# POLICY AND PROCEDURE

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| **POLICY NAME:** Medicaid Prior Authorization Review Process | **POLICY ID:** CC.PHARM.03A |
| **BUSINESS UNIT:** Clinical Pharmacy Operations | **FUNCTIONAL AREA:** Pharmacy |
| **EFFECTIVE DATE:** 4/01/17 | **PRODUCT(S):** Medicaid |
| **REVIEWED/REVISED DATE:** 7/17; 1/18; 7/18; 1/19; 3/19; 7/19; 8/19; 10/19/, 11/19, 12/19, 1/20, 2/20, 3/20, 4/20, 5/20, 6/20, 7/20, 8/20, 9/20, 10/20, 11/20, 2/21, 6/21, 2/22, 3/21, 3/22, 4/22, 5/22, 8/22, 5/24 | |
| **REGULATOR MOST RECENT APPROVAL DATE(S):** 8/16/22 | |

**POLICY STATEMENT:**
This policy is the overarching business requirements and operational processes for Clinical Pharmacy Operations - Prior Authorization department to manage Medicaid line of business.

**PURPOSE:**
To document the prior authorization (PA) review process for Medicaid PA reviews, wherein pharmacy services reviews requests for medications designated as “PA required” on the Plan’s Preferred Drug List (PDL) (also referred to as a formulary).

The Prior Authorization (PA) and Medical Necessity (MN) criteria are developed to promote clinically appropriate utilization of selected high risk and/or high-cost medications and include consideration of program exception requests for medications not included on the Health Plans’ Preferred Drug List (PDL). The criteria for approval have been established by the Clinical Pharmacy Advisory Committee (CPAC), in conjunction with the Centene Health Plans and are approved through both the Corporate and Health Plan Pharmacy and Therapeutics (P&T) Committees. Decisions on PA and MN criteria content are coordinated with input from pharmacy and medical practitioners, Centene Health Plan representatives, and review of current available medical literature and professional standards of practice.
PA policies approved by CPAC that have not yet been presented at the Corporate P&T Committee are considered to be interim PA policies. Pharmacists reviewing PA requests use interim criteria as reference when evaluating coverage requests until the criteria are reviewed and approved at Corporate P&T.

**SCOPE:**
This policy applies to pharmacy services Clinical Pharmacy Operations employees for prior authorization process and provides support to employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the “Company”).

**DEFINITIONS:**
Adverse Benefit Determination: the denial or limited authorization of a requested service, including determinations based on the type or level or service, requirements for medical necessity, appropriateness, or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; denial of payment for a service; or, a failure to provide services in a timely manner.

Utilization Management (UM): the use of managed care techniques such as prior authorization that allow payers, particularly health insurance companies to manage the cost of health care benefits by assessing its appropriateness before it is provided using evidence-based criteria or guidelines.

Prior Authorization (PA): a utilization management process used to determine if coverage of a prescribed procedure, service, or medication will be provided based on evidence-based criteria or guidelines.

**POLICY:**
It is pharmacy services policy to handle all Medicaid PA requests in a manner and timeframe that complies with all Federal and State laws and regulations, applicable accreditation standards (including URAC and NCQA), and satisfies the requirements of each Plan’s contract with pharmacy services.

A prior authorization (prospective review) is performed on all medications designated "PA required" by a Plan's PDL or formulary, and on drugs with edit limitations described in the Plan's pharmacy benefit documentation (e.g., quantity limitations, age restrictions, drug-drug duplication, step-therapy, etc.). These are prospective reviews only. Pharmacy services makes prospective, concurrent and retrospective review determinations solely on the clinical information available to the prescriber or the organization at the time the medical care was provided. Pharmacy services does not conduct concurrent or retrospective reviews. The UM decision-making criteria is based on clinical criteria and the individual needs of the member.

Commercial/Health Insurance Marketplace (HIM) PA review processes are addressed separately in CC.PHARM.03B.

**PROCEDURE:**
The following applies to all Medicaid PA reviews, regardless of State or Health Plan ("Plan"). Separate Standard Operating Procedures (SOPs) are supplied for each State and, if necessary, each Plan we contract with (see Attachment). For excluded drugs, the normal practice is to notify providers. The denial letters will include the reason why the drug was denied due to benefit exclusion. The notification letter will direct providers/members to the health plan for further explanation.

