Drug prior authorization and exception requests: Frequently asked questions

What are the different types of formulary restrictions?

Restrictions on the Quartz formulary include:

- Prior authorization requirements
- Step therapy requirements
- Quantity limits
- Closed formulary (i.e., exclusion of non-formulary drugs)

Members or prescribers may request exceptions to these formulary restrictions.

What is the difference between prior authorization and step therapy?

A **prior authorization (PA)** request is needed when a formulary restricted drug requires review to determine if specific criteria are met before coverage is granted. Part of the criteria may be the required use of a more cost-effective medication; however, that will not be the only criteria that needs to be met.

Step therapy (ST) requires that a person tries the most cost-effective medication(s) in a certain order before coverage of (or "stepping up to") a less cost-effective, restricted medication is granted. Preferred drugs and non-preferred drugs may be included in the step therapy criteria. Most members find the first medication very effective and never need to step up.

What is a quantity limit?

A quantity limit is a restriction on the number of dosage units (tablets, drops, shots, etc.) covered within a period of time. Usually, this is listed as units per day or units per month.

What is a non-formulary medication?

Non-formulary medications are denoted as (NF) on the Quartz formulary and are not otherwise excluded by the certificate or plan documents. That means that non-formulary medications aren't covered unless a formulary exception request is approved.

What is a formulary exception request?

A formulary exception request is needed when the prescriber requests coverage for a non-formulary medication.

What is a step therapy exception request?

A step therapy exception request is needed when the prescriber requests a waiver of the "step therapy" requirements.

Where are the formularies, prior authorization criteria, and forms available?

The Quartz formularies, prior authorization criteria, and medication coverage request form are all available at QuartzBenefits.com.

What is required when requesting a prior authorization or an exception?

Prior authorization (PA) request

- Review the PA criteria document found at **QuartzBenefits.com/medpacriteria**.
- Submit a medication coverage request form and all information needed to evaluate if the request meets the PA criteria.
  - Cite the reason or clinical rationale for the request (relevant past medical history, allergies, lab results, etc.)
  - Include supporting documentation or clinic notes
  - Discuss medication trials (including drug names, doses, dates, and outcomes)
  - Note contraindications to preferred therapies

Step therapy exception request

- Review step therapy information included in the PA criteria document found at **QuartzBenefits.com/medpacriteria**.
- To request a waiver of step therapy requirements, submit a medication coverage request form with all information and supporting documentation needed to complete a review.
  - Include documentation supporting the patient's history of failure, intolerance, or contraindications to prerequisite drug(s); or,
  - Include clinical support for why prerequisite drug(s) are likely to cause an adverse reaction, decrease a patient's functional ability in performing daily activities, or cause physical or mental harm; or,
  - Indicate if the patient is currently stable on the requested medication they received through a current or previous health plan.

Note (for both PA and step therapy exception requests):
When a requirement to try a preferred drug is only one of several PA criteria, the request will be treated as a PA request, not a step therapy exception request. It will follow the required review procedures and timelines accordingly. However, if it is explicitly stated or understood that the intent of the request is asking for an exception to step therapy, the request will be reviewed as both a PA request and a step therapy exception request. The shorter of the two applicable timelines will be followed.

In Illinois, any indication that a prerequisite drug has been ineffective, is likely to be ineffective, or is likely to cause an adverse reaction or harm to the enrollee will be treated as a step therapy exception request, whether provided verbally or in writing.

Quantity limit exception request

- You can find details on quantity limits within the PA criteria at **QuartzBenefits.com/medpacriteria** and on the formulary.
- Submit a medication coverage request form and include documentation that provides an evidence-based, clinical rationale for using a dose outside the quantity limit.

Formulary exception request

- Submit a medication coverage request form and include documentation supporting that:
  - All therapeutic alternatives will be or have been ineffective; or,
  - Would not be as effective as the requested drug; or,
  - It would have adverse effects.

What if the request is time-sensitive and needs an expedited review?

All requests will be considered standard requests unless otherwise noted. If the request needs an expedited review, include "Urgent" at the top of the medication coverage request form and submit

documentation and a statement describing how the situation matches one of the following definitions.

Urgent request

- Urgent requests are for situations in which making routine determinations could jeopardize the life, health, or safety of the patient or others, should the requested medication not be expedited. This could be due to the patient's psychological state or, in the documented opinion of the provider, would subject the patient to adverse health consequences. Clinical documentation is required to support urgent requests.

Exigent request

- An exigent request is a non-formulary exception request in which:
  - The patient is suffering from a health condition that may seriously jeopardize the person's life, health, or ability to regain maximum function or,
  - The patient is currently undergoing a treatment course using non-formulary medication.

Concurrent request

- A request for coverage of a medication that the member is currently using on an ongoing basis, even if Quartz did not previously approve the medication.

What happens after a request has been submitted?

Once a request and the supporting documentation have been submitted, including any specific circumstances that can be considered, a pharmacist or appropriate staff review the PA criteria and exception requirements separately to make a coverage decision. Notification of the coverage decision will be made to the requesting provider by fax and to the member by mail. The drug formulary, quantity limits, drug-specific PA criteria, and drugs that will require step therapy are reviewed and approved by the Quartz Pharmacy & Therapeutics (P&T) committee.

How long does it take for a decision to be made?

The chart below illustrates the time allowed for each type of request. Unless otherwise noted, all requests will be processed as standard requests.*

Request type	Wisconsin	Minnesota	Iowa	Illinois
Prior Auth – Standard	Up to 15 days	Up to 5 days	5 days	72 hours
Prior Auth – Urgent preservice	72 hours	48 hours	72 hours	24 hours
Prior Auth – Urgent concurrent	24 hours	24 hours	24 hours	24 hours
Step Therapy – Standard	72 hours	5 days	5 days	72 hours
Step Therapy – Urgent	24 hours	72 hours	72 hours	24 hours
Quantity limit – Standard	Up to 15 days	Up to 15 days	Up to 15 days	72 hours
Quantity limit – Urgent	72 hours	72 hours	72 hours	24 hours
Non-formulary – Standard	72 hours	72 hours	72 hours	72 hours
Non-formulary – Exigent/Urgent	24 hours	24 hours	24 hours	24 hours

*Please note these timelines are based on the member living in the same city/county/state as the employer.

To check on the status of a submitted request, discuss the specifics of a medication request decision with a pharmacist, or if you have general questions about the prior authorization criteria, call Optum Rx Member Services at **(800) 496-7509**.

Additional information about the pharmacy program

Emergency drug supply policy

Quartz members can get a five-day supply of restricted medications at no copay for emergency or urgent situations in which prior authorization cannot be obtained unless:

- A prior authorization was denied within the past month;
- The medication is excluded; or,
- The medication is in the Quartz Specialty Program.

Members, pharmacy staff, and provider staff can call Optum Rx Member Services at **(800) 496-7509** to get this authorization. Beyond the five days, we require prior authorization for consideration of coverage. A five-day supply does not guarantee continued coverage.

New member drug supply policy

Members new to Quartz and currently taking a restricted medication can get three one-month fills within the first 90 days of eligibility. Members, pharmacy staff, and providers can call Optum Rx Member Services at **(800) 496-7509** to get this authorization by requesting a "new member override." A prior authorization still needs to be submitted for consideration of coverage after the first 90 days of eligibility.

Complaints and appeals

Members may express any dissatisfaction with their plan to Quartz Customer Success at **(800) 362-3310 (TTY: 711)**. For information about appealing a decision on a pharmacy prior authorization or formulary exception request, visit **QuartzBenefits.com/appeals**.