
 - a. Requests for non-formulary drugs that do not include this information will be approved with modification to a recommended formulary alternative(s).
3. The request is reviewed by the Director of Pharmacy or Plan Pharmacist who will either approve the drug for up to 12 months, recommend alternative therapy(ies) or deny the request.
 - a. Decisions to modify or deny a request for non-formulary medications may be made by the Director of Pharmacy or Plan Pharmacist, with general oversight from the Medical Director or physician designee.
 - b. Medications will not be authorized under the following special circumstances:
 - The Medical Director, Director of Pharmacy or Plan Pharmacist determines that the potential harm to the member is greater than the potential benefit.
 - Upon consultation with the prescribing physician by the Director of Pharmacy, Plan Pharmacist, or Medical Director, an equally effective formulary agent is determined to be available.
 - Continuation of a non-formulary medication based on a sample given to the member will not be accepted as a valid reason for approving the request.
4. If authorization for a non-formulary drug is denied after retrospective review, HPSJ will continue to cover the non-formulary drug up to sixty (60) days if medically necessary to taper the member off of the drug before providing an alternative formulary medication or discontinuing the medication.
5. If authorization for a non-formulary drug is denied because an equivalent formulary drug is available, and the prescribing physician does not agree to prescribe the formulary drug, the decision to approve, modify or deny the prescription will be made by the Medical Director. In no case will HPSJ allow potentially hazardous treatment to be applied to its members.

C. Prescriptions for non-formulary medications that do not indicate a medical necessity will be approved with modification to a recommended formulary alternative(s).

1. If the prescribing physician verifies that the prescription is for a non-formulary drug, required documentation indicating medical necessity must be included with the PA request.
2. If insufficient information for medical necessity is provided, HPSJ will request such information from the prescribing physician and the PA request will remain open for three (3) business days before it is denied due to inadequate information.

D. If a member does not accept the formulary equivalent and the prescribing physician does not or cannot define a medical reason for deviating from the formulary, and the member believes that he/she is entitled to the non-formulary medication, the member can contact the Health Plan's Member Services Department and seek a resolution to the situation through the Member Grievance process.

E. Maintenance medications.

1. If a drug has previously been approved for a member’s medical condition and the physician continues to prescribe for the same medical condition, the Health Plan will continue to approve the use of that medication, even if the medication is no longer on the Health Plan’s formulary, provided the drug is safe and effective for the use. However, this does not apply to a drug that has been previously prescribed for a medical condition of a limited timeframe, and then discontinued.
2. Nothing in this section shall prohibit the prescribing physician from prescribing another drug covered by the Health Plan that is medically appropriate for the member, nor shall anything in this section prohibit generic drug substitutions as appropriate.

F. Timelines and Notification Requirements

1. All complete prior authorizations will be approved, modified or denied within twenty-four (24) hours of receipt, during normal business hours.
2. Members are notified of a denial or modification in writing, a copy of which is mailed to the physician, and includes a description of the grievance process and the member’s right to appeal the denial or modification.

G. Monitoring of Timelines of Review Process

1. The Director of Pharmacy or Plan Pharmacist will randomly select 20 prior authorization requests in the prior authorization log per month to verify that the requests have been reviewed and responded within the established timeline, and investigate reason for non-compliance and make modification of internal process to ensure compliance. An audit report with results and recommendation and action plan will be forwarded to the Medical Director and Director of Medical Management monthly.

H. Medical Director Review

1. The Medical Director will review all appealed denials for appropriateness and periodically conduct a review of unappealed denials and member generated complaints/grievances of pharmacy denials.

REFERENCE

- A. Title 22, CCR, §53914
- B. Health & Safety Code, §1363.01, 1367.20, 1367.22, and 1367.24
- C. Title 28, CCR, §1300.68
- D. DHCS Contract, Exhibit A, Attachment 5, #2 & 3

| Created by/Date | Revised by/Date | Revised by/Date | Revised by/Date | Revised by/Date | Revised by/Date | Revised by/Date |
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