Drug Exceptions Time Frames and Enrollee Responsibilities

Internal and external exceptions process for people to get non-formulary drugs

Internal:

Criteria for medical exception for coverage:

- Drug is medically necessary AND
- Medication provides clinically superior outcomes compared to currently available agents based upon review of the published literature; OR
- Documentation of trial and failure of currently available agents in the same therapeutic class, including over the counter (OTC); OR
- Documentation of allergic reactions or contraindications to currently available agents, including OTC, in the same therapeutic class.

Practitioner's Office submits the formulary exception request, signed by the practitioner, and submits supporting documentation (i.e., medical records) to the Health Alliance Pharmacy.

Health Alliance Pharmacy Department Procedure

- Pharmacy coordinator inputs the request for pharmacist to review.
- Pharmacist reviews request for the required criteria. The timeline for review and making a determination once all the information is received is 72 hours. In cases of an emergency, an expedited review will take 24 hours.
- If not enough information has been provided to make a decision, the pharmacist may call or have a pharmacy coordinator draft a letter requesting that the practitioner's office send additional information.
- If the Medical Exception request is denied, the pharmacy coordinator drafts a letter to the physician and member stating the reason for denial, an alternative covered medication, if applicable and communicates the appeals process. The Member Relations Department within Quality Management is responsible for processing all member and practitioner appeals.
- If the Medical Exception is approved, a letter is drafted and sent to the physician.

Non-Covered Drug

- An approved Medical Exception request for a non-covered drug will be covered at the non-preferred tier copay (Tier 3 for small molecules; Tier 6 for drugs that meet specialty drug criteria).

External:

Appeals processes vary according to the applicable State and Federal regulations. You or any person you have chosen as your authorized representative, including your Physician or other healthcare provider or attorney, may appeal a denial or partial denial of your claim. The appeal may be submitted either orally or in writing. Refer to your Policy or Subscription Certificate for further details. To submit an appeal in writing, you or your authorized representative may send written comments, documents, records or other information relevant to the review to Health Alliance Member Relations Department, 301 S. Vine St., Urbana, IL 61801. To request an appeal by phone, you or your authorized representative may call the Member Relations Department at 1-800-500-3373. You have the right to review all documents, records,

benefit provisions, clinical criteria and information relevant to your claim upon request. This information will be provided to you free of charge.

You may request more explanation by calling the Customer Service Department at 1-866-247-3296 if you do not understand the reason for the denial, do not understand why the healthcare service or treatment was not fully covered, or do not understand why a request for coverage of healthcare service or treatment was denied. If your claim was denied due to missing or incomplete information, you or your healthcare provider may resubmit the missing information to us and we will review it again.

In the event of conflict or inconsistency between the information presented here and your Policy or Subscription Certificate, the provisions of your Policy or Subscription Certificate will control in all respects.

Appeals are divided into two categories: administrative denials and denials of coverage based on medical necessity. You may appeal an initial denial within 180 days of receiving the denial notice. If your appeal is for medical necessity, a Clinical Peer not involved in the initial determination will make the decision. If your appeal is based on an administrative issue, a review committee or individual not involved in the initial denial will make the decision. The steps and time limits for responding to appeal requests are listed as follows:

Non-Urgent Care and Urgent Care Decisions (Pre-Service Claims)
For Non-Urgent appeal requests, your appeal decision and notification will be made within 15 days of receipt of all requested information, but not later than 30 days after receipt of the request for an appeal. If your request is in need of an urgent review, Health Alliance will make a decision and notify you or your authorized representative, primary care physician and/or treating physician by phone within 24 hours of receipt of all requested information, but no later than 48 hours after receipt of the appeal request. Written notice will be given within three days of the decision.

Concurrent Care Decisions
You, or your authorized representative, physician or other healthcare provider must make the appeal at least 24 hours before the scheduled reduction or termination of coverage for ongoing treatment. Health Alliance will make a decision and notify you or your authorized representative and primary care physician.

Time frame for decision making

- The Pharmacy Department will, within 24 hours after receipt of an expedited coverage determination, either approve or deny the request.
- The Pharmacy Department will, within 72 hours after receipt of a standard (non-urgent) coverage determination, either approve or deny the request.
- The Pharmacy Department will, within 30 days after receipt of a post-service coverage determination, either approve or deny the request.

How to complete the application

Requests for coverage determinations are accepted from members, members' authorized representatives or prescribing providers via the following forms of communication and are not subject to submission of information on a standardized form in order to qualify for review.

- **Verbal** (Monday through Friday; 8 a.m. to 5 p.m. CT) 1-866-247-3296, Option 4
  After-hours messages left with Customer Service will be addressed the next business day
- **Facsimile** (24 hours) 217-255-4598
  Facsimile receipts are timestamped automatically by the fax server
- **Online prescriber portal** (24 hours)
- **Online eviCore portal** (24 hours)
- **Online member portal** (24 hours)
- **Written communication** (Monday through Friday; 8 a.m. to 5 p.m. CT)
  Health Alliance Medical Plans
  Attention: Pharmacy Department
  301 S. Vine St.
  Urbana, IL 61801