Summary of Research Findings and Stakeholder Input

New Hampshire Uniform Prescription Drug Prior Authorization Form

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Background

In June 2016, New Hampshire House Bill 1608 (HB 1608) was enacted into law, tasking the New Hampshire Insurance Department (NHID) with creating a uniform form for prior authorization (PA) of prescription drugs to be used by commercial insurers. The law also requires the NHID to enact regulations regarding the form and standards for electronic prior authorization (ePA). The form must be no more than two pages. The purpose of HB 1608 is to provide administrative simplification in the prescription drug PA process.

HB 1608 requires HMOs, PPOs, and other commercial insurers[1] in New Hampshire to use *only* the form and/or standards adopted by the NHID for PA of prescription drugs by December 31, 2017.

The statute requires the NHID to seek stakeholder input and to incorporate national standards when creating the form. Several states have already gone through this process and may also serve as guides to the NHID in its work. In particular, the NHID has stated a desire to use the recently developed uniform form in Massachusetts as a starting point in the development of the New Hampshire form.

The following report outlines the findings of the Public Consulting Group (PCG), which was hired by the NHID to conduct research, facilitate a stakeholder input process, and support this process more generally.

Research Findings

Existing Prior Authorization Process

In order to assist the NHID with the development of a uniform PA form, PCG conducted a landscape review of existing PA forms – both those developed via similar initiatives in other states and those currently in use in the market in New Hampshire.

Specifically, PCG reviewed the following types of prior authorization forms for prescription drugs (Rx PA forms):

- Uniform Rx PA forms developed in other states
- The Medicare Rx PA form
- NH Medicaid Rx PA forms
- Rx PA forms used by carriers and Pharmacy Benefit Managers (PBM) with members in New Hampshire

Overall, the forms are very similar as far as content and most are one to two pages. All forms reviewed require the following categories of information and information points within each:[2]

[1] HB 1608 does not apply to Medicaid managed care plans.
[2] The information below also reflects the uniform form in Massachusetts.

- Information about the carrier/PBM:
  - Forms commonly provide or request carrier name, phone and fax.
- Information about the patient:
  - Forms commonly request name and member ID number; most also request date of birth.
- Information about the prescriber:
  - Almost all forms request the prescribing provider's name and phone and fax numbers.
  - Most Rx PA forms also request the National Provider Identifier and a point of contact for the provider with contact information.
- Information about the prescription drug being requested:
  - All Rx PA forms request the medication name.
  - Most also request strength, quantity, frequency, length of therapy, start date, and whether it is a new request.
- Information about the patient's diagnosis/health:
  - All Rx PA forms ask for patient diagnosis and most also ask for the relevant International Classification of Disease (ICD) code(s).
  - Most also ask for basic health information, including allergies, height, and weight (some only as relevant to the request).
  - Most ask for information regarding the rationale for the request, including other therapies previously tried, other clinical information including relevant lab results, and additional relevant data.
- Most forms allow for the identification of urgent requests.

At the same time, there are some notable differences that are worth consideration. In looking at the differences between forms, we have used the uniform Rx PA form in Massachusetts (MA form) as the starting point because of the NHID's stated interest in working from the MA form. By category, notable differences when comparing other forms reviewed to the MA form include:

- Information about the carrier/PBM:
  - Some of the forms have carrier information already completed or allow it to be pre-populated by the carrier.
  - While the MA form does not, several of the forms include carrier address.
  - Unlike the MA form, some of the forms include space for carriers to include a webpage for electronic PA.
  - Only Minnesota's form includes space for a carrier contact name and "other" information.
  - Only Oregon's form includes a space for a carrier email address.
- Information about the patient:
  - Only about half of the forms reviewed – including the MA form - request gender.
  - While the MA form does not request patient contact information, most other forms require at least phone numbers and many others also request address.
  - Only Colorado also requests patients' email addresses.
  - Several of the Rx PA forms request more insurance information than Massachusetts, including requesting secondary insurance information.
  - While the MA form does not request information about an authorized representative of the patient, several do.

- Information about the prescriber:
  - Like the MA form, just over half of the forms request specialty and Drug Enforcement Agency registration number.
  - Like the MA form, over half of the forms require the prescriber's signature; some also require attestation.
  - While the MA form does not request a provider address, more than half of the Rx PA forms do.
  - A couple of the Rx PA forms also request the prescriber's facility information, carrier-designated or state licensure number, email, pager number, and/or tax ID number.
- Information about the prescription drug being requested:
  - Unlike most Rx PA forms, the MA form also asks questions about compound and off-label drugs and whether this is a "dispense as written" request.
  - Like the MA form, several Rx PA forms also ask about provider-administered drugs, though the questions on the MA form are the most comprehensive.
  - Unlike the MA form, a few Rx PA forms also ask for the prescription directions, route of administration, and form.
  - Only Colorado and Minnesota ask if the request relates to a clinical trial.
- Information about the patient's diagnosis/health:
  - The MA form is one of only two forms that ask about symptom improvement for patients already on the medication.
  - Only the MA form and Texas ask about comorbidities.
  - Only the MA form asks about other medications and opioid management.
  - Only the MA form asks whether prior pharmacologic therapies were samples.
  - Only the MA form asks if nonpharmacological therapies were tried.
  - A couple of the carrier and PBM forms ask for more detailed health care information.
- Other:
  - Just under half of the forms have variations for certain drugs; it has been reported that the Massachusetts form will as well though those forms are still in development.
  - A couple of the forms ask for pharmacy information.
  - While some Rx PA forms include a place for the payer decision to be documented, most, like the MA form, do not.
  - Unlike the MA form, over half of the forms include confidentiality information.
  - Three of the state uniform forms are writable.
  - Many of the forms are also used for other types of requests, such as step therapy, formulary, dosage, quantity or tier exceptions, and out of pocket appeals.
  - Several of the forms are accompanied by FAQs or instructions.

A detailed side-by-side of the forms (each compared to the MA form) is included in Appendix A.

Overview of State Laws and Rules/Guidance

Summary

The governing statute in New Hampshire (enacted at RSA 420-J:7-b (IV-c); RSA 420-E:4-a) includes the following key requirements, which should be reflected in regulations:[3]

- Carriers must use *only* the paper form or electronic standards for prior authorization by December 31, 2017; carriers *may* use the form/standards starting July 1, 2017.
- The NHID must adopt rules specifying the content and format of the uniform form and electronic standard.
    - Those rules must support adoption of nationally recognized standards for ePA, including those of the National Council for Prescription Drug Programs.
    - The form cannot exceed 2 pages.
- Carriers may not require ePA in enumerated circumstances.

Many of these provisions align with the contents of governing regulations in other states, including the requirement that carriers only use the state's uniform form and the inclusion of a timeline for implementation. While many of the additional provisions included in regulations in other states expand beyond the scope of the New Hampshire statute, others of those provisions from other states are worthy of consideration, including:

- Definitions
- Requiring carriers to make the form available electronically
- Allowing or requiring carriers to *accept* different forms with the same information
- Specifying that the ePA system must be consistent with paper form
- Enforcement provisions

Key Provisions from other States

Massachusetts

Similar to the New Hampshire law, the Massachusetts statute (MGL Chapter 176O section 25) requires carriers to use the state's uniform form developed by the Department of Insurance (DOI) and which cannot exceed 2 pages. If the form is not used, PA is automatically deemed granted.

Carriers in Massachusetts may use an ePA system instead of a paper form as long as the system is consistent with the paper form.

The Massachusetts statute requires that the form be both:

- made available electronically; and
- capable of being electronically accepted.

[3] Requirements apply all health insurers, health maintenance organization, health services corporations, medical services corporations and preferred provider programs. Medicaid managed care is specifically excluded.

The Massachusetts statute also includes a maximum timeline for PA responses.

The Massachusetts DOI issued the final form and a bulletin in early August.[4] The bulletin reiterates the statutory requirement that carriers only use the state's uniform form. Carriers must begin use of the form within 90 days but can continue to accept existing forms for six months. After six months, only the state form can be used and that form must be considered sufficient information for processing PA requests. Additionally, after six months following the issuance of the bulletin, carriers' ePA systems must only ask questions included in the state's uniform form and in a format and order that is substantially similar to the form. Carriers can submit requests to DOI seeking approval to vary their ePA system from the form.

The bulletin also encourages carriers to educate their network providers about the uniform prescription drug prior authorization form.

We understand that the state is continuing to work with stakeholders to develop forms specific to Synagis and Hepatitis C drugs.

Colorado

The Colorado statute (CO Rev. Stat. 10-16-124.5) requires the state's DOI to develop a uniform Rx PA form. That form must be made available electronically by the carrier or PBM. The Colorado statute also requires carriers and PBMs to make the following available and accessible on a centralized location on the carrier or PBM website:

- PA requirements and restrictions
- Written clinical criteria

Providers must be allowed to, but cannot be required to, submit the form electronically. If providers submit PA forms electronically, they must do so through a secure, web-based internet portal and not via email.

Like in Massachusetts, the law states that PA requests will be deemed granted if a carrier or PBM fails to use the state's form as required. The statute also includes: maximum timelines for requesting and submitting additional information and for decisions; content requirements for determination notices; requirements for using evidence-based standards for making determinations; and minimum timelines for the duration for PA approvals.

The regulations in Colorado (Colo Code Regs 702-4:4-2-49) set forth a number of definitions:

- Adverse determination
- Carrier
- Drug benefit
- Health benefit plan
- HMO
- PBM
- Prescribing provider

[4] Available at http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2016-doi-bulletins/bulletin-2016-08.html

- Urgent PA request

The regulations reiterate the following requirements regarding carriers' PA processes:

- Forms must be made available electronically
- Requirement that carriers make certain information accessible on the carrier website (requirements and restrictions, list of drugs that require PA, written clinical criteria, uniform form)
- Requirement that carriers use evidence-based guidelines
- Requirement that carriers allow for but not require electronic submission
- Timelines for decisions and duration of PA approvals
- Required content for determination notices
- Requirement that carriers respond to PA requests in same medium as the request is made

The regulations also include enforcement provisions.

Minnesota

The Minnesota statute (Laws 2010, chapter 336, section 5) requires prescription drug PAs to be submitted by providers and accepted by payers electronically through secure electronic transmissions subject to a standard companion guide[5] and via a standardized outline.

Oregon

The Oregon statute (ORS 743.035) requires that the state develop a uniform PA form that:

- is uniform for all providers;
- does not exceed 2 pages; and
- is electronically available and transmittable.

The Oregon form must include a provision under which additional info may be requested and provided.

The Oregon regulations (836-053-1205) include a few definitions:

- Material information
- Payer
- Request form

The regulations reiterate the requirement that payers must accept PA requests on the uniform request form. Payers *may accept* PA requests submitted on different forms. Payers must make request forms available electronically on their website and must accept requests through any reasonable means of transmission (including, but not limited to, paper, electronic or other mutually agreeable accessible methods of transmission or using an online system). In requesting additional information as permitted by the form, the regulations specify that the carrier must request only the minimum amount of material information necessary. Requiring information in excess is considered a failure to accept the required form.

[5] Available at http://www.health.state.mn.us/asa/compguide.html

The regulations set forth a timeline for requesting additional information and issuing decisions. Decisions must be provided in same manner as the request was submitted or another mutually agreeable accessible method.

The regulations require that payers have written policies and procedures to ensure compliance with these standards.

California

The California statute (CA Ins Code § 10123.191) requires carriers to use and accept the state's uniform PA form as sufficient.[6] Failure to do so results in PA requests being deemed granted. Forms *may* be submitted electronically.

The statute requires carriers and the DOI to make the form available electronically and also sets a maximum timeline for responding to a completed form.

The California regulations (CCR title 10, chap 5, subchap 2, article 1.2) reiterate:

- the requirement that carriers and their third party administrators (TPAs) use and accept only the state's uniform form;
- the requirement that carriers make the form electronically available online; and
- the maximum timeline for processing PA requests.

The regulations clarify that carriers must request only the minimum amount of material information necessary to complete PA requests except where additional information is required by state or federal law for dispensing restricted prescription drugs. Under the regulations, carriers must respond to PA requests in the same manner as submitted or a mutually agreeable accessible manner and must comply with standards for denial notices.

Carriers must require their TPAs to comply with these requirements in their contracts and have written policies and procedures in place to ensure compliance.

Texas

The Texas statute (S.B. 644, 83rd Legislature, Regular Session, 2013) requires commercial health insurers as well as Medicaid, Medicaid managed care plan, CHIP, state employee plans and school district plans to use the state's uniform form for prescription drug PA requests.

Regulations in Texas (19.1820) require the state's DOI to adopt a form and instructions, which carriers must reproduce without changes and use and accept for all prescription drug PAs. Carriers and PBMs must make the form available on their websites and may have an electronic process *available*. Providers must be *allowed* to attach supporting information to the form.

Other

The state of Vermont explored adopting a uniform Rx PA form but determined that prescription drug PAs are "too complex" for a uniform form. According to the state's Department of Financial Regulation (DFR),

[6] We understand that California is considering revising its law to allow for additional follow-up by carriers.

"[b]ased on stakeholder research and feedback regarding prior authorization of prescription drug [sic], DFR has determined that the extent of the operations and clinical differences among health plans for authorizing prescription drugs were too complex to be effectively transformed to a standardized form." [7]

Both New Jersey and New York have adopted statutes to require development of uniform Rx PA forms but those forms have not yet been made public.

National Standards

National Council for Prescription Drug Programs

The National Council for Prescription Drug Programs (NCPDP) - a not-for-profit organization that represents drug manufacturers, chain and independent pharmacies, drug wholesalers, insurers, mail order prescription drug companies, claims processors, pharmacy benefit managers, physician services organizations, prescription drug providers, software vendors, telecommunication vendors, service organizations, government agencies, and other parties interested in electronic standardization within the pharmacy services sector of the health care industry - has developed standards for the adoption of ePA.[8] The NCPDP expresses the following concerns with typical PA processes:

- The process is too cumbersome.
- The process involves too many parties (prescribers, payers, pharmacists, patients).
- The process results in unnecessary delays.
- Information submitted manually cannot be systematically reviewed.

In particular, prescribers often do not know PA is required until a prescription claim is rejected at the pharmacy. This delays the prescriber's ability to discuss the process with the patient and to consider prescribing another medication. Ultimately, treatment is delayed (or the patient must pay out-of-pocket) as a result. In addition, pharmacists end up in the middle, having to contact the prescriber, notify the patient, and contact the payer for updates.

To alleviate these concerns, NCPDP has published a SCRIPT Standard for ePA, which attempts to make the PA process more efficient and less burdensome. The standard:

- supports a method to convey a set of PA questions so that it can be presented logically in any system and the answers returned reliably; and
- supports features to minimize what the prescriber is asked, based on earlier answers or data in their Electronic Health Record (EHR) system.

[7] http://www.dfr.vermont.gov/insurance/health-insurance/vermonts-uniform-prior-authorization-form-medical-services
[8] http://ncpdp.org/Resources/ePrescribing

American Medical Society

The American Medical Society has expressed concern that the PA process for prescription drugs leads to administrative burden and treatment delays. The AMA has advocated for:[9]

- accurate, real-time formulary information being available online;
- the reduced use of manual and different processes; and
- the PA process to be available at no or low cost to providers.

Maryland Health Care Commission

In a report on ePA for its state's legislature,[10] the Maryland Health Care Commission found that PA processes vary greatly across payers, are typically manual (with requests submitted by phone or fax), and require follow-up for additional information. Processes vary by:

- the list of prescription drugs subject to PA;
- work flows for submitting and processing requests; and
- criteria for responding to requests.

The Commission recommended that there be a single standard process across payers and that ePA be phased in.

Stakeholder Input

Summary

The input of key stakeholders from across the state of New Hampshire has been gathered regarding the development of the New Hampshire uniform Rx PA form, electronic standards, and regulations. Feedback has been sought from prescribers and other providers, pharmacists, carriers, pharmacy benefit managers, consumer advocates, and key legislators.

To-date, stakeholder engagement has been conducted over the course of a month via the following activities:

- Initial outreach to key stakeholders
- Targeted follow-up outreach
- Facilitation of two workgroup meetings, which included the opportunity for web-based participation

[9] http://www.ncvhs.hhs.gov/wp-content/uploads/2014/05/140219p26.pdf
[10] Available at http://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Recommend_Implement_Electronic_Prior_Auth_Rpt_20111201.pdf

- Follow-up outreach, including to practicing providers who were unable to participate in workgroup meetings

The workgroup meetings resulted in robust discussions amongst all interested parties. Presentations and all feedback shared during the two workgroup meetings are included in Appendix C. Some of the most significant feedback from the two meetings is outlined below.

Workgroup Meeting 1

The first workgroup meeting was held on August 1, 2016. At that meeting, the NHID and PCG presented information about key NHID staff, PCG role and staff, HB 1608, and the steps and timeline for the process. Following the presentation, input was solicited from participants and included the following:

- General acceptance of the MA form as a model, given that most carriers in New Hampshire are also in Massachusetts and providers in New Hampshire treat patients with coverage from both states; several attendees stated that they also participated in the Massachusetts process and believe it to have been comprehensive and resulted in as good a product as possible
- Questions about whether providers will be able to submit the same information on another form and whether carriers can request additional information
- Concern that providers may think a Massachusetts patient has Massachusetts coverage when in fact his/her employer is in New Hampshire
- Comments about the importance of provider education

Workgroup Meeting 2

The second workgroup meeting was held on August 11, 2016. At that meeting, PCG presented information about research conducted and research findings, as well as the preliminary thinking regarding direction moving forward. Following the presentation, input was solicited from participants and included the following:

- Some retreat from the consensus support of the MA form, including expression of concern that MA form is much more detailed than some of the most commonly used forms in New Hampshire and requires more information than should be necessary
- Concern that if the form is simplified too much, carriers will not get the information they need to process requests, particularly given the increase in complexity of drugs (and specific pushback against removing date of birth and prescriber national provider identifier numbers)
- Support for a writable form that can be prepopulated and instructions
- Concern about statutory limitations on follow-up by carriers, which some believe will be necessary, including to follow-up on clinical information
- Concern about the requirement that electronic systems be consistent with the uniform Rx PA form, which would require different systems to be established for different states

Provider Meeting

In order to facilitate input from practicing providers, the New Hampshire Medical Society hosted a meeting of providers on August 16, 2016. At that meeting, providers expressed the following:

- The desire that the form be simple and include only information necessary to process requests, as too much unnecessary detail provides more opportunities for mistakes
- Preference for the Cigna and Anthem forms over the MA form
- It is common for Anthem and Cigna to request follow-up information in order to process the PA request
- Most prescribers know what is important to include on Rx PA form to get approval
- Provider offices may be able to pre-populate a Rx PA form; electronic medical record systems may have that capability, but ePA will be the best solution down the road

Key Takeaways and Decision-Points

Given the lack of consensus among stakeholders regarding how closely to adhere to the MA form in developing New Hampshire's uniform Rx PA form, it will be important for the NHID to closely consider the differences between the MA form and those forms commonly in use currently in New Hampshire. The NHID should balance the desire to prevent over-burdening of providers completing the form with the risk of requesting too little information, which may result in time-consuming follow-up and/or unnecessary denials.

We recommend that the NHID look to the common trends in forms in use in New Hampshire more broadly for indication of what information is widely considered necessary to process prior authorization requests. Specifically, in considering those information points included in the Massachusetts form above and beyond the contents of the most commonly used forms in New Hampshire, the NHID should consider which of those information points are typically included in other forms and, therefore, are likely important to include. This includes:

- NPI number
- Basic prescription information (strength, quantity, dosing schedule, length of therapy, date initiated)
- ICD codes
- Basic health information (drug allergies, height, weight)
- Previous therapies tried (pharmacologic and non-pharmacologic)
- Contraindications to alternative therapies
- Lab values
- General questions about professionally-administered drugs

On the other hand, it appears that other information included on the MA form is rarely requested and, therefore, more likely unnecessary, including:

- Identification of "dispense as written" requests

- Information about compound drugs and off-label uses
- Information about co-morbidities
- Information about concurrent medications
- Information about opioid management tools
- Strength of previous therapies tried and whether they were samples
- Information about efficacy of requested medication previously taken
- Specific questions about professionally-administered medications

The NHID should also independently consider each information point and whether it is necessary. For example, date of birth and gender are commonly requested but should be information the carrier has and not necessary for verification of identity.

It is also worth considering including three information points that are not on the MA form but would be worthy of inclusion:

- Carrier address
- Carrier ePA webpage
- Confidentiality statement

This information can be included with no additional burden on providers as it will be provided by the state and carriers and, at the same time, provides information that will assist providers and ensure consumer protection.

Likewise, we recommend that the state consider state-specific formatting (as far as colors, font, and header) so that providers can easily identify the New Hampshire Rx PA form. We also recommend that the state consider providing writable forms and instructions to accompany the form.

We recommend that carriers be encouraged or required to populate their information on the forms. The NHID must consider parameters for customization of the form. Will it be limited to prepopulating information? Alternatively, can logos be added? The NHID must also consider whether to review carrier-customized versions of the form prior to use. We also recommend that carriers be required to make the form available on their website and to accept both variations of the New Hampshire form (blank New Hampshire form and carrier-populated New Hampshire form).

The state will also need to consider whether to create different forms for specific drugs (it has been reported that Massachusetts will develop unique forms for Synagis and Hepatitis C drugs).

Regarding use of the form, the statute is clear that only the state's uniform form can be used, but the state will need to consider whether carriers can request follow-up information specific to the questions on the form (such as regarding those answers that are incomplete or inconsistent with records), which seems permissible and may help prevent unnecessary denials without end-running the uniform form.

Regarding the electronic standards, we recommend that the state specifically require ePA to mirror the state form and adhere to national ePA and security standards. Requiring ePA systems to mirror the uniform form (questions, order and presentation) will ensure ePA cannot be used to end-run the uniform form. At the same, time, we encourage the NHID to consider whether to allow carriers and

PBMs to request permission to make some variations to ease the potential burden of a state-specific system when changes may not be burdensome to providers.

We also recommend that the state include enforcement provisions and education requirements in the regulations.

Appendix A: Overview of Existing Prior Authorization Forms

Overview of Forms: State Uniform Forms

Content	MA[1]	CO	MN	OR
State Uniform Forms (1 of 2)				
Length	2 pages	1 page	2 pages	2 pages
Varies by drug?	Yes (as reported)	No	No	No
Can urgent requests be identified?	Yes (with an attestation)	Yes (definition provided)	No	Yes
Carrier / PBM information included	• Name • Phone • Fax Can be prepopulated (is that better, worse?? Both options)	• To be completed by carrier (Space for carrier formatting (name, logo))	• Name • **Address** • Phone • Fax • **Contact name** • **Other** Can be prepopulated	• Name • **Address** • Phone • Fax • **Email**
Patient information requested	• Name • DOB • Gender • Member ID #	• Name • **Address** • **Phone** • **Email** • DOB • Member ID # • **Policy / group #**	• Name • **Address** • DOB • Gender • **Health / prescription plan** • Plan number	• Name • Gender • DOB • Member ID # • **Group number** • **Secondary insurance member ID #**
Prescriber / other provider information requested	• Prescribing clinician • Specialty • Phone • Fax • NPI # • DEA # • Prescriber point of contact, phone, fax, email (if different) • Signature and date	• Prescriber name • Fax • Phone • **Pager** • **Address** • Office contact • NPI # • DEA # • **Tax ID** • Specialty / facility name (if applicable) • **Email** • Signature	• Prescriber name • NPI # • Specialty • **Address** • Phone • Fax • Prescriber point of contact name, phone, fax (if different) • **Clinic / location / facility name, contact name, phone, fax, address**	• Requesting and / or servicing name • Specialty • **Tax ID #** • Phone • Fax • NPI # • DEA # (if required) • **Address** • Contact name • Phone • Fax

[1] Based on initial feedback, comparisons across states are based on the Massachusetts form. Bolded text in MA column reflect content unique to MA; Bolded text in other columns reflect content not included in the MA form.