## I. Initial Receipt of a Prior Authorization Request

a) Providers, pharmacies, members and/or member representatives submit PA requests to pharmacy services by mail, telephone, fax, or automated process (if implemented) utilizing the appropriate Prior Authorization Request form (forms vary by State/Plan).
   - Pharmacy Technicians (PTs) transcribe verbal requests into the PA processing system for subsequent review by a PT or pharmacist depending on the medication or reason requested.
   - All information relevant to the PA request must be received from a reliable source (e.g., prescriber, pharmacy, or when applicable, the member). Only information from reliable sources is used in the PA determination.
   - All information is treated as Protected Health Information (PHI) and kept confidential in accordance with all federal and state privacy laws.

## II. Pharmacy Technician Duties

a) A Pharmacy Technician (PT) will track and triage all PA requests using the PA processing system.

b) PTs may review and respond to the prescriber if the PA request falls into one of the following three categories:
   - Administrative Notification
     a. "Administrative Notification" categories include duplicate requests, member not eligible, PA already on file, medicines that do not require a PA and requests for any medication not delegated for review by pharmacy services.
     b. If the PA falls into an "Administrative Notification" category, the PT will notify the prescriber by telephone, fax, or automated process.
   - Missing Clinical Information
     a. If the PA request is missing clinical information necessary to make a decision, staff will make a minimum of one outreach attempt, via verbal outreach or fax, to the requesting provider to gather missing information. Only information necessary to certify the prescription will be collected. The prescriber is not required to submit the member's entire medical record but only data relevant to the clinical parameters of the prescription. See attached Missing Information Work Process documentation for specific directions for obtaining missing information.
        i. Pharmacy services collects only enough information to certify the prescription. The prescriber will not be asked for the member's entire medical record.
        ii. Staff will never attempt to coerce a prescriber to negotiate or accept an alternative medication.
     b. All outreach attempts will be documented in the PA processing system.
     c. If unable to obtain the necessary information within the 24-hour TAT, the PA will be reviewed and decided based on the information presently available to the reviewer.
   - Coverage Approvals
     If a PA request is for a medication that has specific approval criteria and does not require clinical judgment, an appropriately credentialed Pharmacy Technician with a license in good standing may, under the direction of a licensed pharmacist, review the PA (where allowable by law).

a. Where allowable by law or state contract, a PT may only approve PA requests that meet specific approval criteria. When possible, these criteria will be embedded in the PA Triage Criteria table within the PA processing system to allow for efficient and timely responses.
b. If the PT is unable to approve the request based on the plan criteria and information provided by the prescriber, the PA is referred to a pharmacist to make the final determination.
c. Review criteria will be developed by pharmacy services licensed pharmacist staff and be approved by the Pharmacy & Therapeutics (P&T) Committee. Periodic audits of requests approved by PT staff will be conducted.
d. **Refer to State-specific SOPs** for States/Plans that do not allow PTs to perform approvals.
    i. If operational circumstances impact the continued support of a previously implemented State-specific SOP, either fully or partially, the Vice President of PA Operations is responsible to notify the Health Plan's Account team members and assigned Compliance team member(s) as soon as possible but in no circumstances beyond within two (2) business days following the change in operational support. The notification will provide relevant information about the change in support (root cause), interim procedures that are or will be in place to address the gap, and an estimated time when support will return in the manner provided before the change.

## III. Pharmacist Duties

a) **Refer to State-specific SOPs** as some States/Plans require in-state pharmacist licensing, or do not allow pharmacists to make denials (see Section IV).

- If operational circumstances impact the continued support of a previously implemented State-specific SOP, either fully or partially, the Vice President of PA Operations is responsible to notify the Health Plan's Account team members and assigned Compliance team member(s) as soon as possible but in no circumstances beyond within two (2) business days following the change in operational support. The notification will provide relevant information about the change in support (root cause), interim procedures that are or will be in place to address the gap, and an estimated time when support will return in the manner provided before the change.

b) An appropriately licensed pharmacist who holds an unrestricted license will review the PA requests remaining in the PA processing queue.

c) The Drug Information and Account Management teams will provide the most up to date criteria, clinical guidelines, PDL, and state approve documents for citation for Pharmacists to use when reviewing requests and rendering determinations.

d) The pharmacist will utilize the most up to date and clinical criteria, clinical guidelines, PDL, and state approved documents for citation to ensure the appropriate duration of approval is provided.

e) The pharmacist will ensure that a mock paid claim is performed for all approvals submitted for claims processing and all associated steps for claims approval process.

f) If the pharmacist identifies the request is missing necessary clinical information, he or she will follow the process described in the attached Missing Information Work Process documentation.

g) The pharmacist will make a decision to approve or deny based on several factors, including, but not limited to the pharmacist's clinical judgment, medical necessity criteria as approved by the Plan's P&T Committee, FDA-approved indications, and other evidence-based medical practices.

h) If a PA request requires board-certified consultant (i.e., physician) review to render a determination, the pharmacist will provide the most up to date clinical criteria, clinical guidelines, PDL, and state approved documents for citation to the physician. Only an appropriately credentialed physician (i.e., a contracted independent review organization, as in the case of MRIOA peer reviewer or employed physician) who holds an unrestricted license and is board certified will review the PA.

i) Peer-to-Peer Consultation:

1. Pharmacists will conduct post-denial peer-to-peer consultation requests (or forward them to the contracted independent review organization for physician P2P).

