



Health Alliance Medical Plans

ONLINE PORTAL

Quick Reference Guide

Last Updated June 2021

Information provided is subject to change without notice

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Contact Information

Phone: (800) 851-3379, Option 4

Fax: (217) 902-9798

HOW TO SET UP A PHARMACY PRIOR AUTHORIZATION FOR MEDICATION THROUGH THE ONLINE PROVIDER PORTAL

The online provider portal can be reached at <https://provider.healthalliance.org/>. Providers are required to create an account that may require a NPI number. If any issues, can always contact provider services. Once logged in, the provider can request a preauthorization through Altruista Health.

Select the Pharmacy tab to start PA process for medication review.

OutPatient Pharmacy HCBS

Auth Details

Search By: Select Auth Type: Select Auth Id:

Auth Priority: Select From Date: To Date: Auth Creation Date:   [Config Columns](#)

	Member ID	Last Name	First Name	Auth#	Auth priority	Auth Type	Provider Name	From Date	To Date	Created Date and Time	Appr.	Auth Closed Date and Time
:	54035536401	BOGUS	TEST	0614MLDUH	UM Urgent	OutPatient - DME	N/A	06/14/2021	07/01/2022	06/14/2021 01:54:53 PM	0	N/A

Input member name (First Last) and DOB (MM/DD/YYYY).

Request Authorization

Member Search

Index Name: Select

* Member DOB: MM/DD/YYYY

Member First Name: Enter

Member Id: Enter

Member Last Name: Enter

* Member Name: Enter

Determine the correct template.

Plan Type **MEDICARE ADV/SUP** Status **Active**
Code M Start Date 01/01/2014 End Date 12/31/2099

Entity **BOGUS ENTITY** Group Code **HCFA BILLING** Subgroup **HCFA BILLING**
Code BOG Code HCFA02 Code HCFA02_001

Plan Code **WASHINGTON MC ADV BOGUS**
Code WAM

Additional Details
Member ID **94036003403**

Care Setting/Auth type
Select

The only options that should be used by providers for medications are:

Pharmacy – Medicare Part B (Used for medications that are billed medically, supplied by the provider, and administered in office.)

Pharmacy – Medicare Part D (Used for medications that are filled by the pharmacy.)

**For medication that requires B vs D determination, use the Part D template to start. Health Alliance staff will alter as needed upon completion.

Pharmacy – Commercial Medical (Used for medications that are billed medically, supplied by the provider and administered in office.)

Pharmacy – Commercial Rx (Used for medications that are filled by the pharmacy.)

**The Vital and Evicore options are not for use by providers and should never be selected by PA staff.

Member's plan type determines if the Medicare or Commercial template should be used.

Provider Details

Fill in provider's information. Note: Provider information is for PA review and notification purposes only. Pharmacy approvals are for the medications themselves. If a medication is approved, the member can use any in-network provider. (Providers looking for out-of-network coverage would need to submit a separate review through medical utilization management.)

***Fax number input should be the office we can contact for additional information if needed. ***

Pharmacy – Medicare Part B Template

Provider Details

Where Are Requested Services Performed?

Facility Provider Name

Provider Name

Begin typing name or code to select

Q

Requesting Provider Name

Provider Name

Begin typing name or code to select

Q *

Requesting Provider Fax

00000-0000

*

Provider Details

Where Are Requested Services Performed?

Requesting Provider Name

Provider Name

Begin typing name or code to select

Q *

Requesting Provider Fax

00000-0000

*

Pharmacy – Commercial Medical

Provider Details

Where Are Requested Services Performed?

Requesting Provider Name

Provider Name

Begin typing name or code to select

Q *

Referred By Provider Fax

00000-0000

*

Rendering Provider Name

Provider Name

Begin typing name or code to select

Q

Auth Basic Details

Only the highlighted selection below should be filled in by provider office staff. They are noted with a star next to the field name.

Pharmacy – Medicare Part B and Pharmacy – Medicare Part D Templates

Auth Basic Details

Where Are Requested Services Being Performed?

Request Received on Date/Time

MM/DD/YYYY

*

Supporting Statement Received

MM/DD/YYYY

Auth Priority

Select

*

☐ Is Extension

Treatment Type

Select

Request Received Via

Select

*

Place Of Service

Select

*

Auth Basic Details

Where Are Requested Services Being Performed?

Request Received on Date/Time

MM/DD/YYYY

*

Auth Priority

Select

*

☐ Is Extension

Treatment Type

Select

Request Received Via

Select

Request received on Date/Time: Fill in with the time the Auth is submitted.

Auth Priority: Select if review is for post service, expedited or standard preservice.

- **Post Service:** Use when the claim has already been billed. ***Approval is not guaranteed for any claims submitted before prior was obtained. ***
- **Expedited (urgent):** Use when a decision is needed within 24 hours. By marking the request as expedited, this limits the time for review. Provider should be prepared to respond to any request for additional information within 24 hours from time of original review submission.
 - Per health care reform, urgent means medical care or treatment where using the timetable for non-urgent care determination could seriously jeopardize the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.
 - DO NOT MARK EXPEDITED IF:
 - Member has already received medication.
 - Requesting reauthorization and previous Auth has not expired.
- **Standard Preservice:** Use on most claims. Review is done within 72 hours. Timeframe for review depends on whether additional information is needed and, if so, how long it takes to collect that information.

Request Received Via: Provider selects **Web Portal**.

Place of Service: Where is member receiving/using medication?

Diagnosis and Services Codes

Diagnosis Description: Please include an ICD-10 Dx code. The portal allows reviews to be submitted without this information. However leaving out this code may result in extended review times or denial due to lack of information.