Content	MA[1]	CO	MN	OR
				• **PCP information (if applicable): name, phone, fax**
Prescription / drug information requested	• Medication requested. • Strength • Quantity • Dosing schedule • Length of therapy • Date initiated • Initial vs renewal request • Is the patient currently being treated with the drug? If yes, date started • **Dispense as Written (DAW) specified? Rationale** • **Is the medication a compound? If yes, list ingredients** • **For a compound or off label use, include citation to peer reviewed literature** **For professionally administered medications:** • **Start date, end date** • **Servicing prescriber / facility name (same as prescriber?), address, NPI / Tax ID #** • **Name of billing provider / NPI #** • **Request for reauthorization?** • **CPT code** • **# of visits** • **J Code** **# of units**	• **Prescription date** • Drug name (brand and scientific; with J-Code if applicable) • Strength • Dose • Unit / volume • **Route** • Frequency • Quantity • Start date and length of therapy • New request or reauthorization • Number of refills • Where product will be delivered (patients home, physician office, other); including name, Type 2 NPI (if applicable), address and tax ID • **For use in clinical trial? (if yes, provide trial name and registration number)**	• Drug requested • Strength • Dosing schedule • Date therapy initiated • Duration expected • Authorization start date • **Clinical trial request?** • DAW? Rationale • Is the patient currently being treated with drug requested? Date started	• Medication • Dosage / strength • Frequency • Length of therapy / # of refills • Quantity • New or renewal? If renewal, existing authorization number; Date initiated • **Route of administration** • Where administered
Diagnosis / clinical information requested	• Primary diagnosis related to request • ICD codes • **Pertinent comorbidities**	• Diagnosis and ICD code(s) • Clinical criteria for approval, including pertinent information to support the request, other medications	• Diagnosis related to request (including ICD-codes) • Rationale As relevant: • Drug allergies • Height	• Height • Weight • Allergies • Previous drugs tried (name and dosage) • diagnosis

Content	MA[1]	CO	MN	OR
	(refers to plan-specific criteria for details related to required information) As relevant: • Drug allergies • Height • Weight • **Pertinent concurrent medications** • **Opioid management tools in place (risk assessment, treatment plan, informed consent, pain contract, pharmacy / prescriber restriction)** • Previous therapies tried / failed (name, strength, dosing schedule, date prescribed, date stopped, description of adverse reaction or failure). **Sample?** • Contraindications to alternative therapies • **Were nonpharmacological therapies tried? Details** • Relevant lab values (name, value, date) • **If renewal, has patient shown improvement in related condition while on therapy? Describe** • May attach additional data relevant to medical necessity criteria	tried (names, duration and patient response)	• Weight • Previous therapies tried / failed (name, strength, dosing schedule, date prescribed, date stopped, adverse reaction or efficacy failure)	• ICD-9 and 10 codes and descriptions • Must also submit: history and physical; lab / radiology / testing results**; current symptoms and functional impairments;** treatment history; other relevant information • Rationale, with chart notes and supporting labs
Decision-making information included? If yes, list	No	Yes (decision and if denied: reason, alternative medications on formulary)	Yes (date received, date of decision, payer responder / contact name, phone and / or email, decision, reference #, comments)	No
Signature and / or attestation required?	Yes (signature)	Yes (signature)	No	No

Content	MA[1]	CO	MN	OR
Confidentiality language included?	**No**	Yes	Yes	No
How is form submitted?	Mailed / faxed directly to carrier via info provided	Mailed / faxed directly to carrier	Printed and mailed / faxed directly to carrier	Unknown
Writable form?	Unknown	No	Yes	No
Other information included / requested	• Also used for: step therapy, formulary or quantity exception, specialty drug, other • Directs providers to consult health plan policies	• **Includes a FAQ** • Dispensing pharmacy name and phone number	• **Includes instructions** • Also used for formulary exceptions • Group purchasers may supply additional instructions or information.	• **Includes a FAQ** • Date

Content	MA	CA	TX	Medicare
State Uniform Forms (2 of 2), plus Medicare				
Length	2 pages	2 pages	2 pages	1 page
Varies by drug?	Yes (as reported)	No	No	No
Can urgent requests be identified?	Yes (with an attestation)	No	Yes	Yes (definition provided)
Carrier / PBM information included	• Name • Phone • Fax Can be prepopulated (is that better, worse?? Both options)	• Name	• Name	• Plan name • Phone • Fax
Patient information requested	• Name • DOB • Gender • Member ID #	• Name • **Phone** • Address • DOB • Gender • **Rep (if applicable) and phone #** • Member ID # • **Secondary Insurance** • **Member ID #**	• Name • Gender • DOB • **Phone** • **Address** • Member or Medicaid ID # • **Group #** • **BIN #** • **PCN #** • **RX ID #**	• Name • Member ID # • **Address** • **Phone** • Gender • DOB
Prescriber / other provider information requested	• Prescribing clinician • Specialty • Phone • Fax • NPI # • DEA # • Prescriber point of contact, phone, fax, email (if different) • Signature and date	• Name • Specialty • **Address** • **Requestor (if different than prescriber)** • Office contact person • NPI # • DEA # • Fax • **Email address**	• Prescriber name • Specialty • NPI # • **Address** • Phone • Fax • Contact person	• Name • NPI # • **Address** • Phone • Fax • Contact person • Signature and date
Prescription / drug information requested	• Medication requested. • Strength • Quantity • Dosing schedule • Length of therapy • Date initiated • Initial vs renewal request	• Name • New or renewal, and start date/duration • **How did the patient receive the meds? Paid under what insurance or other** • Dose • Strength	• Name • Strength • **Route of administration** • Expected duration • New or date initiated? • Quantity	• Name • Strength • **Route of administration** • Frequency • New prescription? If not, date started • Expected length of therapy • Quantity

Content	MA	CA	TX	Medicare
	• Is the patient currently being treated with the drug? If yes, date started • **Dispense as Written (DAW) specified? Rationale** • **Is the medication a compound? If yes, list ingredients** • **For a compound or off label use, include citation to peer reviewed literature** **For professionally administered medications:** • **Start date, end date** • **Servicing prescriber / facility name (same as prescriber?), address, NPI / Tax ID #** • **Name of billing provider / NPI #** • **Request for reauthorization?** • **CPT code** • **# of visits** • **J Code** **# of units**	• **Frequency** • Length • Quantity • Administration method • Location of administration	• Provider Administered only: HCPCS Code, NDC #, Dose per administration For compound drugs • Name • Ingredient • NDC# • Quantity •	
Diagnosis / clinical information requested	• Primary diagnosis related to request • ICD codes • **Pertinent comorbidities (refers to plan-specific criteria for details related to required information)** As relevant: • Drug allergies • Height • Weight • **Pertinent concurrent medications** • **Opioid management tools in place (risk assessment, treatment plan, informed**	• Height • Weight • Allergies • Has the patient tried any other medications for this condition? If yes, name / therapy, dosage, duration (specific dates), response / reason for failure • Diagnoses • ICD-9/10 • All relevant clinical information (symptoms, lab results with dates and / or justifications)	• Diagnosis • ICD Version & Code • Drugs patient has taken including strength, frequency, date started and stopped, and response/reason for failure • Allergies • Height • Weight • Relevant lab values / dates • Rationale (including, any comorbid conditions and contraindications for formulary drugs; details regarding titration regimen or	• Height • Weight • Drug allergies • Diagnosis • Rationale (options provided and explanation required)

Content	MA	CA	TX	Medicare
	consent, pain contract, pharmacy / prescriber restriction) • Previous therapies tried / failed (name, strength, dosing schedule, date prescribed, date stopped, description of adverse reaction or failure). **Sample?** • Contraindications to alternative therapies • **Were nonpharmacological therapies tried? Details** • Relevant lab values (name, value, date) • If renewal, has patient shown improvement in related condition while on therapy? Describe • May attach additional data relevant to medical necessity criteria		oncology staging, if applicable; Attach supporting clinical documentation, including medical records, progress notes, lab reports, etc.)	
Decision-making information included? If yes, list	No	Yes (date of decision, approved / denied, comments / info requested)	No	No
Signature and / or attestation required?	Yes (signature)	Yes (both)	Only for expedited requests	Yes (signature)
Confidentiality language included?	**No**	Yes	No	Yes
How is form submitted?	Mailed / faxed directly to carrier via info provided	Faxed directly to carrier	Mailed / faxed directly to carrier	Print and send to carrier
Writable form?	Unknown	Yes	Yes	No
Other information included / requested	• Also used for: step therapy, formulary or quantity exception, specialty drug, other • Directs providers to consult health plan policies	None	• **Includes instructions** • Some issuers may require more information or additional forms.	• Also used for different dosage requests and formulary tier exceptions

Overview of Forms: Carrier, PBM and Medicaid Forms

Content	MA	HPHC	Anthem	Minuteman	Cigna
Carrier, PBM and Medicaid Forms (1 of 5)					
Length	2 pages	1 page (with additional pages for different drugs)	1 page	1 page	1 page
Varies by drug?	Yes (as reported)	Yes	No	No	Yes
Can urgent requests be identified?	Yes (with an attestation)	No	No	No	Yes (standards provided)
Carrier / PBM information included	• Name • Phone • Fax Can be prepopulated (is that better, worse?? Both options)	• Name • Fax	• Name • **Address** • Fax • Phone	• Name • Fax	• Name • Phone • Fax • **Website**
Patient information requested	• Name • DOB • Gender • Member ID #	• Name • Member ID #	• Name • **Address** • Member ID # • **Group ID #**	• Name • Member ID # • DOB	• Name • Member ID # • DOB • **Address** • **Phone** • Information about authorized representative
Prescriber / other provider information requested	• Prescribing clinician • Specialty • Phone • Fax • NPI # • DEA # • Prescriber point of contact, phone, fax, email (if different) • Signature and date	• Name • NPI # • Phone • Fax • Contact person (name and phone #)	• Name • **Address** • Phone • Fax • Signature	• Name • Specialty • NPI # • **MM health provider #** • Office contact name • Phone • Fax • Signature	• Name • Specialty • DEA # or TIN • Contact person • Phone • Fax • **Address**
Prescription / drug information requested	• Medication requested. • Strength • Quantity • Dosing schedule • Length of therapy • Date initiated • Initial vs renewal request	• Projected start and end date • New request or reauthorization • Dose • Dosing interval • Other questions vary by drug requested, but	• Name	• Name • Dosage strength and **form** • Quantity (per month)	• Name • Duration

Content	MA	HPHC	Anthem	Minuteman	Cigna
	• Is the patient currently being treated with the drug? If yes, date started • **Dispense as Written (DAW) specified? Rationale** • **Is the medication a compound? If yes, list ingredients** • **For a compound or off label use, include citation to peer reviewed literature** **For professionally administered medications:** • **Start date, end date** • **Servicing prescriber / facility name (same as prescriber?), address, NPI / Tax ID #** • **Name of billing provider / NPI #** • **Request for reauthorization?** • **CPT code** • **# of visits** • **J Code** **# of units**	include justification for need and, for reauthorization requests, evidence of symptom improvements • Servicing provider o Name o NPI #			
Diagnosis / clinical information requested	• Primary diagnosis related to request • ICD codes • **Pertinent comorbidities** **(refers to plan-specific criteria for details related to required information)** As relevant: • Drug allergies • Height • Weight	• Diagnosis • ICD-9 code	• Diagnosis • Reason for request • Have other formulary products been used? If yes, list; if no, state reason	• Allergies • Diagnosis • Relevant co-morbidities • Past treatment failures and reason for discontinuation	• Diagnosis • Formulary alternative tried • Additional pertinent information

Content	MA	HPHC	Anthem	Minuteman	Cigna
	• **Pertinent concurrent medications** • **Opioid management tools in place (risk assessment, treatment plan, informed consent, pain contract, pharmacy / prescriber restriction)** • Previous therapies tried / failed (name, strength, dosing schedule, date prescribed, date stopped, description of adverse reaction or failure). **Sample?** • Contraindications to alternative therapies • **Were nonpharmacological therapies tried? Details** • Relevant lab values (name, value, date) • If renewal, has patient shown improvement in related condition while on therapy? Describe • May attach additional data relevant to medical necessity criteria				
Decision-making information included? If yes, list	No	No	Yes	No	No
Signature and / or	Yes (signature)	No	Yes (signature)	Yes (signature)	No

Content	MA	HPHC	Anthem	Minuteman	Cigna
attestation required?					
Confidentiality language included?	**No**	Yes	No	No	No
How is form submitted?	Mailed / faxed directly to carrier via info provided	Directly to carrier	Mail or fax to carrier	Fax to carrier	Faxed or phone to carrier
Writable form?	Unknown	Unknown	Unknown	Unknown	Unknown
Other information included / requested	• Also used for: step therapy, formulary or quantity exception, specialty drug, other • Directs providers to consult health plan policies		• Date	• Date • Space for additional information • Type of PA and reason (quantity limit, step therapy, brand only, new-to-market drug)	

Content	MA	NH Medicaid	NH Healthy Families / US Script	Well Sense / Envision Rx Options	ExpressScripts
Carrier, PBM and Medicaid Forms (2 of 5)					
Length	2 pages	1 page	1 page	2 pages	1 page
Varies by drug?	Yes (as reported)	Yes	Different form(s) for specialty and biopharmaceutical drugs	Yes, different forms by drug type	No
Can urgent requests be identified?	Yes (with an attestation)	No	No	Yes	Yes
Carrier / PBM information included	• Name • Phone • Fax Can be prepopulated (is that better, worse?? Both options)	No	• Name	• Name • Phone • Fax	• Name • Phone • Fax • **Web address for electronic PA**
Patient information requested	• Name • DOB • Gender • Member ID #	• Name • Medicaid # • DOB • Gender	• Name • Member ID # • Gender • DOB • **Address** • **Phone(s)** •	• Name • Member ID # • DOB • **Group number** • **Address** • **Phone**	• Name • Member ID # • DOB • **Phone**
Prescriber / other provider information requested	• Prescribing clinician • Specialty • Phone • Fax • NPI # • DEA # • Prescriber point of contact, phone, fax, email (if different) • Signature and date	• Name • NPI # • Phone • Fax • Signature and date	• Name • specialty • NPI # or DEA # • **Group or hospital** • **Address** • Phone • Fax • Office contact name	• Name • Fax • Phone • Office contact • NPI # • **State License ID** • **Address** • Specialty • **Facility** • Signature and date	• Name • DEA # / NPI # • Phone • Fax • **Address** • Office contact name and phone • Signature and date
Prescription / drug information requested	• Medication requested. • Strength • Quantity • Dosing schedule • Length of therapy • Date initiated • Initial vs renewal request • Is the patient currently being treated with the	• Name • Strength • Dosing directions • Length of therapy	• Name • Dosage / strength • Dosage form • **Route of administration** • Quantity per day • **Directions** • Refills / length of therapy • Therapy start date	• Name • Strength • **Directions / SIG** • Initial or continuing therapy and start date? • **Higher quantity needs and rationale**	• Name • Strength • Quantity • Duration

Content	MA	NH Medicaid	NH Healthy Families / US Script	Well Sense / Envision Rx Options	ExpressScripts
	drug? If yes, date started • **Dispense as Written (DAW) specified? Rationale** • **Is the medication a compound? If yes, list ingredients** • **For a compound or off label use, include citation to peer reviewed literature** **For professionally administered medications:** • **Start date, end date** • **Servicing prescriber / facility name (same as prescriber?), address, NPI / Tax ID #** • **Name of billing provider / NPI #** • **Request for reauthorization?** • **CPT code** • **# of visits** • **J Code # of units**		• Is the member currently on the medication? If so: How long? Is this a request for continuation of a previous approval? **Has the strength, dosage or quantity per day increased / decreased / stayed the same?** • Rationale for request and clinical information (check list and room for additional information)		
Diagnosis / clinical information requested	• Primary diagnosis related to request • ICD codes • **Pertinent comorbidities** **(refers to plan-specific criteria for details related to required information)** As relevant: • Drug allergies • Height • Weight	• Diagnosis • **Recent procedures, date, findings** • Medication failure in past 2 years? If yes, medication name, date • **Condition / medication specific questions or required lab tests** • Additional information	• Medication allergies • Previous medications and outcomes (name, strength, dosage, dates of therapy, reason for discontinuation) As relevant: • Diagnosis • ICD-9 and description • **Date of diagnosis** • Diagnostic clinicals (labs, radiology, etc)	• Diagnosis • Other medications tried and outcomes • Condition / medication - specific questions • **Date of last office visit** • Pertinent medical history or information	• Diagnosis • ICD code • Other medications / therapies tried and reason(s) for failure • Other information

Content	MA	NH Medicaid	NH Healthy Families / US Script	Well Sense / Envision Rx Options	ExpressScripts
	• **Pertinent concurrent medications** • **Opioid management tools in place (risk assessment, treatment plan, informed consent, pain contract, pharmacy / prescriber restriction)** • Previous therapies tried / failed (name, strength, dosing schedule, date prescribed, date stopped, description of adverse reaction or failure). **Sample?** • Contraindications to alternative therapies • **Were nonpharmacological therapies tried? Details** • Relevant lab values (name, value, date) • If renewal, has patient shown improvement in related condition while on therapy? Describe • May attach additional data relevant to medical necessity criteria				
Decision-making information included? If yes, list	No	No	No	No	No
Signature and / or	Yes (signature)	Yes (both)	Yes (signature)	Yes (signature)	Yes (signature)

Content	MA	NH Medicaid	NH Healthy Families / US Script	Well Sense / Envision Rx Options	ExpressScripts
attestation required?					
Confidentiality language included?	**No**	No	Yes	Yes	Yes
How is form submitted?	Mailed / faxed directly to carrier via info provided	Unclear	Fax or mail to PBM	Fax to PBM	Faxed or online direct to PBM
Writable form?	Unknown	Yes	Unknown	No	Unknown
Other information included / requested	• Also used for: step therapy, formulary or quantity exception, specialty drug, other • Directs providers to consult health plan policies	• Also used for non-preferred drug approval • Date			• Disclaimer that may request additional information

Content	MA	CVS	Cigna Medicare PDP	Humana	SilverScript
Carrier, PBM and Medicaid Forms (3 of 5)					
Length	2 pages	1 page plus drug specific form	3 pages	2 pages	3 pages (plus 3 additional pages for Remicade)
Varies by drug?	Yes (as reported)	Yes	Yes	No	Yes
Can urgent requests be identified?	Yes (with an attestation)	No	Yes (standards provided)	No	Yes (standards provided)
Carrier / PBM information included	• Name • Phone • Fax Can be prepopulated (is that better, worse?? Both options)	• Name • Fax	• Name • **Address** • Fax • Phone • **Webpage for coverage determinations**	• Name • Phone • Fax	• Name • **Address** • Fax • Phone • **Website**
Patient information requested	• Name • DOB • Gender • Member ID #	• Name • DOB • **Address** • **Phone** • Member ID #	• Name • DOB • **Address** • **Phone** • Member ID #	• Name • **Phone** • **Address** • DOB • Gender • **Authorized representative name and phone (if applicable)** • Primary insurance name and member # • **Secondary insurance name and member #**	• Name • DOB • **Address** • **Phone** • **Member ID #** **If different than the patient and prescriber** • **Requestor's name** • **Relationship to enrollee** • **Address** • **Phone** • **Documentation**
Prescriber / other provider information requested	• Prescribing clinician • Specialty • Phone • Fax • NPI # • DEA # • Prescriber point of contact, phone, fax, email (if different) • Signature and date	• Name • **Address** • Phone • Fax • Signature and date	• Name • **Address** • Phone • Fax • Signature and date	• Name • Specialty • **Address** • **Requestor (if different**) • Office contact • NPI # • Phone • DEA # (if applicable) • Fax • **Email** • Signature and date	• Name • **Address** • Phone • Fax • Signature and date

Content	MA	CVS	Cigna Medicare PDP	Humana	SilverScript
Prescription / drug information requested	• Medication requested. • Strength • Quantity • Dosing schedule • Length of therapy • Date initiated • Initial vs renewal request • Is the patient currently being treated with the drug? If yes, date started • **Dispense as Written (DAW) specified? Rationale** • **Is the medication a compound? If yes, list ingredients** • **For a compound or off label use, include citation to peer reviewed literature** **For professionally administered medications:** • **Start date, end date** • **Servicing prescriber / facility name (same as prescriber?), address, NPI / Tax ID #** • **Name of billing provider / NPI #** • **Request for reauthorization?** • **CPT code** • **# of visits** • **J Code** **# of units**	• Name • Strength	• Name • Strength • Route of administration • Frequency • New? If not, date started • Quantity per month • Expected duration	• Name • New or renewal (date initiated and duration) • **How did the patient receive the medication?** • Dose / strength • Frequency • Length of therapy and # of refills • Quantity • **Administration route** • Administration location	• Name • Strength • **Route of administration** • Frequency • New prescription or date initiated • Expected length of therapy • Quantity
Diagnosis / clinical	• Primary diagnosis related to request • ICD codes	• *On drug specific forms*	• Height / weight • Drug allergies • Diagnosis	• Height • Weight • Allergies	• Height • Weight • Drug allergies

Content	MA	CVS	Cigna Medicare PDP	Humana	SilverScript
information requested	• **Pertinent comorbidities (refers to plan-specific criteria for details related to required information)** As relevant: • Drug allergies • Height • Weight • **Pertinent concurrent medications** • **Opioid management tools in place (risk assessment, treatment plan, informed consent, pain contract, pharmacy / prescriber restriction)** • Previous therapies tried / failed (name, strength, dosing schedule, date prescribed, date stopped, description of adverse reaction or failure). **Sample?** • Contraindications to alternative therapies • **Were nonpharmacological therapies tried? Details** • Relevant lab values (name, value, date) • If renewal, has patient shown improvement in related condition while on therapy? Describe • May attach additional data relevant to		• Rationale (list of options and required explanation) • Additional pertinent information • Other supporting information may be required	As applicable • Other medications tried for condition (name, dosage, duration / dates, response / reason for failure / allergy) • Diagnoses • ICD-9 / ICD-10 • Relevant clinical information (symptoms, lab results with dates and / or justifications for changes)	• Diagnosis • Rationale for request (list of options and required explanation) • Additional information for considerations • Other supporting information may be required • Additional information required for Remicade

Content	MA	CVS	Cigna Medicare PDP	Humana	SilverScript
	medical necessity criteria				
Decision-making information included? If yes, list	No	No	No	Yes	No
Signature and / or attestation required?	Yes (signature)	Yes (signature)	Yes (signature)	Yes (both)	Yes (requestors and physician)
Confidentiality language included?	**No**	Yes	No	Yes	No
How is form submitted?	Mailed / faxed directly to carrier via info provided	Faxed to PBM	Mailed, faxed or phone to carrier or **online**	Faxed direct to carrier	Mailed, faxed or **online**
Writable form?	Unknown	Unknown	unknown	Unknown	Unknown
Other information included / requested	• Also used for: step therapy, formulary or quantity exception, specialty drug, other • Directs providers to consult health plan policies		• Information about authorized rep / requestor if applicable (and supporting documentation) • Also used for formulary exceptions, quantity limit exceptions, tiering exceptions, out of pocket cost appeals	• Can attach additional information	• Also used for formulary exceptions, tiering exceptions, out-of-pocket charge appeals

Content	MA	Optum Rx	WellCare	Envision Rx Options
Carrier, PBM and Medicaid Forms (4 of 5)				
Length	2 pages	4 pages	1 page	1 page
Varies by drug?	Yes (as reported)	Yes	Yes	No
Can urgent requests be identified?	Yes (with an attestation)	No	Yes (standards provided)	Yes
Carrier / PBM information included	• Name • Phone • Fax Can be prepopulated (is that better, worse?? Both options)	• Name • **Address** • Phone • **Hours** • **Webpage for online submission**	• Name • Fax • **Website**	• Name • Phone • Fax
Patient information requested	• Name • DOB • Gender • Member ID #	• Name • Member ID # • DOB • **Address** • Phone	• Name • Member ID # • DOB • **Phone**	• Name • DOB • **Group #** • **Address** • **Phone**
Prescriber / other provider information requested	• Prescribing clinician • Specialty • Phone • Fax • NPI # • DEA # • Prescriber point of contact, phone, fax, email (if different) • Signature and date	• Name • NPI # • Specialty • Phone • Fax • **Address** • Signature and date	• Name • Specialty • Signature • Office contact • NPI # • Phone • Fax	• Name • Fax • Phone • Office contact • NPI # • **State license #** • **Address** • Signature and date
Prescription / drug information requested	• Medication requested. • Strength • Quantity • Dosing schedule • Length of therapy • Date initiated • Initial vs renewal request • Is the patient currently being treated with the drug? If yes, date started • **Dispense as Written (DAW) specified? Rationale**	• Name • Strength • **Dosage form** • New? If not, start date • **Directions for use**	• Name • Strength • **Route of administration** • Frequency • Quantity • Duration of therapy	• Name • **Directions**

Content	MA	Optum Rx	WellCare	Envision Rx Options
	• **Is the medication a compound? If yes, list ingredients** • **For a compound or off label use, include citation to peer reviewed literature** **For professionally administered medications:** • **Start date, end date** • **Servicing prescriber / facility name (same as prescriber?), address, NPI / Tax ID #** • **Name of billing provider / NPI #** • **Request for reauthorization?** • **CPT code** • **# of visits** • **J Code** **# of units**			
Diagnosis / clinical information requested	• Primary diagnosis related to request • ICD codes • **Pertinent comorbidities (refers to plan-specific criteria for details related to required information)** As relevant: • Drug allergies • Height • Weight • **Pertinent concurrent medications** • **Opioid management tools in place (risk assessment, treatment plan, informed consent, pain contract, pharmacy / prescriber restriction)** • Previous therapies tried / failed (name, strength, dosing	• Diagnosis • ICD-9/10 code(s) • Medications tried and failed • Supporting labs and test results • Other comments, diagnoses, symptoms, medications tried / failed, relevant information	• Diagnosis • Drug allergies • Rationale	• Diagnosis • Have other formulary alternatives in this drug category / class been tried and failed. If yes, list with dates and issues. • Supporting clinical statements (lab values, adverse outcomes, treatment failures, other additional clinical information • Attach pertinent medical history or information

Content	MA	Optum Rx	WellCare	Envision Rx Options
	schedule, date prescribed, date stopped, description of adverse reaction or failure). **Sample?** • Contraindications to alternative therapies • **Were nonpharmacological therapies tried? Details** • Relevant lab values (name, value, date) • **If renewal, has patient shown improvement in related condition while on therapy? Describe** • May attach additional data relevant to medical necessity criteria			
Decision-making information included? If yes, list	No	No	No	No
Signature and / or attestation required?	Yes (signature)	Yes (signature)	No	Yes (signature)
Confidentiality language included?	**No**	Yes	No	Yes
How is form submitted?	Mailed / faxed directly to carrier via info provided	Fax or **online**	Faxed directly to carrier	Faxed direct to PBM
Writable form?	Unknown	Unknown	unknown	Unknown
Other information included / requested	• Also used for: step therapy, formulary or quantity exception, specialty drug, other • Directs providers to consult health plan policies	• Date	• Date • **Pharmacy name** • **Pharmacy phone** • Questions specific to transplant drugs and hospice patients • Also used for non-formulary exceptions, step therapy exceptions, quantity limit formulary exceptions, tiering exceptions	

Content	MA	First Health Part D / Advantra / Coventry Health	Magellan
Carrier, PBM and Medicaid Forms (5 of 5)			
Length	2 pages	2 pages	1 page
Varies by drug?	Yes (as reported)	No	No
Can urgent requests be identified?	Yes (with an attestation)	Yes	Yes
Carrier / PBM information included	• Name • Phone • Fax Can be prepopulated (is that better, worse?? Both options)	• Name • Fax	• Name • Phone • Fax
Patient information requested	• Name • DOB • Gender • Member ID #	• Name • Member ID # • **Address** • **Phone** • Gender • DOB	• Member ID # • Name • DOB • Gender • **Phone**
Prescriber / other provider information requested	• Prescribing clinician • Specialty • Phone • Fax • NPI # • DEA # • Prescriber point of contact, phone, fax, email (if different) • Signature and date	• Name • Specialty • NPI # / DEA # • **Address** • Phone • Fax • Signature and date	• NPI # • Name • Specialty • **Clinic name** • Phone • Fax • Contact name • Signature and date
Prescription / drug information requested	• Medication requested. • Strength • Quantity • Dosing schedule • Length of therapy • Date initiated • Initial vs renewal request • Is the patient currently being treated with the drug? If yes, date started • **Dispense as Written (DAW) specified? Rationale** • **Is the medication a compound? If yes, list ingredients** • **For a compound or off label use, include citation to peer reviewed literature**	• Name • Strength • **Route of administration** • Frequency • New prescription or date initiated • Quantity • **Day supply** • Expected length of therapy • For injectable, location of administration	• Name • Strength and **form** • **Route of administration** • Frequency • Date therapy initiated • Expected length of therapy • Quantity

Content	MA	First Health Part D / Advantra / Coventry Health	Magellan
	For professionally administered medications: • **Start date, end date** • **Servicing prescriber / facility name (same as prescriber?), address, NPI / Tax ID #** • **Name of billing provider / NPI #** • **Request for reauthorization?** • **CPT code** • **# of visits** • **J Code** **# of units**		
Diagnosis / clinical information requested	• Primary diagnosis related to request • ICD codes • **Pertinent comorbidities** **(refers to plan-specific criteria for details related to required information)** As relevant: • Drug allergies • Height • Weight • **Pertinent concurrent medications** • **Opioid management tools in place (risk assessment, treatment plan, informed consent, pain contract, pharmacy / prescriber restriction)** • Previous therapies tried / failed (name, strength, dosing schedule, date prescribed, date stopped, description of adverse reaction or failure). **Sample?** • Contraindications to alternative therapies • **Were nonpharmacological therapies tried? Details** • Relevant lab values (name, value, date) • **If renewal, has patient shown improvement in related condition while on therapy? Describe** • May attach additional data relevant to medical necessity criteria	• Diagnosis **(including all supporting office notes)** • **Cancer diagnosis?** • **Is patient stable on current drugs and / or quantity and therapy change would likely result in adverse clinical outcome?** • **All coverage drugs on any tier would not be as effective and / or would likely have adverse effects?** • **Acknowledgement that medication benefits outweigh potential risks in the elderly** • **Acknowledgement that requested medication is medically necessary and the clinical benefits outweigh the risks for the specific patient** • **Does the patient require a higher dosage? If yes, quantity requested? Why?** • All medications patient has tried specific to diagnosis (name, dates, outcome) • Other supporting information (prescriber statements and other information may be required	• Diagnosis • Height • Weight • Drug allergies • Alternate drugs contraindicated or previously tried with adverse outcome (name, adverse outcome, dose and duration of therapy) • **Current medications and doses** • **Target symptom / indication for requested medication** • Clinical rationale for treatment

Content	MA	First Health Part D / Advantra / Coventry Health	Magellan
Decision-making information included? If yes, list	No	No	No
Signature and / or attestation required?	Yes (signature)	Yes (both)	Yes (both)
Confidentiality language included?	**No**	Yes	Yes
How is form submitted?	Mailed / faxed directly to carrier via info provided	Faxed directly to carrier	Faxed direct to PBM
Writable form?	Unknown	Unknown	Unknown
Other information included / requested	• Also used for: step therapy, formulary or quantity exception, specialty drug, other • Directs providers to consult health plan policies		

MASSACHUSETTS STANDARD FORM FOR MEDICATION PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

This form is being used for:		
Check one:	☐ Initial Request	☐ Continuation/Renewal Request
Reason for request *(check all that apply)*:	☐ Prior Authorization, Step Therapy, Formulary Exception ☐ Quantity Exception ☐ Specialty Drug ☐ Other *(please specify)*: _____	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)	

A. Destination — Where this form is being submitted to; payers making this form available on their websites may prepopulate section A	
Health Plan or Prescription Plan Name:	
Health Plan Phone:	Fax:

B. Patient Information		
Patient Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Unknown
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information	
Medication Being Requested:	
Strength:	Quantity:
Dosing Schedule:	Length of Therapy:
Date Therapy Initiated:	
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started:	
Dispense as Written (DAW) Specified? ☐ Yes ☐ No	
Rationale for DAW:	

E. Compound and Off Label Use	
Is Medication a Compound? ☐ Yes ☐ No	
If Medication Is a Compound, List Ingredients:	
For Compound or Off Label Use, include citation to peer reviewed literature:	

(continued on next page)

F. Patient Clinical Information

Please refer to plan-specific criteria for details related to required information.