## IV. Denials

Pharmacy services reserve the right to adjust the approval dates so as to prevent a member from receiving additional medication in the case of therapy changes (upon prescriber request), fraud, material misrepresentation, or if the

medicine is not being provided consistent with the prescriber's plan of care. The adjustment in approval dates of any authorization will be communicated to the requesting prescriber and impacted member.

## V. Timing and Notification of PA Decision

a) Turnaround Times for PA Decision

1. Pharmacy services will review and resolve Medicaid PA requests and notify the prescriber of the decision by telephone, fax, or other electronic telecommunication device within **24 hours**.
   a. Exception: Tolling a request is allowed by State regulations (**refer to State-specific SOPs**)
2. PA requests not decided within the prescribed timeframe are treated as an adverse benefit determination and the appropriate written notifications made (*see* below).
   a. Exception: When contrary to State law (**refer to State-specific SOPs**).

b) Emergency Supply

- If the PA Department is unable to make an immediate determination (e.g., the request arrives after hours, the prescriber is unavailable to supply missing information), the pharmacy will be authorized to dispense a 72-hour supply of medication.
- **Refer to State-specific SOPs** as some States/Plans provide for a greater than 72-hour supply.

c) Written Notification of Approvals

1. Pharmacy services will fax an approval notification to the prescriber followed by written approval notification mailed to the member. Written member notification shall be mailed no later than the next postal business day following the approval determination.

d) Written Notification of Denials

1. Pharmacy services will fax a denial notification, which includes the UM criteria (with the exception of states that do not require criteria to be provided – see State-specific SOPs) to the prescriber. In the event a fax cannot be successfully delivered, telephonic outreach will be made allowing the criteria to be available upon the practitioners' request and logged in the PA processing system.
2. Medicaid members will receive a notice of adverse benefit determination (written in language that is easy to understand) to contain, *at the minimum*, the following:
   a. The decision made (i.e., prescription request denied)
   b. The reasons for the denial, which includes a reference to the benefit provision, guideline, protocol, or similar criteria on which the denial decision is based (if missing information, must include the specific information needed in order to perfect the PA request)
   c. The member's right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denial. This information may include medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits
   d. The member's right to request an appeal, the procedure and time limits to do so
   e. The circumstances under which a member may request an expedited appeal
   f. The member's right to request a State fair hearing
   g. The circumstances under which a member may request an expedited resolution
   h. The procedures to follow to exercise these rights
   i. The member's right to have benefits continue pending an appeal resolution, how to request the continuation, and the circumstances when the member may be required to pay the costs of continued benefits
3. A prescriber may request a peer-to-peer review or reconsideration when a PA request is not approved (denied) by contacting the Prior Authorization department by telephone or resubmitting the prior authorization with additional clinical information.

   The notification of a prescriber's right is included in the notification response to the provider. The prescriber may present significant additional clinical information to have a previous denial of coverage overturned. Upon request, disclosure of the clinical oversight process will be provided to the prescriber. A technician can answer any non-clinical questions from a prescriber; however, any clinical questions will be forwarded to a pharmacist.

   When a prescriber calls for a peer-to-peer review, the technician will contact the reviewing pharmacist. If the reviewing pharmacist is not available, then the technician will contact an alternative pharmacist assigned to that plan. If that pharmacist is not available, a third pharmacist will be contacted who may or may not be

assigned to that particular plan. If a pharmacist is still not available, the technician will provide the prescriber the option of scheduling a call back to avoid prolonged waiting time.

Once a call back time range is scheduled, the technician will send the reviewing pharmacist an email and also notify the pharmacist in person if possible. The pharmacist will contact the prescriber within 1 business day of the request. The pharmacist must make at least two attempts, when requested or prior to an appeal request (if required by State regulations), to reach the prescriber and each attempt must be clearly documented in the notes section of the PA request.

a. Exception: When contrary to state law, Physician reviewers licensed in accordance to state specific law(s) will also act on the peer-to-peer review.

4. **Refer to State-specific SOPs** as some States/Plans include additional information, require specific language, or provide mandated letter templates. Some Plans generate Notices of Action (NOA) in-house, and pharmacy services only provides the member information.
5. The NOA is issued in the same timeframe as the decision turnaround time and mailed first-class no later than the next standard USPS mail date (e.g., Monday – Saturday except federal holidays).