Procedure Description (on medical templates): Please use J codes/Q codes. (Pharmacy templates are for medications only, do not include any codes for any other services, testing, or equipment. Those codes should be submit through medical utilization management (UM).)

Medication Description (on prescription templates): When possible use NDC codes to find the appropriate medication. Please make sure to specify if request is for Brand or generic. (Picking a Brand name could change the results of the decision. If a generic cannot be located, please note whether request is for name brand or generic in the notes section.)

Diagnosis and Service Codes

Diagnosis Codes

ICD Version : ICD-10

Diagnosis Description

Begin typing Code or Description

Diagnosis Code

+

-

Procedure Codes

Procedure Description

Begin typing Code or Description

Q

*

Procedure Code

*

Unit Type

Select

From Date

MM/DD/YYYY

*

To Date

MM/DD/YYYY

*

Requested/Approved

*

+

-

Medication Codes

Medication Description

Begin typing Code or Description

Medication Code

Strength

Frequency

Select

From Date

MM/DD/YYYY

To Date

MM/DD/YYYY

Req.

Appr.

+

-

Diagnosis and Service Codes

Diagnosis Codes

ICD Version : ICD-10

Diagnosis Description

Diagnosis Code

Begin typing Code or Description

Medication Codes

Medication Description

Medication Code

Strength

Frequency

From Date

To Date

Requested

Approved

Begin typing Code or Description

Select

MM/DD/YYYY

MM/DD/YYYY

Diagnosis and Service Codes

Diagnosis Codes

ICD Version : ICD-10

Diagnosis Description

Begin typing Code or Description

Diagnosis Code

+

-

Procedure Codes

Procedure Description

Begin typing Code or Description

Procedure Code

Unit Type

Select

From Date

MM/DD/YYYY

To Date

MM/DD/YYYY

Requested/Approved

+

-

For All Templates

Providers please leave the Additional Details section blank. This is for health plan staff use.

Additional Details

Service Dates/Discharge Details

Additional Information Details

Additional Information Requested Date

MM/DD/YYYY

Additional Information Received Date

MM/DD/YYYY

Is Complete

☐

Notes

Add notes in the Notes section and then save to create the prior authorization request.

DO NOT copy and paste chart notes in this section. Chart notes should be added as an attachment in the documents section.

DO use this section to add in any additional free form comments.

Notes

Notes

provider notes

Save

10

Documents can be added by going out to the main authorizations page and locating the authorization that was just created. Select the three dots located on the left hand side of the new/existing authorization.

	Member ID	Last Name	First Name	Auth#	Auth priority	Auth Type	Provider Name	From Date	To Date	Created Date and Time	Appr.	Auth Closed Date and Time	
	94036003403	BOGUS	HEALTH	0621MPKRY	Rx Medicare Part B Standard Preservice	Pharmacy - Medicare Part B	N/A	06/21/2021	06/21/2021	06/21/2021 02:25:44 PM	0	N/A	

Select Add Document which will bring up the screen below.

Add Document 

* Type of Document

Select 

* Description

Add notes here

* Select File 

 [Upload Files](#)

Save

[Cancel](#)

***Please note: Missing documentation can result in delayed decisions and/or a denial due to lack of information.**

Select note type, add a note description, and load document. Then save.

This completes the PA submission.

Health Alliance Medical Plans Preferred Product Quick Reference

		Commercial	Medicare
Diabetes - DPP4	Tradjenta	P	T3
	Januvia	P	T3
	Jentadueto	P	T3
	Janumet	P	T3
Diabetes - GLP-1	Ozempic	P	T3
	Rybelsus	P	T3
	Trulicity	P	T3
	Victoza	P	T3
	Bydureon	P	T4
	Byetta	P	NF
Diabetes - SGLT2i	Invokana	P	T3
	Invokamet	P	T3
	Jardiance	P	T3
	Synjardy	P	T3
Diabetes - Insulin	Humulin vials	P	T1
	Humulin pens	P	T3
	Humalog	P	T3
	Lantus	P	T3
	Levemir	P	T3
	Toujeou	P	T3
	Tresiba	P	T4
Diabetes - Test strips	Freestyle	P	B
	Precision Xtra	P	B
	all others	Exc	NF

		Commercial	Medicare
Inhaler - Beta Agonist	albuterol HFA	P	T2
	albuterol neb	P	T2
	Proair HFA	P	T2
	Ventolin	P	T2
	levalbuterol neb	P	T4
	levalbuterol inh	Exc	T2
Inhaler - ICS	Asmanex	P	T3
	Pulmicort	P	T3
	Qvar	P	T3
Inhaler - LABA	Brovana	NP	T4
	Perforomist	NP	NF
	Arcapta Neohaler	Excl	T4
	Serevent Diskus	P	T3
	Striverdi	P	T3
Inhaler - LABA/ICS	Symbicort	P	T3
	Dulera	P	T3
	Wixela	P	T2
	fluticasone/salmeterol (gen.Advair)	P	T2
	fluticasone/salmeterol (gen.AirDuo)	P	T2
Inhaler - LAMA	Tudorza	Exc	T3
	Atrovent HFA	P	T3
	Spiriva	P	T3
	Incruse Ellipta	P	NF
Inhaler - LAMA/SAMA	Combivent	P	T3
	ipatropium/albuterol neb	P	T1
Inhaler - LAMA/LABA	Anoro Ellipta	P	T3
	Stiolto Respimat	P	T3
Inhaler - Triple	Trelegy	P	T3
	Breztri	P	NF