Primary Diagnosis Related to Medication Request:

ICD Codes:

Pertinent Comorbidities:

If Relevant to This Request:

Drug Allergies:

Height: | Weight:

Pertinent Concurrent Medications:

Opioid Management Tools in Place: ☐ Risk assessment ☐ Treatment Plan ☐ Informed Consent ☐ Pain Contract ☐ Pharmacy/Prescriber Restriction

Previous Therapies Tried/Failed:

Previous Therapies

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Description of Adverse Reaction or Failure	Check if Sample
						☐
						☐
						☐
						☐
						☐

Are there contraindications to alternative therapies? ☐ Yes ☐ No

If yes, please list details:

Were nonpharmacologic therapies tried? ☐ Yes ☐ No

If yes, provide details:

Relevant Lab Values

Lab Name and Lab Value	Date Performed	Lab Name and Lab Value	Date Performed

If renewal, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No ☐ N/A

If yes, please describe:

Additional information pertinent to this request:

Complete this section for Professionally Administered Medications *(including Buy and Bill).*

Start Date: _____ End Date: _____

Servicing Prescriber/Facility Name: _____ ☐ Same as Prescribing Clinician

Servicing Provider/Facility Address: _____

Servicing Provider NPI/Tax ID #: _____

Name of Billing Provider: _____

Billing Provider NPI #: _____

Is this a request for reauthorization? ☐ Yes ☐ No

CPT Code: _____ # of Visits: _____ J Code: _____ # of Units: _____

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.

New Uniform Prescription Drug Benefit Prior Authorization Process and Request Form for Colorado Health Insurers, Effective January 1, 2015

Questions and Answers

Background

Beginning on January 1, 2015, certain health insurers in Colorado will be required to follow new uniform requirements for processing prior authorization (PA) requests for prescription drug benefits, including the use of a standardized PA request form. Health insurers will also be required to make the plan's PA requirements and approval criteria more transparent to patients and prescribers. These requirements were established by a state law enacted in May 2013 with the goal of easing the administrative burden on prescribing providers and expediting patient access to prescription drugs.[1] Importantly, the new requirements do not expand the list of drugs subject to PA requirements or otherwise alter existing PA criteria for drugs, nor do they modify the PA process for medical services and procedures other than prescription drugs.

This Questions & Answers (Q&A) document provides an overview of the implementation of the uniform PA requirements. For your reference, a copy of the "Uniform Pharmacy Prior Authorization Request Form" that health insurers must adopt is included as an attachment.

Q. Which health insurers in Colorado will be required to adopt the uniform PA process and request form for prescription drug benefits?

A. The uniform PA requirements apply to all health insurance "carriers" regulated by the Colorado Department of Regulatory Agencies, Division of Insurance that offer health plans with prescription drug benefits. The PA requirements also apply to pharmacy benefit management firms (PBMs) that administer the prescription drug benefits on behalf of such health insurers. Notably, in addition to other fully insured plans, the uniform PA requirements apply to qualified health plans offered through the "Connect for Health Colorado" health insurance marketplace.

[1] Colo. Rev. Stat. § 10-16-124.5.

The uniform PA requirements do not apply to the following types of health plans in Colorado:

- Self-funded employer-sponsored health plans;
- Medicare Part D plans (including standalone prescription drug plans and Medicare Advantage plans offering prescription drug coverage); and
- Medicaid fee-for-service (Colorado Medicaid) and Medicaid Managed Care Organizations.

Q. When will the uniform PA process and request form requirements take effect?

A. Health insurers must abide by the uniform PA process requirements and request form beginning on January 1, 2015.[2]

Q. Does the law affect the turnaround times that health insurers must follow when processing prescription drug PA requests?

A. Yes. Health plans subject to the new uniform PA requirements must abide by certain timeframes for processing and notifying healthcare providers, patients, and pharmacies about PA requests. These required timeframes depend on whether the PA request is considered "urgent," as well as the method by which the prescribing provider submits the PA request to the health insurer, as described in more detail below.

Non-Urgent PA Requests

Health insurers must process and provide notification of the approval or denial of "non-urgent" PA requests to the patient, prescribing provider, and dispensing pharmacy within:

- Two business days if the PA request was submitted through the health insurer's electronic PA system; or
- Three business days if the PA request was submitted via facsimile, e-mail, or verbally (with written confirmation).[3]

If the health insurer does not approve or deny the PA request (or request additional information from the prescribing provider) within such timeframes, then the request will be deemed to be automatically approved. Importantly, however, if the health insurer requests additional

[2] 3 Colo. Code. Regs. § 702-4:4-2-49(5)(A).
[3] *Id.* § 702-4:4-2-49(5)(D)(1), (2).

information from the prescribing provider that is needed to process the PA request, then the provider must submit the requested information within two business days of receiving the request or else the request will be deemed denied.[4]

Urgent PA Requests

PA requests are considered "urgent" when, based on the reasonable opinion of the prescribing provider with knowledge of the patient's medical condition, the timeframes allowed for non-urgent PA requests could:

- seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function; or
- subject the patient to severe pain that cannot be adequately managed without the drug that is the subject of the PA request.[5]

For urgent PA requests, health insurers must process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within one business day of receiving the request.[6] If the health insurer does not provide notification of approval or denial of the PA request (or request additional information from the prescribing provider) within that timeframe, then the PA request is deemed to be approved.[7] Prescribing providers have two business days to respond to a health insurer's request for additional information to process an urgent PA request or else the request will be deemed denied.[8]

Q. What methods can prescribing providers use to submit the uniform PA form?

A. The law does not specify the particular methods that prescribing providers must use to submit PA requests for prescription drugs. However, health insurers must allow for the electronic submission of PA requests.[9] As noted above, the method that a prescribing provider uses to submit a non-urgent PA request for a prescription drug may affect the turnaround time that the health insurer must follow in processing such request.

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[4] *Id.* § 702-4:4-2-49(5)(D)(1), (3).
[5] Colo. Rev. Stat. § 10-16-124.5(8)(b); *Id.* § 702-4:4-2-49(4)(H).
[6] 3 Colo. Code. Regs. § 702-4:4-2-49(5)(C)(1).
[7] *Id.* § 702-4:4-2-49(5)(C)(2).
[8] *Id.* § 702-4:4-2-49(5)(C)(1)(c).
[9] *Id.* § 702-4:4-2-49(5)(B)(4).

Q. Can providers submit additional clinical information to support a PA request beyond that requested by the uniform PA form?

A. According to the law, health insurers and prescribing providers must follow the PA process requirements and use the uniform PA request form beginning January 1, 2015. Note that the uniform PA request form includes a field requesting the "clinical criteria for approval," which healthcare providers can use to submit any pertinent information to support the PA request.

Q. Does the law place any requirements on health insurers (and their PBMs) related to the transparency of the PA process for prescription drugs?

A. Yes. In addition to adopting the uniform process and request form, health insurers must make certain information available to prescribing providers in a central location on the plan's website regarding the PA requirements for prescription drugs. Such information must include, for example, a listing of the drugs that require PA, including the clinical criteria and supporting references that the health insurer will use in making its PA determination.[10]

Q. Who can providers contact if they have additional questions about the uniform prescription drug PA process and request form?

A. Providers should contact the individual health insurer through the applicable provider contact number if they have questions about implementation of the new uniform PA process and request form. Providers and patients may also contact the relevant state agency as follows:

Colorado Department of Regulatory Agencies, Division of Insurance:
- Website: www.dora.colorado.gov/insurance
- Contact:
  - For consumer affairs representative, call: (303) 894-7490 or (800) 930-3745 (toll free).
  - For general questions/inquiries, call: (303) 894-7499 (main phone).
  - E-mail information: http://cdn.colorado.gov/cs/Satellite?c=Page&childpagename=DORA-DI%2FDORALayout&cid=1251626415460&pagename=CBONWrapper.

[10] *Id.* § 702-4:4-2-49(5)(B)(2).

APPENDIX A

[CARRIER LOGO]
[CARRIER NAME]

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:
[CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM CONTACT INFORMATION]

☐ **Urgent** [1]	☐ **Non-Urgent**
Requested Drug Name:	

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	☐ New Request ☐ Reauthorization
Patient Diagnosis and ICD Diagnostic Code(s):	
Drug(s) Requested (with J-Code, if applicable):	
Strength/Route/Frequency:	
Unit/Volume of Named Drug(s):	
Start Date and Length of Therapy:	
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:	
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]	
For use in clinical trial? (If yes, provide trial name and registration number):	
Drug Name (Brand Name and Scientific Name)/Strength:	

Dose:	Route:	Frequency:
Quantity:	Number of Refills:	

Product will be delivered to:	☐ Patient's Home	☐ Physician Office	☐ Other:
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			

☐ **Approved**	☐ **Denied**
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:	

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

INSTRUCTIONS

Important: Please read all instructions and information before completing the form.

Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

Note: This version of the form (C-1.0) is current as of July 2010, and supersedes the following previous versions of Minnesota Department of Health forms for PA requests and formulary exceptions:

- Example Minnesota Prescription Drug Prior Authorization (PA) Request Form, version 1.0 2/15/10
- Minnesota Uniform Formulary Exception Form, version 1.0 September, 2009

This form will not change frequently. The form version number and most recent revision date are displayed in the lower right corner.

Overview:

The following form is made available by the Minnesota Department of Health (MDH) pursuant to statute, to facilitate exchanges of information between prescribers and patients' insurance carriers, HMOs, Pharmacy Benefits Managers (PBMs), or other payers* of prescription drug claims.

Intended use and requirements:

The form is intended primarily for use by prescribers, or those designated and authorized to act on behalf of prescribers, to:

1. **Request an exception to a prescription drug formulary.**
   - Requests for formulary exceptions are requests to make nonformulary prescription drugs available to a patient as a formulary drug.
     - Laws 2010, chapter 336, section 4 requires that all health care providers must submit requests for formulary exceptions using the uniform form, and that all payers must accept this form from health care providers. No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. Note: A previous restriction in law that facsimile was not considered "secure electronic transmission" was removed in 2010.
2. **Request a prior authorization (PA) for a prescription drug.**
   - Prescription drug prior authorization requests are requests for pre-approval from a payer for specified medications or quantities of medications.
     - Laws 2010, chapter 336, section 5 requires that by January 1, 2015, drug PA requests must be accessible and submitted by health care providers, and accepted by payers, electronically through secure electronic transmissions.

Additional Instructions:

- Prescribers, or their designees, use parts A-F as applicable. Payers making the form available on their websites may pre-populate section A. Payers use section G when responding to requests.
- Payers may request additional information or clarification needed to process formulary exceptions and PA requests.
- Payers may supply additional instructions or other relevant or legally required information with their response.
- Complete section F when submitting prescription drug PA requests to the Minnesota Department of Human Services.

* Note: The term "payers" is used to avoid possible confusion. The electronic submission and acceptance requirements of Minnesota Statutes § 62J.497, subd. 4 and 5, apply to "group purchasers". The term "group purchaser" is defined in Minnesota Statutes § 62J.03, subd. 6 and can be considered more commonly as "payer".

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

See additional instructions and overview, Instructions page.

Please check the appropriate box below (check only one box). This form is being used for:

☐ **Formulary Exception** ☐ **Prior Authorization (PA) Request** ☐ **Unsure/Unknown**

A | Destination This form is being submitted to: (Payers making this form available on their websites may pre-populate section A.)

Payer Name: MedImpact Healthcare Systems, Inc., on behalf of Medica Health Plans

Payer Contact Name: Prior Authorization Department
(IF AVAILABLE)

Payer Address: 10181 Scripps Gateway Court City, State, ZIP: San Diego, CA 92131

Payer Phone: (800) 788-2949 Secure Fax: (858) 790-7100 Other: _____

B | Patient Information

When filling Patient Health Plan ID number below, please note: If the patient has prescription benefits that are separate or "carved out" from the health plan benefits, provide the patient's prescription benefit card ID number (the "cardholder ID"). If the patient's prescription benefits are integrated with the health plan coverage (if there is no separate prescription benefit ID number), provide the patient's health plan ID number.

Patient Name: _____ DOB: _____
(LAST, FIRST, MI) (MM / DD / YYYY)

Patient Address: _____ City, State, ZIP: _____

Gender. Please Check Box: ☐ Male ☐ Female ☐ Unknown

Health Plan or Prescription Plan: _____ Patient Health Plan ID No.: _____
(OR PRESCRIPTION PLAN ID IF DIFFERENT THAN HEALTH PLAN ID)

C | Prescriber Information

Prescriber Name: _____ NPI: _____ Specialty: _____
(LAST, FIRST, MI)

Prescriber Business Address: _____ City, State, Zip: _____

Prescriber Phone: _____ Prescriber Secure Fax: _____

Prescriber Point of Contact (POC) Name: _____ POC Phone: _____ POC Secure Fax: _____
(IF DIFFERENT THAN PRESCRIBER) (IF DIFFERENT THAN PRESCRIBER)

Clinic/Location/Facility Name: _____ Clinic/Location/Facility Contact Name: _____

Clinic/Location/Facility Phone: _____ Secure Clinic/Location/Facility Fax: _____

Clinic/Location/Facility Address: _____ City, State, ZIP: _____

D | Prescription Drug Information (Medication information)

When completing this section and the following section (E), medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.

Drug Being Requested: _____ Strength: _____
(REQUESTED DRUG NAME) (E.G., 30 MG, 15 MG/ML, ETC)

Dosing Schedule: _____ Date Therapy Initiated: _____

Duration of Therapy Expected: _____ Authorization Start Date: _____

Clinical Drug Trial Request? ☐ Yes ☐ No
(NOTE: THE MINNESOTA DEPT. OF HUMAN SERVICES DOES NOT COVER CLINICAL DRUG TRIALS.)

Is Dispense as Written (DAW) Specified? ☐ Yes ☐ No

Rationale for DAW? _____

Is patient currently being treated with the drug requested? ☐ Yes ☐ No Date Started: _____

Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions

E | Patient Clinical Information

Diagnosis Related to Medication Request: _____
(INCLUDE ICD-9 CODES WHEN AVAILABLE)

Drug Allergies: _____ Height: _____ Weight: _____
(IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST) (IF RELEVANT TO THIS REQUEST)

PREVIOUS THERAPIES TRIED / FAILED (list name, date prescribed, etc., in boxes below. Note: Medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.):

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Describe Adverse Reaction or Efficacy Failure

RATIONALE FOR REQUEST (and also include any additional pertinent clinical information/comments regarding rationale): _____

F | Pharmacy Information – For PA Requests to the Minnesota Department of Human Services (DHS)

Pharmacy Name: _____ National Provider Identifier: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

NDC Number for Prescription Drug Being Requested: _____ Pharmacy Fax: _____

G | Request Determination (may be completed by payers and sent to providers)

Date Request Received by Payer: _____ Date of Decision: _____

Payer Responder/Contact Name: _____ Payer Respondent/Contact Phone and/or Email: _____

Request Approved/Denied: ☐ **Approved** ☐ **Denied** Pharmacy Authorization/Reference No.: _____
(IF APPLICABLE TO PAYER)

Comments Regarding Decision: _____
(INCLUDE EFFECTIVE AND END DATES OF DECISION IF APPLICABLE)

Additional Information or Instructions
Note: Group purchasers may supply additional instructions or other relevant or legally required information with their response. Examples of additional information might include: Appeals rights and processes; other notifications; other information required for legal or clarification purposes. _____

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health July, 2010

V. C-1.0 JULY2010

New Uniform Prescription Drug Prior Authorization Request Form and Notification Requirements for Health Plans in Oregon

Questions and Answers

Background

Effective July 1, 2015, health plans in Oregon are required to accept a new uniform Prior Authorization (PA) Request Form, as well as abide by certain timelines and notification procedures, when processing PA requests for prescription drug benefits. The new rules are intended to streamline and simplify the PA process for prescription drugs. Importantly, these new requirements do not expand the list of drugs subject to PA or otherwise modify the PA approval criteria for particular drugs. In addition, the new PA requirements only apply to prescription drug benefits, not medical services or other procedures.

This "Questions & Answers" document provides an overview of the PA Request Form and related PA requirements. For your reference, a copy of the two-page "Uniform Prior Authorization Prescription Request Form" is included as an attachment. The Form is also available on the Oregon.gov website at: http://www.oregon.gov/DCBS/insurance/legal/laws/Documents/OAR/div53-1205_ex1-440-4992.pdf.

Q. Which health plans in Oregon are required to adopt the uniform PA Request Form and other PA requirements?

A. The new rules apply to all healthcare "payers" that require PA for prescription drug benefits. The definition of "payers" includes the following entities:

- health insurers,
- prepaid managed care organizations,
- third-party administrators,
- entities that establish self-insurance plans,
- healthcare clearinghouses, and
- other entities that perform claims processing and other administrative functions.[1]

[1] Or. Admin. R. 836-053-1205(1)(b); Or. Rev. Stat. § 743.061(2).

Medicaid managed care plans in Oregon must comply with the uniform PA requirements. However, the requirements do not apply to Medicare Part D plans. (In general, providers should check with the health plan to confirm the applicable PA procedures.)

Q. Do the uniform PA Request Form and related requirements apply to physician-administered drugs covered under a health plan's medical benefit in addition to drugs covered under the pharmacy benefit?

A. Yes. The PA requirements apply whenever a plan requires PA for a prescription drug, regardless of whether the drug is covered under the plan's medical benefit or pharmacy benefit.

Q. Must health plans accept only the uniform PA Request Form when processing prescription drug PA requests?

A. No. Although they must accept the uniform PA Request Form, health plans subject to the new requirements may also accept PA requests for prescription drugs using other forms.[2]

Q. What methods can prescribing providers use to submit the PA Request Form?

A. Providers can submit the PA Request Form through any reasonable means of transmission, including, but not limited to, paper, electronic, internet or web-based system, or another mutually agreeable accessible method (e.g., phone or fax).[3] Providers should confirm the available methods and procedures for submitting the PA Request Form with the individual health plan. Plans are prohibited from mandating that prescribers provide more information than is required by the PA Request Form, regardless of the method of transmission.[4]

Q. Do the new requirements address turnaround times for processing PA requests?

A. Yes. Health plans subject to the new PA requirements must notify the prescribing provider within two business days of receiving a completed prescription drug PA Request Form. The plan notification must indicate either that:

[2] Or. Admin. R. 836-053-1205(2).
[3] Or. Admin. R. 836-053-1205(3)(b)(A).
[4] Or. Admin. R. 836-053-1205(3)(b)(B).

1) The provider's PA request is approved;
2) The provider's PA request is denied as not medically necessary or not a covered benefit;
3) The provider's PA request is denied as missing material information necessary to make a determination on the request; OR
4) The patient is no longer eligible for coverage.[5]

Q. How must health plans communicate with prescribing providers about their submitted PA requests?

A. Health plan notifications to the provider must be delivered in the same manner as the PA Request Form was submitted, or through another mutually agreeable accessible method.[6] In the event that a health plan denies a prescriber's PA request, the plan's denial notice must contain an accurate and clearly written explanation of the specific reasons for the denial. In addition, if a health plan denies a PA request as missing information necessary for the plan to approve or deny the request, the notice must contain an accurate and clearly written explanation that specifically identifies the missing information.[7]

Q. Can health plans require additional information from prescribing providers beyond what is required on the uniform PA request form?

A. No. Health plans cannot require prescribing providers to provide information beyond the minimum information specified on the PA Request Form.[8]

Q. Who can providers contact if they have additional questions about the PA Request Form requirements and implementation?

A. Providers should contact the individual health plan through the applicable provider contact number if they have questions about the new uniform PA requirements. Providers and patients may also find the following contact information useful:

Oregon Department of Consumer and Business Services, Insurance Division
- Contact:

[5] Or. Admin. R. 836-053-1205(3)(b)(C).
[6] Or. Admin. R. 836-053-1205(4).
[7] Or. Admin. R. 836-053-1205(6)(a), (b).
[8] Or. Admin. R. 836-053-1205(8).

- Phone: (503) 947-7980
- E-mail: dcbs.insmail@oregon.gov

o Website: http://www.oregon.gov/DCBS/insurance/Pages/index.aspx

Plan name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: ___ - ___ - ____ Fax: ___ - ___ - ____

Email: _____

Instructions: This pre-authorization request form should be filled out by the provider. Before completing this form, please confirm the patient's benefits and eligibility. Benefits for services received are subject to eligibility and plan terms and conditions that are in place at the time services are provided.

Is this request urgent? Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. –Or– In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment. If this request is urgent and meets the definition as indicated above, please check this box.

☐ **Urgent request**

Uniform Prior Authorization Prescription Request Form

Date: ___ / ___ / ____

Verify with the preauthorization list on the ["One Health Port" hyperlink]*, according to the company's procedure, or call the number on the back of the member's card.*

Is this request: ☐ New ☐ Authorization extension ☐ Providing additional information

If you already have an authorization number, list it here: _____

1. Patient information

Name Last: _____ First: _____ MI: ___

Member ID #: _____ and Group number: _____

Secondary insurer member ID #: and Group number:

Height: _____ Weight: _____ ☐ Male ☐ Female DOB: ___ / ___ / ____

Allergies: _____

2. Prescriber / Provider information

Check one: You are the ☐ Requesting provider ☐ Servicing provider ☐ Specialty: _____

Provider name: _____ Tax ID number: _____

Phone: ___ - ___ - ____ Fax: ___ - ___ - ____

NPI: _____ DEA number (if required): _____

Provider address: _____

Who should we contact if we require more information? Name: _____

Phone: ___ - ___ - ____ Fax: ___ - ___ - ____

3. Patient's PCP information (if applicable)

Name: _____

Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐ ext. ☐☐☐☐ Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

4. Medication / Medical and Dispensing Information

Medication name: _____

Dose/strength: _____ Frequency: _____ Length of therapy/#refills: _____ / _____ Quantity: _____

☐ New therapy ☐ Renewal If Renewal: date therapy initiated ☐☐ / ☐☐ / ☐☐☐☐

Route of administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: _____

Administered: ☐ Doctor's office ☐ Dialysis center ☐ Home health ☐ By patient ☐ Other: _____

List of previous drugs tried

Drug name:	Dosage:

Provide the medical rationale for requested drug (inlude chart notes and supporting labs) and why a formulary alternative is not acceptable:

Provide all ICD-9 or ICD-10 codes and their descriptions, if available; this will help us process your request.

Diagnosis: _____

Codes and descriptions are: ☐ ICD-9 ☐ ICD-10

Primary: _____

Second: _____

Third:

Submit the following clinical information with this form as appropriate for this request: History & Physical • Lab/radiology/testing results • Current symptoms and functional impairments • Treatment history • *Any other information such as chart notes that support medical necessity for the request.* *[Hyperlink to Plan's Pharmacy Policy]*

New Uniform Prescription Drug Prior Authorization Request Form and Notification Requirements for Health Plans in California

Questions and Answers

Background

Over the next several months, certain health plans in California will be required to implement a new uniform Prior Authorization (PA) Request Form, as well as abide by new timelines and notification procedures, when processing PA requests for prescription drug benefits. These new PA requirements were established under Senate Bill (S.B.) No. 866, which was signed into law in October 2011 with the goal of streamlining and expediting the PA process for prescribers.[1] Importantly, the new requirements do not expand the list of drugs subject to PA requirements or otherwise alter existing PA criteria for drugs, nor do they modify the PA process for medical services and procedures other than prescription drugs. Health plans subject to the law will be prohibited from utilizing any prescription drug PA form other than the approved PA Request Form, which was jointly developed by the California Department of Insurance (CDI) and Department of Managed Health Care (DMHC) with stakeholder input. As discussed in more detail below, the implementation deadline for the PA Request Form is either October 1, 2014 or January 1, 2015, depending on the type of health plan.

This Questions & Answers (Q&A) document provides an overview of the implementation of the uniform PA Request Form and associated requirements. For your reference, a copy of the two-page "Prescription Drug Prior Authorization Request Form" (Form No. 61-211) is included as an attachment. The Form is also available at http://wpso.dmhc.ca.gov/regulations/docs/regs/29/1395159562398.pdf.

Q. Which health plans are required to adopt the uniform PA Request Form?

A. The PA Request Form requirements apply to traditional indemnity insurers regulated by CDI.[2] The CDI-regulated health insurers subject to the PA requirements include most preferred

[1] S.B. 866 (Oct. 2011) (codified at Cal. Health & Safety Code § 1367.241 & Cal. Ins. Code § 10123.191).
[2] Cal. Code Regs., tit. 10, § 2218.30(b).

provider organizations (PPOs). The PA requirements also apply to health plans, risk-bearing organizations, and physicians or physician groups that assume financial risk for prescription drug benefits, which are regulated by DMHC.[3] DMHC-regulated health plans include health maintenance organizations and their contracted physician groups, among other types of managed care entities (including certain PPOs).[4] The PA requirements also apply to any third-party administrator and/or pharmacy benefit manager contracted to perform PA services for prescription drug benefits on behalf of any of these health plan types.[5]

Self-funded employer-sponsored health plans are not subject to the PA Request Form requirements. Likewise, the PA requirements do not apply to Medicare Part D plans operating in California (i.e., standalone prescription drug plans and Medicare Advantage plans offering prescription drug coverage) or the Medi-Cal fee-for-service program.

Note that the PA Request Form requirements do apply to Medi-Cal managed care plans and qualified health plans offered through the Covered California health insurance exchange.