## VI. Post-Denial Peer-to-Peer (Informal Reconsideration)

a) Federal Medicaid regulations do not require a post-denial informal review (*see* Section III.C). However, **refer to State-specific SOPs** as some States/Plans mandate such conversations take place, while other States/Plans consider all post-denial conversations to be a formal appeal.

**REFERENCES:**
III.C - 42 CFR § 438.210(b)(2)(ii)
IV.A.1 - Social Security Act § 1927(d)(5)(A), 42 CFR § 438.210(d)(3)
IV.A.2 - 42 CFR § 438.404(c)(5)
IV.B – Social Security Act § 1927(d)(5)(B)
IV.D.2 - 42 CFR § 438.404(b)
NCQA Utilization Management Standards
URAC PBM Standards: DrUM
Work Instructions are stored on SharePoint: https://cnet.centene.com/sites/EPS-PBM/WORK_INSTRUCTIONS/Forms/AllItems.aspx
Step Actions are stored on SharePoint: https://wellcareportal19.wellcare.com/Pharmacy/PharmDept/Pages/default.aspx

**ATTACHMENTS:**
- CC.PHARM.03A State Specific SOPs
- PRISM Batch Schedule (Excel)

**ROLES & RESPONSIBILITIES:**
Admin Clerks: employees of pharmacy services Clinical Pharmacy Operations that perform non-clinical work actions including but not limited to data entry, outbound calls, fax failures, pharmacy outreach, and claims processing.
PA Technician Reviewers (PATR): employees of pharmacy services Clinical Pharmacy Operations that perform limited clinical work actions (approval determinations where allowable by law) including but not limited to the functions of an Admin Clerk, and approval determinations (where allowable by law).
Clinical Pharmacist Reviewers: employees of pharmacy services Clinical Pharmacy Operations that perform clinical work actions including but not limited to the functions of a PATR, approval and adverse determinations (where allowable by law), peer to peers, and clinical recommendations.
Medical Provider Reviewers (EPS/MRIOA): employees of pharmacy services Clinical Pharmacy Operations or their appointed third-party vendor delegate that perform clinical work actions including but not limited to the functions of a Clinical Pharmacist Reviewer, approval and adverse determinations, appeals, peer to peers, and clinical recommendations.

**REGULATORY REPORTING REQUIREMENTS**: N/A

**REVISION LOG**

| REVISION TYPE | REVISION SUMMARY | DATE APPROVED & PUBLISHED |
|---|---|---|
| Ad Hoc Review | Changed TAT for initial answer to 24 hours across the board to comply with Mega Reg changes as of July 1, 2017 | 6/21/17 |

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| Annual Review | Reviewed for Content – no change identified | 1/29/18 |
| Ad Hoc Review | Clarified: PAs missing information may be pended so long as closed within 72 hours (unless prohibited by State); Member Notices are issued in the same 24-hour timeframe and placed in the mail on the next USPS pick-up date. | 7/2/18 |
| Annual Review | Reviewed for content – Clarification made in IV.D related to mailing of provider letter if fax cannot be successfully sent | 1/25/19 |
| Ad Hoc Review | Added reference to Missing Information Work Process documentation as required by NCQA | 3/21/19 |
| Ad Hoc Review | Review and revised for updated content:<br>A. The pharmacist will be provided the most up to date criteria for review from drug information team and account management to utilize the most up to date and clinical criteria, clinical guidelines, PDL, and state approve documents for citation to render all determinations.<br>B. The pharmacist will utilize the most up to date and clinical criteria, clinical guidelines, PDL, and state approve documents for citation to ensure the appropriate duration of approval is provided.<br>C. The pharmacist will ensure that a mock paid claim id performed for all approvals submitted for claims processing and all associated steps for claims approval process.<br>D. When a provider is required to render a determination, as in the case of MRIOA, the pharmacist will provide the most up to date and clinical criteria, clinical guidelines, PDL, and state approve documents for citation to render all determinations by MRIOA providers." | 7/8/19 |
| Ad Hoc Review | Removed incorrect attachment. | 7/9/19 |
| Ad Hoc Review | Updated "EPS.PHARM.03A State Specific SOPs" Attachment | 8/29/19 |
| Ad Hoc Review | 1. Added "DE Role Work Instructions" Attachment<br>2. Added "RxAdvance Failed Fax Queue Work Instructions" Attachment<br>3. Added "RxAdvance Outgoing Fax Queue Guide Work Instructions" Attachment<br>4. Added "RxAdvance RPh Role Work Instructions" Attachment<br>5. Added "RxAdvance Technician Role Work Instructions" Attachment | 10/14/19 |
| Ad Hoc Review | Corrected name of attachment, as listed in this policy, from "EPS.PHARM.03A State Specific Addendum" to "EPS.PHARM.03A State Specific SOPs" as named within RSA Archer<br><br>Added an additional related attachment, "AZCH Work Instructions" | 10/29/19 |
| Ad Hoc Review | Added an additional related attachment, "Oregon Trillium Work Instructions"<br><br>Ordered related attachments by attachment name (alphabetical) | 10/31/19 |
| Ad Hoc Review | Added an additional related attachment, "IL Illinicare Work Instructions" | 11/5/19 |
| Ad Hoc Review | Added an additional related attachment, "WA CCWA Work Instructions" | 11/14/19 |
| Ad Hoc Review | Added language to Procedure section 'For excluded drugs, the normal practice is to notify providers. The denial letters will include the reason why the drug was denied due to benefit exclusion. The notification letter will direct providers/members to the health plan for further explanation.'<br>Added FL Sunshine Work Instructions<br>Added MS Magnolia Work Instructions | 11/21/19 |
| Annual Review | Updated Oregon Trillium Work Instructions and FL Sunshine Work Instructions | 1/2/20 |