P=Preferred product, NP=Non-preferred product, NF=Non-formulary, Exc=Excluded, T1=Preferred generic (Medicare), T2=Non-preferred generic (Medicare), T3=Preferred brand (Medicare), T4=Non-preferred drug (Medicare), T5=Rx Specialty (Medicare), B=coverage on Medicare B

****Last Updated 6/1/2021. Preferred drug lists are subject to change without notice.**

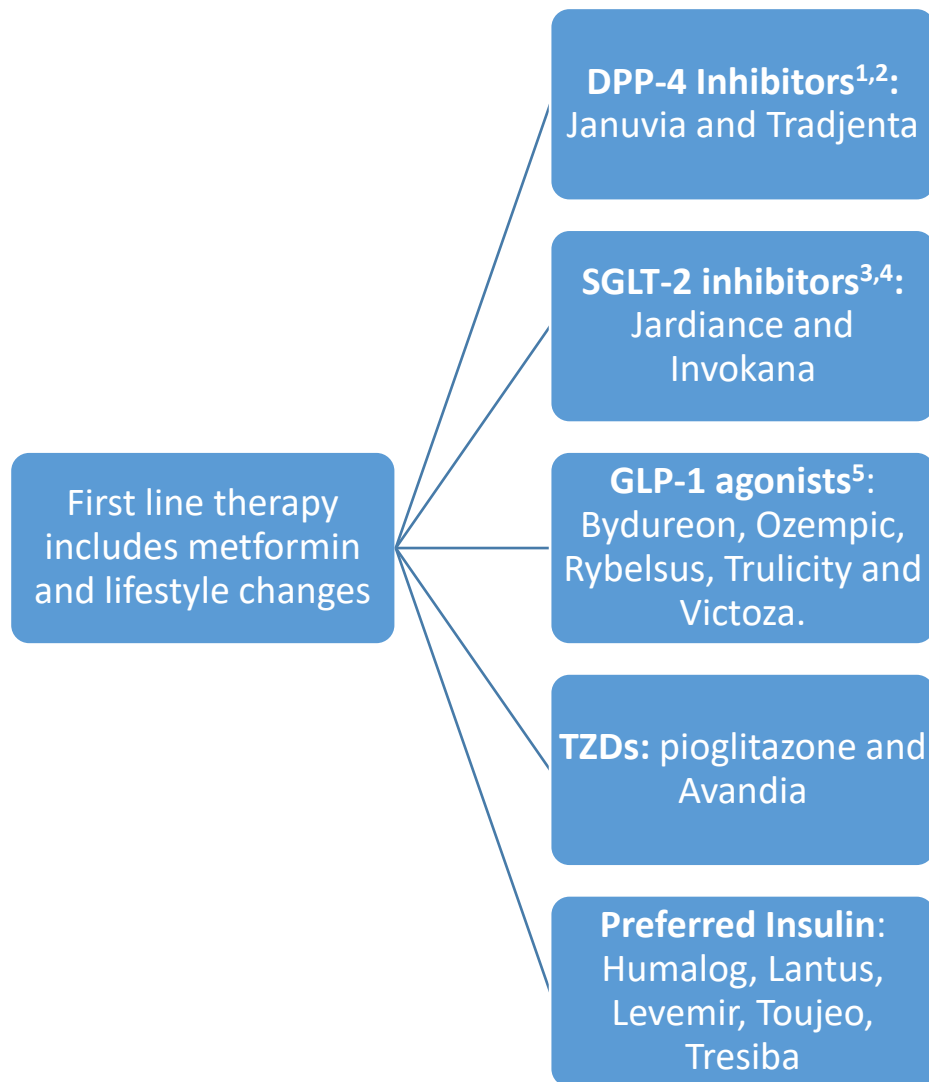
Health Alliance Medical Plans Preferred Product Quick Reference

		Commercial	Medicare
Rheumatoid Arthritis	Cimzia	P	T5
	Humira	P	T5
	Simponi	P	NF
	Simponi Aria	P	NF
	Xeljanz/XR	P	T5
	Rinvoq	P	T5
	Inflectra	P	T5/B
	Renflexis	P	T5/B
	Avsola	P	T5/B
Psoriatic Arthritis	Cimzia	P	T5
	Humira	P	T5
	Simponi	P	NF
	Simponi Aria	P	NF
	Stelara IV	P	T5/B
	Stelara SQ	P	T5
	Tremfya	P	NF
	Otezla	P	T5
	Xeljanz/XR	P	T5
	Inflectra	P	T5/B
	Renflexis	P	T5/B
	Avsola	P	T5/B
Psoriasis	Cimzia	P	T5
	Humira	P	T5
	Stelara IV	P	T5/B
	Stelara SQ	P	T5/B
	Tremfya	P	NF
	Otezla	P	T5
	Skyrizi	P	NF
	Inflectra	P	T5/B
	Renflexis	P	T5/B
	Avsola	P	T5/B
Crohn's Disease	Cimzia	P	T5
	Humira	P	T5
	Stelara IV	P	T5/B
	Stelara SQ	P	T5
	Inflectra	P	T5/B
	Renflexis	P	T5/B
	Avsola	P	T5/B
Ulcerative Colitis	Humira	P	T5
	Simponi	P	T5
	Simponi Aria	P	T5/B
	Stelara IV	P	T5/B
	Stelara SQ	P	T5/B
	Xeljanz/XR	P	T5
	Inflectra	P	T5/B
	Renflexis	P	T5/B
Atopic Dermatitis	Dupixent	P	T5
Ankylosing Spondylitis	Cimzia	P	T5
	Humira	P	T5
	Simponi	P	NF
	Simponi Aria	P	NF
	Inflectra	P	T5/B
	Renflexis	P	T5/B
	Avsola	P	T5/B

