

## Recommendations from Pharmacy

The ultimate goal of this workgroup should be:

- A. Streamline the Current Process
- B. Preserve patient's timely access to prescribed procedures, therapy, and medications
- C. Eliminate Duplication of Effort
- D. Relieve Workload from Prescribers Where Possible

Likewise, the questions we should be asking are:

- A. What elements can we include on this form to accomplish these goals?
- B. How can we deploy this form to accomplish these goals?
- C. Who can access this form to accomplish these goals?

Therefore, we submit the following recommendations with background explanation:

1. Include a form element that specifies a specific pharmacy for notification purposes but not to limit any prior authorization to a specific pharmacy or healthcare provider.
  - a. Pharmacies are usually the primary point of contact for patients to get a status check on a current prior authorization request. It is not unusual for patients to call a pharmacy multiple times while waiting for a prior to be approved. Currently, the only notification that happens upon PA approval is to the patient (via mail) and to the prescriber's office. The only way a pharmacy can answer the patient's question is to rerun the claim (this costs the pharmacy money with every transmission, which is not reimbursed or compensated for whether the prior authorization is approved or denied). The only other option is to have the patient continuously call the prescriber, which we know is not a sustainable solution. Therefore, listing a pharmacy to notify on the PA form would allow the PBM/plan to communicate with the pharmacy when the status has changed on the PA request which will save everyone valuable resources.
  - b. This recommendation should not be construed as to limit a PA request to only one pharmacy. A PA should be tied to a patient and not to a specific pharmacy as the patient should always have the right to fill at any pharmacy of their choice.
2. Include an **optional** element for duration of prior.
  - a. PA's should be defaulted to a one year approval. We believe every prescriber would agree the less often they have to submit PA requests the better the system works. From talking with prescriber's they often do not realize when they submit a prior it is not going to be considered for one year. From the pharmacy perspective, we see a large number of short dated PA approvals (example: 3 month approval) and patients getting stuck at the end of the 3 month approval waiting several days for the next approval to be completed. If the PA form noted

that all PA requests would be considered for one year unless otherwise noted, this would clear up confusion when the prescriber is submitting the PA request.

3. Allow for multiple authorizations to be requested on the same form submission.
  - a. Many times we will run a claim awaiting approval for “Problem A” to find out “Problem A” was approved but now we need an override approval for “Problem B”. A good example is a formulary exception is approved, but now we need a quantity limit override. So the patient that has waited 72 hours for the primary override now has to wait longer for the secondary override. This form should have some ability to allow all necessary requests to be made on the initial form submission.
  - b. The problem with putting in the missing elements from the start is we don’t know all the secondary rejections until the primary rejection is corrected and cannot alert the prescriber ahead of time.
4. If this PA form is to be utilized to correct a previously denied request it should be pre-populated with previously submitted information and include allowable alternatives or next steps for positive outcome.
  - a. In an attempt to not duplicate effort we should provide as much information back to the prescriber as possible, including any information needed to change a negative outcome to a positive one and alternative drugs that could be approved with proper documentation. If we can utilize the same portal and form that was originally submitted the turn around time saved would be significant. Also, if a PA was rejected because of lack of documentation or there are alternative options that should be considered, why not include those on the form to relieve workload.
5. Include Pharmacist credentials to those allowed to complete and submit a PA request.
  - a. There are several instances Pharmacists could provide information necessary to complete a PA request and should be allowed to complete those requests that do not require information not accessible to the Pharmacist. Pharmacists have proven their ability to screen patients, review patient histories, review drug utilization, provide therapy recommendations and administer medications through collaborative practice agreements. And recently Pharmacists have been utilized and granted authority to order and administer COVID-19 tests. This would make sense to allow Pharmacists to relieve some of the workload placed on prescriber’s offices by doing those PA’s that are logical for them to complete and submit.
6. The form should have the ability to request inactive ingredients on a compound formula without listing each ingredient and corresponding characteristics.
  - a. Oftentimes compounds are submitted for PA and are approved, but only the main ingredient is submitted and the rest of the ingredients are denied. This results in great confusion because the patient thinks the prescription is fully approved when it is not. Also, the prescriber has to now submit a new PA request for the extra ingredients. Either the Pharmacist should have the ability to add the inactive ingredients to the initial request or the form should include a way for the initial submission to request **all** ingredients even if they are not listed.

- i. Each pharmacy may have a unique formula for the same general compound request which increases the confusion for completing the request at the prescriber's office
- ii. Ingredients that do not affect the efficacy of the compound but are necessary (ie, glycerin, Ora-Sweet/Ora-Plus, lactose, mineral oil, etc...) do not have clinical significance and it should not be necessary to provide all the same rationale as the active ingredient.
- iii. We understand there may need to be some limits here to prevent unnecessary additions and we are open to suggestions from industry.