FAQ Prior Authorization and Step Therapy

1. **Why did we add Prior Authorization and Step Therapy to the Pharmacy Benefit?**
   More and more medications are available today, and more and more people are taking them. For UnitedHealthcare® Pharmacy, that means more responsibility to monitor each medication's safety, use and cost. It's a complex process requiring continuous and rigorous attention. By providing a wide range of clinical and patient support programs, we help customers manage total drug spend and medical costs while supporting better health outcomes.

2. **How do we make sure that PA or ST is not applied in States that have legislation about these programs?**
   The Rx benefit tool, PhBIT, is designed to incorporate all state specific requirements, and apply the correct benefits accordingly

3. **How do the PA and ST Program benefit the consumer?**
   Prior authorization and step therapy help to ensure that a therapy is appropriate and safe for a specific patient.
   - Work to avoid unsafe medication combinations or ensure that the most appropriate medication is utilized for a specific medical condition.
   - Designed to prevent the consumer being prescribed unneeded or unproven treatments. For example, one of the PA criteria for Humira is that the physician must indicate that the member is not receiving Humira in combination with Enbrel, Cimzia, Simponi, Orencia, Xeljanz or Olumiant. Combining Humira with any of these medications could result in additive toxicity and an increased risk of malignancy.
   - Confirmation of diagnosis for ADHD meds. This ensures that the medication is being used to treat ADHD or another qualified diagnosis, and is not being used inappropriately.

4. **How does the addition of PA and ST affect the clients Premium/Financials?**
   The impact of adding prior authorization and Step therapy will vary based on client prescription drug utilization. The range of savings should fall between 3-7% of prescription drug premium, or 0.5% - 1.5% of total premium

5. **Why did Student Resources add the Rx Prior Authorization Program?**
   Obtaining prior authorization before a medication is covered promotes safe and effective medication use, and helps both clients and members save on pharmacy costs. This helps ensure that the coverage provided is for the right medication, the right dose and the right duration of therapy.

6. **Describe Prior Authorization.**
   The prescriber will need to notify us prior to benefit drug coverage.

7. **Is there more than one type of Prior Authorization?**
   Yes, there are two types or Prior Authorizations
   - ***Prior Authorization-Notification*** — Requires the prescriber to notify UHC first, which helps determine that the prescription is covered for the approved FDA indications for the medication based on the diagnosis.
   - ***Prior Authorization-Medical Necessity*** criteria application — The physician must provide documentation related to additional clinical criteria, such as supporting lab data, and that specific conditions are met in order for a medication to be deemed medically necessary and covered.

8. **How is the Prior Authorization program determined?**
   An expert team of clinical pharmacists develop and maintain our Prior Authorization program, with oversight from the UnitedHealthcare National Pharmacy & Therapeutics Committee. This committee consists of expert physicians and pharmacists who specialize in various therapeutic areas. The Prior Authorization program is based on nationally recognized clinical practice guidelines, FDA-approved product labeling, published clinical literature and input from health care practitioners.

9. **What medications typically require a prior authorization?**
   Medications selected are based on the potential for uses without clinical evidence or for the potential use for excluded conditions or non-covered benefits (e.g., cosmetic indications).

10. **How can I find out if my medication requires prior authorization?**
    - Access the PDL from the school's uhcsr.com page. Medications that require Prior Authorization have a PA to the right of the medication name
    - Access drug lookup from member's MyAccount. Medication description will indicate if PA is needed
    - Call UHCSR customer service at the toll-free number on the back of the plan ID card
    - When the member fills a new prescription, the pharmacist will tell the member if a PA is required.

11. **What does the member do if the medication needs a prior authorization?**
    The member should let the doctor know that a prior authorization is required or call OptumRx at 800-711-4555.

12. **How will members be notified that some of their medications will now need prior authorization?**

    Returning members will receive a letter advising of a change to their prescription drug coverage at least 60 days prior to the plan effective date. The letter will explain the program and how it will affect their prescription drug coverage along the process for member and doctor to follow if a PA is required.

    - If a PA is approved, member may keep filing their prescription.
    - If PA is not approved and you fill a prescription after (date), you may have to pay the full cost of the drug.

13. **What does "coverage may be extended" mean?**

    UHC offers a Transition of Care (TOC) process to obtain a one-time 30-day override if their medication is impacted by PA or ST. This will allow members more time to work with their physician to either switch to a covered alternative, or satisfy the clinical requirements.

14. **How does the Transition of Care process work?**

    The member must call OptumRx at 1-855-828-7716 to obtain the override. The Rx claim history must indicate a fill within the past 120 days for the drug in question. Member must confirm that drug had previously been covered without the need for PA. If the drug is eligible for TOC, the CS rep will enter an override that will allow a 30 day refill. Drugs that are **not** eligible for overrides are Specialty medications, Compounds, meds for weight loss and cosmetic purposes, OTC meds, and some meds for infertility.

15. **How can the doctor submit information for a Prior Authorization?**

    Visit www.uhcprovider.com and click on the Prior Authorization and Notification-Learn More purple tile. Or access LINK from www.uhcprovider.com.