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| | Added language to Policy section: "These are prospective reviews only. Envolve Pharmacy Solutions does not conduct concurrent or retrospective reviews."<br>Added language to Procedure section II.B.2.a. "Only information necessary to certify the prescription will be collected. The prescriber is not required to submit the member's entire medical record but only data relevant to the clinical parameters of the prescription."<br>Added II.B.3 "Coordinating Intervention<br>1. When treatment alternatives are warranted, the PT will intervene and generate an outbound communication to the prescriber, contracted pharmacy, or consumer. Clear documentation of the prescriber's original requests and any negotiation or agreement to accept an alternative treatment will be maintained."<br>Original #3 is now #4 and so on.<br>Added "IV. Denials<br>Envolve Pharmacy Solutions does not deny a previously approved prior authorization for prescription coverage to a covered person. However, Envolve Pharmacy Solutions reserves the right to adjust the approval date to the date when the following circumstances have been identified so that the member can no longer receive the medication.<br>a) Prior authorization was obtained based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or the provider, or<br>b) The approved medication was not provided consistent with the prescriber's submitted plan of care (medical information) and/or any restrictions included in the prior authorization (i.e. quantity limits, step-therapy)."<br>Original Section IV is now Section V and so on.<br>Added attachments OH Buckeye Work Instructions and PAHW Work Instructions<br>Updated EPS.PHARM.03A State Specific SOP document | |
| Ad Hoc Review | Removed redlines and/or comments that were overlooked prior to previous upload to RSA Archer for the following attachments:<br>• AZCH Work Instructions<br>• MS Magnolia Work Instructions<br>• OH Buckeye Work Instructions<br>• WA CCWA Work Instructions | 1/6/20 |
| Ad Hoc Review | Updated WA CCWA Work Instructions and OR Trillium Work Instructions | 1/9/20 |
| Ad Hoc Review | Added language to policy section "Envolve Pharmacy Solutions makes prospective, concurrent and retrospective review determinations solely on the clinical information available to the prescriber or the organization at the time the medical care was provided."<br><br>Added language to Procedure #3 "A prescriber may request a peer-to-peer review or reconsideration when a PA is not approved (denial) by contacting the Prior Authorization department by telephone or resubmitting the prior authorization with additional clinical information. The notification of a prescriber's right is included in the notification response to the provider. The prescriber may present significant additional clinical information to have a previous denial of coverage overturned. Upon request, disclosure of the clinical oversight process will be provided to the prescriber. A technician can answer any non-clinical questions from a prescriber; however, any clinical questions will | 1/14/20 |