P=Preferred product, NP=Non-preferred product, NF=Non-formulary, Exc=Excluded, T1=Preferred generic (Medicare), T2=Non-preferred generic (Medicare), T3=Preferred brand (Medicare), T4=Non-preferred drug (Medicare), T5=Rx Specialty (Medicare), B=coverage on Medicare B

****Last Updated 6/1/2021. Preferred drug lists are subject to change without notice.**

Diabetes Preferred Products



1. All products require a minimum 3-month trial with metformin or a formulary insulin product.
2. Non-preferred products require trial of both preferred products prior to coverage. Non-preferred products include: Onglyza, Kombiglyze, Kombiglyze XR, Nesina, Oseni, Kazano, alogliptin, alogliptin-pioglitazone, alogliptin-metformin.
3. All products require a minimum 3-month trial with metformin or a formulary insulin product.
4. Non-preferred products require trial of both preferred products prior to coverage. Non-preferred products include: Farxiga, Xigduo XR, Steglatro, Segluromet.
5. All products require a minimum 3-month trial with metformin or a formulary insulin product.

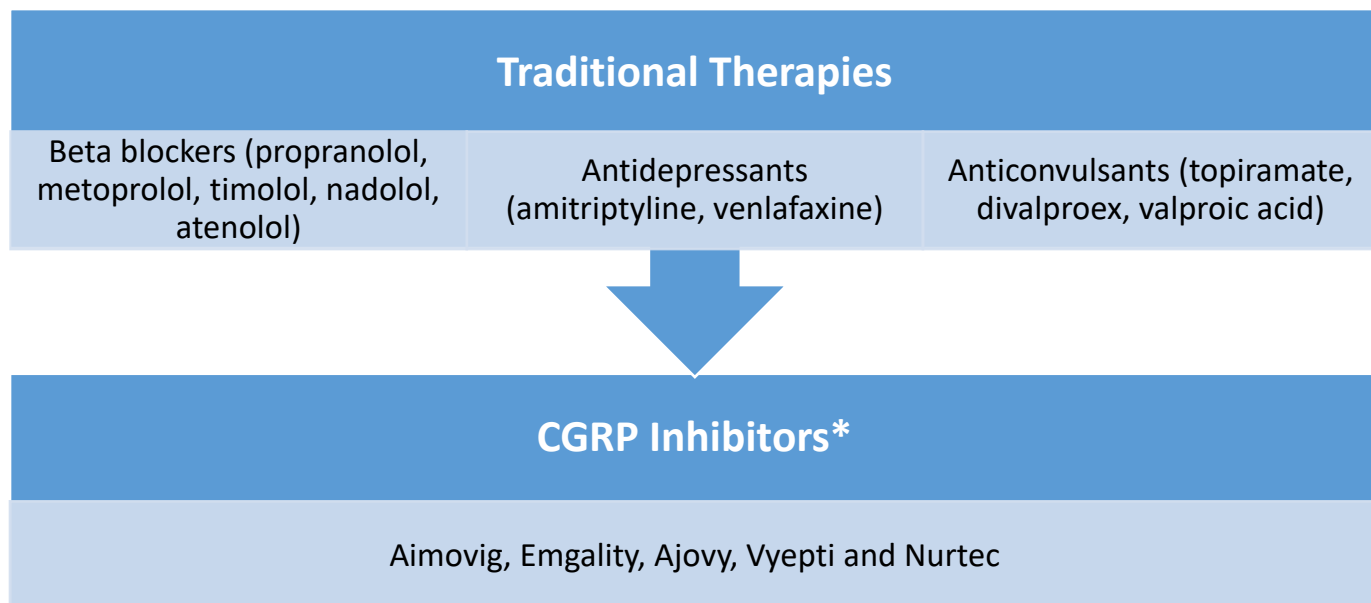
****Please note:** Xultophy and Soliqua require a minimum 3-month trial with a GLP-1 or long acting insulin. Soliqua is non-formulary for Medicare patients.

Preferred Glucometer and testing supplies includes Abbott (Freestyle) products.

American Diabetes Association. 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Medical Care in Diabetes – 2021. Diabetes Care 2021; 44: S111-124.

