Medical Director and Medical Administrator Frequently Asked Questions
Uniform PA Implementation for Community Mental Health Centers and the Health Plans

Question 1: Can I start the prior authorization (PA) process now? I've been told that the plan will not process the PA until the end of the year or September 5.
Answer 1: *The PA process can be started now.*

Question 2: How far back do I have to go for a therapeutic failure? Do I need to attach documentation?
Answer 2: *When possible, provide as much documentation as available. If a failure date is not available because of the EHR, cite that the date is not available on the PA form. See below sample.*

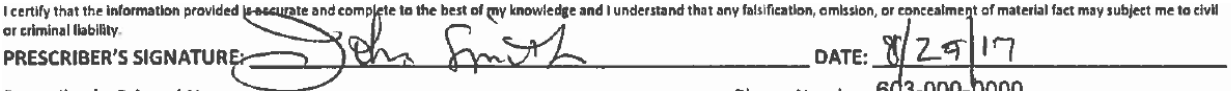

☒ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
Tried and failed or was non-compliant due to side effects on chlorpromazine, Depakote ER, Zyprexa, Risperdol, Seroquel, Abilify, Geodon and Invega tablets. Specific failure dates are unavailable in the EHR.

Question 3: I know that I am allowed to attest to previous episodes of unacceptable side effect or therapeutic failure, as well as provide clinical information on the PA form. Can I simply list the meds tried along with date if available and if not available for date, cite this on the PA form?
Answer 3: *When possible, provide as much documentation as available. If a failure date is not available because of the EHR, cite that the date is not available on the PA form. See below sample.*


☒ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
Tried and failed or was non-compliant due to side effects on chlorpromazine, Depakote ER, Zyprexa, Risperdol, Seroquel, Abilify, Geodon and Invega tablets. Specific failure dates are unavailable in the EHR.

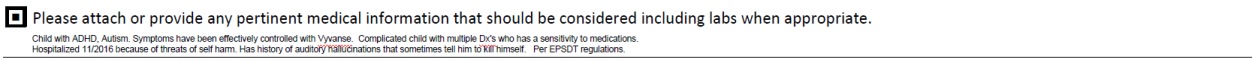
Question 4: What if my electronic record indicates that there has been a reaction, but I do not have a date? Can I simply attest to this?
Answer 4: *Yes, cite that the date is unavailable because of the EHR.*

Question 5: Do I have to sign the PA form or is an initial okay?
Answer 5: *The prescriber must sign the PA form. See below sample.*


I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.
PRESCRIBER'S SIGNATURE: John Smith DATE: 8/29/17

Question 6: Can a covering provider sign the form?
Answer 6: *Yes, if you delegate to another prescriber, that prescriber should sign the form.*

Question 7: What box do I sign to submit information regarding EPSDT?
Answer 7: *Check off "Please attach or provide any pertinent medical information that should be considered." See below sample.*


☒ Please attach or provide any pertinent medical information that should be considered including labs when appropriate.
Child with ADHD, Autism. Symptoms have been effectively controlled with Vyvanse. Complicated child with multiple Dx's who has a sensitivity to medications.
Hospitalized 11/2016 because of threats of self harm. Has history of auditory hallucinations that sometimes tell him to kill himself. Per EPSDT regulations.

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Question 8: Do I have to answer all the questions on the guidance?
Answer 8: *No, answer the questions that are pertinent to the facts of your patient, including why the definition of medical necessity is met.*

Question 9: Can you confirm that I only check the box for brand medically necessary when I want a brand specific prescription?
Answer 9: *Correct.*

Question 10: For off-label must I provide documentation and peer reviewed articles for PA approval?
Answer 10: *If a peer reviewed article is available, attach it. If a peer reviewed article is not available, note on the PA form that there is not one available and be specific in your medical necessity rationale for use of the drug off-label. You may also request a Peer to Peer review to explain the medical necessity.*

Question 11: Is there a timeframe within which a prescribing provider must request a specialist Peer to Peer review after denial of an initial PA request?
Answer 11: *After the denial is received, a request for a specialist Peer to Peer review must be submitted by the close of the next business day. See below definition of timeframes.*

Term	Definition
Business Day	8:00 am - 5:00 pm Eastern Standard Time. This applies to CMHC PA processing timeframes for SMI drugs, CMHC requests for a peer-to-peer following a denial of SMI drugs, and MCO timeframes for conducting a peer-to-peer review for denied SMI drugs.
Timely Processing of CMHC Prior Authorization Request SMI Drugs.	A prior authorization for an SMI drug requested by a CMHC that is processed within 24 hours from the time it is submitted to the MCO.
Timely Requests for a Peer-to-Peer	A Peer-to-Peer that is requested by the CMHC by the next Business Day following the denial of prior authorization for an SMI drug. For example, the MCO denies a PA for an SMI drug on Monday at 4 pm, the CMHC must request a Peer-to-Peer from the MCO by Tuesday 5 pm to be considered timely. NOTE: For denials that occur outside of the Business Day, the timeframes for a timely peer to peer request will begin during the start of the next Business day. For example, the MCO denies a PA for an SMI drug on Monday at 7 pm, the CMHC must request a peer to peer from the MCO by Wednesday 5 pm to be considered timely.
Timely Completion of a Timely Requested Peer-To-Peer	A Peer-to-Peer that is completed by the next Business Day following a Timely Request for a Peer-to-Peer. For example, a Timely Request for a Peer-to-Peer is made on Monday at 4 pm, the MCO must complete the Peer-to-Peer by Tuesday 5 pm. For Timely Requests for a Peer-to-Peer that occur outside of the business day, the timeframes for completing the Peer-to-Peer will begin during the start of the next business day. For example, a Timely Request for a Peer-to-Peer is made on Monday at 7 am, the MCO must complete the Peer-to-Peer by Wednesday at 5 pm.

