HIGHMARK HEALTH OPTIONS

Updated: 09/2024
Approved: 1/2024

**Request for Prior Authorization for Medical Necessity Medication**
**Website Form – www.wv.highmarkhealthoptions.com**
**Submit request via: Fax - 1-833-547-2030.**

All requests for medications that require medical necessity review and require a prior authorization will be screened for medical necessity and appropriateness using the criteria listed below. This policy applies to medications outside the scope of the West Virginia PDL that do not have Bureau for Medical Services (BMS) restrictions. For requests for medications on the West Virginia PDL that require prior authorization or are non-preferred, refer to the West Virginia PDL prior authorization guidelines.

**Medical Necessity Medication Prior Authorization Criteria:**

For all requests, all of the following criteria must be met:

- The requested medication has a diagnosis that is one of the following:
  - An FDA-approved indication or
  - A medically accepted indication that is supported by nationally recognized compendia defined as one of the following:
    - American Hospital Formulary Service Drug Information (AHFS-DI): "supportive"
    - Drugdex (Micromedex): level of evidence Class I, Class IIa, or Class IIb
    - United States Pharmacopeia Drug Information (USP-DI)
  - Supported by peer-reviewed medical literature:
    - Use supported by clinical research that appears in at least 2 Phase III clinical trials that definitively demonstrate safety and effectiveness
    - If no Phase III trial evidence is available, at least 2 Phase II clinical trials with reasonably large patient samples showing consistent results of safety and efficacy.
    - Phase II or Phase III trials must come from different centers and be published in national or international peer-reviewed journals.
    - Literature including scientific and medical publications. This does not include in-house publications of pharmaceutical manufacturing companies or abstracts (including meeting abstracts).
- The medication is aligned with pertinent clinical treatment modalities based on current national treatment guidelines or peer reviewed literature.
- If an FDA-approved companion diagnostic test for the requested agent exists, documentation that the test was performed to confirm the diagnosis
- If a test with adequate ability is necessary to confirm a disease mutation exists, documentation that the test was performed to confirm the diagnosis
- The requested medication is being prescribed by or in consultation with an appropriate specialist (when applicable (i.e. a formulary product from the same class requires a specialist in its specific prior authorization criteria)).
- Documentation of all pertinent clinical information related to the request from available sources (i.e., Primary Care Physician, Facility Utilization Review Department, Medical Record Department) including but not limited to:
  - Age
  - Contraindications or intolerances member had to previous therapies
  - Treatment history
  - Past medications
  - Diagnosis/co-morbidities

        - Medical history
        - Current medications
        - Previous test results
        - Current laboratory results
        - Physical exam findings
        - Any other data or rationale to support the medical necessity of the request
    - The request cannot be for an experimental, cosmetic, or investigational treatment
    - The dose and frequency of the requested medication is appropriate based upon the FDA-approved package insert, nationally recognized compendia or peer-reviewed medical literature.
    - The medication does not interact with other medications, which may result in a serious or life threatening adverse reaction.
    - The member does not have a contraindication to the requested medication
- **Initial Duration of Approval:** Up to 12 months dependent upon clinical discretion with consideration given to if the requested medication is classified as a maintenance drug.
- **Reauthorization criteria:**
    - Documentation from the provider the member had a positive clinical response and is able to tolerate therapy.

**Reauthorization Duration of Approval:** Benefit is approved for the requested duration or up to 12 months dependent on clinical discretion.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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# MEDICAL NECESSITY MEDICATION PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

## PROVIDER INFORMATION

| | |
|---|---|
| Requesting Provider: | NPI: |
| Provider Specialty: | Office Contact: |
| Office Address: | Office Phone: |
| | Office Fax: |

## MEMBER INFORMATION

| | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

## REQUESTED DRUG INFORMATION

| | | |
|---|---|---|
| Medication: | Strength: | |
| Directions: | Quantity: | Refills: |
| Is the member currently receiving requested medication? ☐ Yes ☐ No | Date Medication Initiated: | |
| Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No | | |

## Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

## Place of Service Information

| | |
|---|---|
| Name: | NPI: |
| Address: | Phone: |

## MEDICAL HISTORY (Complete for ALL requests)

| | |
|---|---|
| Diagnosis: | ICD Code: |

## CURRENT or PREVIOUS THERAPY

| Medication Name | Strength/ Frequency | Dates of Therapy | Status (Discontinued & Why/Current) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

## SUPPORTING INFORMATION or CLINICAL RATIONALE

**Please submit documentation including recent chart notes, diagnostic evaluations, test results, etc.**

| Prescribing Provider Signature | Date |
|---|---|
| | |