Q. When will the uniform PA Request Form requirements take effect?

A. The implementation timetable for the PA Request Form and associated requirements depends on the type of health plan, as CDI and DMHC are implementing the new law on slightly different schedules. Health insurers regulated by CDI are required to implement the PA Request Form on or before October 1, 2014.[6] Managed care plans regulated by DMHC, on the other hand, are required to implement the PA Request Form by no later than January 1, 2015.[7]

Because implementation schedules may vary, providers should check with the individual health plan to determine how it intends to implement the PA Request Form. Keep in mind that some health plans may elect to adopt the PA Request Form prior to the mandatory deadlines. For

[3] Cal. Code Regs., tit. 28, § 1300.67.241(a).
[4] A summary of the types of health plans in California regulated by CDI and DMHC is available at: http://www.dmhc.ca.gov/HealthPlansCoverage/ViewCompareHealthPlans/AgenciesthatOverseeHealthPlans.aspx.
[5] Cal. Code Regs., tit. 10, § 2218.30(h); Cal. Code Regs., tit. 28, § 1300.67.241(b).
[6] Cal. Code Regs., tit. 10, § 2218.30(c).
[7] Cal. Code Regs., tit. 28, § 1300.67.241(c).

example, Anthem Blue Cross has notified California providers that it intends to implement the PA Request Form for all of its health plan types effective October 1, 2014.[8]

Q. Does the law affect the required turnaround times and transparency of health plan notifications regarding prescription drug PA requests?

A. Yes. Health plans subject to the new uniform PA requirements must notify the prescribing provider within two business days of receipt of a prescription drug PA request that either:

1) The provider's PA request is approved;
2) The provider's PA request is denied as not medically necessary or not a covered benefit;
3) The provider's PA request is denied as missing material information necessary to make a determination on the request;
4) The enrollee is no longer eligible for coverage; OR
5) The PA request was not submitted on the required form, and must be resubmitted using the approved PA Request Form.[9]

Health plan notices to the prescribing provider must be delivered in the same manner as the PA Request Form was submitted, or through another mutually agreeable accessible method of notification.[10] In the event that a health plan denies a prescriber's PA request, the health plan's denial notice to the provider must contain an accurate and clearly written explanation of the specific reasons for the denial. In addition, if a health plan denies a PA request as missing material information necessary to approve or deny the request, the notice must contain an accurate and clearly written explanation that specifically identifies the missing information.[11]

Significantly, if a health plan fails to appropriately respond within two business days upon receipt of a completed PA request from a prescribing provider, the PA request shall be automatically deemed approved by the plan. Note, however, that this "deemed approved" policy does not apply to PA requests submitted by providers to Medi-Cal managed care plans.[12]

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[8] Anthem Blue Cross, *Network Update: Professional* (July 2014), http://www.anthem.com/ca/provider/f5/s3/t3/pw_e217511.pdf?refer=provider (last visited Sept. 18, 2014).
[9] Cal. Code Regs., tit. 10, § 2218.30(c)(4); Cal. Code Regs., tit. 28, § 1300.67.241(c)(4).
[10] Cal. Code Regs., tit. 10, § 2218.30(d); Cal. Code Regs., tit. 28, § 1300.67.241(e).
[11] Cal. Code Regs., tit. 10, § 2218.30(f); Cal. Code Regs., tit. 28, § 1300.67.241(g).
[12] Cal. Health & Safety Code § 1367.241(b); Cal. Ins. Code § 10123.191(b).

Rather, Medi-Cal managed care plans must continue to respond to PA requests for prescription drugs within 24 hours or one business day, as required under existing law.[13]

Q. What methods can prescribing providers use to submit the PA Request Form?

A. Providers can submit the PA Request Form through any reasonable means of transmission, including, but not limited to, paper, electronic transmission, telephone, web portal, fax, or another mutually agreeable accessible method.[14] Providers should confirm the available methods and procedures for submitting the PA Request Form with the individual health plan. Health plan prescription drug PA procedures, whether conducted telephonically, through a web portal, or any other method of transmission, must not require the prescribing provider to provide more information than is required by the PA Request Form.[15]

Q. Can providers submit additional clinical information to support a PA request beyond that requested by the PA Request Form?

A. According to the law, every prescribing provider must use and every health plan must accept the PA Request Form for prescription drug PA requests. Also, health plans must only request from the prescribing provider the minimum amount of information necessary to make a decision on the PA request.[16] Notably, Section 3 of the PA Request Form (see attached) allows providers to attach any relevant clinical information (e.g., lab results) and submit any additional comments to support the PA request. Prescribers should utilize this Section of the PA Request Form to provide the health plan with any additional information that may be relevant to the plan's PA review (e.g., additional information that may be required for dispensing certain restricted drugs under state or federal law).

Q. Who can providers contact if they have additional questions about the PA Request Form requirements and implementation?

A. Providers should contact the individual health plan through the applicable provider contact number if they have questions about the new uniform PA requirements. Providers and consumers may also find the following contact information useful:

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[13] Cal. Welf. & Inst. Code § 14185(a)(1).
[14] Cal. Code Regs., tit. 10, § 2218.30(c)(2); Cal. Code Regs., tit. 28, § 1300.67.241(c)(2).
[15] Cal. Code Regs., tit. 10, § 2218.30(e); Cal. Code Regs., tit. 28, § 1300.67.241(d).
[16] Cal. Code Regs., tit. 10, § 2218.30(b), (c)(3); Cal. Code Regs., tit. 28, § 1300.67.241(a), (c)(3).

Department of Managed Health Care
- Contact:
  - (916) 324-8176 (Health Plans and Providers)
  - (888) 466-2219 (DMHC Help Center)
- Website: http://www.dmhc.ca.gov/

Department of Insurance
- Contact: (800) 927-4357 (Consumer Services)
- Website: http://www.insurance.ca.gov/

California Office of the Patient Advocate (OPA)
- Contact:
  - (916) 324-6407 (OPA Information)
  - (888) 466-2219 (DMHC Help Center)
- Website: http://www.opa.ca.gov/Pages/Home.aspx

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#:** (_____)_____
Plan/Medical Group Fax#: (_____)_____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:		
☐ Physician's Office	☐ Patient's Home	☐ Long Term Care
☐ Ambulatory Infusion Center	☐ Home Care Agency	☐ Other (explain):_____
	☐ Outpatient Hospital Care	

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

_____

Texas Standard Prior Authorization Request Form for Prescription Drug Benefits

NOFR002 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standardized Prior Authorization Request Form for Prescription Drug Benefits if the plan requires prior authorization of a prescription drug or device.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a prescription drug, a prescription device, formulary exceptions, quantity limit overrides, or step-therapy requirement exceptions. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a prescription drug benefit.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a prescription drug or device requires prior authorization; or 6) request prior authorization of a health care service.

Additional Information and Instructions:

Section I – Submission:
Enter the issuer's name and contact information. An issuer may have already entered this information on the copy of this form posted on its website.

Section VI – Prescription Compound Drug Information:
List the quantities of ingredients in units of measure (mg, ml, etc.).

Section VIII – Patient Clinical Information:
Enter ICD Version 9 or 10, as applicable.

Section IX — Justification:
In the space provided or on a separate page:

- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency.
- Explain any comorbid conditions and contraindications for formulary drugs.
- Provide details regarding titration regimen or oncology staging, if applicable.
- Provide pertinent information about any step-therapy exception, if applicable.

Note: *Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*

TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

Clear Form | Print

SECTION I — SUBMISSION

Submitted to:	Phone:	Fax:	Date:

SECTION II — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:

Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:
BIN # (if available):	PCN (if available):	Rx ID # (if available):

SECTION IV — PRESCRIBER INFORMATION

Name:	NPI#:	Specialty:
Address:	City:	State: ZIP Code:

Phone:	Fax:	Office Contact Name:	Contact Phone:

SECTION V — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:

Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated:_____)

For Provider Administered Drugs only:

HCPCS Code:_____ NDC#:_____ Dose Per Administration: _____

SECTION VI — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:

Ingredient	NDC#	Quantity	Ingredient	NDC#	Quantity

SECTION VII — PRESCRIPTION DEVICE INFORMATION

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION VIII — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION IX — JUSTIFICATION (SEE INSTRUCTION PAGE SECTION IX)

Plan Name _____
Phone # _____
Fax # _____

Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- **Biotech or other specialty drugs for which drug-specific forms are required. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]**

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Member ID#:		NPI# (if available):		
Address:		Address:		
City:	State:	City:		State:
Home Phone:	Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle): M F	DOB:	Contact Person:		

Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Qty:
Height/Weight:	Drug Allergies:	Diagnosis:	
Prescriber's Signature:			Date:

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)

➔ Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change

➔ Specify below: Anticipated significant adverse clinical outcome

☐ Medical need for different dosage form and/or higher dosage

➔ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

☐ Request for formulary tier exception

➔ Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

☐ Other:_____ ➔ Explain below

REQUIRED EXPLANATION:_____
_____
_____

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]

➔ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Harvard Pilgrim Health Care

Immune Modulating Drugs
Prior Authorization Request Form

FAX: 800-232-0816

Clear Form

For Buy and Bill Physician Administered Drugs Only

Patient:	HPHC member ID #:
Requesting provider:	Requesting provider NPI:
Phone:	Fax:
Servicing provider:	Servicing provider NPI:
Diagnosis:	ICD 9 code:
Contact for questions (name and phone #):	
Projected start and end date for requested treatment:	

ACTEMRA® (TOCILIZUMAB)	DIAGNOSIS (*CHECK ALL THAT APPLY*):	CLINICAL AND DOSING INFORMATION (*CHECK ALL THAT APPLY*):
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization For the subcutaneous formulation of this drug please contact MedImpact for authorization at **800-788-2949**.	REQUIRED ☐ Rheumatoid Arthritis (RA) ☐ Systemic juvenile idiopathic arthritis (SJIA) ☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) ☐ Other (please specify): _____ _____ _____ _____ _____ _____ _____ _____	REQUIRED ☐ Concurrent treatment with traditional DMARD agent (e.g., azathioprine, cyclosporine, d-penicillamine, gold sodium, thiomalate, methotrexate, auranofin, aurothioglucose, hydroxychloroquine, leflunomide, and sulfasalazine) ☐ Treatment failure with traditional DMARD agent ☐ Contraindication to traditional DMARD agent ☐ Treatment failure with Enbrel® (etanercept) ***or*** Humira™ (adalimumab) ☐ Contraindication to Enbrel® ***or*** Humira™ *Required* — Dose and Dosing Interval: _____ _____ Reauthorization request **must** include evidence of symptom improvement(s): _____ _____ _____

CIMZIA® (CERTOLIZUMAB PEGOL)	DIAGNOSIS (*CHECK ALL THAT APPLY*):	CLINICAL AND DOSING INFORMATION (*CHECK ALL THAT APPLY*):
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization For the subcutaneous formulation of this drug please contact MedImpact for authorization at **800-788-2949**.	REQUIRED ☐ Ankylosing Spondylitis ☐ Crohn's Disease ☐ Psoriatic Arthritis ☐ Rheumatoid Arthritis ☐ Other (please specify): _____ _____ _____ _____ _____ _____ _____ _____	REQUIRED ☐ Treatment failure with, or contraindication to: ☐ Corticosteroids (e.g. prednisone, prednisolone, methyl-prednisolone, budesonide) ☐ 5-Aminosalicylates (e.g. sulfasalazine, mesalamine, olsalazine, balsalazide) ☐ Immunosupressants/immunomodulators (e.g. 6-mercaptopurine, azathioprine, methotrexate) ☐ Previous treatment failure with Humira™ ☐ Previous treatment failure with Enbrel® ☐ Treatment failure with prescription NSAID *Required* — Dose and Dosing Interval: _____ _____ Reauthorization request **must** include evidence of symptom improvement(s): _____ _____ _____

(Continued)

Ilaris® (canakinumab)	**DIAGNOSIS (*CHECK ALL THAT APPLY*):**	**CLINICAL AND DOSING INFORMATION (*CHECK ALL THAT APPLY*):**
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization If obtaining through Accredo Specialty Pharmacy, please contact MedImpact for authorization at **800-788-2949.**	REQUIRED ☐ Cryopyrin-associated periodic syndromes (CAPS) including familial cold auto-inflammatory syndrome (FCAS) and Muckle-Wells syndrome ☐ Systemic Juvenile Idiopathic Arthritis (SJIA) ☐ Other (please specify): _____ _____ _____ _____ _____ _____	REQUIRED ☐ Treatment failure with, or contraindication to: ☐ One or more Corticosteriods or NSAIDs *Required* — Dose and Dosing Interval: _____ _____ Reauthorization request **must** include evidence of symptom improvement(s): _____ _____ _____ _____ _____
Orencia™ (abatcept)	**DIAGNOSIS (*CHECK ALL THAT APPLY*):**	**CLINICAL AND DOSING INFORMATION (*CHECK ALL THAT APPLY*):**
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization For the subcutaneous formulation of this drug please contact MedImpact for authorization at **800-788-2949.**	REQUIRED ☐ Rheumatoid Arthritis ☐ Active polyarticular juvenile idiopathic arthritis ☐ Other (please specify): _____ _____ _____ _____ _____ _____ _____ _____	REQUIRED ☐ Treatment failure with traditional DMARD agent (azathioprine, cyclosporine, d-penicillamine, gold sodium, thiomalate, methotrexate, auranofin, aurothioglucose, hydroxychloroquine, leflunomide, sulfasalazine) ☐ Contraindication to traditional DMARD agent ☐ Treatment failure with biological DMARD agent (e.g., Cimzia® [certolizumab], Kineret® [anakinra], Orencia™ [abatacept], Remicade® [infliximab], Simponi [golimumab]). ☐ Contraindication to biological DMARD agent ☐ Previous treatment failure with Enbrel® ***or*** Humira™. *Required* — Dose and Dosing Interval: _____ _____ Reauthorization request **must** include evidence of symptom improvement(s): _____ _____ _____ _____ _____

(Continued)

Immunologic Drug Prior Authorization Request Form

REMICADE (IMFLIXIMAB)	DIAGNOSIS (CHECK ALL THAT APPLY):	CLINICAL AND DOSING INFORMATION (CHECK ALL THAT APPLY):
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization	REQUIRED ☐ Moderately to severely active rheumatoid arthritis ☐ Active psoriatic arthritis ☐ Moderately to severely active Crohn's Disease ☐ Fistulizing Crohn's Disease ☐ Moderately to severely active ulcerative colitis ☐ Active ankylosing spondylitis ☐ Severe (extensive, disabling) plaque psoriasis ☐ Other (please specify): _____ _____ _____ _____ _____ _____ _____ _____	REQUIRED ☐ Treatment failure with oral or injectable DMARD agent (e.g., azathioprine, cyclosporine, d-penicillamine, gold sodium thiomalate, methotrexate, auranofin, aurothioglucose, hydroxychloroquine, leflunomide, sulfasalazine) ☐ Contraindication to one oral or injectable DMARD agent ☐ Treatment failure with: ☐ Corticosteroids (e.g. prednisone, prednisolone, methylprednisolone) ☐ 5-Aminosalicylates (e.g. sulfasalazine, mesalamine, olsalazine, balsalazide) ☐ Immunosupressants/immunomodulators (e.g., 6-mercaptopurine, azathioprine, methotrexate) ☐ Prescription NSAID ☐ Systemic therapy for psoriasis (e.g., acitretin, azathioprine, cyclosporine, hydroxyurea, methotrexate, Mycophenolate mofetil, oral methoxsalen plus UVA light [PUVA], propylthiouracil, sulfasalazine, tacrolimus, 6-thioguanine) ☐ Previous treatment failure with Humira™ ☐ Previous treatment failure with Enbrel® *Required* — Dose and Dosing Interval: _____ _____ Reauthorization request **must** include evidence of symptom improvement(s): _____ _____ _____ _____ _____ _____

(Continued)

RITUXAN (RITUXIMAB)	DIAGNOSIS (CHECK ALL THAT APPLY):	CLINICAL AND DOSING INFORMATION (CHECK ALL THAT APPLY):
REQUIRED	REQUIRED	REQUIRED
Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization	☐ GPA/Wegener's Granulamatosis ☐ Microscopic polyangiitis ☐ Idiopathic thrombocytopenic purpura ☐ Refractory pemphigous vulgaris ☐ Refractory bullous pemphigoid ☐ Moderate to severely active rheumatoid arthritis (RA) ☐ Other (please specify): _____ _____ _____ _____ _____ _____ _____ _____	☐ Treatment failure with or contraindication to methotrexate and/or cyclophosphamide in combination with glucocorticoids. ☐ Documented concerns about fertility, high risk of malignancy, relapsing disease or cyclophosphamide resistance. ☐ Treatment failure or contraindication to steroid therapy: ☐ Corticosteroids ☐ High-dose topical steroids ☐ Systemic steroids ☐ Treatment failure with or contraindication to immunosuppressive glucocorticoid-sparing agent (e.g., my-cophenolate mofetil, azathioprine, ***or*** methotrexate ☐ Treatment failure with immunosuppressive glucocorticoid-sparing agent (e.g., mycophenolate mofetil, azathioprine, ***or*** methotrexate) ☐ Contraindication to immunosuppressive glucocorticoid-sparing agent ☐ Treatment failure with traditional DMARD agent (e.g., azathioprine, cyclosporine, d-penicillamine, gold sodium thiomalate, methotrexate, auranofin, aurothioglucose, hydroxychloroquine, leflunomide, and sulfasalazine) ☐ Contraindication to traditional DMARD agent ☐ Treatment failure with biological DMARD (e.g., Cimzia® [certolizumab]), Kineret® [anakinra], Orencia™ [abatacept], Remicade® [infliximab], Simponi [golimumab]; ☐ Contraindication to biological DMARD ☐ Previous treatment failure with Enbrel® ***or*** Humira™ *Required* — Dose and Dosing Interval: _____ _____ **Reauthorization request <u>must</u> include evidence of symptom improvement(s):** _____ _____ _____ _____ _____ _____

(Continued)

SIMPONI® -ARIA™ (GOLIMUMAB)	DIAGNOSIS (CHECK ALL THAT APPLY):	CLINICAL AND DOSING INFORMATION (CHECK ALL THAT APPLY):
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization For the subcutaneous formulation of this drug please contact MedImpact for authorization at **800-788-2949.**	REQUIRED ☐ Moderately to severely active rheumatoid arthritis ☐ Other (please specify):	REQUIRED ☐ Treatment failure with or contraindication to oral or injectable traditional DMARD agent ((e.g., azathioprine, cyclosporine, d-penicillamine, gold sodium, thiomalate, methotrexate, auranofin, aurothioglucose, hydroxychloroquine, leflunomide, and sulfasalazine) ☐ Treatment failure with or contraindication to Enbrel® ***or*** Humira™ *Required* — Dose and Dosing Interval: Reauthorization request **must** include evidence of symptom improvement(s):
STELARA™ (USTEKINUMAB)	**DIAGNOSIS (CHECK ALL THAT APPLY):**	**CLINICAL AND DOSING INFORMATION (CHECK ALL THAT APPLY):**
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization If obtaining through Accredo Specialty Pharmacy, please contact MedImpact for authorization at **800-788-2949.**	REQUIRED ☐ Moderate to severe plaque psoriasis ☐ Active psoriatic arthritis ☐ Other:	REQUIRED ☐ Treatment failure or contraindication to one course of systemic therapy for psoriasis (e.g., methotrexate, azathioprine, acitretin, tacrolimus, cyclosporine, mycophenolate mofetil, 6-thioguanine, sulfasalazine, hydroxyurea, propylthiouracil, oral methoxsalen plus UVA light (PUVA). ☐ Previous treatment failure with Enbrel® ***or*** Humira™ ☐ Treatment failure with oral or injectable DMARD agent (e.g., Hydroxychloroquine (Plaquenil), Leflunomide (Arava), Cyclosporine (Neoral), Sulfasalzine (Azulfidine), Methotrexate (Rheumatrex, Trexall), Azathioprine (Imuran), Cyclophosphamide (Cytoxan), Biologics (Actemra, Cimzia, Kineret, Orencia, Remicade, Rituxan, Simponi) ☐ Contraindication to oral or injectable DMARD agent *Required*— Dose and Dosing Interval: Reauthorization request **must** include evidence of symptom improvement(s):

TYSABRI® (NATALIZUMAB)	DIAGNOSIS (CHECK ALL THAT APPLY):	CLINICAL AND DOSING INFORMATION (CHECK ALL THAT APPLY):
REQUIRED Check the appropriate treatment: ☐ New Start (Drug Naïve) ☐ Ongoing treatment ***or*** Reauthorization	REQUIRED ☐ Multiple sclerosis ☐ Moderately to severely active Crohn's Disease ☐ Other (please specify):	REQUIRED ☐ Relapsing multiple sclerosis ☐ Treatment failure with, or contraindication, Avonex®, Betaseron®, Copaxone®, Extavia® or Rebif® within the past 6 months ☐ Treatment failure with, or contraindication to Tumor Necrosis Factor (TNF) blocking agent (i.e. Cimzia®, Humira® or Remicade®) *Required* — Dose and Dosing Interval: Reauthorization request **must** include evidence of symptom improvement(s):

If requesting step therapy with Enbrel or Humira please contact MedImpact at 800-788-2949

Payment is based on member eligibility and benefit limitation at the time the service is rendered, as well as Harvard Pilgrim provider contractual agreement. All services are subject to applicable copayments, co-insurance, and deductibles.

Harvard Pilgrim mails decision letters to the requesting and servicing providers, and to the member, within one business day of making a determination. If you require an authorization number sooner, you may log onto *HPHConnect* via the Provider Portal. If you require assistance accessing *HPHConnect*, call 800-708-4414, option one (1) and then option six (6), or email Provider_eBusiness_Services@hphc.org.

Register for *HPHConnect* online at *www.harvardpilgrim.org/providers.*

PRIOR AUTHORIZATION / NON-FORMULARY EXCEPTIONS REQUEST FORM

Anthem

for Anthem Pharmacy Programs

Date:	Physician Telephone Number: Physician FAX Number:
Requesting Physician Name and Address:	Member ID #: Group ID #:

Member (Patient) Name and Address:
Medication Requested:
Diagnosis:
Reason for Request:
Have other formulary products been used to treat this patient's condition? Yes No If yes, please list: If no, state reason:
Physician's signature:

For Anthem Prescription Management Use Only

Date Received:		Information Reviewed By:
Recommendations:	one time use only	maintenance use
Comments:		

Return to: ***Anthem Prescription Prior Authorization Center***
8990 Duke Blvd., MP2-826
Mason, OH 45040

Fax: 800-601-4829
Phone: 1-800-338-6180

PLEASE COPY THIS FORM FOR FUTURE REQUESTS

Prior Authorization and Non-Formulary Exception Policies

Description

The Pharmacy & Therapeutics (P&T) Committee decisions for formulary inclusion are based on many criteria including clinical data, safety, cost and utilization. However, every member may not be able to tolerate formulary drugs due to ineffectiveness or adverse/allergic reactions. Other specific formulary drugs require that prior authorization criteria be met prior to dispensing. Therefore, a prior authorization and non-formulary exception process has been established.

Process and Considerations

Prior authorization (PA):

- In the majority of cases, each therapeutic category that contains a drug with PA criteria also contains other drug choices without criteria. These choices should be considered first.
- When prescribing or dispensing a medication that requires prior authorization, there are three methods of communication available to make this process work efficiently:

Three Communication Options

1. When a prescription is written for a drug with PA criteria please indicate on the prescription specific documented justification for that drug based on our criteria (i.e. diagnosis or drugs previously used).
2. Or, call our PA center at 1-800-338-6180 to discuss approval prior to writing the prescription, or the pharmacist can call to coordinate or obtain PA.
3. Or, using our provided PA Form, complete and fax to our PA center at 1-800-601-4829.

Each case will be reviewed in the order in which it is received, and a decision will be made in a timely fashion.

Non-Formulary Exception

- In the majority of cases, the formulary will contain a drug that will meet the health care need of the member, and these choices should be considered first.
- To be considered for exception, a member must have had one of the following:
  - Documented allergic/adverse reaction to formulary agents
  - Documented failure on formulary agents
  - Documented patient stability/control issues where change to a formulary agent is contraindicated or not advisable.
- The three means of communication listed for the PA process also apply here, although in some situations written documentation may be requested.
- Each case will be reviewed in the order in which it is received, and a decision will be made in a timely fashion.

PA Center and Customer Service Hours

Monday - Friday 9 a.m. - 11 p.m. EST
Saturday & Sunday 9 a.m. - 5 p.m. EST

Off-Hours Process

- On occasion, the customer service center and PA center may be closed and a claim will be rejected for PA or, for some programs, non-formulary. In these cases, the pharmacist should dispense an appropriate supply until the prescription can be reviewed for approval during normal business hours.

Non-formulary and PA appeals will be forwarded to an Anthem Blue Cross and Blue Shield Pharmacy Manager/Medical Director for review.

Minuteman Health

Medication Request Form

Instructions:

This form is to be used by participating providers to obtain coverage for the restrictions listed below. Please complete this form and fax to Minuteman Health's Pharmacy Department at **413-233-2777**.

To prevent any delays in processing, please complete all Patient, Physician and Drug Information

Patient Information (all required)	Physician Information (all required)
Patient Name:	**Physician Name:** **Specialty:**
Patient Minuteman Health ID#:	**NPI #:**
Patient Date of Birth:	**Minuteman Health Provider #:**
Allergies:	**Office contact name:**
Diagnosis:	**Office Telephone #: ( ) -**
Relevant co-morbid conditions:	**Fax #: ( ) -**
Physician Signature:	**Date:**

Drug Information (all required)	Type of Prior Authorization (check all that apply)
Requested Drug Name:	☐ **QUANTITY LIMIT** Reason for exceeding limit: _____
Dosage Strength and Form (be specific):	☐ **STEP THERAPY** ☐ Patient has tried and failed a first line drug in the previous 180 days. (This excludes the use of samples) ☐ There are contraindications to use of a first line medication Please list: _____
Quantity (per month):	
Past treatment failures:	☐ **BRAND ONLY** (Request for brand only, no substitution) ☐ Patient has documented allergic reaction to generic formulation
Reason for discontinuation (attach additional info when applicable):	☐ **NEW TO MARKET DRUG** (approval may result in a $50 copay or 50% co-insurance, whichever is greater)

Additional information relative or pertinent to request: _____

Effective date: 1/1/2014

CIGNA
Pharmacy Services
Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare
- Medication Prior Authorization Form -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested: (*please specify name, strength, and dosing schedule*):

Diagnosis related to use:

Duration of therapy:

Formulary alternatives tried: (*please include length of trial and/or if samples were given*):

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.*):

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

V 040805

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

Proton Pump Inhibitor

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

Patient's Name

Medicaid Number

Date of Birth (MM/DD/YYYY) / /

Gender ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: CLINICAL HISTORY

1. **Patient's Diagnosis:**
2. **Have any recent GI procedures been performed?** *(check and complete all that apply)*

PROCEDURE	DATE OF PROCEDURE	FINDINGS
☐ Upper GI Series	_____ / _____ / _____	
☐ Barium Swallow	_____ / _____ / _____	
☐ Serum Gastrin	_____ / _____ / _____	
☐ Endoscopy	_____ / _____ / _____	
☐ Serum Secretion Stimulation Test	_____ / _____ / _____	

3. **Has patient had a failure (4-week trial) on an acute dose of an H2 Receptor Antagonist in the past two years?** ☐ Yes ☐ No
   If yes, name medication: Date of Trial: _____ / _____ / _____
4. **Is the patient H. Pylori positive?** ☐ Yes ☐ No **Date**: _____ / _____ / _____
5. **Recurrent GERD symptoms on acute dose of H2 blockers or PPI > 4 weeks?** ☐ Yes ☐ No
   If yes, which one:
6. **Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.**

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.

