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: _____

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