What can I do to help the process?

Communicate.

Make sure your chart is updated with your complete medical history, conditions, treatments you tried with another doctor, over the counter medications, etc. The more accurate and complete the information in your chart, the easier it is for us to submit PAs for you.

Don't wait until your next visit to tell us when your insurance changes. Check your medical insurance card for prescription benefit information including PBM name, RxBIN, RxPCN, and RxGRP, or find out if you have a separate pharmacy insurance card. If you have more than one insurance plan, find out which plans cover prescriptions. Always provide the most current information both to your doctor's office and to your pharmacy to prevent delays.

Let us know if you get information about your medications from your pharmacy or insurance. If you have not heard from our office a few days after a PA was requested, send us a message to follow up. If you receive a letter from your insurance about changes to prescription coverage, bring us a copy of the letter or upload it to your patient portal.

Be Patient.

Allow plenty of time for the pharmacy to fill your prescriptions. Even if you got your medication with no delay last month, this month your plan might have changed its requirements, a previous approval might have expired, or another issue might need to be resolved. Our office cannot respond to every request immediately and we have no control over how quickly insurance responds. We work to process PAs in a timely manner and offer samples when we are able. **We want you to have your medication – otherwise we would not have prescribed it!**

For more information:

www.ama-assn.org/practice-management/prior-authorization/what-doctors-wish-patients-knew-about-prior-authorization

fixpriorauth.org

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INSURANCE AND PRESCRIPTIONS

What is Prior Authorization?

Prior Authorization is a process in which a prescription insurance plan determines if a medication will be covered based on whether the patient meets the plan's criteria for coverage of that medication.

The doctor's office answers questions and submits clinical records to the insurance company, then that information is compared to the specific plan criteria and a decision is made to approve or deny coverage of the medication. Common **prior authorization (PA) criteria** include diagnosis codes, lab results, trial of other medications, and various details from the patient's medical history. PA criteria may change at any time, and PA requirements are not always consistent among different plans handled by the same insurance company or pharmacy benefit manager.

What are the components of prescription insurance?

Medical insurance companies (such as Anthem, Humana, Aetna, etc.) determine coverage for medical services. **Pharmacy benefit managers (PBMs)** (such as Express Scripts, CVS Caremark, Optum Rx, etc.) work with insurance companies to determine coverage for prescription drugs. **Your health plan** might combine medical and pharmacy benefits, or you might have separate plans with separate insurance cards. We might refer to any or all of these components as **insurance**.

A **formulary** is the list of drugs covered by the insurance company, pharmacy benefit manager, or plan. Formularies are divided into tiers determining cost-sharing amounts. Some medications on a formulary have restrictions such as prior authorization requirements, step therapy requirements, or quantity limits; these are only covered if the conditions set by the plan are met. Some **non-formulary** medications might be covered with a PA or exception review. Some non-formulary medications are **plan exclusions** and exceptions are not made.

Why did the pharmacy say my medication is not covered?

When we send a prescription, the pharmacy will try to run it through insurance. A prescription claim might be rejected for various reasons, for example if it is too soon to refill, if only a smaller quantity is covered, if you are not using an in-network pharmacy, if it is a plan exclusion, or if it requires prior authorization. If a PA is needed, the pharmacy will often send a PA request fax to our office. Sometimes an automated request is sent in error when the rejection is for a different reason, and we must clarify the reason to determine if we can resolve the issue.

If a pharmacist tells you that your medication is not covered, ask them to specify the reason for the rejection, and communicate that reason with our office. Sometimes there is nothing that can be done, but sometimes issues can be resolved so the medication might be covered in the future. A pharmacy **rejection** is not always the same as an insurance **denial**.

Why can't you just call and approve it?

A common miscommunication patients hear is "your doctor must approve this prescription" when it is actually insurance that approves or denies coverage if a PA is required. The information to process a PA is submitted by the doctor's office, and insurance will make a decision by comparing the plan's PA criteria to the clinical information submitted.

PAs may be submitted by phone, by fax, or online. Our preferred method is online with **electronic prior authorization (ePA)** through a website called **CoverMyMeds (CMM)** as this is usually the fastest. Most major PBMs have PA forms available on CMM, and many pharmacies can start a PA request on CMM for us to complete. We use other ePA websites, fax, or phone in cases when CMM is not an option, or when a case is already in progress with another method. We submit each PA with the method that seems best for that case.

What happens after you submit a PA?

Some PAs get a response within minutes, most get a response within a few days, and occasionally insurance takes two weeks or longer to review a PA request. Once they make their determination, they notify us online or by fax, phone, or mail, and we update you about the decision.

If the PA is **approved**, the medication can be filled by the pharmacy and insurance will cover their portion of the cost. The pharmacy might need to run the prescription again and might need to update the claim date before the approval will show up in their system. Some approvals have restrictions on dose or quantity, but most cover routine dose changes.

If the PA is **denied**, options might include changing to an alternative preferred by insurance, using a coupon or discount program, filing an appeal, or other options that we will discuss with you. Most plans include instructions for appeal with every denial notice, but in many cases appeals are automatically denied for the same reasons the PA was denied, and appealing is often not the best option. We will work with you to determine the next best steps.

You said this was approved, why is it still so expensive?

PA approval does not mean that insurance pays the entire cost. Medications on higher tiers and formulary exceptions usually have higher patient costs, and some plans have prescription deductibles. Sometimes insurance pays only a small portion of the cost for covered medications whether they require PA or not. Insurance generally will not communicate details of prescription cost-sharing with the doctor's office so you will need to call your plan to ask about cost issues.

If you cannot afford your medication, please let our office know. We will work with you to determine if you are eligible for savings or to find more affordable options for treatment.

I've been taking this for years, why is it suddenly not covered now?

Insurance plans can change their formularies and coverage criteria at any time. Major changes happen at the beginning of each year or quarter, making those particularly busy times for PAs. Common formulary changes include switching preferred brands, adding or removing medications, and adding or removing PA requirements.

I called my insurance and they told me something different.

Member service representatives at most insurance companies have limited access to plan details and do not have any access to PA criteria details. They may give you general information that does not apply in your particular situation, or they may tell you something is frequently covered that now has different requirements, or they may say something ***will*** be approved when they should say it ***might*** be approved. They cannot tell you accurately if a medication will be approved or not, as PA criteria are determined by the insurance PA department and change frequently.