SECTION III: NON-PREFERRED DRUG APPROVAL CRITERIA

CHAPTER 188 OF THE LAWS OF 2004 REQUIRES THAT MEDICAID ONLY COVER NON-PREFERRED DRUGS UPON A FINDING OF MEDICAL NECESSITY BY THE PRESCRIBING PHYSICIAN. CHAPTER 188 REQUIRES THAT YOU BASE YOUR DETERMINATION OF MEDICAL NECESSITY ON THE FOLLOWING CRITERIA.

☐ Allergic reaction ☐ Drug-to-drug interaction **Please describe reaction:**

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information:

☐ Age specific indications. Please provide patient age and explain:

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:

☐ Unacceptable clinical risk associated with therapeutic change. Please explain:

SECTION IV: PRESCRIBER INFORMATION

Name

NPI Number

Prescriber Phone Number -

Prescriber Fax Number -

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-866-675-7755
Fax: 1-888-603-7696

Revision Date: 09/23/2015

Magellan Rx MANAGEMENT℠

NEW HAMPSHIRE HEALTHY FAMILIES

USscript
Integrity. Innovation. Outcomes.

NEW HAMPSHIRE HEALTHY FAMILIES
MEDICATION PRIOR AUTHORIZATION REQUEST FORM

>>> Please DO NOT USE this form for Specialty and/or Biopharmaceutical Requests <<<

Sumbit the request by sending the completed form to US Script by FAX @ 1-866-399-0929 or MAIL to US Script c/o Prior Authorization Department at 2425 West Shaw Avenue, Fresno, California 93711

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		Phone:	
Alternate Phone:		Fax:	
Medication Allergies:		Office Contact Name:	

III. MEDICATION REQUESTED (one medication request per form)			
Drug Name:		Dosage/Strength:	
Dosage Form:		Route of Admin:	
Quantity Per Day:		Directions:	
Refills/Length of Tx:		Therapy Start Date:	

IV. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD9 and Description:	
Date of Diagnosis:		*NOTE: Include diagnostic clinicals (labs, radiology, etc.).*	

V. MEDICATION HISTORY (for this diagnosis)

A. Is the member currently on this medication? ☐**Yes**; how long? _____ ☐**No**; skip to items B&C, go to **D**.

B. Is this a request for continuation of a previous approval? ☐**Yes**; go to item **C**. ☐**No**; skip item C, go to **D**.

C. Has the strength, dosage, or quantity required per day: ☐**INCREASED** ☐**DECREASED** ☐Remained the **SAME**

D. Indicate PREVIOUS medications treatment/outcomes below. *NOTE: Confirmation will be made using claims history.*

	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			
4			

VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION

NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.

☐ Medical intolerance to the preferred drug. Provide clinical symptoms.
☐ Inadequate response to the preferred drug.
☐ Absence of appropriate formulation or indication of the drug. Please specify.
☐ Other – Provide rationale for the request.

Prescriber Signature – **Dispense as Written (DAW)**:

X_____ Date: _____

Prescriber Signature – **Substitution Permitted**:

X_____ Date: _____

Please access http://www.NHhealthyfamilies.com/ or contact provider services for a current listing of preferred products. A response will be provided via fax or phone within one business day of the receipt of the complete information. Incomplete and illegible forms will delay processing. Be sure to include lab reports with requests when appropriate. To request a 72 hour emergency supply of medication you may call US Script at 1-877-277-0413. ***NOTE: The 72 hour supply does not apply to specialty medications.*** Requests can also be mailed to: US Script, c/o Prior Authorization Department, 2425 West Shaw Avenue, Fresno, California 93711.

WELL SENSE HEALTH PLAN

ENVISION RX OPTIONS

PRIOR AUTHORIZATION REQUEST FORM

Well Sense Proton Pump Inhibitors - Policy 9.109
Aciphex Sprinkle, Omeprazole-Bicarbonate (RX), rabeprazole, Dexilant, Nexium (RX), Nexium granules, Prevacid SoluTab, Lansoprazole SoluTab, Prilosec powder packet, Protonix granules, Zegerid powder packet
Phone: 877-957-1300 Fax back to: 866-414-3453

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:
Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy?

☐ Initial Therapy
☐ Continuing Therapy (Start date MM/YY): _____

Q2. Please indicate the diagnosis below.

☐ GERD
☐ Refractory GERD despite trial of once daily therapy on requested PPI
☐ Zollinger-Ellison Syndrome
☐ Laryngopharyngeal reflux with symptomatic gastroesophageal reflux disease
☐ Eradication of Helicobacter Pylori as part of triple or quadruple therapy
☐ Barrett's Esophagus
☐ Other (Please explain): _____

Q3. Has the member had a 14-day trial of any of the following medications listed below (mark all that apply)? Please explain the patient's inadequate response, intolerance, or contraindication to the medication.

☐ Omeprazole (OTC or Rx)
☐ Lansoprazole (OTC or Rx)
☐ Nexium 24HR (OTC)
☐ Pantoprazole

WELL SENSE HEALTH PLAN

ENVISION RX OPTIONS

PRIOR AUTHORIZATION REQUEST FORM

Well Sense Proton Pump Inhibitors - Policy 9.109
Aciphex Sprinkle, Omeprazole-Bicarbonate (RX), rabeprazole, Dexilant, Nexium (RX), Nexium granules, Prevacid SoluTab, Lansoprazole SoluTab, Prilosec powder packet, Protonix granules, Zegerid powder packet
Phone: 877-957-1300 Fax back to: 866-414-3453

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**

☐ Rabeprazole
☐ Omeprazole Suspension
☐ Lansoprazole Suspension
☐ None of the above

Q4. Does the member have any conditions that may cause swallowing difficulties?
☐ Yes (please explain):
☐ No

Q5. FOR CONTINUATION OF THERAPY: Do the clinical benefits outweigh the risks of chronic PPI use?
☐ Yes ☐ No

Q6. Has the patient been evaluated within the most recent one year period? If the answer is yes, please provide the date of the patient's last office visit.
☐ Yes (Date of last evaluation): _____
☐ No

Q7. If the patient requires a higher quantity than the plan allows, the prescriber may provide any additional rationale or details why this member requires a quantity above the plan limit (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support this request):

_____ _____
Prescriber Signature Date

EXPRESS SCRIPTS®

Prior Authorization Form
General Request Form

Did you know PAs can be completed, submitted and processed faster electronically?
Get started at **Express-Scripts.com/pa.** If this an **URGENT** request, please call **800.753.2851**

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Diagnosis: _____ **ICD Code:** _____

Please indicate which drug and strength is being requested: _____

Quantity Requested _____ **for** _____ **days supply**

Other Medications/Therapies tried and reason(s) for failure and/or any other information the physician feels is important to the review:

_____

_____

_____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____ Phone Number: _____

Fax completed form to **877.329.3760**

This fax form is based on Express Scripts standard criteria; certain plans and situations may require additional information.

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.

CVS CAREMARK

CLINICAL PRIOR AUTHORIZATION CRITERIA REQUEST FORM

Please complete this form and fax it to CVS Caremark at 1-888-836-0730 to receive a DRUG SPECIFIC CRITERIA FORM for prior authorization. Once received, a DRUG SPECIFIC CRITERIA FORM will be faxed to the specific physician along with patient specific information, appropriate criteria for the request and questions that must be answered. Once received, reviewed and approved an override will be processed and the pharmacist can resubmit the claim for payment. If the request is denied, the physician and patient will be sent a notification and reason for the denial.

ALL fields must be completed before faxing. Please fax the completed form to CVS Caremark at 1-888-836-0730.

SECTION I: PATIENT INFORMATION

LAST NAME, FIRST NAME (PLEASE PRINT)	DOB (MM/DD/YYYY)
STREET ADDRESS	PHONE NUMBER ( )
CITY	STATE
CARDHOLDER ID #	ZIP CODE

SECTION II: DRUG INFORMATION

DRUG NAME (PLEASE PRINT)	DRUG STRENGTH

SECTION III: PHYSICIAN INFORMATION

PHYSICIAN NAME (PLEASE PRINT)	
PHYSICIAN ADDRESS (STREET, CITY, STATE, ZIP CODE)	
PHYSICIAN PHONE NUMBER ( )	PHYSICIAN FAX NUMBER ( )

SIGNATURE	DATE

DISCLAIMER: Incomplete or illegible forms and missing fields may delay the processing of your request. Please complete all fields to ensure appropriate processing.

Cigna Medicare Rx® (PDP)

Medicare Part D Prescription Drug Plans

Request For Medicare Prescription Drug Coverage Determination

This form may be sent to us by mail or fax:

Address:
Cigna Pharmacy Services
P.O. Box 42005
Phoenix, AZ 85080-2005

Fax Number:
(855) 840-1676

You may also ask us for a coverage determination by phone at (800) 558-9363 or through our website at www.cignamedicarerx.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:
Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider *(attach any supporting documents)*:

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature:	**Date:**

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72–hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:

Rationale for Request

☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure.** [Specify below: (1) drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change.** [Specify below: Anticipated significant adverse clinical outcome]

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) dosage form(s) and/or dosage(s) tried; (2) explain medical reason]

☐ **Request for formulary tier exception** [Specify below: (1) formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]

☐ **Other** (explain below)

Required Explanation _____

Cigna.

831019 c 09/13 © 2013 Cigna

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Humana.

Plan/Medical Group Phone#: 1-800-555-2546
Plan/Medical Group Fax#: 1-877-486-2621

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:
Address:	City:	State: Zip Code:
Requestor (if different than prescriber):	Office Contact Person:	
NPI Number (individual):	Phone Number:	
DEA Number (if required):	Fax Number (in HIPAA compliant area):	
Email Address:		

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Patient's Home ☐ Long Term Care
☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

_____

SilverScript®

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:
SilverScript® Insurance Company
Prescription Drug Plan
P.O. Box 52000, MC109
Phoenix AZ 85072-2000

Fax Number:
1-855-633-7673

You may also ask us for a coverage determination by phone at 1-866-235-5660, (TTY: 711), 24 hours a day, 7 days a week or through our website at www.silverscript.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State_____ Zip Code _____

Phone _____Enrollee's Member ID # _____

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:
Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

- ☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*
- ☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*
- ☐ I request prior authorization for the drug my prescriber has prescribed.*
- ☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
- ☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*
- ☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- ☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- ☐ My drug plan charged me a higher copayment for a drug than it should have.
- ☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

* **NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider *(attach any supporting documents)*:

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature of person requesting the coverage determination (the enrollee, or the enrollee's prescriber or representative):

Date: _____

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION (Cont'd)

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Prescriber's Signature _____ **Date** _____

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:

Height/Weight:	Drug Allergies:	Diagnosis:

Rationale for Request

- ☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]
- ☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]
- ☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]
- ☐ **Request for formulary tier exception** [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]
- ☐ **Other** (explain below)

Required Explanation: _____

This information is available for free in other languages. Please call our Customer Care number at 1-866-235-5660 (TTY: 711), 24 hours a day, 7 days a week. Esta información está disponible gratuitamente en otros idiomas. Llame a nuestro Cuidado al Cliente, al 1-866-235-5660 (teléfono de texto (TTY: 711), las 24 horas del día, los 7 días de la semana.

SilverScript is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal.

OPTUMRx®

Please note: All information below is required to process this request
For urgent requests please call 1-800-711-4555
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

Prior Authorization Request Form

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: Dosage Form:
Is This Medication a New Start? ☐Yes ☐No	Directions for Use:

Clinical Information (required)

What is the patient's diagnosis?

ICD-9/10 Code(s): _____

What medication(s) has the patient tried and failed?

Are there any supporting labs or test results? (Please specify)

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
- ☐ Titration purpose
- ☐ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ☐ Requested strength/dose is not commercially available
- ☐ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

OPTUMRx™

Date Sent: **To:** Fax: RE: Pending Provider Response
From: **OptumRx Prior Authorization Department** Number of pages, including cover sheet: **3** If you did not receive all the pages, please call 1-800-711-4555 reference #
Please have the doctor or a qualified member of the office staff complete the next page and **Fax completed form to:** **Standard** (Oral, topical and insulins): **1-800-527-0531** **Specialty** (Injectables excluding insulin): **1-800-853-3844** **OR go to www.optumrx.com** *If you have any questions or would like to speak to a Prior Authorization Advocate please call 1-800-711-4555 Option 1 for Standard; 2 for Specialty*

OPTUMRx™

MEMBER & PROVIDER INFORMATION

* Indicates **REQUIRED** Fields

*Member ID:	*Provider Name:
*Member Name:	*Provider Address (below):
*Member D.O.B.:	
*Member Address:	
	*Provider NPI #:
	*Provider Phone:
*Member Phone:	*Provider Fax:
Reference #:	*Provider Specialty:

MEDICATION INFORMATION

*Medication Name and Strength:	
*Direction for Use:	
***Continuation of therapy?**	Yes No
*(If Yes please give start date)	***Start date:**

*CLINICAL INFORMATION

Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses OptumRx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

Please answer the following questions

1) What is the diagnosis for the requested medication:
(ICD-9 code if available) _____

2) Please provide a list of all relevant medications tried and failed:

Medication_____ Date _____

Medication_____ Date _____

Additional Information _____

_____

OPTUMRx™

THIS IS NOTIFICATION THAT YOU OR YOUR PATIENT'S REQUEST FOR COVERAGE OF THIS MEDICATION MAY BE DENIED IF ALL OF THE ABOVE INFORMATION IS NOT COMPLETE. PLEASE PROVIDE COMPLETE INFORMATION REQUESTED ABOVE TO SUPPORT THIS REQUEST FOR COVERAGE.
PLEASE FAX BACK AT THE NUMBER LISTED ABOVE OR CALL AT 1-800-711-4555 BY YOU MAY ALSO VISIT OUR WEBSITE AT WWW.OPTUMRX.COM AND NAVIGATE TO THE HEALTHCARE PROFESSIONALS SECTION.

PHYSICIAN SIGNATURE

DATE

If you have any questions regarding your patient's plan drug limits you may call us at: 1-800-711-4555.

WellCare Health Plans

Medicare Part D Coverage Determination Request Form

Instructions: Please complete ALL FIELDS and fax this form to WellCare's Pharmacy Department at **1-866-388-1767**. Formulary and utilization management criteria may be reviewed at **www.wellcare.com/medicare**.

Who is making this request? Provider ☐ Member ☐

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

☐ **REQUEST FOR EXPEDITED REVIEW (24 HOURS)**

By checking the expedited box, the requestor certifies that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***REQUIRED FIELDS – ONE medication per form**

*Member Name:		*Date of Request:	
*WellCare ID #:	*Date of Birth:	*Physician FULL Name/Specialty:	
*Member's Telephone Number:		*Physician Signature:	
*Diagnosis of Requested Medication:		*Contact Name at MD Office:	*Physician NPI:
*Medication, Strength, and Route of Administration:		*Physician Phone #:	*Physician Fax #:
		Pharmacy Name:	Pharmacy Phone #:
*Frequency:	*Quantity:	If TRANSPLANT DRUG: Was the transplant covered by Medicare? ☐ Yes ☐ No	
*Duration of Therapy:	*Drug Allergies:	If HOSPICE PATIENT: Is medication related to the terminal condition? ☐ Yes ☐ No	

Type of Coverage Determination Request (Please check applicable boxes):

❑ **Prior Authorization** – provide the relevant clinical information below that fulfills PA criteria.

❑ **Non-Formulary Exception** – list below at least 2 formulary alternatives that have been tried for the same condition or why all covered Part D drugs on any tier of our formulary would not be as effective for the patient as the non-formulary drug, and/or would have adverse effects.

❑ **Step Therapy Formulary Exception** – provide a statement that other medications have (A) been ineffective in the treatment of the patient's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the patient, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; OR (B) based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the patient.

❑ **Quantity Limit Formulary Exception** – provide a statement that the number of doses available under a dose restriction for the prescription drug has been ineffective in the treatment of the patient's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the patient, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

❑ **Tiering Exception*** (requesting medication to be covered at a lower tier) – provide statement that drugs in the lower cost-sharing tier would not be as effective as the requested drug in the higher cost-sharing tier; and/or would have adverse effects. ***Please note:** You cannot ask for a tiering exception for a drug on Tier 1, Specialty Tier or for Non-Formulary Drugs.

Rationale for Request

PRIOR AUTHORIZATION REQUEST FORM

EnvisionRxOptions
Pioneers in Transparency

EOC ID:

EnvisionRxOptions General Prior Authorization Form

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name: ☐ Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. Please indicate the patient's diagnosis below
Q2. Have other formulary alternatives in this drug category/class been tried and failed? ☐ Yes ☐ No
Q3. Please list them below along with the date the medication was tried and failed
Q4. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having?
Q5. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-label use. Please attach any medical information that may support approval
Q6. Please provide any supporting clinical statements (such as lab values, adverse outcomes, treatment failures, or any other additional clinical information to support a formulary exception request)

Physician Signature **Date**

2015 Request for Medicare Prescription Drug Coverage Determination* Form (Must complete both pages)

PLEASE FAX COMPLETED FORM TO: 1-800-639-9158

Patient Information		Prescriber Information	
Patient Name		Today's Date	Physician Specialty
Patient Insurance ID Number		Physician Name	NPI/DEA Number
Patient Address, City, State, ZIP		Physician Address	
Patient Home Telephone		M.D. Office Telephone Number	
Gender ☐ Male ☐ Female	Patient Date of Birth	M.D. Office Fax Number	

Diagnosis and Medical Information

Medication Requested	Strength, and Route of Administration	Frequency

New Prescription OR Date Therapy Initiated:	Quantity	Day Supply	Expected Length of Therapy

Diagnosis: ***(Please include all office notes supporting diagnosis.)***

PLEASE CHECK ALL BOXES THAT APPLY:

1. **If injectable medication, where is it being administered?**
   ☐ Home (self-administered) ☐ Office administered (office supplies drug) /J CODE :_____
   ☐ Office administered (pharmacy supplies drug)
2. ☐ **Does the patient have a diagnosis of cancer? ☐ Yes ☐ No**
3. ☐ **Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result adverse clinical outcome.**
4. ☐ **All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/ or would likely have adverse effects for the enrollee.**
5. **The American Geriatric Society recommends avoiding high risk medications (HRM) in the elderly as a safety concern. To ensure safe use of potentially high risk medications (HRM) in the elderly population, prescriber must acknowledge that medication benefits outweigh potential risks in the elderly.** *Note: Members under 65 years of age are not subject to the prior authorization requirements*

   ☐ The requested medication is medically necessary and the clinical benefits outweigh the risks for this specific patient.
6. ☐ **Yes ☐ No Does the patient require higher dosage (quantity limit exception)?**
   - If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day

   ☐ The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

   ☐ The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

For urgent requests please call 1-800-551-2694
Visit our websites at http://www.firsthealthpartd.com, http://www.chcadvantra.com, http://www.summithealthplan.com and http://www.vistahealthplan.com

7. ☐ **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

8. ☐ **Other supporting information**

*NOTE: Formulary exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature	**Date**

MAGELLAN HEALTH SERVICES
Getting Better All the Time

General Prior Authorization Request Form for Medications

Please fax all Prior Authorization requests for medications to the Magellan Pharmacy Helpdesk at **866-498-0628**
Only one medication request per form • All fields must be complete and legible for review

If the request is urgent, please call 800-790-1631.

All requests for reconsideration, regardless of reason, should be faxed to 866-498-0628 clearly marked "Reconsideration Request"

PRESCRIBER

PRESCRIBER NPI

PRESCRIBER NAME

PRESCRIBER SPECIALTY

CLINIC NAME

OFFICE PHONE

OFFICE FAX

CONTACT NAME

RECIPIENT

RECIPIENT ID NUMBER (CIS OR AHCCCS ID)

RECIPIENT NAME

RECIPIENT DATE OF BIRTH (MM/DD/YYYY)

RECIPIENT SEX (CIRCLE) FEMALE MALE HEIGHT WEIGHT

RECIPIENT PHONE

RECIPIENT DIAGNOSIS (AXIS I – III)

RECIPIENT DRUG ALLERGIES

REQUEST

MEDICATION NAME | STRENGTH AND FORM | ROUTE OF ADMINISTATION | FREQUENCY

DATE THERAPY INITIATED (MM/DD/YYYY) | EXPECTED LENGTH OF THERAPY | QUANTITY PER FREQUENCY

RATIONALE FOR EXCEPTION OR PRIOR AUTHORIZATION

List alternate drug(s) contraindicated or previously tried, but with adverse outcome(s) (e.g. toxicity, allergy, or therapeutic failure)

1. MEDICATION NAME | ADVERSE OUTCOME | DOSE AND DURATION OF THERAPY
2. MEDICATION NAME | ADVERSE OUTCOME | DOSE AND DURATION OF THERAPY
3. MEDICATION NAME | ADVERSE OUTCOME | DOSE AND DURATION OF THERAPY
4. MEDICATION NAME | ADVERSE OUTCOME | DOSE AND DURATION OF THERAPY

LIST CURRENT MEDICATIONS AND DOSES

TARGET SYMPTOM / INDICATION FOR REQUESTED MEDICATION

CLINICAL RATIONALE FOR TREATMENT

PRESCRIBER'S SIGNATURE DATE

By signing this form, the prescriber is attesting that documentation supporting the above information is recorded in the Patient's Medical Chart.

Appendix B: State Laws and Rules/Guidance

CHAPTER 228
HB 1608-FN - FINAL VERSION

10Mar2016... 0799h
10Mar2016... 0917h
04/28/2016 1498s
04/28/2016 1655s

2016 SESSION

16-2349
01/10

HOUSE BILL ***1608-FN***

AN ACT relative to uniform prior authorization forms.

SPONSORS: Rep. Fothergill, Coos 1; Rep. Sherman, Rock. 24; Rep. Hunt, Ches. 11; Sen. Bradley, Dist 3; Sen. Woodburn, Dist 1

COMMITTEE: Commerce and Consumer Affairs

AMENDED ANALYSIS

This bill requires health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs to use and accept only the uniform prior authorization forms and criteria developed by the commissioner of insurance in accordance with rules adopted pursuant to RSA 541-A after December 31, 2017.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

CHAPTER 228
HB 1608-FN - FINAL VERSION

10Mar2016... 0799h
10Mar2016... 0917h 16-2349
04/28/2016 1498s
04/28/2016 1655s 01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Sixteen

AN ACT relative to uniform prior authorization forms.

Be it Enacted by the Senate and House of Representatives in General Court convened:

228:1 Purpose. The purpose of this act is to provide administration simplification in the prior authorization process for prescription drugs and to encourage the use of electronic prior authorization technology.

228:2 New Paragraph; Managed Care Law; Uniform Prior Authorizations Forms and Electronic Standard for Prescription Drug Benefits. Amend RSA 420-J:7-b by inserting after paragraph IV-b the following new paragraph:

IV-c.(a) Beginning July 1, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs may, when requiring prior authorization for a prescription drug, use and accept the prior authorization paper forms or electronic standard described in this paragraph.

(b) Beginning December 31, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs shall, when requiring prior authorization for a prescription drug, use and accept only the prior authorization paper forms or electronic standard described in this paragraph.

(c) On or before March 1, 2017, the commissioner shall adopt rules, pursuant to RSA 541-A, specifying the contents and format of the uniform prior authorization paper forms and the electronic prior authorization standard, consistent with the requirements of this paragraph. In developing the paper forms and the electronic standard, the commissioner shall seek input from interested stakeholders, including, but not limited to, prescribers, pharmacists, carriers, and prescription benefits managers, and shall support adoption of nationally recognized standards for electronic prior authorization of prescription drugs, including those provided by the National Council for Prescription Drug Programs or an equivalent organization as available.

(d) The prior authorization paper forms adopted under this paragraph shall not exceed 2 pages in length.

(e) Nothing in this paragraph shall require a carrier or pharmacy benefits manager to use electronic prior authorization. A carrier or pharmacy benefits manager shall not require use of electronic prior authorization when:

(1) A pharmacist or prescriber lacks broadband Internet access;

(2) A pharmacist or prescriber has low patient volume;

(3) A pharmacist or prescriber has opted-out for a certain medical condition or for a patient request;

(4) A pharmacist or prescriber lacks an electronic medical record system;

(5) The electronic prior authorization interface does not provide for the pre-population of prescriber and patient information; or

(6) The electronic prior authorization interface requires an additional cost to the prescriber.

(f) Nothing in this section shall prohibit the use of prior authorization for prescription drug benefits.

(g) This section shall apply to RSA 420-J and shall not apply to the Medicaid managed care program under RSA 126-A:5, XIX.

228:3 New Section; Licensure of Medical Utilization Review Entities; Uniform Prior Authorization Forms and Electronic Standard for Prescription Drug Benefits. Amend RSA 420-E by inserting after section 4 the following new section:

420-E:4-a Uniform Prior Authorization Forms and Electronic Standard for Prescription Drug Benefits.

I. Beginning July 1, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs may, when requiring prior authorization for a prescription drug, use and accept the prior authorization paper forms or electronic standard described in this section.

II. Beginning December 31, 2017, all health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs shall, when requiring prior authorization for a prescription drug, use and accept only the prior authorization paper forms or electronic standard described in this section.

III. On or before March 1, 2017, the commissioner shall adopt rules, pursuant to RSA 541-A, specifying the contents and format of the uniform prior authorization paper forms and the electronic prior authorization standard, consistent with the requirements of this section. In developing the paper forms and the electronic standard, the commissioner shall seek input from interested stakeholders, including but not limited to prescribers, pharmacists, carriers, and prescription benefits managers, and shall support adoption of nationally recognized standards for electronic prior authorization of prescription drugs, including those provided by the National Council for Prescription Drug Programs or an equivalent organization as available.

IV. The prior authorization paper forms adopted under this section shall not exceed 2 pages in length.

V. Nothing in this section shall require a carrier or pharmacy benefits manager to use electronic prior authorization. A carrier or pharmacy benefits manager shall not require use of electronic prior authorization when:

(a) A pharmacist or prescriber lacks broadband Internet access;

(b) A pharmacist or prescriber has low patient volume;

(c) A pharmacist or prescriber has opted-out for a certain medical condition or for a patient request;

(d) A pharmacist or prescriber lacks an electronic medical record system;

(e) The electronic prior authorization interface does not provide for the pre-population of prescriber and patient information; or

(f) The electronic prior authorization interface requires an additional cost to the prescriber.

VI. Nothing in this section shall prohibit the use of prior authorization for prescription drug benefits.

VII. This section shall apply to RSA 420-J and shall not apply to the Medicaid managed care program under RSA 126-A:5, XIX.

228:4 Effective Date. This act shall take effect upon its passage.

Approved: June 9, 2016

Effective Date: June 9, 2016

Print

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XXII CORPORATIONS
CHAPTER 176O HEALTH INSURANCE CONSUMER PROTECTIONS
Section 25 Use and acceptance of specifically designated prior authorization forms

Section 25. (a) A payer or any entity acting for a payer under contract, when requiring prior authorization for a health care service or benefit, shall use and accept only the prior authorization forms designated for the specific types of services and benefits developed under subsection (c).

(b) If a payer or any entity acting for a payer under contract fails to use or accept the required prior authorization form, or fails to respond within 2 business days after receiving a completed prior authorization request from a provider, pursuant to the submission of the prior authorization form developed as described in subsection (c), the prior authorization request shall be deemed to have been granted.

