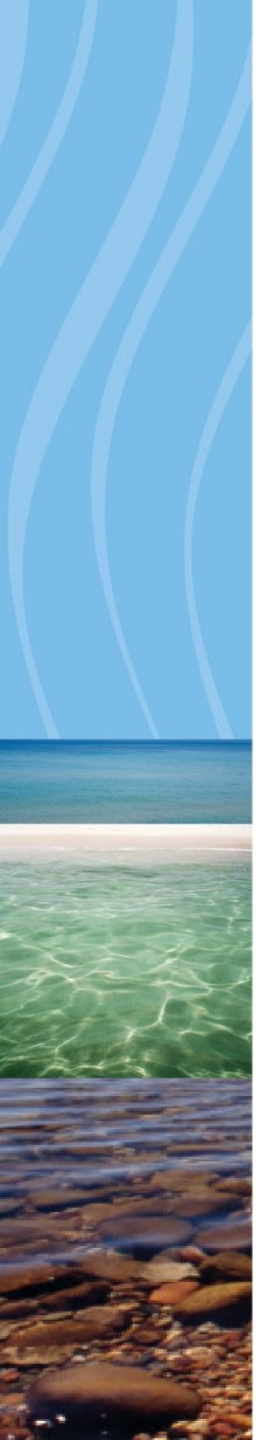


Navitus Prior Authorization and Exception to Coverage

October 2016

NAVITUS HEALTH SOLUTIONS

PRIOR AUTHORIZATIONS
DEFINITION AND PURPOSE

Prior Authorizations (PA) are predetermined criteria a member must meet for a request to be approved to allow the drug to be covered for the member.

The purpose of the Prior Authorization process is to control usage of medications:

- requiring regular physician interaction
- have high cost
- are known to be commonly abused

PRIOR AUTHORIZATIONS
CRITERIA

The P&T Committee determines what criteria would justify coverage of the drug.			
Criteria for coverage is listed on the PA form to be completed by the member's physician	Submitted forms must clearly show the member has met all criteria	PA form criteria is reviewed annually and modified as needed	Each PA form indicates how long the drug is granted approval if criteria is met

PRIOR AUTHORIZATIONS
TURNAROUND TIMES

If a physician feels a PA decision is urgent, they may:

- mark the form as “Urgent” to expedite processing
- call/email the PA team for immediate review

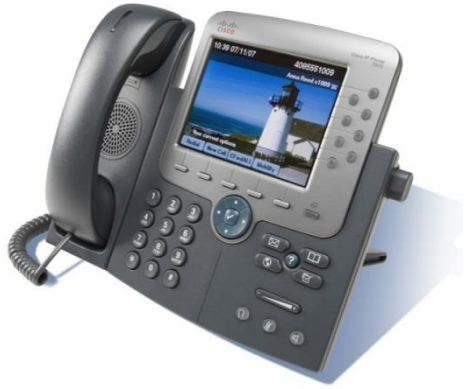
Navitus allows 2 business days for processing standard requests and 1 business day for processing urgent requests

PRIOR AUTHORIZATIONS
OVER THE PHONE PA PROCEDURE

Customer Care agents will fax PA forms first; however, the prescriber may request to complete the PA over the phone.

Over the Phone PA steps:

1. Agent will verify the drug PA can be completed over the phone.
2. Agent will warm transfer the caller to the Prior Authorization team
   - Monday-Friday, 8a-8p
   - Saturday & Sunday, 8a-12p
3. If a PA Specialist is not available, agent will offer the provider an opportunity to leave a voicemail for callback.



PRIOR AUTHORIZATIONS
COVERAGE DECISION

When approved:

- If there is a recent (≤ 7 days) rejected claim in the member's claims history, the pharmacy will be notified by Navitus to reprocess the claim.

When denied:

- If a PA is denied because it does not appear to meet criteria, a pharmacist must make the final decision.
- The denial letter informs the provider and member of alternatives or their next option (for example, an appeal option).

PRIOR AUTHORIZATIONS
STEP THERAPY

Step Therapy (ST) criteria requires the member to try and fail (step through) a formulary (preferred) medication before getting coverage for a non-preferred/ST medication. The ST code would be listed next to the medication name on the formulary.

Any Member Services Specialists (MSS) can take confirmation over the phone from the pharmacy or provider's office that Step Therapy criteria have been met. If confirmed, the MSS would enter the ST override.

If the provider is unable to confirm ST has been met or if it is, the ST PA form can be faxed to the provider. If the pharmacy is unable to confirm, or if the member is calling, they may advise the provider's office to contact Navitus to initiate the form.

PRIOR AUTHORIZATIONS
RESTRICTED TO SPECIALIST

Restricted to Specialist (RS) medications must be prescribed by specialists in order to have coverage on the medication listed as RS on the formulary.