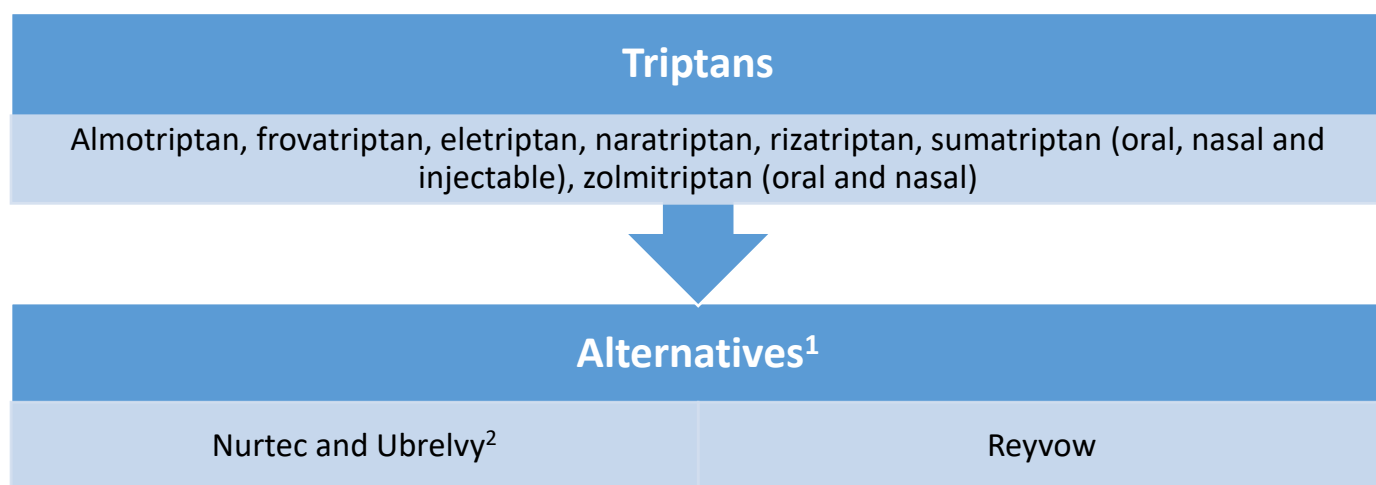
Migraine Preferred Products

Prophylaxis



*CGRP Inhibitor coverage requires consultation with a neurologist, pain specialist or other migraine management specialist in addition to failure to TWO traditional therapies.

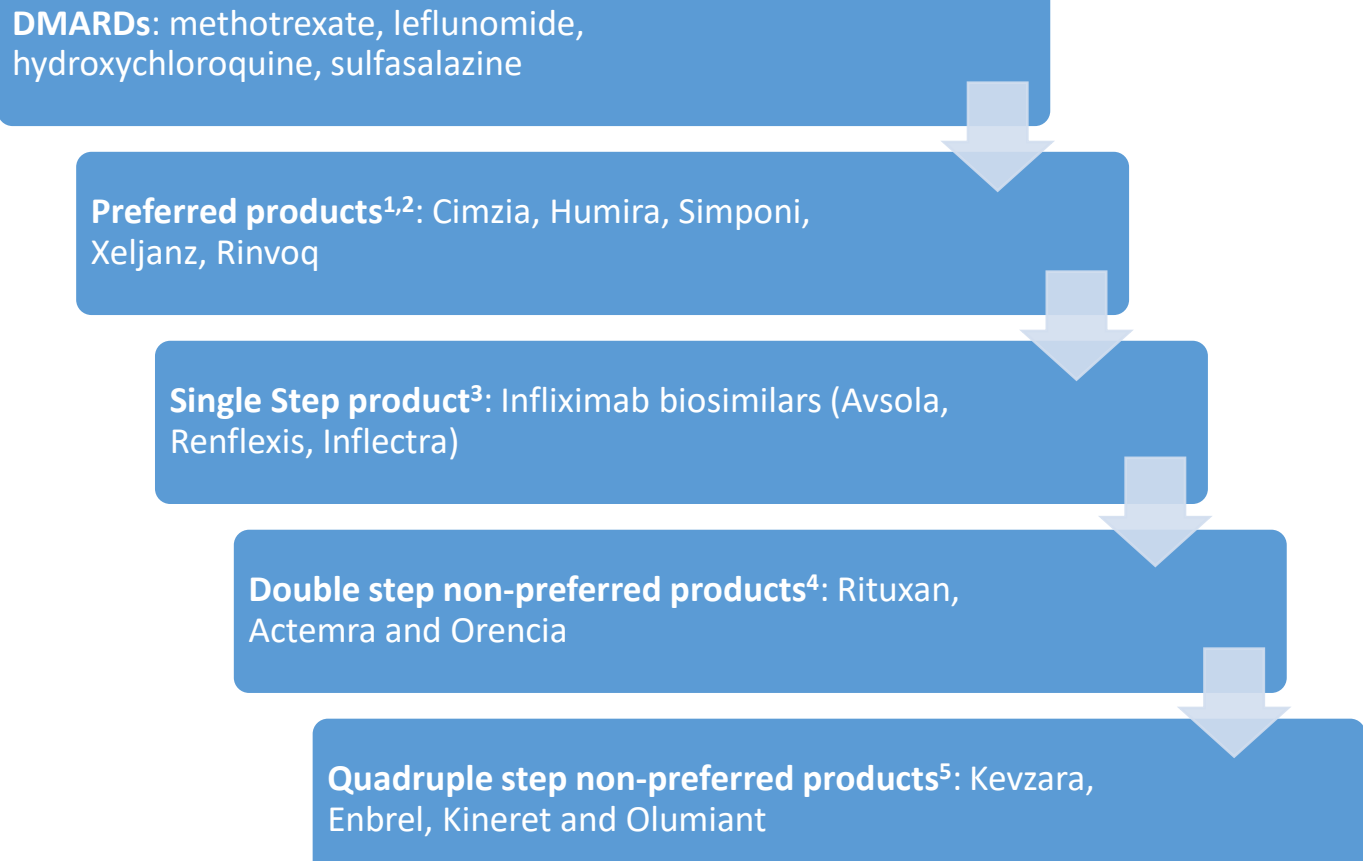
Abortive



1. Coverage of alternative therapies requires consultation with a neurologist, pain specialist or other migraine management specialist in addition to TWO Triptans. Patients must be established on a supported preventative therapy if having more than 4 migraines per month.
2. Nurtec and Ubrelvy are not covered if the patient is also taking an injectable CGRP inhibitor.