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Question 12: Can I do an appeal and then do a Peer to Peer?
Answer 12: *If you appeal, you will not receive a Peer to Peer review. The Department recommends that you follow the process of doing a Peer to Peer review first. If you are dissatisfied with the outcome of the Peer to Peer review, you can appeal.*

Question 13: Is there a timeframe within which prescribing providers must initiate Next Business Day PA requests following notification that a PA is needed?
Answer 13: *There are no timeframes for providers submitting PA requests. However, you should aim to upfront as many PA requests as possible to help reduce obstacles that may lead to a patient's lapse of medication. Patients and providers can also request a 72 hours emergency supply if needed.*

Question 14: Regarding the Next Business Day PA and Peer to Peer Process, bullet point 2 states that the actual peer to peer must be conducted by the prescribing provider or by a "delegate with clinically appropriate authority that has knowledge of the clinical condition of the member." Must this be another prescriber, or could it be an RN who works with the member? I'm assuming that it cannot be a nonmedical person.
Answer 14: *It must be a prescriber. It cannot be an RN or a nonmedical person.*

Question 15: I believe that you advised that we may verbally request an Expedited Health Plan Appeal during our phone peer to peer request if it is denied - does that alone constitute "filing" an expedited appeal (Health Plan Appeals, bullet point 2)? If not, or if that verbal request is not made at that time, is there a timeframe within which a prescribing provider must request an Expedited Health Plan Appeal, or is that the same as the 60-day window as for a Standard Appeal? What is the mechanism for making that appeal request?
Answer 15: Well Sense Health Plan (WSHP): *an expedited appeal can be requested on behalf of the patient during a Peer to Peer review. The provider will be transferred to Well Sense's Customer Care Department to file the appeal.*
NH Healthy Families (NHHF): *the provider can file an appeal on behalf of a patient by contacting the appeals department at 866-769-3085.*

Question 16: If, after a Peer to Peer discussion, the denial is upheld and the prescriber agrees to a taper, what is the process for requesting the authorization for the taper?
Answer 16: WSHP: *The provider may indicate during the Peer to Peer review agreement to switch to an alternative covered product and request a short-term approval for the requested product in order to appropriately taper the patient off of the product. The provider should specify the duration of the requested approval on the PA form.*
NHHF: *Upon the upholding of the denial, if the provider requires a tapering dose that allows them to transition a member to a formulary alternative, they may reach out to NH Healthy Families at 844-761-1064.*

Question 17: If a provider decides to preemptively request a taper, what is the process for that PA request?

Answer 17: WSHP: *The provider should indicate on the PA form that the patient will be switched to an alternative covered product, but is requesting a short-term approval of the requested product in order to appropriately taper the patient off of the product. The provider should specify the duration of the requested approval on the PA form.*
NHHF: *In the event a provider would like to taper a member preemptively, they may complete a PA form with strengths required with information regarding the need for this approval for a tapering regimen.*

Question 18: I believe that you advised that a request for "aid pending appeal," if needed, should be made when filing an Expedited or Standard Health Plan Appeal as well as when requesting a State Fair Hearing later in the process if that proves necessary. The information about "aid pending appeal" is included under the State Fair Hearing heading, so I just wanted to confirm that it may be requested earlier in the appeal process. If "aid pending appeal" is requested at this earlier point (when an Expedited or Standard Health Plan Appeal is requested), is there a timeframe in which this aid request must be made (the timeframe specified in the information pertains only to requests made after a denial on Expedited Appeal)? Must the request for "aid pending appeal" come directly from the member, or can this be initiated by the provider/treating staff or pharmacist? How is this request made? Is a second request for "aid pending appeal" required if an initial request was approved during a Health Plan Appeal and the process continues to a State Fair Hearing, or will the initial approval automatically extend until a final decision is reached?
Answer 18: *Aid pending appeal means that the patient receives medication while the appeal is pending an outcome. The patient, authorized representative, or the provider with written permission from the patient, is able can request aid pending appeal any time an appeal is requested. Aid pending appeal must be requested within ten calendar days of the denial notice or within ten days of the intended effective date of the health plan's action. A second request for aid pending appeal would need to be initiated if the process continues to State Fair Hearing. If the health plan's action is upheld, the patient may be liable for the cost of the continued medication.*

Question 19: Who may request a State Fair Hearing, and how is this request made?
Answer 19: *The patient, authorized representative, or the provider with written permission from the patient, is able to request a State Fair Hearing. Information on how to make this request is included in the denial letter.*

Question 20: How do I register a complaint about a health plan and this process?
Answer 20: *Each plan has provided for a complaint mailbox for providers so that issues can be resolved and/or responded to by the close of the next business day from receipt of complaint. Well Sense Health Plan can be reached at pharmacym@bmchp-wellsense.org. NH Healthy Families can be reached at NH_Pharmacy@Centene.com. It is very important that complaints, with as much specificity as possible, be emailed to each health plan since a complaint log is submitted weekly to the Department as outlined in the weekly reporting requirements. This complaint log will inform reporting requirements specific to HB517.*

Question 21: How do patients complain or raise a grievance?
Answer 21: *Patients should outreach to their health plan. Well Sense Health Plan can be reached at 877-957-1300. NH Healthy Families can be reached at 866-769-3085.*