POLICY AND PROCEDURE	
Title: 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 & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☒ Case 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) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☒ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☒ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☒ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☒ Medical Management (MM)
Product Type: ☒Medi-Cal ☐D-SNP	**Supersedes Policy Number:** N/A

I. PURPOSE

This policy provides a structure on how physicians administered drug prior authorization requests are to be handled.

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

A. Prior Authorization is used to promote cost effective and appropriate use of pharmaceuticals.

B. Drugs are considered for Prior Authorization when any of the following criteria are met:

1. The drug has the potential to be used for cosmetic purposes.
2. The drug has the potential to be used for indications that are not covered benefits.
3. There is significant clinical concern about potential overuse of an agent.
4. There is potential for significant use that is deemed not to be cost effective.
5. There is significant concern about the potential for sub-optimal use.

C. Prior Authorization criteria fall into three main categories:

1. Diagnostic criteria identify indications that constitute acceptable uses for a drug.
2. Prescriber criteria identify those prescribing practitioners who are approved to use specific drugs or drug classes.
3. Drug-specific criteria identify approved doses, frequency of administration, duration of therapy, or other aspects that are specific to use of a drug.

D. Prior Authorization criteria are based upon information from authoritative sources considered in light of the characteristics of Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan")'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:

1. Published scientific literature
2. Facts and Comparison Formulary Services
3. Micromedex
4. Medical and pharmacy review services
5. National Guidelines Clearinghouse of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services
6. American Hospital Formulary Services
7. Food and Drug Administration
8. FDA-approved manufacturer labeling information
9. Recommendations of medical and health care specialty and standard-setting organizations
10. Recommendations of governmental health care, research, and regulatory bodies
11. Provider network composition
12. Membership characteristics

E. Upon P&T Committee approval of a Prior Authorization requirement for a physician administered drug, the Pharmacy Director:
    1. Verifies documentation of the Prior Authorization requirement in the P&T meeting minutes.
    2. Notifies individuals responsible for implementing the requirement of the Prior Authorization requirement and of the relevant restrictions (if any).
    3. Formally documents the Prior Authorization criteria.
    4. Ensure that:
        a. Providers are notified via a provider alert, no less than forty-five (45) business days before the changes take effect.

b. 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.

F. The information needed, including relevant forms, to support a Prior Authorization request is on Health Plan's website, and available by phone and in hard copy, upon request, from the Pharmacy Department.

G. Prior Authorization (PA) Review by Health Plan Pharmacy Staff:

1. All clinical prior authorization requests are reviewed by licensed Pharmacists or Physicians (i.e., Peer Reviewers).
2. Determinations available to Pharmacists and Peer Reviewers include:
    a. Approve – The request is approved as requested.
    b. Approve with Modification (Modify) - An authorization request may be modified by Clinical Pharmacists or Physicians for the following reasons:
        i. If portions of the requested services meet for medical necessity, however others do not meet for medical necessity.
        ii. A determination may be modified when the quantity of the requested services does not meet medical necessity.
    c. Deny **–** Deny coverage for the requested drug or service.
3. Documentation of failed medication regimens must be available to Health Plan in the form of prescription fill history (located within First CI, Health Plan's 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 are reviewed on a case-by-case basis.
4. Pharmacy Staff document all clinical relavant information prior to making a determination.

a. If clinical notes are not provided by the provider, pharmacy staff will reach out to provider prior to making a determination.

b. Reviewers document the clinical rationale used to make a prior authorization determination.

c. If enough clinical information is not available, pharmacy staff document attempts to procure information from provider prior to makiing any final determinations.

5. Prior Authorization Denials

a. Reviewers will include a list of all criteria required for approval of the prior authorization letter being sent.

b. The reviewers handwritten signature will be included along with the credentials of the reviewer on the denial letter.

c.

6. Hierarchy of Medical Criteria
   a. The following review criteria is used when evaluating specific authorization requests for medical treatment, in the following order:
      i.
      ii. The State of California's Medi-Cal Provider Manual Criteria serves as the primary reference for benefit coverage determinations. If the primary or secondary review criteria directs the decision towards an adverse determination, the Medi-Cal Provider Manual will be reviewed for the medical necessity criteria related to the request. If the Medi-Cal Provider Manual has medical necessity criteria for the requested drug, it will be utilized to make the final determination of medical necessity. Health Plan Pharmacy and Therapeutics (P&T) Committee approved coverage criteria/policies that serve as the primary medical review criteria for physician administered drug authorization

determinations if Med-Cal Provider Manual Criteria does not exist.

iii. Milliman Care Guidelines (MCG) – A nationally recognized vendor and serving as Health Plan's second source for medical review criteria for authorization determinations.

iv. Nationally recognized, peer reviewed, published guidelines, such as, but not limited to the United States Preventive Services Task Force (USPSTF) Recommendations, American Academy of Pediatrics (AAP).

v. Health Plan Pharmacists, UM staff, medical directors and physician peer reviewers use Health Plan's General Utilization Management Criteria when medical necessity criteria cannot be found within Health Plan Pharmacy Coverage Policies, MCG Guidelines, and the Medi-Cal Provider Manual.

vi. EPSDT requirements per DHCS APL 23-005, and Health Plan policy UM48.