Rheumatoid Arthritis Preferred Products

DMARDs: methotrexate, leflunomide, hydroxychloroquine, sulfasalazine



Preferred products^{1,2}: Cimzia, Humira, Simponi, Xeljanz, Rinvoq

Single Step product³: Infliximab biosimilars (Avsola, Renflexis, Inflectra)

Double step non-preferred products⁴: Rituxan, Actemra and Orencia

Quadruple step non-preferred products⁵: Kevzara, Enbrel, Kineret and Olumiant

1. Preferred products require a minimum 3-month trial with a DMARD.
2. Medicare preferred products are Humira and Enbrel.
3. Infliximab biosimilars (Renflexis, Inflectra and Avsola) require a minimum 3-month trial with a DMARD AND trial with a preferred product (Cimzia, Humira, Simponi, Xeljanz or Rinvoq). Please note brand Remicade requires previous trial with an infliximab biosimilar.
4. Actemra and Orencia require a minimum 3-month trial with TWO preferred products.
5. These products require a minimum 3-month trial with TWO preferred products AND BOTH Actemra AND Orencia.

****MEDICARE patients:** Simponi, Olumiant and Kevzara are non-formulary so coverage would require trial with all formulary alternatives.

Psoriatic Arthritis Preferred Products

DMARDs: methotrexate, leflunomide, hydroxychloroquine, sulfasalazine

Preferred products^{1,2}: Cimzia, Humira, Simponi, Stelara, Tremfya, Otezla

Single step non-preferred product³: Taltz

Double step non-preferred products⁴: Xeljanz and Orencia

Quadruple step non-preferred products: Enbrel⁵ and Cosentyx⁶

1. Preferred products require a minimum 3-month trial with a DMARD.
2. Medicare preferred products are Humira and Enbrel.
3. Taltz requires a minimum 3-month trial with Cimzia, Humira, Simponi, Stelara or Tremfya.
4. These products require a minimum 3-month trial with TWO of the following: Cimzia, Humira, Simponi, Stelara or Tremfya.
5. Enbrel requires a minimum 3-month trial with TWO of the following: Cimzia, Humira, Simponi, Stelara or Tremfya; AND TWO of the following: Orencia, Taltz or Xeljanz.
6. Cosentyx requires a minimum 3-month trial with TWO of the following: Cimzia, Humira, Simponi, Stelara or Tremfya; AND Taltz AND either Orencia or Xeljanz.

****MEDICARE patients:** Simponi, and Tremfya are non-formulary so coverage would require trial with all formulary alternatives.

American Academy of Dermatology Work Group, Menter A, Korman NJ, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. J Am Acad Dermatol 2011; 65:137.

Plaque Psoriasis Preferred Products

Traditional Therapy: topical steroids, phototherapy
AND oral immunosuppressants (such as
methotrexate, cyclosporine and acetretin)



Preferred products^{1,2}: Cimzia, Humira, Stelara,
Tremfya, Skyrizi, and Otezla



Single step non-preferred product³: Taltz



Quadruple step non-preferred products⁴: Enbrel,
Cosentyx, Siliq, and Ilumya

1. Preferred products require a minimum 3-month trial with a topical steroids, phototherapy AND an oral immunosuppressant.
2. Medicare preferred products are Humira and Enbrel.
3. Taltz requires a minimum 3-month trial with Cimzia, Humira, Skyrizi, Stelara or Tremfya.
4. These products require a minimum 3-month trial with Taltz AND THREE of the following: Cimzia, Humira, Skyrizi, Stelara or Tremfya.

****MEDICARE patients:** Tremfya, Ilumya and Siliq are non-formulary so coverage would require trial with all formulary alternatives.

Menter A, Strober, BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. Journal of the American Academy of Dermatology. Clinical Practice Guideline. 2019 April 1: 80(4); 1029-1072.

Crohn's

Traditional Therapy: corticosteroids and oral immunosuppressants (such as azathioprine, mercaptopurine or methotrexate)



Preferred products¹: Humira, Cimzia, Stelara



Single Step product²: Infliximab biosimilars (Avsola, Renflexis, Inflectra)

1. Preferred products require a minimum 3-month trial with oral steroids AND an oral immunosuppressant.
2. Infliximab biosimilars (Renflexis, Inflectra and Avsola) require a minimum 3-month trial with an oral immunosuppressant AND trial with a preferred product (Cimzia, Humira, Simponi, Xeljanz or Rinvoq). Please note brand Remicade requires previous trial with an infliximab biosimilar.

Ulcerative Colitis

Traditional Therapy: corticosteroids, mesalamine products (mesalamine, sulfasalazine, or balsalazide) and oral immunosuppressants (such as mercaptopurine or methotrexate)



Preferred products¹: Humira, Simponi, Stelara, Infliximab biosimilars (Avsola, Renflexis, Inflectra)



Preferred product with step²: Xeljanz

1. Preferred products require a minimum 3-month trial with oral steroids AND an oral immunosuppressant. Please note brand Remicade requires previous trial with an infliximab biosimilar.
2. Xeljanz requires a minimum 3-month trial with oral steroids AND an oral immunosuppressant or mesalamine product in addition to trial with TWO of the following: Humira, Simponi or Stelara.

Lichtenstein G, Loftus E, Isaacs K, et al. Clinical Guideline: Management of Crohn's Disease in Adults, American Journal of Gastroenterology; April 2018 - Volume 113 - Issue 4 - p 481-517.

Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. Gastroenterology 2020; 158:1450.