(c) The division shall develop and implement uniform prior authorization forms for different health care services and benefits. The forms shall cover such health care services and benefits including, but not limited to, provider office visits, prescription drug benefits, imaging and other diagnostic testing, laboratory testing and any other health care services. The division shall develop forms for different kinds of services as it deems necessary or appropriate; provided that, all payers and any entities acting for a payer under contract shall use the uniform form designated by the division for the specific type of service. Six months after the full set of forms has been developed, every provider shall use the appropriate uniform prior authorization form to request prior authorization for coverage of the health care service or benefit and every payer or any entity acting for a payer under contract shall accept the form as sufficient to request prior authorization for the health care service or benefit.

Nothing in this section shall prohibit a payer or any entity acting for a payer under contract from using a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system in lieu of a paper form, provided that it is consistent with the paper form, developed pursuant to subsection (c).

(d) The prior authorization forms developed under subsection (c) shall:

(1) not exceed 2 pages;

(2) be made electronically available; and

(3) be capable of being electronically accepted by the payer after being completed.

(e) The division, in developing the forms, shall:

(1) seek input from interested stakeholders and shall seek to use forms that have been mutually agreed upon by payers and providers;

(2) ensure that the forms are consistent with existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services; and

(3) consider other national standards pertaining to electronic prior authorization.

(f) Nothing in this section shall limit a health plan from requiring prior authorization for services.

Bulletin 2016-08; Using Standard Prior Authorization Forms when Reviewing Requests for Medication and for Imaging Services; Issued 8/9/16

Bulletin 2016-08

TO: Commercial Health Insurers; Blue Cross Blue Shield of Massachusetts, Inc.; and Health Maintenance Organizations Offering or Renewing Insured Health Products in the Massachusetts

FROM: Daniel R. Judson, Commissioner of Insurance

DATE: August 9, 2016

RE: Using Standard Prior Authorization Forms when Reviewing Requests for Medication and for Imaging Services

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The Division of Insurance ("Division") issues this bulletin to inform insured health carriers ("Carriers") about the use of standard prior authorization forms when reviewing requests for medication and for imaging services. Pursuant to M.G.L. c. 176O, §25(c), the Division is mandated to implement health services prior authorization forms.

The Massachusetts Collaborative, composed of representatives from insurance carriers, provider groups and associations, developed and submitted a series of standard prior authorization forms for use in reviewing requests for medication and for imaging services. Based on the work of the members of the Collaborative, the group developed the following forms:

1. Massachusetts Standard Form for Medication Prior Authorization Request
2. Cardiac Imaging Prior Authorization Form to be used with Myocardial Perfusion Imaging (MPI); Stress Echocardiogram; Multiple Gated Acquisition Scan (MUGA); Transthoracic Echocardiogram (TTE); Transesophageal Echocardiogram (TEE)
3. PET – PET CT Prior Authorization Form
4. CT/CTA/MRI/MRA Prior Authorization Form

The Division held informational sessions on April 11 and April 28, 2016 to hear all thoughts about potential changes. In response to comments provided during the information sessions, the Massachusetts Collaborative submitted amended forms to the Division on June 10, 2016. The amended forms, as included in the Appendix to this bulletin, are approved by the Division as the standard prior authorization forms for medication and imaging services under insured health plans. Carriers may no longer require the use of any other paper form other than the standard form, which it shall make available for use by all contracted providers.

By no later than 90 days after the issuance of the bulletin, the Division expects that insured health plans shall take all necessary steps to amend their utilization review systems to accept any standard prior authorization form for medication and imaging services that may be submitted by providers by mail, as an attachment to electronic mail, or by facsimile machine. The applicable standard prior authorization form will serve as sufficient information upon which the insured health plan should make its decisions about the medical necessity and appropriateness of the requested service or procedure. For providers who use existing forms for prior authorization, Carriers will continue to accept these forms until six months after the issuance of this bulletin.

Six months after the issuance of this bulletin, the Division expects that all insured health plans will amend any electronic or internet-based systems used to collect utilization review information, so that those systems will only ask questions as stated in the approved forms in a format and order substantially similar to the format of the approved format. Carriers wishing to modify the format or order from the standard form are required to submit screenshots of all such forms for the Division's review before their use in the market. Data collected electronically by Carriers for prior authorizations should be identical to the data collected on these paper forms.

The Division is aware that Carriers and providers may be at differing degrees of readiness for implementing standard prior authorization forms. Although many provider organizations may be ready to implement the new forms, it appears that other providers may not yet be prepared. The Division is sending this guidance to remind all Carriers of their obligations under federal rules. As the paper forms become available, the Division strongly encourages Carriers to consider taking steps to work with provider organizations to educate contracted and other providers about the use of uniform prior

authorization forms for medication and imaging services. Carriers are encouraged to work with contracted providers to use the standard forms within 90 days and electronic form by no later than six months after the issuance of this bulletin.

If you have any questions about this Bulletin, please contact Kevin Beagan at 617-521-7323 or Kevin.beagan@state.ma.us.

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Colorado General Assembly

Session Laws of Colorado 2013
First Regular Session, 69th General Assembly

CHAPTER 229

INSURANCE

SENATE BILL 13-277 [Digest]

BY SENATOR(S) Aguilar, Morse, Balmer, Giron, Guzman, Jahn, Kefalas, King, Lundberg, Newell, Nicholson, Tochtrop, Todd;
also REPRESENTATIVE(S) Ginal, Duran, Fields, Garcia, Gerou, Hamner, Hullinghorst, Joshi, Melton, Moreno, Peniston, Pettersen, Primavera, Rosenthal, Ryden, Salazar, Schafer, Singer, Williams, Conti, Pabon, Young.

AN ACT

CONCERNING THE DEVELOPMENT OF A PRIOR AUTHORIZATION PROCESS TO BE USED IN OBTAINING PRIOR APPROVAL FROM CARRIERS FOR COVERAGE OF DRUG BENEFITS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly hereby finds that:

(a) Carriers and pharmacy benefit management firms routinely require health care providers to request prior authorization when prescribing medications or treatments not routinely covered by health plan formularies;

(b) Each carrier and pharmacy benefit management firm has its own prior authorization process, and the multiplicity of prior authorization processes imposes a significant administrative burden on health care providers, resulting in delayed patient access to medication and increased administrative costs; and

(c) A standardized prior authorization process that any health care provider can use, regardless of the carrier, pharmacy benefit management firm, or health plan that covers that provider's patient, will simplify the administrative process and improve patient care by allowing health care providers to devote less time to administrative duties and more time to patient care.

SECTION 2. In Colorado Revised Statutes, **add** 10-16-124.5 as follows:

10-16-124.5. Prior authorization form - drug benefits - rules of commissioner - definition. (1) (a) NOTWITHSTANDING ANY OTHER PROVISION OF LAW BUT SUBJECT TO PARAGRAPH (b) OF THIS SUBSECTION (1), ON AND AFTER JANUARY 1, 2015, A CARRIER OR, IF A CARRIER CONTRACTS WITH A PHARMACY BENEFIT MANAGEMENT FIRM TO PERFORM PRIOR AUTHORIZATION SERVICES FOR DRUG BENEFITS, THE PHARMACY BENEFIT MANAGEMENT FIRM, SHALL UTILIZE THE PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION (3) OF THIS SECTION WHEN REQUIRING PRIOR AUTHORIZATION FOR DRUG BENEFITS.

(b) THIS SECTION DOES NOT APPLY TO A NONPROFIT HEALTH MAINTENANCE ORGANIZATION WITH RESPECT TO MANAGED CARE PLANS THAT PROVIDE A MAJORITY OF COVERED PROFESSIONAL SERVICES THROUGH A SINGLE

CONTRACTED MEDICAL GROUP.

(2) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS SUBSECTION (2), A PRIOR AUTHORIZATION REQUEST IS DEEMED GRANTED IF A CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM FAILS TO:

(I) UTILIZE THE PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION (3) OF THIS SECTION;

(II) FOR PRIOR AUTHORIZATION REQUESTS SUBMITTED ELECTRONICALLY:

(A) NOTIFY THE PRESCRIBING PROVIDER, WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED, DENIED, OR INCOMPLETE, AND IF INCOMPLETE, INDICATE THE SPECIFIC ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (a) OF SUBSECTION (3) OF THIS SECTION, THAT IS REQUIRED TO PROCESS THE REQUEST; OR

(B) NOTIFY THE PRESCRIBING PROVIDER, WITHIN TWO BUSINESS DAYS AFTER RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM PURSUANT TO SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (II), THAT THE REQUEST IS APPROVED OR DENIED;

(III) FOR NONURGENT PRIOR AUTHORIZATION REQUESTS SUBMITTED ORALLY OR BY FACSIMILE OR ELECTRONIC MAIL, NOTIFY THE PRESCRIBING PROVIDER, WITHIN THREE BUSINESS DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED OR DENIED; AND

(IV) FOR URGENT PRIOR AUTHORIZATION REQUESTS SUBMITTED ORALLY OR BY FACSIMILE OR ELECTRONIC MAIL, NOTIFY THE PRESCRIBING PROVIDER, WITHIN ONE DAY AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED OR DENIED.

(b) IF A CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM NOTIFIES THE PRESCRIBING PROVIDER PURSUANT TO SUB-SUBPARAGRAPH (A) OF SUBPARAGRAPH (II) OF PARAGRAPH (a) OF THIS SUBSECTION (2) THAT A PRIOR AUTHORIZATION REQUEST IS INCOMPLETE AND THAT ADDITIONAL INFORMATION IS REQUIRED, THE PRESCRIBING PROVIDER SHALL SUBMIT THE ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE FROM THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM. IF THE PRESCRIBING PROVIDER FAILS TO SUBMIT THE REQUIRED ADDITIONAL INFORMATION WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE NOTICE, THE REQUEST IS NOT DEEMED GRANTED PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (2). AFTER RECEIPT OF THE REQUIRED ADDITIONAL INFORMATION, THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM SHALL RESPOND TO THE PRIOR AUTHORIZATION REQUEST IN ACCORDANCE WITH SUB-SUBPARAGRAPH (B) OF SUBPARAGRAPH (II) OF PARAGRAPH (a) OF THIS SUBSECTION (2).

(3) (a) ON OR BEFORE JULY 31, 2014, THE COMMISSIONER SHALL DEVELOP, BY RULE, A UNIFORM PRIOR AUTHORIZATION PROCESS THAT:

(I) IS MADE AVAILABLE ELECTRONICALLY BY THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM BUT THAT DOES NOT REQUIRE THE PRESCRIBING PROVIDER TO SUBMIT A PRIOR AUTHORIZATION REQUEST ELECTRONICALLY;

(II) REQUIRES EACH CARRIER AND PHARMACY BENEFIT MANAGEMENT FIRM TO MAKE THE FOLLOWING AVAILABLE AND ACCESSIBLE IN A CENTRALIZED LOCATION ON ITS WEB SITE:

(A) ITS PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS, INCLUDING A LIST OF DRUGS THAT REQUIRE PRIOR AUTHORIZATION;

(B) WRITTEN CLINICAL CRITERIA THAT ARE EASILY UNDERSTANDABLE TO THE PRESCRIBING PROVIDER AND THAT INCLUDE THE CLINICAL CRITERIA FOR REAUTHORIZATION OF A PREVIOUSLY APPROVED DRUG AFTER THE PRIOR AUTHORIZATION PERIOD HAS EXPIRED; AND

(C) THE STANDARD FORM FOR SUBMITTING REQUESTS;

(III) ENSURES THAT CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS USE EVIDENCE-BASED GUIDELINES, WHEN POSSIBLE, WHEN MAKING PRIOR AUTHORIZATION DETERMINATIONS;

(IV) PERMITS, BUT DOES NOT REQUIRE, A PRESCRIBING PROVIDER TO SUBMIT A REQUEST FOR A PRIOR AUTHORIZATION FOR DRUG BENEFITS ELECTRONICALLY TO THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM;

(V) REQUIRES CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN NOTIFYING THE PRESCRIBING PROVIDER OF ITS DECISION TO APPROVE A PRIOR AUTHORIZATION REQUEST, TO INCLUDE IN THE NOTICE A UNIQUE PRIOR AUTHORIZATION NUMBER ATTRIBUTABLE TO THE PARTICULAR REQUEST, SPECIFICATION OF THE PARTICULAR DRUG BENEFIT APPROVED, THE NEXT DATE FOR REVIEW OF THE APPROVED DRUG BENEFIT, AND A LINK TO THE CURRENT CRITERIA THAT THE PRESCRIBING PROVIDER WILL NEED TO SUBMIT FOR REAPPROVAL OF THE PRIOR AUTHORIZATION; AND

(VI) REQUIRES CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN NOTIFYING A PRESCRIBING PROVIDER OF ITS DECISION TO DENY A PRIOR AUTHORIZATION REQUEST, TO INCLUDE A NOTICE THAT THE COVERED PERSON HAS A

RIGHT TO APPEAL THE ADVERSE DETERMINATION PURSUANT TO SECTIONS 10-16-113 AND 10-16-113.5.

(b) IN DEVELOPING THE UNIFORM PRIOR AUTHORIZATION PROCESS, THE COMMISSIONER SHALL TAKE INTO CONSIDERATION THE RECOMMENDATIONS, IF ANY, OF THE WORK GROUP ESTABLISHED PURSUANT TO SUBSECTION (4) OF THIS SECTION AND THE FOLLOWING:

(I) NATIONAL STANDARDS PERTAINING TO ELECTRONIC PRIOR AUTHORIZATION, INCLUDING, BUT NOT LIMITED TO, STANDARDS REFERENCED IN FEDERAL LAW;

(II) WHETHER THE PRIOR AUTHORIZATION PROCESS SHOULD REQUIRE CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN REVIEWING A PRIOR AUTHORIZATION REQUEST, TO USE CLEARLY ACCESSIBLE, CONSISTENTLY APPLIED, AND WRITTEN CLINICAL CRITERIA BASED ON MEDICAL NECESSITY OR THE APPROPRIATENESS OF THE DRUG BENEFIT FOR THE COVERED PERSON;

(III) WHETHER THE PRIOR AUTHORIZATION PROCESS SHOULD REQUIRE CARRIERS TO TAKE INTO ACCOUNT, IN DETERMINING CRITERIA FOR PRIOR AUTHORIZATIONS, THE COLORADO PART B MEDICARE CONTRACTOR LOCAL COVERAGE DETERMINATIONS, THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES NATIONAL COVERAGE DETERMINATIONS, AND SPECIALTY SOCIETY GUIDELINES, SUCH AS THOSE OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY; AND

(IV) WHETHER CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS COULD USE A RULES ENGINE WITH CRITERIA-DRIVEN QUESTIONS THAT LEAD TO AN IMMEDIATE DETERMINATION OF A PRIOR AUTHORIZATION REQUEST OR REQUEST FOR SUBMITTAL OF SPECIFIC ADDITIONAL INFORMATION NEEDED TO MAKE THE DETERMINATION.

(c) IN ADDITION TO THE PRIOR AUTHORIZATION PROCESS, THE COMMISSIONER SHALL DEVELOP, BY RULE, A STANDARDIZED PRIOR AUTHORIZATION FORM, NOT TO EXCEED TWO PAGES IN LENGTH, FOR USE IN SUBMITTING ELECTRONIC AND NONELECTRONIC PRIOR AUTHORIZATION REQUESTS. IN DEVELOPING THE FORM, THE COMMISSIONER SHALL TAKE INTO CONSIDERATION EXISTING FORMS, INCLUDING EXISTING PRIOR AUTHORIZATION FORMS ESTABLISHED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES OR THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

(4) (a) WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, THE COMMISSIONER SHALL ESTABLISH A WORK GROUP COMPRISED OF REPRESENTATIVES OF:

(I) THE DEPARTMENT OF REGULATORY AGENCIES;

(II) LOCAL AND NATIONAL CARRIERS;

(III) CAPTIVE AND NONCAPTIVE PHARMACY BENEFIT MANAGEMENT FIRMS;

(IV) PROVIDERS, INCLUDING HOSPITALS, PHYSICIANS, ADVANCED PRACTICE NURSES WITH PRESCRIPTIVE AUTHORITY, AND PHARMACISTS;

(V) DRUG MANUFACTURERS;

(VI) MEDICAL PRACTICE MANAGERS;

(VII) CONSUMERS; AND

(VIII) OTHER STAKEHOLDERS DEEMED APPROPRIATE BY THE COMMISSIONER.

(b) THE WORK GROUP SHALL ASSIST THE COMMISSIONER IN DEVELOPING THE PRIOR AUTHORIZATION PROCESS AND SHALL MAKE RECOMMENDATIONS TO THE COMMISSIONER ON THE ITEMS SET FORTH IN PARAGRAPH (b) OF SUBSECTION (3) OF THIS SECTION. THE WORK GROUP SHALL REPORT ITS RECOMMENDATIONS TO THE COMMISSIONER NO LATER THAN SIX MONTHS AFTER THE COMMISSIONER APPOINTS THE WORK GROUP MEMBERS. REGARDLESS OF WHETHER THE WORK GROUP SUBMITS RECOMMENDATIONS TO THE COMMISSIONER, THE COMMISSIONER SHALL NOT DELAY OR EXTEND THE DEADLINE FOR THE ADOPTION OF RULES CREATING THE PRIOR AUTHORIZATION PROCESS AS SPECIFIED IN PARAGRAPH (a) OF SUBSECTION (3) OF THIS SECTION.

(5) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, ON AND AFTER JANUARY 1, 2015, EVERY PRESCRIBING PROVIDER SHALL USE THE PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION (3) OF THIS SECTION TO REQUEST PRIOR AUTHORIZATION FOR COVERAGE OF DRUG BENEFITS, AND EVERY CARRIER AND PHARMACY BENEFIT MANAGEMENT FIRM SHALL USE THAT PROCESS FOR PRIOR AUTHORIZATION FOR DRUG BENEFITS.

(6) UPON APPROVAL BY THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM, A PRIOR AUTHORIZATION IS VALID FOR AT LEAST ONE HUNDRED EIGHTY DAYS AFTER THE DATE OF APPROVAL. IF, AS A RESULT OF A CHANGE TO THE CARRIER'S FORMULARY, THE DRUG FOR WHICH THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM HAS PROVIDED PRIOR AUTHORIZATION IS REMOVED FROM THE FORMULARY OR MOVED TO A LESS PREFERRED TIER STATUS, THE CHANGE IN THE STATUS OF THE PREVIOUSLY APPROVED DRUG DOES NOT AFFECT A COVERED PERSON WHO RECEIVED PRIOR

AUTHORIZATION BEFORE THE EFFECTIVE DATE OF THE CHANGE FOR THE REMAINDER OF THE COVERED PERSON'S PLAN YEAR. NOTHING IN THIS SUBSECTION (6) LIMITS THE ABILITY OF A CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM, IN ACCORDANCE WITH THE TERMS OF THE HEALTH BENEFIT PLAN, TO SUBSTITUTE A GENERIC DRUG, WITH THE PRESCRIBING PROVIDER'S APPROVAL AND PATIENT'S CONSENT, FOR A PREVIOUSLY APPROVED BRAND-NAME DRUG.

(7) FOR PURPOSES OF THIS SECTION, A PRIOR AUTHORIZATION REQUEST IS SUBMITTED "ELECTRONICALLY" IF THE PRESCRIBING PROVIDER SUBMITS THE REQUEST TO THE CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM THROUGH A SECURE, WEB-BASED INTERNET PORTAL. A PRIOR AUTHORIZATION REQUEST SUBMITTED BY ELECTRONIC MAIL IS NOT SUBMITTED "ELECTRONICALLY".

(8) AS USED IN THIS SECTION:

(a) "PRESCRIBING PROVIDER" MEANS A PROVIDER WHO IS:

(I) AUTHORIZED BY LAW TO PRESCRIBE ANY DRUG OR DEVICE TO TREAT A MEDICAL CONDITION OF A COVERED PERSON; AND

(II) ACTING WITHIN THE SCOPE OF THAT AUTHORITY.

(b) "URGENT PRIOR AUTHORIZATION REQUEST" MEANS A REQUEST FOR PRIOR AUTHORIZATION OF A DRUG BENEFIT THAT, BASED ON THE REASONABLE OPINION OF THE PRESCRIBING PROVIDER WITH KNOWLEDGE OF THE COVERED PERSON'S MEDICAL CONDITION, IF DETERMINED IN THE TIME ALLOWED FOR NONURGENT PRIOR AUTHORIZATION REQUESTS, COULD:

(I) SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED PERSON OR THE ABILITY OF THE COVERED PERSON TO REGAIN MAXIMUM FUNCTION; OR

(II) SUBJECT THE COVERED PERSON TO SEVERE PAIN THAT CANNOT BE ADEQUATELY MANAGED WITHOUT THE DRUG BENEFIT THAT IS THE SUBJECT OF THE PRIOR AUTHORIZATION REQUEST.

SECTION 3. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the division of insurance cash fund created in section 10-1-103 (3), Colorado Revised Statutes, not otherwise appropriated, to the department of regulatory agencies, for the fiscal year beginning July 1, 2013, the sum of $8,756 and 0.1 FTE, or so much thereof as may be necessary, for allocation to the division of insurance for personal services related to the implementation of this act.

SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: May 15, 2013

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

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These notices, except for the notice found in paragraph 4, shall be provided regardless of whether or not claims are incurred during the three (3) month grace period. The notice in paragraph 4 in Section 5.C. of this regulation must only be provided if claims are incurred during the three (3) month grace period.

D. The carrier must continue to collect advance payments of the premium tax credit on behalf of the policyholder during the three (3) month grace period.

E. The carrier shall return the advance payments of the premium tax credit collected during the second and third month of the three (3) month grace period if all delinquent premium payments have not been received by the end of the third month.

F. If a policyholder receiving APTC does not pay all outstanding premiums during the three (3) month grace period, the carrier must terminate coverage in accordance with §§ 10-16-222, 10-16-325, and 10-16-429, C.R.S.

G. The carrier must receive all past-due premium from the policyholder prior to allowing the policyholder to change to another plan offered by the carrier.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on July 1, 2014.

Section 9 History

New regulation effective July 1, 2014.

Regulation 4-2-49 CONCERNING THE DEVELOPMENT AND IMPLEMENTATION OF A UNIFORM DRUG BENEFIT PRIOR AUTHORIZATION PROCESS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-124.5(3)(a), and 10-16-124.5(3)(c), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements, process, and form to be utilized by carriers and contracted pharmacy benefit management firms for the prior authorization process for prescription drug benefits.

Section 3 Applicability

Except as noted, the provisions of this regulation shall apply to all carriers that market health benefit plans in the state of Colorado which provide prescription drug benefits. The provisions of this regulation do not apply to non-profit health maintenance organizations with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

Section 4 Definitions

A. "Adverse determination" shall have the same meaning as found at § 10-16-113(1)(b), C.R.S.

B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S., and shall, for the purposes of this regulation, include a pharmacy benefit management firm contracted by a carrier.

C. "Drug benefit" means, for the purposes of this regulation, the provision of a drug used to treat a covered medical condition of a covered person.

D. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. "Health Maintenance Organization" shall have the same meaning as found at § 10-16-102(35), C.R.S.

F. "Pharmacy benefit management firm" shall have the same meaning as found at § 10-16-102(49), C.R.S.

G. "Prescribing provider" shall have the same meaning as found at § 10-16-124.5(8)(a), C.R.S.

H. "Urgent prior authorization request" shall have the same meaning as found at § 10-16-124.5(8)(b), C.R.S.

Section 5 Rules

A. Beginning on January 1, 2015, all carriers shall utilize the uniform prior authorization process established by this regulation.

B. A prior authorization process for a drug benefit, as developed by a carrier, shall:

1. Be made available electronically to the prescribing provider;

2. Make the following information available and accessible in a centralized location on the carrier's or its designated pharmacy benefit management firm's website:

a. The prior authorization requirements and restrictions, including, but not limited to:

(1) The prescribing provider's obligation to respond to requests for additional information; and

(2) When requests will be deemed "approved" or "denied";

b. An alphabetical list of drugs, including both brand name and scientific name, that require prior authorization, including the clinical criteria and supporting references that will be used in making a prior authorization determination;

c. Written clinical criteria that include the criteria for reauthorization of a previously approved drug, if applicable, after the previous approval period has expired; and

d. The standard form for prior authorization for a drug benefit, provided in Appendix A of this regulation.

3. Include evidence-based guidelines to be used by the carrier when making prior authorization determinations;

4. Allow for, but not require, the electronic submission of prior authorization requests for a drug benefit to the carrier.

C. Urgent prior authorization requests.

1. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within one (1) business day of receiving an urgent prior authorization request. Carriers shall include appropriate information on the expedited appeals process related to urgent care situations, as found in § 10-16-113, C.R.S., and associated regulations, with any denial of an urgent prior authorization request.

a. If additional information is required to process an urgent prior authorization request, the carrier must advise the prescribing provider of any and all information needed within one (1) business day of receiving the request.

b. If additional information is required to process an urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.

c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the denial within one (1) business day of the date the request was deemed denied.

d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.C.1., of this regulation.

2. If a carrier does not request additional information or provide notification of approval or denial, as required by Section 5.C.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within one (1) business day of date the request was deemed approved.

D. Non-urgent prior authorization requests.

1. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within two (2) business days of receiving a non-urgent prior authorization request that has been submitted through the carrier's electronic pre-authorization system.

   a. If additional information is required, the carrier must advise the prescribing provider of any and all information needed within two (2) business days of receiving the non-urgent prior authorization request.

   b. If additional information is required to process a non-urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.

   c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the denial within two (2) business days of the date the request was deemed denied.

   d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.D.1. or Section 5.D.2., of this regulation, as applicable

2. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within three (3) business days of receiving a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation.

3. If a carrier does not request additional information or provide notification of approval or denial within:

   a. Two (2) business days of the receipt of an electronically filed non-urgent prior authorization request, as required by Section 5.D.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved; or

   b. Three (3) business days of the receipt of a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation, as required by Section 5.D.2., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved.

E. When notifying a prescribing provider of a prior authorization approval, a carrier shall include:

1. A unique prior authorization number attributable only to that drug benefit approval request;

2. Specifications for the particular approved drug benefit, and the source and date of the clinical criteria used to make the determination for each particular drug;

3. The next date for review of the approved drug benefit; and

4. A link to the current criteria that will need to be submitted in order to reapprove the current prior authorization.

F. When notifying a prescribing provider of a prior authorization denial, a carrier shall include a notice to the prescribing provider, and dispensing pharmacy, if provided, that the covered person has the right to appeal the adverse determination pursuant to §§ 10-16-113 and 10-16-113.5, C.R.S.

G. A prior authorization approval is valid for at least one hundred eighty (180) days after the date of approval.

H. If a prior authorization request is submitted electronically, verbally, via facsimile, or electronic mail, the response to that request shall be made through the same medium, or in a manner specifically requested by the provider.

Section 6 Form

Beginning on January 1, 2015, all carriers shall utilize the uniform prior authorization form found in Appendix A of this regulation.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on July 15, 2014.

Section 10 History
New regulation effective July 15, 2014.