16. **What other programs and tools are there to speed and simplify the Prior Authorization Process?**

    - **Expiring Prior Authorization Program:** UnitedHealthCare proactively notifies a physician during the standard medication renewal process to extend the authorization for continued refills or discontinue the medication if clinically appropriate. This helps member stay adherent to their treatment
    - **Medical Diagnosis to Script (Dx2Rx) program:** UHC Streamlines prior authorization requirements by conducting a real-time check to automatically find a member's diagnosis in claims history. For a new diagnosis, the pharmacist can enter the prescriber-provided diagnosis code. This helps members start taking their medication as soon as possible. Dx2Rx avoids 30—40% of prior authorizations with medical diagnosis match.

- **PreCheck MyScript:** It is a sophisticated tool that gives providers real-time access into member pricing, lower-cost alternatives and prescription drug list placement. Using patient-specific benefit information within the prescriber's electronic medical records helps providers prescribe the appropriate medication for each member. Prescribers can use this tool to initiate the Prior Authorization process when necessary. **All** prescribers have access to the UHC provider portal *LINK*, which allows access to PreCheck MyScript. It is also integrated into many EHR platforms, such as DrFirst, AthenaHealth, NewCrop, AllScripts, Epic Integrator and Cerner Integrator.

17. **How does the member know if a medication has been approved for coverage?** Once the information from the doctor is reviewed, OptumRx will send a letter to the member and the doctor letting them know if the medication is approved or denied. The member can also call the dispensing pharmacy or UHCSR customer service for status and assistance.

18. **What is the appeals process if OptumRx denies Prior Authorization?**
    The provider can request a medical necessity appeal (along with medical records) through UHCSR SIU Appeals Department via mail or fax. Once the appeal is received by SIU, the turnaround time to respond is 72 business hours.
    - If member meets drug specific criteria, SIU will allow the request and request override through PBM Department.
    - If a Medical Necessity review is required of if the member does not meet criteria, a clinical review is sent over to UHC Medical Director for review. This review is done to make sure the process was followed and to ensure nothing needs to be clarified.
    - The member and provider will receive letters explaining criteria required and the reason for denial/approval.

19. **Approximately how many medications are on the Prior Authorization List?**
    Prior authorization programs are in place for drugs involved in about 5% of Rx claims, but may impact 40% of total drug costs.

20. **How many members are affected by Prior Authorization?**
    Using PY 2019 data, of a total 72,293 members currently utilizing the Rx benefit, 8,134 would be affected by Prior Authorization. That is approximately 11% of members that utilize the Rx benefit. This 11% may be decreased by the use of Dx2Rx and/or PreCheck MyScript.
    - Also, Student Resources has historically applied Prior Authorization to Specialty Medications, so the 11% of members that are impacted are not all new to the concept.

21. Describe Step Therapy.

This program requires the member to try a lower-cost medication before a higher-cost medication is covered.

22. How many members are affected by Step Therapy?

Using PY 2019 data, of a total 72,293 members utilizing the Rx benefit, 1,391 would be affected by Step Therapy. That is approximately 1.9% of members that utilize the Rx benefit.

23. Is the less expensive first step medication just as effective?

Most therapeutic classes have multiple medication options. Clinical effectiveness may be similar, but pricing can vary. Step Therapy is an effective way to move members to less expensive medications, while still allowing access to the higher cost medications if needed

24. Explain the Step Therapy Process at the pharmacy.

When a member presents a Step 2 prescription at the pharmacy, their claims history may automatically be checked to see if they previously filled a prescription for a Step 1 medication.

- If the member has a claims history of a Step 1 medication, the Step 2 medication may be processed without member disruption.
- If not, the prescriber is contacted to discuss the Step 1 options and process for coverage reviews. The prescriber may agree to change the member to the Step 1 medication.
- Or, if a coverage review was requested and the member meets the clinical criteria, a Step 2 medication is covered.

25. How can I find out if my medication is subject to Step Therapy?

Medications that require Step Therapy can be found located several ways:

- Access the PDL from the school's uhcsr.com page. Medications that require Step Therapy have a ST to the right of the medication name.
- Access drug lookup from member's MyAccount. Medication description will indicate if Step Therapy is needed.
- Call UHCSR customer service at the toll-free number on the back of the plan ID card.
- The pharmacist will tell the member if Step Therapy is needed when the member fills a new prescription.

26. How far back is the member's prescription history reviewed for ST1 medication?

For some step therapy programs, if the member's full claim history is available in the Optum system, it will be scanned for prior use of a Step 1 agent. Information on trial of Step 1 agents will also be accepted from the prescriber. In some instances, step therapy protocols require medical record submission confirming prior failure, contraindication or intolerance to the Step 1 agent.

27. Are there specific criteria are used to determine if a member may move from a ST1 to ST2 medication?

A step therapy criterion varies from drug to drug and all protocols can be found on uhcprovider.com (https://www.uhcprovider.com/en/resource-library/drug-lists-pharmacy/clinical-drug-step-therapy.html).

28. What is the turnaround time for approval of a ST2 medication?

Turnaround times for PA review vary from state to state; however, most PAs are turned around by OptumRx within 24 hours.

29. If Coverage Review is denied by OptumRx, what is the appeals process for a member to continue use of current medication and not move to Step 1 medication under ST program

A request can be submitted by the prescriber to United Healthcare Student**Resources** Appeals Department via mail or fax. All relevant clinical information should be submitted with the request to ensure the request is not delayed for lack of information.

- If the appeal of Coverage Review is approved, an email is sent to PBM Department to allow override for the Step 2 medication. A letter will be sent to provider and member informing of the approval.
- If the appeal of Coverage Review is denied, a letter will be sent to provider and member informing of the denial with explanation of the decision.
- Turnaround time is 3 days.