Asthma

Initial therapy with as needed SABA (albuterol) or leukotriene receptor antagonist (montelukast or zafirlukast)

ICS¹: Asmanex, Pulmicort or Qvar

ICS-LABA²: Symbicort, Dulera, fluticasone/salmeterol diskus, Wixela

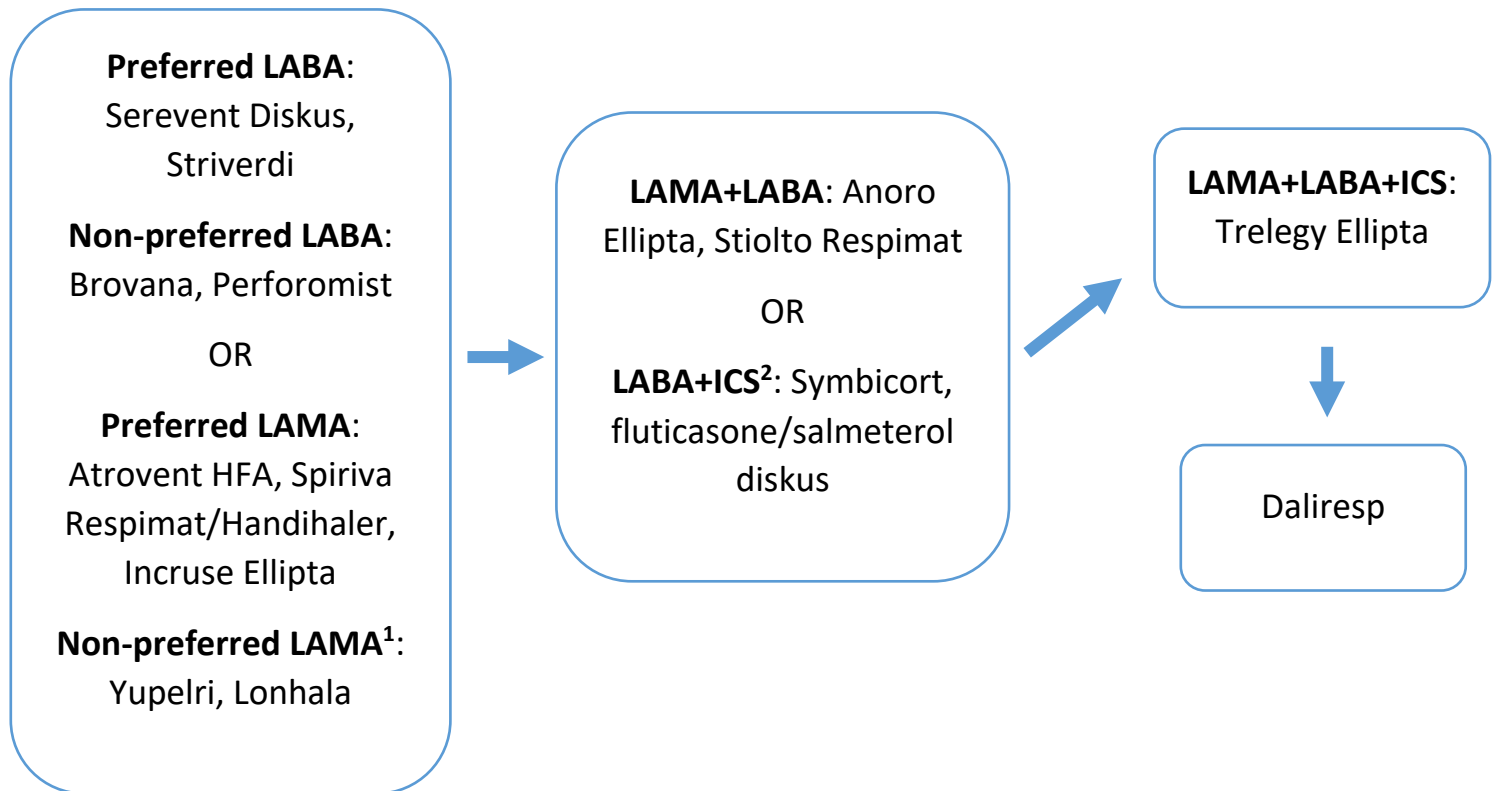
LAMA: Spiriva Respimat
LAMA+LABA+ICS: Trelegy Ellipta

Refer for further assessment and potential addition of a biologic (Xolair, Nucala, Cinqair, Fasenra)

1. Non-preferred ICS inhalers require trial with all three preferred products (Asmanex, Pulmicort and Qvar).
2. Non-preferred ICS/LABA inhalers require trial with BOTH Symbicort and Dulera.

Boulet LP, Reddel HK, Bateman E, et al. Global Initiative for Asthma (GINA), Global Strategy for Asthma Management and Prevention. 2019 Update. Eur Respir J. 2019 Aug 29;54(2):190-598.

Chronic Obstructive Pulmonary Disease (COPD)