APPENDIX A

[CARRIER LOGO]
[CARRIER NAME]

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:
[CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM CONTACT INFORMATION]

☐ **Urgent** [1]	☐ **Non-Urgent**
Requested Drug Name:	

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	☐ New Request ☐ Reauthorization
Patient Diagnosis and ICD Diagnostic Code(s):	
Drug(s) Requested (with J-Code, if applicable):	
Strength/Route/Frequency:	
Unit/Volume of Named Drug(s):	
Start Date and Length of Therapy:	
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:	
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]	
For use in clinical trial? (If yes, provide trial name and registration number):	
Drug Name (Brand Name and Scientific Name)/Strength:	
Dose:	Route: / Frequency:
Quantity:	Number of Refills:
Product will be delivered to: ☐ Patient's Home ☐ Physician Office	☐ Other:
Prescriber or Authorized Signature:	Date:
Dispensing Pharmacy Name and Phone Number:	

☐ **Approved**	☐ **Denied**
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:	

CHAPTER 336–S.F.No. 2974

An act relating to health; amending provisions for electronic health record technology; providing for administrative penalties; defining significant disruption to normal operations; appropriating money; amending Minnesota Statutes 2009 Supplement, sections 62J.495, subdivisions 1a, 3, by adding a subdivision; 62J.497, subdivisions 4, 5; proposing coding for new law in Minnesota Statutes, chapter 62J.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH Act to meet the standards and implementation specifications adopted under section 3004 as applicable.

(b) "Commissioner" means the commissioner of health.

(c) "Pharmaceutical electronic data intermediary" means any entity that provides the infrastructure to connect computer systems or other electronic devices utilized by prescribing practitioners with those used by pharmacies, health plans, third-party administrators, and pharmacy benefit managers in order to facilitate the secure transmission of electronic prescriptions, refill authorization requests, communications, and other prescription-related information between such entities.

(d) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act in division A, title XIII and division B, title IV of the American Recovery and Reinvestment Act of 2009, including federal regulations adopted under that act.

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that meets requirements specified in subdivision 3, and national requirements for certification under the HITECH Act.

(f) "Qualified electronic health record" means an electronic record of health-related information on an individual that includes patient demographic and clinical health information and has the capacity to:

(1) provide clinical decision support;

(2) support physician order entry;

(3) capture and query information relevant to health care quality; and

(4) exchange electronic health information with, and integrate such information from, other sources.

Sec. 2. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be a qualified electronic health record.

(b) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers ~~only~~ if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(c) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(d) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(e) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a state-certified health data intermediary as defined in section 62J.498.

~~(c)~~ (f) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 3. Minnesota Statutes 2009 Supplement, section 62J.495, is amended by adding a subdivision to read:

Subd. 6. **State agency information system.** Development of state agency information systems necessary to implement this section is subject to the authority of the Office of Enterprise Technology in chapter 16E, including, but not limited to:

(1) evaluation and approval of the system as specified in section 16E.03, subdivisions 3 and 4;

(2) review of the system to ensure compliance with security policies, guidelines, and standards as specified in section 16E.03, subdivision 7; and

(3) assurance that the system complies with accessibility standards developed under section 16E.03, subdivision 9.

Sec. 4. Minnesota Statutes 2009 Supplement, section 62J.497, subdivision 4, is amended to read:

Subd. 4. **Development and use of uniform formulary exception form.** (a) The commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, shall develop by July 1, 2009, a uniform formulary exception form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. Upon development of the form, all health care providers must submit

requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers.

(b) No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. ~~Facsimile shall not be considered secure electronic transmissions.~~

Sec. 5. Minnesota Statutes 2009 Supplement, section 62J.497, subdivision 5, is amended to read:

Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, ~~2011~~ 2015, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

Sec. 6. **[62J.498] HEALTH INFORMATION EXCHANGE.**

Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to 62J.4982:

(a) "Clinical transaction" means any meaningful use transaction that is not covered by section 62J.536.

(b) "Commissioner" means the commissioner of health.

(c) "Direct health information exchange" means the electronic transmission of health-related information through a direct connection between the electronic health record systems of health care providers without the use of a health data intermediary.

(d) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(e) "Health data intermediary" means an entity that provides the infrastructure to connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit managers to facilitate the secure transmission of health information, including pharmaceutical electronic data intermediaries as defined in section 62J.495. This does not include health care providers engaged in direct health information exchange.

(f) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(g) "Health information exchange service provider" means a health data intermediary or health information organization that has been issued a certificate of authority by the commissioner under section 62J.4981.

(h) "Health information organization" means an organization that oversees, governs, and facilitates the exchange of health-related information among organizations according to nationally recognized standards.

(i) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.

(j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors of the health information organization.

(k) "Meaningful use" means use of certified electronic health record technology that includes e-prescribing, and is connected in a manner that provides for the electronic exchange of health information and used for the submission of clinical quality measures as established by the Center for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(l) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(m) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization or health data intermediary has contracts or other agreements for the provision of health information exchange service providers:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

(n) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of meaningful use transactions.

(o) "State-certified health data intermediary" means a health data intermediary that:

(1) provides a subset of the meaningful use transaction capabilities necessary for hospitals and providers to achieve meaningful use of electronic health records;

(2) is not exclusively engaged in the exchange of meaningful use transactions covered by section 62J.536; and

(3) has been issued a certificate of authority to operate in Minnesota.

(p) "State-certified health information organization" means a nonprofit health information organization that provides transaction capabilities necessary to fully support clinical transactions required for meaningful use of electronic health records that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from health data intermediaries and health information organizations for certificates of authority to operate in Minnesota;

(2) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(3) respond to public complaints related to health information exchange services;

(4) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(5) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences;

(6) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) hold public hearings that provide an adequate opportunity for participating entities and consumers to provide feedback and recommendations on the application under consideration. The commissioner shall make all portions of the application classified as public data available to the public at least ten days in advance of the hearing. The

applicant shall participate in the hearing by presenting an overview of their application and responding to questions from interested parties;

(2) make available all feedback and recommendations gathered at the hearing available to the public prior to issuing a certificate of authority; and

(3) consult with hospitals, physicians, and other professionals eligible to receive meaningful use incentive payments or subject to penalties as established in the HITECH Act, and their respective statewide associations, prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 7. **[62J.4981] CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.**

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require an entity providing health information exchange services to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information organization whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary that provides health information exchange services for the transmission of one or more clinical transactions necessary for hospitals, providers, or eligible professionals to achieve meaningful use must be registered with the state and comply with requirements established in this section.

(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) interoperate with at least one state-certified health information organization;

(2) provide an option for Minnesota entities to connect to their services through at least one state-certified health information organization;

(3) have a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions; and

(4) hold reciprocal agreements with at least one state-certified health information organization to enable access to record locator services to find patient data, and for the transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services. Reciprocal agreements must meet the requirements established in subdivision 5.

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization that provides all electronic capabilities for the transmission of clinical transactions necessary for meaningful use of electronic health records must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do so may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established, nonprofit organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans clearly address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time;

(4) the entity addresses the parameters to be used with participating entities and other health information organizations for meaningful use transactions, compliance with Minnesota law, and interstate health information exchange in trust agreements;

(5) the entity's board of directors is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with criteria established under the Health Information Exchange Accreditation Program of the Electronic Healthcare Network Accreditation Commission (EHNAC) or equivalent criteria established by the commissioner;

(8) the entity maintains a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the Nationwide Health Information Network (NHIN) within the federally mandated timeline or within a time frame established by the commissioner and published in the State Register. If the state timeline for implementation varies from the federal timeline, the State Register notice shall include an explanation for the variation;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) increasing adoption rates to include a sufficient number of participating entities to achieve financial sustainability; and

(ii) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(3) develop and maintain a business plan that addresses:

(i) plans for ensuring the necessary capacity to support meaningful use transactions;

(ii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iii) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(iv) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(4) annually submit a rate plan to the commissioner outlining fee structures for health information exchange services for approval by the commissioner. The commissioner shall approve the rate plan if it:

(i) distributes costs equitably among users of health information services;

(ii) provides predictable costs for participating entities;

(iii) covers all costs associated with conducting the full range of meaningful use clinical transactions, including access to health information retrieved through other state-certified health information exchange service providers; and

(iv) provides for a predictable revenue stream for the health information organization and generates sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest;

(5) enter into reciprocal agreements with all other state-certified health information organizations to enable access to record locator services to find patient data, and transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services. Reciprocal agreements must meet the requirements in subdivision 5; and

(6) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information exchange service providers.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following:

(1) a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a copy of each contract intended to bind major participating entities and the health information organization. Contract information filed with the commissioner under this section shall be nonpublic as defined in section 13.02, subdivision 9;

(6) a statement generally describing the health information organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(7) financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent certified financial statement;

(8) strategic and operational plans that specifically address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time, a description of

the proposed method of marketing the services, a schedule of proposed charges, and a financial plan that includes a three-year projection of the expenses and income and other sources of future capital;

(9) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(10) a description of the complaint procedures to be used as required under this section;

(11) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(12) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(13) a copy of the conflict of interest policy that applies to all members of the board of directors and the principal officers of the health information organization; and

(14) other information as the commissioner may reasonably require to be provided.

(b) Within 30 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of subdivision 2 for health data intermediaries or subdivision 3 for health information organizations. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a health information organization, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information exchange entities.** (a) Reciprocal agreements between two health information organizations or between a health information organization and a health data intermediary must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of transactions necessary to achieve meaningful use;

(2) does not charge a fee for the exchange of meaningful use transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization or health data intermediary either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization or state-certified health data intermediary from entering into contractual agreements for the provision of value-added services beyond meaningful use.

(e) The commissioner of human services or health, when providing access to data or services through a certified health information organization, must offer the same data or services directly through any certified health information organization at the same pricing, if the health information organization pays for all connection costs to the state data or service. For all external connectivity to the respective agencies through existing or future information exchange implementations, the respective agency shall establish the required connectivity methods as well as protocol standards to be utilized.

Subd. 6. **State participation in health information exchange.** A state agency that connects to a health information exchange service provider for the purpose of exchanging meaningful use transactions must ensure that the contracted health information exchange service provider has reciprocal agreements in place as required by this section. The reciprocal agreements must provide equal access to information supplied by the agency as necessary for meaningful use by the participating entities of the other health information service providers.

Sec. 8. **[62J.4982] ENFORCEMENT AUTHORITY; COMPLIANCE.**

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information exchange service provider, levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization or a health data intermediary by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information exchange service provider;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information exchange service provider attempted to correct previous violations;

(11) how the health information exchange service provider responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information exchange service provider including, but not limited to, whether the health information exchange service provider had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information exchange service provider to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information exchange service provider of the intent to levy the penalty and the reasons for them. A health information exchange service provider may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information exchange service provider and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information exchange service provider or a representative of a health information exchange service provider to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information exchange service provider may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a health data intermediary or health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information exchange service provider is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information exchange service provider is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information exchange service provider is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information exchange service provider has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information exchange service provider, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information exchange service provider would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information exchange service provider has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information exchange service provider is suspended, the health information exchange service provider shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information exchange service provider is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information exchange service provider in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information exchange service provider may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information exchange service provider to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information exchange service provider.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information exchange service provider written notice of

the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information exchange service provider's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** (a) The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information exchange service providers when implementing sections 62J.498 to 62J.4982.

(b) By January 1, 2011, the commissioner shall report to the governor and the chairs of the senate and house of representatives committees having jurisdiction over health information policy issues on the status of health information exchange in Minnesota, and provide recommendations on further action necessary to facilitate the secure electronic movement of health information among health providers that will enable Minnesota providers and hospitals to meet meaningful use exchange requirements.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information exchange service provider subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $10,500;

(2) filing an application for certificate of authority to operate as a health data intermediary, $7,000;

(3) annual health information organization certificate fee, $14,000;

(4) annual health data intermediary certificate fee, $7,000; and

(5) fees for other filings, as specified by rule.

(b) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 9. **FEDERAL FUNDING.**

To the extent that the commissioner of health applies for additional federal funding to support the commissioner's responsibilities of developing and maintaining state-level health information exchange under section 3013 of the HITECH Act, the commissioner of

health shall ensure that applications are made through an open process that provides health information exchange service providers equal opportunity to receive funding.

Sec. 10. **NONSUBMISSION OF HEALTH CARE CLAIM BY CLEARINGHOUSE; SIGNIFICANT DISRUPTION.**

A situation shall be considered a significant disruption to normal operations that materially affects the provider's or facility's ability to conduct business in a normal manner and to submit claims on a timely basis under Minnesota Statutes, section 62Q.75, if:

(1) a clearinghouse loses, or otherwise does not submit, a health care claim as required by Minnesota Statutes, section 62J.536; and

(2) the provider or facility can substantiate that it submitted a complete claim to the clearinghouse within provisions stated in contract or six months of the date of service, whichever is less.

This section expires January 1, 2012.

Sec. 11. **APPROPRIATION; HEALTH INFORMATION EXCHANGE OVERSIGHT.**

$104,000 in fiscal year 2011 is appropriated from the state government special revenue fund to the commissioner of health for the duties required under Minnesota Statutes, sections 62J.498 to 62J.4982. Base funding shall be $97,000 in fiscal year 2012 and $97,000 in fiscal year 2013.

Presented to the governor May 11, 2010

Signed by the governor May 13, 2010, 10:10 a.m.

2015 ORS § 743.035[1]

Uniform prior authorization form for prescription drug benefits

- **consultation with Oregon Health Authority**
- **rules**

(1) The Department of Consumer and Business Services, in consultation with the Oregon Health Authority, shall develop by rule a form that providers in this state shall use to request prior authorization for prescription drug benefits. The form must:

(a) Be uniform for all providers;

(b) Not exceed two pages;

(c) Be electronically available and transmissible; **and**

(d) Include a provision under which additional information may be requested and provided.

(2) If a person described in ORS 743.029 (Uniform standards for health care financial and administrative transactions) (2) requires prior authorization for prescription drug benefits, the person must allow the use of the form developed under subsection (1) of this section.

(3) An insurer meets the requirement set forth in ORS 743B.423 (Utilization review requirements for insurers offering health benefit plan) (2)(d) if the insurer answers a providers request for prior authorization within two business days of having received a completed form developed under subsection (1) of this section and all supporting documentation needed to process the request.

(4) The department may adopt rules to implement this section. [Formerly 743.065]

Note: 743.035 (Uniform prior authorization form for prescription drug benefits) was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

• • •

(No annotations for this section.)

Related Statutes[3]

- 743B.001
  Definitions

[1] Legislative Counsel Committee, *CHAPTER 743—Health and Life Insurance*, https://www.oregonlegislature.gov/bills_laws/ors/ors743.html (2015) (last accessed Jul. 16, 2016).

[2] OregonLaws.org contains the contents of Volume 21 of the ORS, inserted alongside the pertinent statutes. See the preface to the ORS Annotations for more information.

[3] OregonLaws.org assembles these lists by analyzing references between Sections. Each listed item refers back to the current Section in its own text. The result reveals relationships in the code that may not have otherwise been apparent.

by Robb Shecter, robb@oregonlaws.org
www.oregonlaws.org

(8) An insurer may not impose a restriction or condition on its prior authorization determinations that limits, restricts or effectively eliminates the binding force established for such determinations in ORS 743.837 and this rule.

(9) When an insurer answers requests by providers for prior authorization of nonemergency services as required by ORS 743.807(2)(d), the answer to a request by a provider for prior authorization of nonemergency services must be one of the following:

(a) The requested service is authorized.

(b) The requested service is not authorized.

(c) The entire requested service is not authorized, but a specified portion of the requested service or a specified alternative service is authorized.

(d) The requested service is not authorized because the insurer needs additional specified information in order to make a decision on the request.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 743.837 & 743.807
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

836-053-1205

Uniform Prescription Drug Prior Authorization Request Form

(1) As used in this rule:

(a) “Material information” means information that is:

(A) Related to the patient’s clinical condition sufficient to enable an individual with the appropriate training and experience to determine whether the prescription authorization request should be approved or disapproved; or

(B) Required by state or federal law for dispensing restricted prescription drugs.

(b) “Payer” means a person described in ORS 743.061(2) that requires prior authorization for prescription drug benefits.

(c) “Request form” means the Uniform Prescription Drug Prior Authorization Request Form set forth in Exhibit A of this rule.

(2) Any payer that requires prior authorization for a prescription drug benefit must accept a request for prior authorization for a prescription drug on the request form. A payer also may accept a prescription drug prior authorization request submitted on a form other than the request form.

(3)(a) On or before July 1, 2015, a payer shall make the request form electronically available on their websites.

(b) On and after July 1, 2015, a payer shall:

(A) Accept the request form through any reasonable means of transmission, including but not limited to paper, electronic, or another mutually agreeable accessible method of transmission or using an internet or web-based system.

(B) Request from the prescribing provider only the minimum amount of material information necessary to approve or disapprove the prescription drug prior authorization request.

(C) Notify the prescribing provider within two business days after receipt of a completed request form that:

(i) The prescribing provider’s request is approved;

(ii) The prescribing provider’s request is disapproved as not medically necessary or not a covered benefit;

(iii) The prescribing provider’s request is missing material information necessary to approve or disapprove the request; or

(iv) The patient is no longer eligible for coverage.

(4) A payer shall deliver any notice to a prescribing provider required under section (3) of this rule in the same manner the provider submitted the request form, or another mutually agreeable accessible method of notification.

(5) If a provider requests prescription drug prior authorization telephonically, through a web portal, or by any other manner of transmission, the payer may not require the prescribing provider to provide more information than is required by the request form.

(6) If a payer disapproves a prescribing provider's prior authorization request:

(a) Pursuant to paragraph (3)(b)(C))(ii) or (iii), the payer shall include in the notice of disapproval an accurate and clear written explanation of the specific reasons for disapproving the prior authorization request.

(b) Pursuant to paragraph (3)(b)(C)(iii), the payer also shall include in the notice of disapproval an accurate and clear written explanation that specifically identifies the missing material information that is necessary to approve or disapprove the prior authorization request.

(7) Every payer that conducts prescription drug prior authorizations shall have written policies and procedures in place to ensure that the payer complies with the requirements of ORS 743.065 and this rule.

(8) Requiring information in excess of the minimum material information specified by the request form shall constitute a failure to accept the request form, in violation of section (2) of this rule. A payer may not disapprove a request form on grounds of missing information under paragraph (3)(b)(C)(iii) of this rule if the form provides the minimum amount of material information in accordance with subsection (3)(b)(B) of this rule.

Stat. Auth.: ORS 731.244, 743.065
Stats. Implemented: ORS 743.065
Hist.: ID 4-2015, f. & cert. ef. 5-27-15

External Review

836-053-1300

Purpose and Scope; Application

(1) OAR 836-053-1300 to 836-053-1365 are adopted by the Director of the Department of Consumer and Business Services to implement ORS 743.857 to 743.862, governing the Director's contracting with independent review organizations for the purpose of resolving disputes relating to adverse decisions by insurers in one or more of the issues specified in 743.857.

(2) OAR 836-053-1300 to 836-053-1365 are operative with respect to disputes for which the initial grievance is filed on or after July 1, 2002 under health benefit plans in existence, issued or renewed on or after July 1, 2002.

Stat. Auth.: ORS 731.244 & 743.858 - 743.862
Stats. Implemented: ORS 743.857 - 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1305

Definitions; Authority to Act for Enrollee

(1) As used in OAR 836-053-1300 to 836-053-1365, "medical reviewer" means any of the following persons who is assigned to an independent review case by an independent review organization:

(a) A doctor of medicine or osteopathy licensed under ORS Chapter 677 or under the laws of another state.

(b) A provider as defined in ORS 743.801.

(c) A health care professional licensed, certified or otherwise authorized or permitted by the laws of another state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(2) An action that may be taken by an enrollee under ORS 743.857 to 743.862 or under OAR 836-053-1300 to 836-053-1365 may be taken on behalf of the enrollee by a representative of the enrollee.

Stat. Auth.: ORS 731.244 & 743.858 - 743.862
Stats. Implemented: ORS 743.857 - 743.862
Hist.: ID 10-2002(Temp), f. & cert. ef. 4-5-02 thru 9-27-02; ID 19-2002, f. 9-27-02, cert. ef. 9-28-02

836-053-1310

Contracting Requirements

(1) To be considered for contracting with the Director of the Department of Consumer and Business Services as an independent review organization under ORS 743.858 for the purpose of providing independent review under ORS 743.857, an independent review organization must submit to the director a response to the director's request for proposal according to its requirements. The response must include:

2011 California Code
Insurance Code
DIVISION 2. CLASSES OF INSURANCE [1880 - 12865]
ARTICLE 1. General Provisions
Section 10123.191

Universal Citation: CA Ins Code § 10123.191 (through 2012 Leg Sess)

(a) Notwithstanding any other provision of law, on and after January 1, 2013, a health insurer that provides prescription drug benefits shall utilize and accept only the prior authorization form developed pursuant to subdivision (c) when requiring prior authorization for prescription drug benefits.

(b) If a health insurer fails to utilize or accept the prior authorization form, or fails to respond within two business days upon receipt of a completed prior authorization request from a prescribing provider, pursuant to the submission of the prior authorization form developed as described in subdivision (c), the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.91 (commencing with Section 14089), or Chapter 8 (commencing with Section 14200) of the Welfare and Institutions Code.

(c) On or before July 1, 2012, the department and the Department of Managed Health Care shall jointly develop a uniform prior authorization form. Notwithstanding any other provision of law, on and after January 1, 2013, or six months after the form is developed, whichever is later, every prescribing provider shall use that uniform prior authorization form to request prior authorization for coverage of prescription drug benefits and that every health insurer shall accept that form as sufficient to request prior authorization for prescription drug benefits.

(d) The prior authorization form developed pursuant to subdivision (c) shall meet the following criteria:

(1) The form shall not exceed two pages.

(2) The form shall be made electronically available by the department and the health insurer.

the health insurer.

(4) The department and the Department of Managed Health Care shall develop the form with input from interested parties from at least one public meeting.

(5) The department and the Department of Managed Health Care, in development of the standardized form, shall take into consideration the following:

(A) Existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(B) National standards pertaining to electronic prior authorization.

(e) For purposes of this section, a prescribing provider shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an insured.

(Added by Stats. 2011, Ch. 648, Sec. 2. Effective January 1, 2012.)

§ 2218.30. Prescription Drug Prior Authorization Requests; Form and Procedure.
10 CA ADC § 2218.30
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 2. Policy Forms and Other Documents
Article 1.2. Prescription Drug Prior Authorization Requests

10 CCR § 2218.30

§ 2218.30. Prescription Drug Prior Authorization Requests; Form and Procedure.

(a) Definitions. The following definitions shall apply to this section:

(1) “Request Form” means the Prescription Drug Prior Authorization Request Form set forth in subdivision (j) of this section.

(2) “Material information” means information that is:

(A) related to the patient's clinical condition sufficient to enable an individual with the appropriate training and experience to determine whether the prescription authorization request should be approved or disapproved; or

(B) required by state or federal law for dispensing restricted prescription drugs.

(b) Health insurers that utilize a prior authorization process for prescription drug benefits shall utilize only the Request Form. Health insurers shall not utilize or accept any prescription drug prior authorization form other than the Request Form.

(c) On or before October 1, 2014, health insurers shall do the following:

(1) Make the Request Form electronically available on their websites.

(2) Accept the Request Form through any reasonable means of transmission, including, but not limited to, paper, electronic, or another mutually agreeable accessible method of transmission.

(3) Request from the prescribing provider only the minimum amount of material information necessary to approve or disapprove the prescription drug prior authorization request.

(4) Notify the prescribing provider within two business days of receipt of a completed Request Form that:

(A) The prescribing provider's request is approved;

(B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit;

(C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the request;

(D) The patient is no longer eligible for coverage; or

(E) The request was not submitted on the required form, and must be resubmitted using the approved Request Form.

(d) Notices to the prescribing provider required under this section shall be delivered in the same manner as the Request Form was submitted, or another mutually agreeable accessible method of notification.

(e) Prescription drug prior authorization procedures conducted telephonically, through a web portal, or any other manner of transmission, shall not require the prescribing provider to provide more information than is required by the Request Form.

(f) In the event that the prescribing provider's prior authorization request is disapproved:

(1) Pursuant to subparagraph (c)(4)(B) or (c)(4)(C), the notice of disapproval shall contain an accurate and clear written explanation of the specific reasons for disapproving the prior authorization request.

(2) Pursuant to subparagraph (c)(4)(C), the notice of disapproval shall contain an accurate and clear written explanation that specifically identifies the missing material information that is necessary to approve or disapprove the prior authorization request.

(g) In the event that the notice of disapproval is not sent to the prescribing provider within two business days of receipt of a completed Request Form, or if a health insurer or its third party administrator either fails to utilize only the Request Form, or accepts any prescription drug prior authorization form other than the Request Form, the prescription drug prior authorization request shall be deemed approved.

(h) If a health insurer contracts with a third party administrator to conduct prior prescription authorization services, failure by the third party administrator to comply with the requirements of this section or of Insurance Code section 10123.191 shall subject the health insurer to the remedies available under Insurance Code section 10123.191 and this regulation.

(i) Review and Enforcement.

(1) Every health insurer that contracts with a third party administrator to conduct prior prescription authorization services shall include a provision in its contract with the third party administrator requiring the third party administrator to comply with the requirements of Insurance Code section 10123.191 and this regulation.

(2) Every health insurer, and any third party administrator that conducts prescription drug prior authorizations shall have written policies and procedures in place to ensure that the insurer and its contracting entities comply with the requirements of Insurance Code section 10123.191 and this regulation.

(3) Utilizing or accepting a drug specific form other than the Request Form shall constitute a violation of subdivision (b).

(4) Requiring information in excess of the minimum material information specified by the Request Form shall constitute a failure to utilize only the Request Form, in violation of subdivision (b). An insurer may not disapprove a Request Form on grounds of missing information pursuant to subparagraph (c)(4)(C) if the form provides the minimum amount of material information pursuant to paragraph (c)(3).

(j) Prescription Drug Prior Authorization Request Form.