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| | be forwarded to a pharmacist. When a prescriber calls for a peer-to-peer review, the technician will contact the reviewing pharmacist. If the reviewing pharmacist is not available, then the technician will contact an alternative pharmacist assigned to that plan. If that pharmacist is not available, a third pharmacist will be contacted who may or may not be assigned to that particular plan. If a pharmacist is still not available, the technician will provide the prescriber the option of scheduling a call back to avoid prolonged waiting time. Once a call back time range is scheduled, the technician will send the reviewing pharmacist an email and also notify the pharmacist in person if possible. The pharmacist will contact the prescriber within 1 business day of the request. The pharmacist must make at least two attempts, when requested or prior to an appeal request (if required by State regulations), to reach the prescriber and each attempt must be clearly documented in the notes section of the PA request." | |
| Ad Hoc Review | Updated EPS.PHARM.03A State Specific SOP - Nebraska and Louisiana<br>Updated EPS.PHARM.03A State Specific SOP - Oregon revision log entry date corrected from 12/24/2019 to 01/02/2020; updated numbering to align with policy<br>Updated numbering and headers of SOP document to align with policy<br>Added document RxAdvance Pharmacy Notifications Work Instructions<br>"Simplified approvals" changed to "coverage approvals"<br>"If the PT determines a request does not meet the approval criteria changed" to "If the PT is unable to approve the request based on the plan criteria and information provided by the prescriber"<br>"Pharmacists will conduct periodic audits of PT approvals to ensure the criteria are being followed." Changed to "Periodic audits of requests approved by PT staff will be conducted."<br>Pharmacist duties section updated as follows:<br>• "The pharmacist will be provided the most up to date criteria for review from drug information team and account management in order to utilize the most up to date clinical criteria, clinical guidelines, PDL, and state approve documents for citation to render all determinations." Changed to "The Drug Information and Account Management teams will provide the most up to date criteria, clinical guidelines, PDL, and state approve documents for citation for Pharmacists to use when reviewing requests and rendering determinations."<br>• Erroneous d. removed<br>• Approve changed to approved<br>• Id changed to is<br>• Provider changed to Peer Reviewer (Physician) and Peer Reviewers<br>• Removed "Envolve Pharmacy Solutions pharmacists will consult with the requesting provider prior to issuing a denial, when medically appropriate"<br>• "If a PA denial request requires physician sign off review Envolve Pharmacy Solutions will securely forward the PA request" Changed to "If a PA request requires physician review Envolve Pharmacy Solutions will securely forward the request"<br>• "Accept" changed to "conduct"<br>Denials section reworded to state: Envolve Pharmacy Solutions reserve the right to adjust the approval dates so as to prevent a member from receiving additional medication in the case of therapy changes (upon prescriber request), fraud, material misrepresentation, or if the medicine is not being provided consistent with the prescriber's plan of care. | 2/13/20 |

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| | Turnaround time section updated to state: Envolve Health Solutions will review and resolve Medicaid PA requests and notify the prescriber of the decision by telephone, fax, or other electronic telecommunication device within 24 hours.<br>Exception: Tolling a request is allowed by State regulations (refer to State-specific SOPs)<br>PA requests not decided within the prescribed timeframe are treated as an adverse benefit determination and the appropriate written notifications made (see below).<br>Exception: When contrary to State law (refer to State-specific SOPs).<br>"PA is not approved (denial)" changed to "PA request is not approved (denied)"<br>Terminating Coverage for a Prior Authorized Drug section removed | |
| Ad Hoc Review | Updated CCWA WI, Trillium WI, RxAdvance RPh Role WI and Missing Information Work Process documents | 3/2/20 |
| Ad Hoc Review | Added language to Policy section to state: "The UM decision-making criteria is based on clinical criteria and the individual needs of the member."<br>Re-wrote coverage approval section to state "If a PA request is for a medication that has specific approval criteria and does not require clinical judgment, an appropriately credentialed Pharmacy Technician with a license in good standing may, under the direction of a licensed pharmacist, review the PA (where allowable by law)."<br><br>Re-wrote written notification section to now read as: "Envolve Pharmacy Solutions will fax a denial notification, which includes the UM criteria to the prescriber. In the event a fax cannot be successfully delivered, telephonic outreach will be made allowing the criteria to be available upon the practitioners request and logged in the PA processing system."<br><br>Added language to Notification of Denials section to #1, #2, #2b, #2d and #2e<br><br>Added language to New Mexico and Kansas State specific SOP | 3/17/20 |
| Ad Hoc Review | Add the following attachments:<br>• New Century Health PA Review Work Instructions<br>• MHS Indiana Work Instructions<br>• Dual Med-D Verification Work Instructions<br>• KS Sunflower Work Instructions<br>Update the following attachments:<br>• Oregon Trillium Work Instructions<br>• IL Illinicare Work Instructions<br>• AZCH Work Instructions<br>Corrected the revision log, moving the revision listed as 12/26/2019 to the 1/2/2020 line and deleting the 12/26/2019 line from the revision log; the 12/26/2019 change "Updated Oregon Trillium Work Instructions and FL Sunshine Work Instructions" was incorporated into the 1/2/2020 revision and published as EPS.PHARM.03A v14 | 4/3/20 |
| Ad Hoc Review | Updated KS Sunflower WIs<br>Updated OR Trillium WIs | 4/29/20 |
| Ad Hoc Review | Added the following attachments:<br>• ARTC Work Instructions<br>• ATC SC Work Instructions<br>• COVID-19 Work Instructions<br>• NHHF Work Instructions | 5/26/20 |

