Commercial Medication Exception Review Process

McLaren Health Plan (MHP) has placed a prior authorization (PA) restriction on certain medications within the formulary (covered medication list). PA means the medication requires special approval before consideration for coverage under MHP. A medication may require PA due to safety concerns or to ensure a formulary alternative cannot be used. If you need a medication that requires PA, your prescribing provider will call us or submit a PA request to begin the authorization process. If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. **The member or prescribing provider** may request a Formulary Exception for a clinically appropriate non-formulary medication. The request must include a justification supporting the need for the non-formulary medication to treat the member's condition, including a statement that all covered formulary medications on any tier will be or have been ineffective, would not be as effective as the non-formulary medication, or would have adverse effects. IF THE PRIOR AUTHORIZATION PROCEDURES ARE NOT FOLLOWED, ramifications include withdrawal of the prior authorization request and non-coverage. MHP will make the determination on a standard formulary exception request and notify you or your authorized representative and the prescriber within 72 hours following receipt of the request. For expedited reviews due to exigent circumstances, MHP will make the determination and notify the member or member's authorized representative and prescribing provider within 24 hours.

Drugs may be designated as non-formulary / non-covered, PA required, for several reasons, including, but not limited to:

1. The drug may be excluded from the benefit.
2. The drug may have been found to be ineffective in routine practice by the Quality Improvement Committee (QIC).
3. Formulary alternatives may exist.
4. The FDA may not have approved the drug.

PRIOR AUTHORIZATION APPLICATION PROCESS FOR MEMBERS OR PRESCRIBERS

Step 1. The **member or prescriber** completes a Request for Prior Authorization which can be found by following the link: Microsoft Word - MedImpact Standard MRF

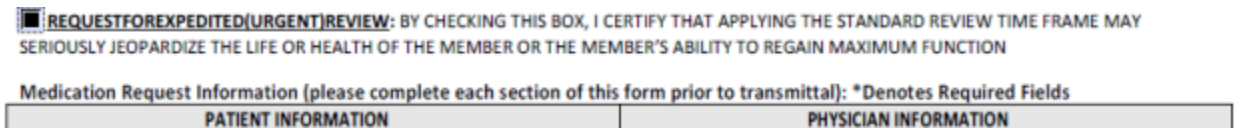
Step 2. The **member or prescriber** will then fax the completed form and all supporting documentation to: MedImpact Fax: (858) 790-7100

Prescribers may also call the **MedImpact Help Desk**: (888) 274-9689 (TTY dial 711) Hours: 24 hours a day, seven days a week to begin the process. The prescriber then submits the completed form and all supporting documentation to the PBM at the fax number above.

FOR EXPEDITED DRUG EXCEPTION REVIEW REQUESTS DUE TO EXIGENT CIRCUMSTANCES

Step 1. The **member or prescriber** completes a Request for Prior Authorization which can be found by following the link: Microsoft Word - MedImpact Standard MRF

Step 2. The member or prescriber must select the **REQUEST FOR EXPEDITED/URGENT REVIEW** option on the request form.



☐ **REQUESTFOREXPEDITED(URGENT)REVIEW:** BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Medication Request Information (please complete each section of this form prior to transmittal): *Denotes Required Fields

PATIENT INFORMATION	PHYSICIAN INFORMATION

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Prescribers may also call the **MedImpact Help Desk:** (888) 274-9689 (TTY dial 711) Hours: 24 hours a day, seven days a week to begin the process. The prescriber then submits the completed form and all supporting documentation to the PBM at the fax number above.

Internal Review Process

A pharmacist at the PBM will review the exception request for content and contact either MHP's CMO or authorized representative for review and benefit determination.

Approved: As directed by MHP, the PBM will enter an authorization (override) into the member's electronic profile for the length of time approved by the health plan. Note: Once a medication is approved by MHP, the dispensing pharmacy will not need any special pre-certification/prior authorization number.

Pending: MHP is pending the request for more information. The PBM will contact the prescriber to request additional information. All Utilization Management time frames established by MHP will apply.

Denied: The Chief Medical Officer (CMO) or authorized representative has denied the request. The Utilization Management denial and appeals policies established by MHP apply to any pharmacy denial. If the drug is denied, you have the right to appeal.

Appeals: Internal Review Process

If you or your provider feels that MHP Community has denied the prior authorization request incorrectly, an appeal may be filed. If the original request was an expedited exception request, the plan will make coverage determination and notify the enrollee or the enrollee's designee and the prescribing provider no later than 24 hours following receipt of the request and no later than 72 hours following receipt of the request if the original was a standard exception request.

To request an appeal with MHP Community's Appeals Committee, you or your authorized representative must send an appeal request in writing within 180 calendar days of MHP Community's resolution to your complaint/grievance or denial of services. Appeal request along with any additional information are to be sent to:

McLaren Health Plan Community
Attn: Member Appeals
G-3245 Beecher Road
Flint, Michigan 48532

If you wish to have someone else act as your authorized representative to file the appeal, you must complete MHP's Authorized Representative Form (mhpauthorizationforrelease.pdf), or call Customer Service at (888) 327 0671 (TTY: 711) for a copy to be mailed to you.

Appeal: External Review Process

If we continue to deny the coverage or service requested, or you do not receive a timely decision, you have the right to an external review. If the original request was a standard exception request, the plan will make a coverage determination on the external exception request and notify the enrollee or the enrollee's designee and the prescribing provider no later than 72 hours following receipt of the request and no later than 24 hours following receipt of the request, if the original request was an expedited exception request. The external review may be filed with the:

Department of Insurance and Financial Services Health Plan Division
Office of General Counsel – Appeals Section
P.O. Box 30220 Lansing, MI 48909-7720
FAX: (517) 241-4168
PHONE: 1-877-999-6442

Or submit the request online at:

https://difs.state.mi.us/Complaints/ExternalReview.aspx