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#:** (_____)_____
Plan/Medical Group Fax#: (_____)_____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth: ☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:	
Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:		

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):	Office Contact Person:		
NPI Number (individual):	Phone Number:		
DEA Number (if required):	Fax Number (in HIPAA compliant area):		
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

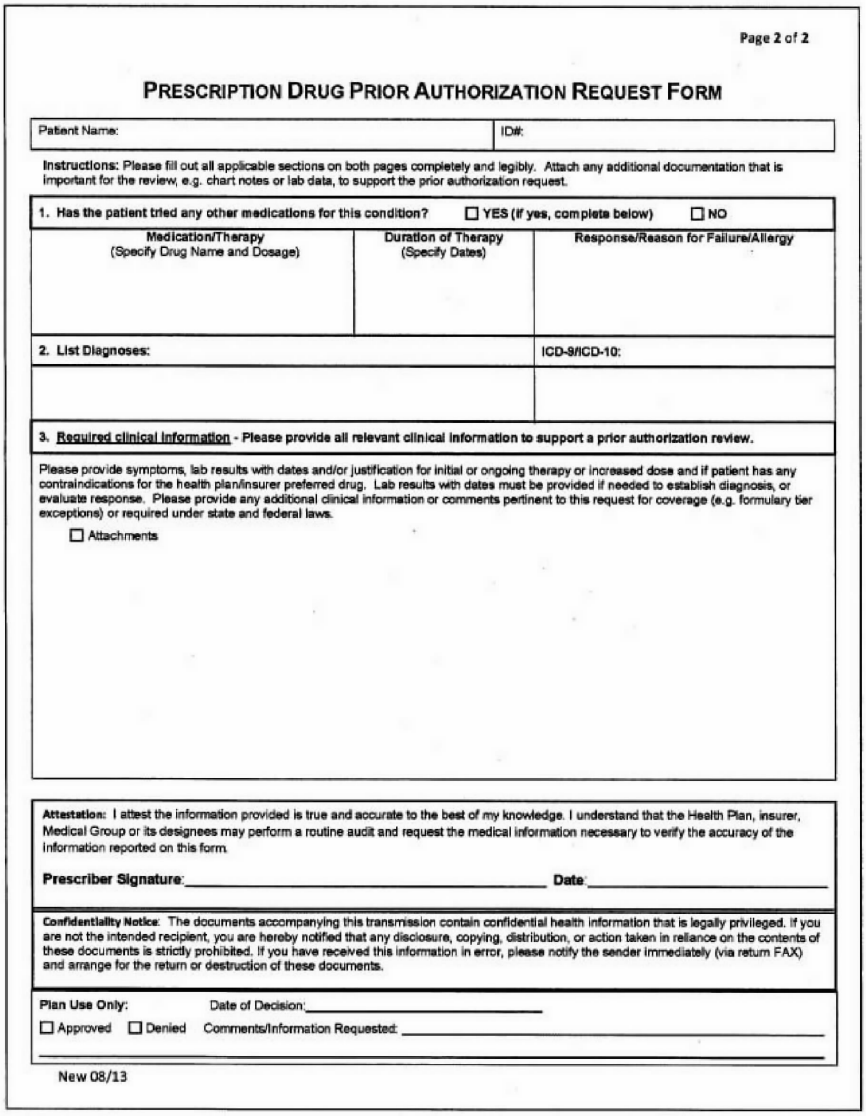
How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (If known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:		
☐ Physician's Office	☐ Patient's Home	☐ Long Term Care
☐ Ambulatory Infusion Center	☐ Home Care Agency	☐ Other (explain):_____
	☐ Outpatient Hospital Care	

New 08/13



Page 2 of 2

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (If yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses:	ICD-9/ICD-10:

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

New 08/13

Note: Authority cited: Section 10123.191, Insurance Code. Reference: Section 10123.191, Insurance Code.

HISTORY

1. New article 1.2 (section 2218.30) and section filed 2-25-2014; operative 4-1-2014 (Register 2014, No. 9).

This database is current through 8/5/16 Register 2016, No. 32

10 CCR § 2218.30, 10 CA ADC § 2218.30

END OF DOCUMENT

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Section 504.314, Transportation Code, is amended to read as follows:

Sec. 504.314. ENDURING FREEDOM VETERANS. *(a)* The department shall issue specialty license plates for persons who served in the United States armed services and participated in Operation Enduring Freedom. The license plates must include the words "Enduring Freedom."

(b) The department shall issue specialty license plates for persons who served in the United States armed services and participated in Operation Enduring Freedom in Afghanistan. The license plates must include the words "Enduring Freedom Afghanistan."

SECTION 2. This Act takes effect September 1, 2013.

Passed the Senate on April 4, 2013: Yeas 31, Nays 0; passed the House on May 22, 2013: Yeas 148, Nays 0, two present not voting.

Approved June 14, 2013.

Effective September 1, 2013.

CHAPTER 1328

S.B. No. 644

AN ACT

relating to the creation of a standard request form for prior authorization of prescription drug benefits.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Chapter 1369, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. STANDARD REQUEST FORM FOR PRIOR AUTHORIZATION OF PRESCRIPTION DRUG BENEFITS

Sec. 1369.251. DEFINITION. In this subchapter, "prescription drug" has the meaning assigned by Section 551.003, Occupations Code.

Sec. 1369.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(d) Notwithstanding any other law, this subchapter applies to coverage under:

(1) the child health plan program under Chapter 62, Health and Safety Code, or the health benefits plan for children under Chapter 63, Health and Safety Code; and

(2) the medical assistance program under Chapter 32, Human Resources Code.

Sec. 1369.253. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) medical payment insurance coverage provided under a motor vehicle insurance policy;

(4) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.252;

(5) health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code; or

(6) a workers' compensation insurance policy.

Sec. 1369.254. STANDARD FORM. (a) The commissioner by rule shall:

(1) prescribe a single, standard form for requesting prior authorization of prescription drug benefits;

(2) require a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits to use the form for any prior authorization of prescription drug benefits required by the plan;

(3) require that the department and a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits make the form available electronically on the website of:

(A) the department;

(B) the health benefit plan issuer; and

(C) the agent of the health benefit plan issuer; and

(4) establish penalties for failure to accept the form and acknowledge receipt of the form as required by commissioner rule.

(b) Not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted, a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits shall exchange prior authorization requests electronically with a prescribing provider who has e-prescribing capability and who initiates a request electronically.

(c) In prescribing a form under this section, the commissioner shall:

(1) develop the form with input from the advisory committee on uniform prior authorization forms established under Section 1369.255; and

(2) take into consideration:

(A) any form for requesting prior authorization of benefits that is widely used in this state or any form currently used by the department;

(B) request forms for prior authorization of benefits established by the federal Centers for Medicare and Medicaid Services; and

(C) national standards, or draft standards, pertaining to electronic prior authorization of benefits.

Sec. 1369.255. ADVISORY COMMITTEE ON UNIFORM PRIOR AUTHORIZATION FORMS. (a) The commissioner shall appoint a committee to advise the commissioner on the technical, operational, and practical aspects of developing the single, standard prior authorization form required under Section 1369.254 for requesting prior authorization of prescription drug benefits.

(b) The advisory committee shall determine the following:

(1) a single standard form for requesting prior authorization of prescription drug benefits;

(2) the length of the standard prior authorization form;

(3) the length of time allowed for acknowledgement of receipt of the form by the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits;

(4) the acceptable methods to acknowledge receipt; and

(5) the penalty imposed on the health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits for failure to acknowledge receipt of the form.

(c) The commissioner shall consult the advisory committee with respect to any rule relating to a subject described by Section 1369.254 or this section before adopting the rule and may consult the committee as needed with respect to a subsequent amendment of an adopted rule.

(d) Not later than the second anniversary of the final approval of the standard prior authorization form, and every two years subsequently, the commissioner shall convene the advisory committee to review the standard prior authorization form, examine the form's effectiveness and impact on patient safety, and determine whether changes are needed.

(e) The advisory committee shall be composed of the commissioner of insurance or the commissioner's designee, the executive commissioner of the Health and Human Services Commission or the executive commissioner's designee, and an equal number of members from each of the following groups:

(1) physicians;

(2) other prescribing health care providers;

(3) consumers experienced with prior authorizations;

(4) hospitals;

(5) pharmacists;

(6) specialty pharmacies;

(7) pharmacy benefit managers;

(8) specialty drug distributors;

(9) health benefit plan issuers for the Texas Health Insurance Pool established under Chapter 1506;

(10) health benefit plan issuers; and

(11) health benefit plan networks of providers.

(f) A member of the advisory committee serves without compensation.

(g) Section 39.003(a) of this code and Chapter 2110, Government Code, do not apply to the advisory committee.

Sec. 1369.256. FAILURE TO USE OR ACKNOWLEDGE STANDARD FORM. If a health benefit plan issuer or the agent of the health benefit plan issuer that manages or administers prescription drug benefits fails to use or accept the form prescribed under this subchapter or fails to acknowledge the receipt of a completed form submitted by a prescribing provider, as required by commissioner rule, the health benefit plan issuer or the agent of the health benefit plan issuer is subject to the penalties established by the commissioner.

SECTION 2. Not later than January 1, 2015, the commissioner of insurance by rule shall prescribe a standard form under Section 1369.254, Insurance Code, as added by this Act.

SECTION 3. The change in law made by this Act applies only to a request for prior authorization of prescription drug benefits made on or after September 1, 2015. A request for prior authorization of prescription drug benefits made before September 1, 2015, under a health benefit plan delivered, issued for delivery, or renewed before that date is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 4. This Act takes effect September 1, 2013.

Passed the Senate on May 2, 2013: Yeas 31, Nays 0; the Senate concurred in House amendments on May 24, 2013: Yeas 31, Nays 0; passed the House, with amendments, on May 21, 2013: Yeas 132, Nays 15, two present not voting.

Approved June 14, 2013.

Effective September 1, 2013.

CHAPTER 1329

S.B. No. 656

AN ACT

relating to providing transparency in the budget adoption process of municipalities and counties.

Be it enacted by the Legislature of the State of Texas:

SECTION 1. Section 102.007, Local Government Code, is amended by amending Subsection (a) and adding Subsections (d) and (e) to read as follows:

(a) At the conclusion of the public hearing, the governing body of the municipality shall take action on the proposed budget. *A vote to adopt the budget must be a record vote.*

(d) An adopted budget must contain a cover page that includes:

(1) one of the following statements in 18-point or larger type that accurately describes the adopted budget:

(A) "This budget will raise more revenue from property taxes than last year's budget by an amount of (insert total dollar amount of increase), which is a (insert percentage increase) percent increase from last year's budget. The property tax revenue to be raised from new property added to the tax roll this year is (insert amount computed by multiplying the proposed tax rate by the value of new property added to the roll).";

(B) "This budget will raise less revenue from property taxes than last year's budget by an amount of (insert total dollar amount of decrease), which is a (insert percentage decrease) percent decrease from last year's budget. The property tax revenue to be raised from new property added to the tax roll this year is (insert amount computed by multiplying the proposed tax rate by the value of new property added to the roll)."; or

(C) "This budget will raise the same amount of revenue from property taxes as last year's budget. The property tax revenue to be raised from new property added to the tax roll this year is (insert amount computed by multiplying the proposed tax rate by the value of new property added to the roll).";

(2) the record vote of each member of the governing body by name voting on the adoption of the budget;

DIVISION 3. Texas Standard Prior Authorization Request Form for Prescription Drug Benefits.

§19.1820. Prior Authorization Request Form for Prescription Drug Benefits, Required Acceptance, and Use.

(a) Form requirements. The commissioner adopts by reference the Prior Authorization Request Form for Prescription Drug Benefits form, to be accepted and used by an issuer in compliance with subsection (b) of this section. The form and its instruction sheet are on TDI's website at www.tdi.texas.gov/forms/form10.html; or the form and its instruction sheet can be requested by mail from the Texas Department of Insurance, Rate and Form Review Office, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104. The form must be reproduced without changes. The form provides space for the following information:

(1) the name of the issuer or the issuer's agent that manages prescription drug benefits, telephone number, and facsimile (fax) number;

(2) the date the request is submitted;

(3) a place to request an expedited or urgent review if the prescriber or the prescriber's designee certifies that applying the standard review time frame may

seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function;

(4) the patient's name, contact telephone number, date of birth, sex, address, identifying insurance information, and, if available, BIN, PCN, and pharmacy ID numbers;

(5) the requesting prescriber's name, NPI number, specialty, telephone and fax numbers, address, and contact person's name and telephone number;

(6) for a prescription drug, its -

(A) name;

(B) strength;

(C) route of administration;

(D) quantity;

(E) number of days' supply;

(F) expected therapy duration; and

(G) whether the medication is:

(i) a new therapy; or

(ii) continuation of therapy, and if so, the approximate date therapy was initiated;

(7) for a provider administered drug, the HCPCS code, NDC number, and dose per administration;

(8) for a prescription compound drug, its name, ingredients, and each ingredient's NDC number and quantity;

(9) for a prescription device, its name, expected duration of use, and if applicable, its HCPCS code;

(10) the patient's clinical information, including:

(A) diagnosis, ICD version number (if more than one version is allowed by the U.S. Department of Health and Human Services), and ICD code;

(B) to the best of the prescriber's knowledge, the drugs the patient has taken for this diagnosis, including:

(i) drug name, strength, and frequency;

(ii) the approximate dates or duration the drugs were taken;

(iii) patient's response, reason for failure, or allergic reaction;

(C) the patient's drug allergies, if any; and

(D) the patient's height and weight, if relevant;

(11) a list of relevant lab tests, and their dates and values; and

(12) a place for the requester to:

(A) include pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency;

(B) explain any comorbid conditions and contraindications for formulary drugs; or

(C) provide details regarding titration regimen or oncology staging, if applicable.

(13) A requesting provider or facility may also attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.).

(b) Acceptance and use of the form.

(1) If a provider submits the form to request prior authorization of a prescription drug benefit for which the issuer's plan requires prior authorization, the issuer must accept and use the form for that purpose. An issuer may also have on its website another electronic process a provider or facility may use to request prior authorization of a prescription drug benefit.

(2) This form may be used by a provider to request prior authorization of:

(A) a prescription drug;

(B) a prescription device;

(C) formulary exceptions;

(D) quantity limit overrides; and

(E) step-therapy requirement exceptions.

(3) This form may not be used by a provider to:

(A) request an appeal;

(B) confirm eligibility;

(C) verify coverage;

(D) ask whether a prescription drug or device requires prior authorization; or

(E) request prior authorization of a health care service.

(c) Effective date. An issuer must accept a request for prior authorization of health care services made by a provider or facility using the form on or after September 1, 2015.

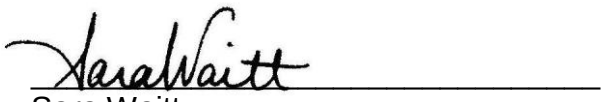
(d) Availability of the form.

(1) A health benefit plan issuer must make the form available electronically on its website.

(2) A health benefit plan issuer's agent that manages or administers prescription drug benefits must make the form available electronically on its website.

10. CERTIFICATION. TDI certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on December 9. 2014



Sara Waitt
General Counsel
Texas Department of Insurance

Appendix C: Materials from Stakeholder Input Meetings

New Hampshire Insurance Department

Standardized Prescription Drug Prior Authorization

Stakeholder Work Group Meeting 1

August 1, 2016

Agenda

Welcome and Introductions

Background

PCG's Role

- Research best practices
- Facilitate stakeholder input process
- Draft report on research findings and stakeholder input
- Draft rules, including form and electronic standard
- Support rule-making process

Background

HB 1608

- Passed in 2016
- Requires HMOs, PPOs and other insurers in New Hampshire to use a uniform prior authorization **paper form** *or* **electronic standards** developed by NHID and adopted via rules
  - Form must be no more than 2 pages
  - Requires opportunities for stakeholder input
- Carriers / PBMs may not require use of electronic prior authorization in enumerated situations
- Sets forth broad timeline for adoption and implementation (slides 8 and 9)

Expected Process

Activity		Date (Approximate)
Report on best practices and stakeholder input	Work Group Meeting: Background and initial feedback	8/1/2016
	Work Group Meeting: Review of and feedback on initial findings and intended direction	8/11/2016
	Report completed	9/1/2016

Expected Process

Best Practices and Stakeholder Input: Research Sources

- States that have adopted similar requirements: MA, MN, OR, CO, CA, TX
- States that are pursuing similar requirements: NJ, NY
- Current carrier forms and NH Medicaid forms
- National standards
  - National Council for Prescription Drug Programs
  - American Medical Association
  - Maryland Health Care Commission
  - Medicare form

Expected Process

Activity		Date (Approximate)
Draft Rules	Draft form and electronic standard	September
	Collect Preliminary stakeholder input via comments and / or work group meeting (tentative)	September
Formal Rule Making Process	Public Hearings and Comment Period	October / November
	Submit Rules to JLCAR	December (tentative)
	Rules to be adopted	March

Expected Process

Activity		Date (Approximate)
Implementation	Insurers **may** use the standard prior authorization paper form or electronic standards	Beginning 7/1/2017
	Insurers **must** use the standard prior authorization paper form or electronic standards.	Beginning 12/31/2017

Work Group Feedback and Comments

Next Steps

- Next Meeting: Thursday, August 11th at 10am (NHID Room 274)
- Key Contacts
  - NHID: Maureen Mustard
    - Maureen.Mustard@ins.nh.gov
    - 715-6702
  - PCG: Lisa Kaplan Howe
    - lkaplanhowe@pcgus.com
    - 860-7851

Standardized Rx Prior Authorization Stakeholder Work Group Meeting 1
August 1, 2016

NHID Presentation

- Opening by Tyler Brennan
  - Provided overview of the work group
  - Introduced NHID and PCG staff
- Slide presentation by Lisa Kaplan Howe
  - Provided overview of:
    - HB 1608
    - Intended process
    - Research sources

Stakeholder Questions and Input

- Will the form be open to changes until the regulations are adopted?
  - NHID: The form is treated as part of the rules. Until the completion date, the form can be changed.

- Will the form exclude certain drug categories?
  - NHID: We would have to take another look at the statute to see if it allows us that flexibility and see if doing so makes sense.
  - NH Medical Society: Statute allows for multiple forms.

- CoverMyMeds has given a lot of input through the Massachusetts (MA) process and is in full support of adopting that form.

- Harvard Pilgrim has also been very engaged in MA process. It was a long process with many iterations of the form and the form is as good as it is going to get.
  - We have some concerns about implementation and how it will work in practice (versus specifics of form).
  - Do not believe the MA form conflicts at all with the NH law.
  - NH allows for exemptions for electronic submissions. MA does not.

- HPHC: Massachusetts has unique forms for certain high price drugs. Three forms total. Doing so allowed form to be kept to 2 pages while getting drug-specific information. That is important.

- CVS: The fact that this will be the only form that can be accepted may be an issue. We want to ensure that a prescriber can submit all the necessary data on a different form without it being rejected (same content / different form).
  - This was clarified in CA rule-making.

- Tufts: Will NH allow for a follow up instead of a rejection/denial? And can we ask for more information?
    - Tyler: That is a good recommendation.

- Tufts: There is a potential for confusion if the forms vary between NH and MA. Patient may live in NH but have coverage through a MA employer. NH form should be as close to MA form as possible.
    - CoverMyMeds: This is an advantage of electronic prior authorization (ePA). Once the information is entered the system will bring up the proper form based on the benefits that were entered into the system. It will result in a faster turnaround for the providers.

- NH Medical Society, Tufts, HPHC: support use of MA form.
    - Standards should be high for varying from MA form in order to promote uniformity.

- HPHC: Provider education will be critical to end-run confusion.
    - Education is being planned in MA though not addressed in bulletin.
    - Tufts: in MA, carrier had to do education but that did not happen.
    - NH Medical Society: We can help.

New Hampshire Insurance Department

Standardized Prescription Drug Prior Authorization

Stakeholder Work Group Meeting 2

August 11, 2016

Agenda

Topic	Slide(s)
I. Introductions and Recap of Meeting 1	3-4
II. Form	5-17
A. Research Findings	5-10
B. Preliminary Direction	11-16
C. Feedback	17
III. Regulations	18-20
A. Research Findings	18
B. Preliminary Direction	19
C. Feedback	20
IV. Next Steps	21-22

Introductions and Recap of Meeting 1

Recap of Meeting 1

Reminder of Research Sources

- States that have adopted similar requirements: MA, MN, OR, CO, CA, TX
- States that are pursuing similar requirements: NJ, NY
- Current carrier forms and NH Medicaid forms
- National standards
  - National Council for Prescription Drug Programs
  - American Medical Association
  - Maryland Health Care Commission
  - Medicare forms

Form: Research Findings

Forms: Predominant Themes

- Information about Carrier / PBM
  - Name
  - Phone
  - Fax
- Information about Patient
  - Name
  - Member ID#
  - Date of birth
- Information about Prescriber
  - Name
  - Phone
  - Fax
  - NPI #
  - Point of contact with contact information

Form: Research Findings

Forms: Predominant Themes

- Information about Medication
  - Medication name
  - Strength
  - Quantity
  - Frequency
  - Length of therapy
  - Start date / whether it is a new request
- Information about Diagnosis / Health
  - Diagnosis / ICD codes
  - Basic health information (allergies, height, weight)
  - Rationale for the request (therapies previously tried, lab results and other clinical information / data)
- Other
  - Designating urgent requests

Form: Research Findings

Forms: Areas of Variation

Format	MA Form
Vary by drug?	As reported
Writable (carrier info, generally)	Unknown
Include instructions	Unknown

Form: Research Findings

Forms: Areas of Variation

Category	Content	MA Form
Carrier Information	Additional contact info (address, website, contact, email, other)	No
Patient Information	Gender	Yes
	Contact information (phone, address, email)	No
	Additional insurance info (identifiers, secondary coverage)	No
	Authorized representative	No
Prescriber Information	Specialty	Yes
	DEA #	Yes
	Licensure, carrier, TIN #	No
	Additional contact info (address, facility, email, pager)	No
	Signature	Yes

Form: Research Findings

Forms: Areas of Variation

Category	Content	MA Form
Medication Information	Questions specific to types of drugs: compound drugs; off-label drugs; provider-administered drugs	Yes
	Questions specific to clinical trials	No
	Question re: DAW	Yes
	Question re: sample	Yes
	Directions / route of administration	No
	Form	No
Diagnosis / Health Information	More specific questions re health: symptom improvement; comorbidities; other medications	Yes
	More specific questions re health: symptoms / stability; functional impairments; recent procedures; cancer diagnosis; elderly	No
	More specific questions re treatment: opioid management; nonpharmacological therapies	Yes

Form: Research Findings

Forms: Areas of Variation

Category	Content	MA Form
Other	Place for the payer decision to be documented	No
	Confidentiality information	No
	Pharmacy information	No

Form: Preliminary Direction

Remain largely consistent with MA form

- NHID will also consider developing drug-specific versions to the extent MA does so.

Form: Preliminary Direction

Proposed content

	To be included	To be excluded
Miscellaneous	Urgent request?	Pharmacy information
	*Confidentiality information	Decision
Carrier / PBM Information	Name	Email
	Phone	Direct contact
	Fax	
	*****Address	
	*ePA webpage	

* Different from MA form

Form: Preliminary Direction

	To be included	To be excluded
Patient Information	Name	Contact information
	Member ID #	Additional insurance information
	Date of birth	Authorized representative
	Gender	
Prescriber Information	Name	Licensure
	Phone	Carrier identifier
	Fax	TIN #
	NPI #	Address
	Point of contact (with contact info)	Email
	Specialty	Pager
	DEA #	Facility
	Signature	

Form: Preliminary Direction

	To be included	To be excluded
Medication Information	Name	Directions / route of administration
	Strength	Form
	Quantity	Questions specific to clinical trials
	Dosing schedule	
	Length of therapy	
	Start date / new request?	
	Questions specific to compound drugs	
	Questions specific to off-label drugs	
	Questions specific to provider-administered drugs	
	DAW? Rationale	
	Sample?	

Form: Preliminary Direction

	To be included	To be excluded
Diagnosis / Heath Information	Diagnosis	Symptoms / condition stable?
	ICD-codes	Functional impairments?
	Basic health information (allergies, height, weight)	Recent procedures
	Rationale (therapies tried, lab results, other clinical information)	Cancer diagnosis
	Symptom improvement under medication	Questions specific to elderly
	Co-morbidities	
	Other medications	
	Opioid management	
	Non-pharmaceutical therapies	

Form: Preliminary Direction

Proposed formatting

- State-specific formatting
- Options for blank and carrier-specific versions
- Considering
  - Writable forms
  - Instructions

Work Group Feedback regarding Form

Regulations: Research Findings

Regulations

- Predominant Themes
  - May only use the state's standard form
  - Timeline for implementation
- Other Provisions for Consideration
  - Making form available electronically
  - Allowing or requiring carriers to *accept* different forms with the same information
  - ePA system must be consistent with paper form
  - Standards and security for ePA
  - Enforcement provisions

Regulations: Preliminary Direction

- Require form to be available on carrier and PBM websites
- Allow carriers to *accept* different forms with the same information (e.g. MA form)
- Require ePA system to be consistent with paper form (same questions, same order, same manner for answering)
- Include standards and security for ePA
  - Must comply with NCPDP SCRIPT Standard for ePA
  - Must be secure / HIPAA compliant transmission
- Include enforcement provisions
- Considering outreach / education requirements

Work Group Feedback regarding Regulatory Provisions

Next Steps

Activity		Date (Approximate)
Draft Rules	Draft form and electronic standard	September
	Collect Preliminary stakeholder input via comments and / or work group meeting (tentative)	September
Formal Rule Making Process	Public Hearings and Comment Period	October / November
	Submit Rules to JLCAR	December (tentative)
	Rules to be adopted	March

Next Steps

Key Contacts

- NHID: Maureen Mustard
  - Maureen.Mustard@ins.nh.gov
  - 715-6702
- PCG: Lisa Kaplan Howe
  - lkaplanhowe@pcgus.com
  - 860-7851

Standardized Rx Prior Authorization Stakeholder Work Group Meeting 2
August 11, 2016

NHID Presentation

- Slide presentation by Lisa Kaplan Howe
    - Provided overview of:
        - Forms
        - Regulations
        - Preliminary direction

Stakeholder Questions and Input

- Comments about MA form
    - MA has two specific forms (ex: one for Hep-C due to high costs of medication). These forms have been drafted but not finalized.
    - Janet (NH Medical Society): Concern that MA form is much more detailed than Anthem/Cigna forms. MA form repeats info that they would already have in systems (ex: pt. date of birth). No need to make it more complex than it already is for patients
    - Is it possible to continue to simplify the form with variety of meds out there? Medications drive cost and there are complexities to consider and it may not be possible to keep it so simple (Anthem is one of most simple).
    - Gail (HPHC): Suggestion to remove DOB.
    - Kim (CoverMyMeds): DOB is essential. It is found on all forms and is key for prior authorization process.
    - Kristina (CBS): There is not a lot of feedback on the MA form because it was just published so there will likely be unexpected issues.

- Will it be useful for form to be writable/include instructions?
    - Easier to submit in digital form rather than fax etc. May be need for exceptions but it is preferable to promote best practices.
    - Kim (CoverMyMeds): Can get info on who uses electronic. Making form writable needs to be incorporated. Forms that can be auto populated are valuable (in workflow they can grab info that cannot be auto populated and fill in those blanks). A lot of industry has moved in the direction of electronic/greater efficiency.
    - MA issued a bulletin on 8/8.
    - Is there a way to include outreach/education to provider community?

- Will a simplified form result in denials?
    - How can you reconcile if a provider has specific questions because a patient does not provide complete info? If the goal is to limit the number of questions, then is this going to result in denials.
    - Kim (CoverMyMeds): May be able to help answer the question of whether the info on the form is sufficient and whether follow up questions can be asked. May be limiting yet

there is a need for industry to use one standard form. NH bill says that as of Dec 31, 2017 carriers can use and accept only this form. Opportunity for someone to use similar form may not be acceptable. There may be limitations in info that a prescriber can provide. A lot of the industry may want an electronic process that answers these questions in seconds (ex: via prepopulated info). We are limiting ourselves by utilizing the form as provider cannot give enough info resulting in a denial. No cost to prescriber to use electronic process.
    - National carrier will have to have a system with many variations.
    - CA had similar language and then had to amend it to address this issue. Can look into this in thinking about how to avoid delays.
    - Deb Nelson (Cigna): Concerned about the delay of patient care especially with the volume of different forms her center sees.

- Additional Comments
    - If there are additional clinical questions, then providers should be able to address them. Don't make patient lives more difficult by fixing a process (ex: if there are grey areas in medical care).
    - Jodi (CVS): Does the legislation say that form should be uniform and we also have to foreclose all additional discussion? Seems unrealistic to have one form and nothing more.
    - Anthem is simple but there is a place for comments.
    - If "only" is not included, then this just creates a new form on top of everything else.