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| | • NMWS Work Instructions<br>• NVSS Work Instructions<br>• Peer to Peer Work Instructions<br>Updated the following attachments:<br>• OR Trillium Work Instructions<br>• PAHW Work Instructions | |
| Ad Hoc Review | Added the following attachments:<br>• GA PSHP Work Instructions<br>• MRIOA Peer to Peer Work Instructions<br>Updated the following attachments:<br>• AZCH Work Instructions<br>• NVSS Work Instructions | 6/22/20 |
| Annual Review | Updated the following attachments:<br>• AZCH Work Instructions<br>• KS Sunflower Work Instructions<br>• OR Trillium Work Instructions<br>• NVSS Work Instructions | 7/29/20 |
| Ad Hoc Review | Updated the following attachments:<br>• KS Sunflower Work Instructions<br>• MHS Indiana Work Instructions<br>• NMWS Work Instructions<br>• NCH Work Instructions<br>Added the following attachments:<br>• NE NTC Work Instructions | 8/21/20 |
| Ad Hoc Review | Updated the following attachments:<br>• OH Buckeye Work Instructions<br>• Missing Information (NCQA outreach) Work Process<br>Added the following attachments:<br>• IL YouthCare Work Instructions<br>• EPS Medical Director Work Instructions | 8/28/20 |
| Ad Hoc Review | Updated III. Pharmacist Duties section, letter G | 9/16/20 |
| Ad Hoc Review | Updated the following attachments:<br>• AR ARTC Work Instructions<br>• NH NHHF Work Instructions<br>• NV NVSS Work Instructions<br>• WA CCWA Work Instructions<br>• NCH Work Instructions<br>Added the following attachments:<br>• IA Iowa Total Care Work Instructions | 10/13/20 |
| Ad Hoc Review | Updated the following attachments:<br>• AZ AZCH Work Instructions<br>• KS Sunflower Work Instructions<br>• OR Trillium Work Instructions<br>Added the following attachments:<br>• Peer-to-Peer Work Instructions (replaces MRIOA Peer to Peer Work Instructions) | 11/12/20 |
| Ad Hoc Review | Updated attachment: NHHF New Hampshire | 11/13/20 |
| Ad Hoc Review | Updated the following attachments:<br>• MHS Indiana Work Instructions<br>• ATC SC Work Instructions<br>• KS Sunflower Work Instructions<br>• FL Sunshine Work Instructions<br>• PAHW Work Instructions<br>Added the following attachments: | 1/24/21 |

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| | • LHCC Work Instructions<br>• TX Superior Work Instructions | |
| Ad Hoc Review | Updated the following attachments:<br>• ATC Work Instructions<br>• NCH Work Instructions<br>• Magnolia Work Instructions<br>• P2P Work Instructions<br>• Peach State Work Instructions<br>• Sunshine Work Instructions<br>• Superior Work Instructions<br><br>Added the following attachments:<br>• Foreign Language Translation | 2/15/21 |
| New Policy Document | Updated to new Archer Template<br>- 2020 P&P version added as documentation of prior revisions to 2021<br>Added Policy statement as new requirement of document:<br>- This policy outlines the business requirements and operational processes for Clinical Pharmacy Operations - Prior Authorization department to manage Medicaid line of business.<br>Updated Scope:<br>- This policy applies to Envolve Pharmacy Solutions Clinical Pharmacy Operations employees for prior authorization process and provides support to employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company").<br>Added Definitions:<br>Utilization Management (UM): the use of managed care techniques such as prior authorization that allow payers, particularly health insurance companies to manage the cost of health care benefits by assessing its appropriateness before it is provided using evidence-based criteria or guidelines.<br><br>Prior Authorization (PA): a utilization management process used to determine if coverage of a prescribed procedure, service, or medication will be provided based on evidence-based criteria or guidelines.<br><br>Added the following updated attachments:<br>• PA Ops Policy and Procedure List (Excel)<br>• PRISM Batch Schedule (Excel)<br>• Foreign Language Translations<br>• IA Member Translations (Excel)<br>• Common Spanish Translations for Pharmacy<br>• Updated State Addendum to include Oklahoma Sooners plan<br>• RxAdvance Technician Role Work Instructions<br>Retired:<br>• IL Illinicare Work Instructions | 3/30/21 |
| Ad Hoc Review | Updated the following attachments:<br>• ARTC Work Instructions<br>• CCWA Work Instructions<br>• FL Sunshine Work Instructions<br>• PAHW Work Instructions<br>• NCH Work Instructions<br>• NM Western Sky Work Instructions<br>• Magnolia Work Instructions<br>• Trillium Work Instructions<br>Added the following attachments: | 06/30/2021 |