All RS medications will have a PA form that can be faxed to the provider which includes a *Provider Credentialing Form* at the end. If the specialist completes the credentialing form:

- their credentials will be entered into NaviClaim
- provider may prescribe RS drugs without the need for another PA form moving forward

For urgent/emergent situations

- If it can be confirmed via NPI Registry that the provider is the specialist in question, a one-time override may be entered while waiting on the forms.
- If the provider's credentials cannot be verified via NPI Registry, contact Clinical Pharmacists at x5022 to discuss if a one-time override would be allowed.

PRIOR AUTHORIZATIONS
EMERGENT SUPPLY

Navitus will ensure its members have access to Prior Authorization medications in the event of an emergency when the parties needed to review a Prior Authorization, a clinical pharmacist and the provider, are not available.

PRIOR AUTHORIZATIONS & ETC

CYCLE OF A PA/ETC

Form is faxed to the provider to be completed and submitted to Navitus

PAX documents are scanned in upon return and automatically attached to a member account	Non-PAX forms go into a pool of all PA/ETC requests (i.e. forms obtained from Navitus.com or blank forms without PHI)	The PA/ETC is put in a queue for PA team/RPh review and assigned a PAX status

Prior Authorization Specialists complete intake and processing of forms

PA team pulls faxes from the pool on a first-come-first-serve basis	Reviews and attaches to a member's account noting Urgent vs. Standard status	PA team or Clinical Pharmacist (RPh) reviews form

A decision is made: Approved or Denied

Decision letter is faxed to provider	Member is mailed the decision letter	An authorized or declined MPA is entered in NCRx for the member

EXCEPTION TO COVERAGE
DEFINITION AND PURPOSE

The Exception to Coverage (ETC) process allows members to request coverage of medications that show formulary restrictions.

The five criteria that would justify an ETC form are:

1. Not Covered (NC)
2. New/Not Reviewed Drug (ND/NR)
3. Quantity Limit (QL)
4. Gender Specific
5. High Dose (HD)

The ETC form cannot be used to request copay lowering or coverage of a direct plan exclusion.

EXCEPTION TO COVERAGE
NEW/NOT REVIEWED DRUGS

When a physician requests coverage of a new drug, they are essentially taking responsibility for the unknown. However, it is important that, as a PBM, Navitus gives physicians the opportunity to treat their patients to the best of their ability, so they may complete an ETC form.

Although the coverage determination is made by Navitus, the patient can always receive what the physician has prescribed, it is just a matter of how much the patient pays.

If approved, the medication will be covered at the highest patient pay amount on the plan until the formulary status changes it to a preferred product.

EXCEPTION TO COVERAGE
TURNAROUND TIMES

Allow 5 business days for processing standard requests

If a physician feels a PA decision is urgent, they may mark the form as “Urgent” to expedite processing.

Based on the information provided on the form, a Clinical Pharmacist will decide whether or not to authorize coverage of the drug within the above mentioned time frame.

EXCEPTION TO COVERAGE
COVERAGE DECISION

When approved:

- If there is a recent (≤ 7 days) rejected claim in the member's claims history, the pharmacy will be notified by PA Support to reprocess the claim.
- Providers are notified by fax and members are notified by mail

When denied:

- If an ETC is denied it is most likely due to the provider not showing the patient has tried and failed all other formulary alternatives or why the member cannot try the other alternatives.
- The denial letter informs the provider and member of alternatives or their next option (for example, an appeal option).

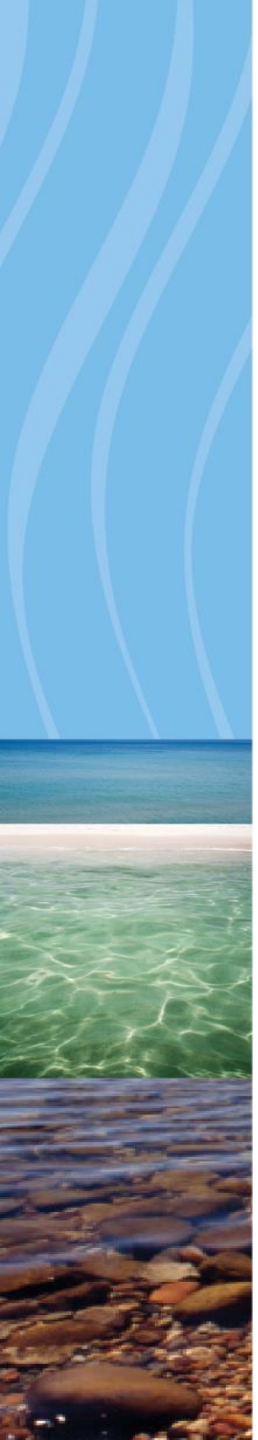
FORMULARY

Sarasota Memorial Health Care System is a Three-Tier Formulary

- Tier 1 = Preferred generics and some lower cost brand products
- Tier 2 = Preferred brand products and some high cost non-preferred generics
- Tier 3 = Non-preferred products (may include some high cost non-preferred generics)

Prescribers can view the entire formulary:

- Go to www.navitus.com and click on the Prescribers link.
- Enter their NPI number and State.
- Search for Sarasota Memorial Health Care System formulary



Share a Clear View

High-Touch Service

Lowest Net Drug Costs

Improved Member Health

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