7. Licensed pharmacy technicians may approve prior authorization requests if they meet specific predetermined criteria (i.e., protocol) for approval developed and validated by Health Plan Pharmacists and/or Physicians.

8. PA requests do 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.

9. PA requests for prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) must be reviewed and covered in a timely manner that is appropriate for the severity of the enrollee's condition.

    a. Covered treatment for PANDAS/PANS includes

antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.

b. Coverage of PANDAS/PANS are not subject to a copayment, coinsurance, deductible, or other cost-sharing that is greater than that applied to other benefits provided by the contract.

c. Requests for PANDAS/PANS are not denied or delayed due to the member having previously received treatment or similar treatment, or because the member was diagnosed with or received treatment for the condition under a different name, including autoimmune encephalopathy.

d. Requests for immunomodulating therapies for PANDAS/PANS may not be limited or require a trial of therapies that treat only neuropsychiatric symptoms prior to authorizing coverage of the immunomodulating therapies.

e. Review of requests for PANDAS/PANS must adhere to treatment recommendations delineated in current clinical practice guidelines published in peer-reviewed medical literature or put forth by organizations composed of expert treating clinicians.

f. Requests for PANDAS/PANS may initially present with a diagnosis code of autoimmune encephalitis, but once a specific code or codes are assigned for PANDAS/PANS, then it is coded following the proper coding and naming convention and the listed requirements would still apply.

H. Decision Timeliness, Hierarchy of Medical Criteria, and Notification of Action Letters for Physician Administered Drug Prior Authorization Requests:

1. The processes outlined in Health Plan policies UM01 - Authorization and Referral Review, UM06 – Medical Review Criteria, and 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.
2. Specific Notification Timeframe details can be found in Table 1. Decision and Notification Timeframes
3. The Appeals process described in Health Plan policy QM65 Member Appeals is available for any non-authorization determination.

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)
D. Table 1. Decision and Notification Timeframes

V. REFERENCES

A. DHCS APL 22-012 – Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
B. DMHC APL 24-023 – Newly Enacted Statues Impacting Health Plans (AB 2105)
C. Health & Safety Code, §1363.01, 1367.20, 1367.22, and 1367.24
D. Health Plan Policy UM01 – Authorization/Referral Process
E. Health Plan Policy UM06 – Medical Review Criteria
F. Health Plan Policy UM07 – Notice of Action for Delayed, Denied, Modified, or Terminated Services
G. Health Plan Policy QM65 - Member Appeals
H. NCQA Standard UM13 – Procedures for Pharmaceutical Management
I. SSA 1927(d)(5)
J. Title 22, CCR, §53914

K. Title 28, CCR, §1300.68
L. Title 28, CCR, §1300.67.214
M. W & I Code 14185(a)(1)

VI. REVISION HISTORY

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	Moved PH05 to new template.	05/20/2024
003	Included a hierarchy for medical criteria and updated when/how an authorization is modified.	08/30/2024
004	Included requirements per AB 2105 in DMHC APL 24-023.	02/20/2025
005	Updated procedure for when the Medi-Cal Provider Manual is referenced in relation to medical necessity determinations.	05/02/2025
Initial Effective Date: 01/01/1999		
Published Date:08/20/2026		

VII. Committee Review and Approval to be Completed by Compliance

Committee Name	Version	Date
Compliance Committee (CC)	005	08/14/2026
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee (PIC)		
• Audits & Oversight Committee (AOC)		
• Policy Review Committee (PRC)	003	11/27/2024

Quality Improvement Health Equity Committee (QIHEC)	003	09/18/2024
• Quality Operations Committee (QOC)		
• Grievance Committee (GC)		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manger	005	06/30/2025
Department of Managed Care (DMHC)			

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

Table 1. Decision and Notification Timeframes			
Type of Request	**Decision**	**Initial Notification from Health Plan 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 the 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 Health Plan and Health Plan 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 when the Member or the Member's provider requests an extension, or 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 additional	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

	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 **<u>Additional information received</u>** • If requested information is received, a 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 **<u>Additional information incomplete or not received</u>** • 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 Health Plan and Health Plan must send the member written notice of all appeal rights.		
Expedited Authorization (Pre-Service) Requests where the provider indicates or the Provider Group /Health Plan determine that	**<u>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</u>** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	<u>Practitioner:</u> Within 24 hours of making the decision <u>Member:</u> None Specified	Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service

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	• In this situation, the member has the right to request an appeal with Health Plan and Health Plan must send the member written notice of all appeal rights.		
Expedited Authorization (Pre-Service) - Extension Needed Requests where the provider indicates or the Provider Group /Health Plan determine 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 **Additional information received** • If requested information is received, a 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	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

	Health Plan and Health Plan 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)) • 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 Health Plan and Health Plan must send the member written notice of all appeal rights.	<u>Practitioner:</u> Within 24 hours of making the decision <u>Member:</u> None Specified	<u>Practitioner:</u> Within 24 hours of making the decision <u>Member</u>: Within 2 working days of making the decision
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	<u>Member & Practitioner:</u> None specified	<u>Member & Practitioner:</u> 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
Hospice - Inpatient Care	**Additional information incomplete or not received** • If the 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