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| | RXClaim Reviewer Work Instructions | |
| Ad Hoc Review | Effective with this 2/11/2022 revision, only two (2) documents will remain as “policy related attachments” in Archer:<br>• State Specific SOPs<br>• PRISM Batch Schedule Current Proposed<br><br>Updated REFERENCES section to indicate the SharePoint URLs for storage of work instructions and step actions.<br><br>The following work instructions **remain in effect** but have been moved to SharePoint (i.e., removed as “policy related attachments” in Archer).<br>• AZ_AZCH Work Instructions<br>• Centene Work Instructions<br>• COVID-19 Work Instructions<br>• Dual Med-D Verification Work Instructions<br>• Envolve Clinical Operations RXA Misdirected Fax Process<br>• EPS Medical Director Work Instructions<br>• Foreign Language Translation<br>• IA ITC Work Instructions<br>• LHCC Louisiana Work Instruction<br>• Missing Information (NCQA Outreach) Process Work Instructions<br>• MS Magnolia Work Instructions<br>• NE NTC Work Instructions<br>• New Century Health PA Review Work Instructions<br>• Peer to Peer Work Instructions with Arkansas<br>• RxAdvance DE Role Work Instructions<br>• RxAdvance Failed Fax Queue Work Instructions<br>• RxAdvance Outgoing Fax Queue Guide Work Instructions<br>• RxAdvance Pharmacy Notifications Work Instructions<br>• RxAdvance RPh Role Work Instructions<br>• RxClaim Reviewer Work Instructions<br>• TX Superior Work Instructions<br>• WA CCWA Work Instructions<br><br>Effective with this 2/11/2022, the following work instructions are being retired. Historical copies of the retired work instructions are archived on SharePoint:<br>• ARTC Work Instructions<br>• ATC SC Work Instructions<br>• FL Sunshine Work Instructions<br>• GA PSHP Work Instructions<br>• IL Illinicare Work Instructions<br>• IL YouthCare Work Instructions<br>• KS Sunflower Work Instructions<br>• MHS Indiana Work Instructions<br>• NHHF Work Instructions<br>• NMWS Work Instructions<br>• NVSS Work Instructions<br>• OH Buckeye Work Instructions<br>• Oregon Trillium Work Instructions<br>• PAHW Work Instructions<br>• RxAdvance Technician Role Work Instructions | 02/11/2022 |

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| | Removed PA Ops Policy and Procedure List (Excel) as an attachment to policy EPS.PHARM.03A. | |
| Ad Hoc Review | Added language to policy section<br><br>The following work instructions **remain in effect** and can be found here: SharePoint (i.e., removed as "policy elated attachments" in Archer).<br>• Alternate Text SOP MHS 1.0 | 3/7/2022 |
| Ad Hoc Review | Added Pharmacy Technician Duties A, B, C, D to Medicaid SOP Addendum 38 (Pennsylvania) | 4/5/2022 |
| Ad Hoc Review | Added following changes to Medicaid SOP Addendum 38 (Pennsylvania)<br>Added "Community HealthChoices Agreement, Exhibit D, Drug Services" to References.<br>Added B sub section (1) and C sub section (1) under Pharmacist Duties<br>Added "Therapeutic Substitution" section | 4/14/2022 |
| Ad Hoc Review | Replaced all EPS references with 'pharmacy services'. Changed policy ID from EPS.PHARM.03A to CC.PHARM.03A | 4/8/2022 |
| Ad Hoc Review | Added subsection to State-specific SOPs under Tech and RPh duties referring to Vice President of PA Operations responsibility to notify Plan. | 4/27/2022 |
| Ad Hoc Review | Updated exception to P2P policy to account for physician reviewer, removing coordinating intervention, updated notice related to changes in authorization dates, and removed specialty language from out-of-scope drugs for PA review. | 5/13/2022 |
| Ad Hoc Review | Addition to Kansas State Specific SOP: Added Adverse determination will be decisioned by a Kansas licensed pharmacist or physician under Timing and Notification of PA Decisions | 8/16/2022 |
| Ad Hoc Review | Reviewed for language additions & redid the policy purpose to ensure that This language from CC.PHAR.08 is used to meet UM 11A Factors 1-3 and UM 11E Factor 1 | 5/9/2024 |

## POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

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| Vice President, Quality and Process Improvement – Quality Improvement | Approval on file |
| Director Clinical Pharmacy Operations, G&A – Service Operations | Approval on file |
| Vice President, Pharmacy Services, COS – Medical Management | Approval on file |