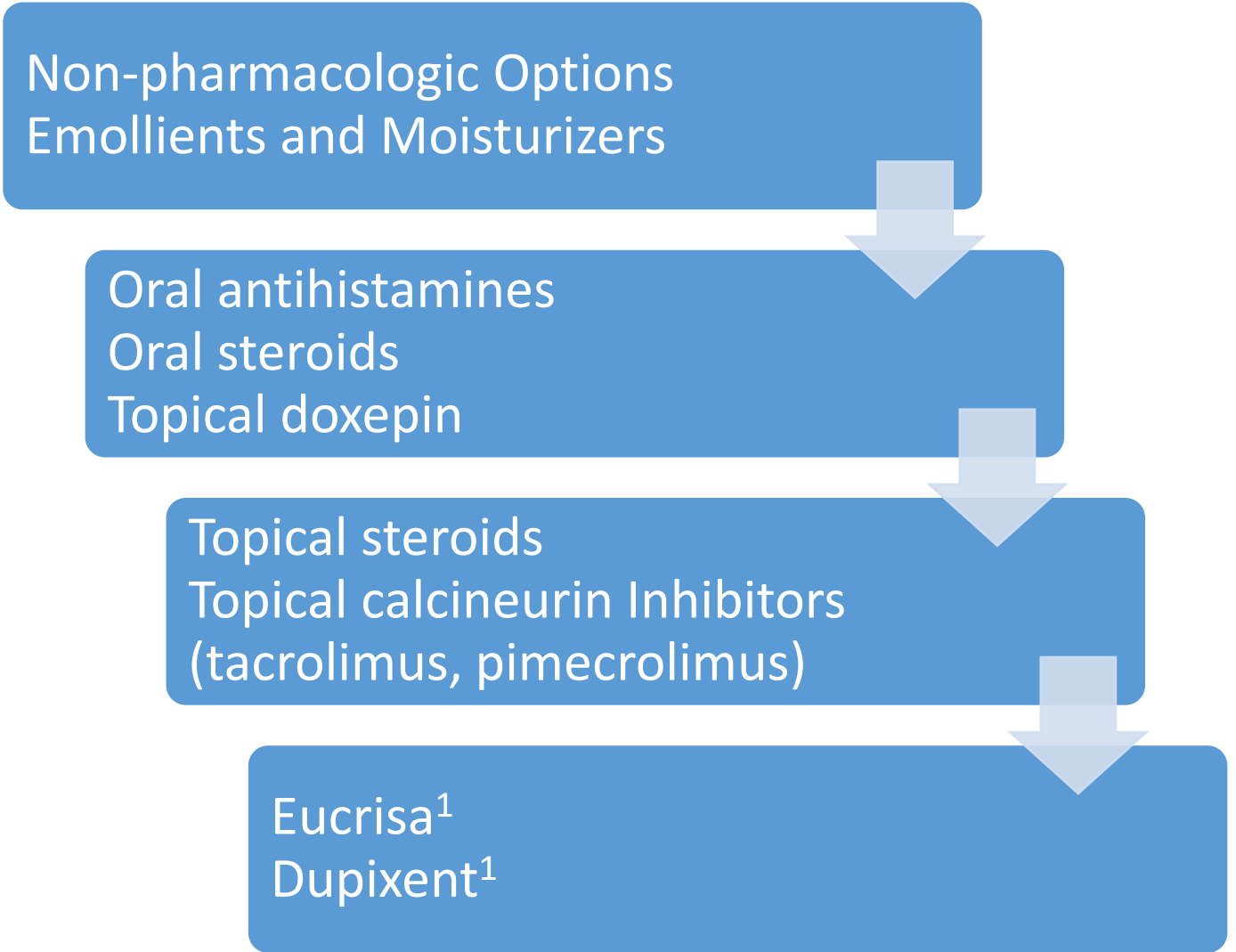


1. Yupelri and Lonhala require trial with at least one preferred LAMA.
2. Coverage of Breo Ellipta and Advair HFA require trial with Symbicort.

Global Initiative for Chronic Obstructive Lung Disease (GOLD), Global Strategy for Prevention, Diagnosis and Management of COPD. 2020 Update.

Atopic Dermatitis

Non-pharmacologic Options
Emollients and Moisturizers



Oral antihistamines
Oral steroids
Topical doxepin

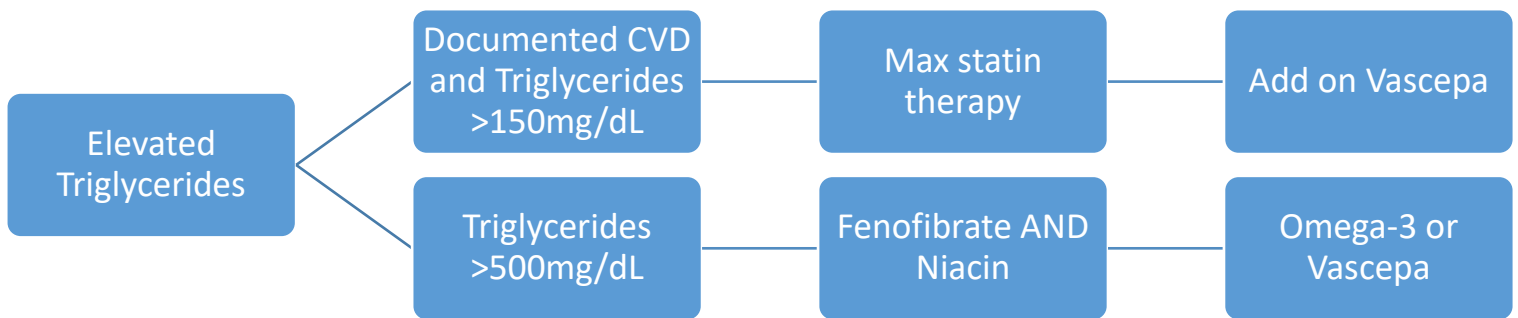
Topical steroids
Topical calcineurin Inhibitors
(tacrolimus, pimecrolimus)

Eucrisa¹
Dupixent¹

1. Eucrisa and Dupixent require trial and failure with a topical steroid AND a topical calcineurin inhibitor (tacrolimus or pimecrolimus).

Eichenfield LF, Tom WL, Berger TG, et al. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. J Am Acad Dermatol. 2014 Jul;71(1):116-32.

Vascepa and Omega-3 Ethyl Esters



Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol. 2019 Jun 25;73(24):e285-e350.

High Risk Medications (HRM) in Elderly*

*Please refer to the American Geriatric Society Beers List for complete list of high risk medications.

Health Alliance Medicare plans require prior authorization for most HRM to ensure their appropriate utilization in our elderly population. The following require attestation from the prescriber that the benefits of therapy outweigh the risks associated given the patient's age (please note additional criteria may be required based on the medication):

- Hydroxyzine
- Cyclobenzaprine
- Amitriptyline
- Doxepin
- Promethazine
- Meprobamate
- Clomipramine
- Imipramine