- Prior Auths should have a clearly defined requested date range: for instance if a PA is submitted, it is usually not requested to only be covered for 1 or 3 months. The default should be 1 year, unless the prescriber denotes otherwise
- If a PA is denied ALL options in the same category that are allowed with AND without prior should be sent back with the denial for the prescriber to choose the best alternative
- Pharmacists should be able to complete PA requests that do not require diagnosis or records requests. For instance: step therapy and prior use should be allowed to be reported by RPh AND tech's. Prescriber has already written the order so we obviously have their blessing to get it covered. Pharmacists are healthcare providers and as medication utilization and pharmacotherapy experts should have the right initiate a PA. Pharmacists have proven their ability to screen patients, review patient histories, review drug utilization, provide therapy recommendations, and administration of medications through collaborative practice agreements and recently through ordering and administering COVID-19 tests.
- PA's should NOT be limited to a specific pharmacy so patient has right to utilize pharmacy of choice
- No request to initiate a prior auth may be denied. The PA may be denied, but the process must always be allowed to be started. (not sure how to word that better.... Humana told a palliative care doc yesterday they would not do a prior for a dose increase for a methadone script. I think the cust serv rep was misinformed... but still, it was scary the initial response to start a prior was that no priors were allowed.)
- should a pharmacy be notified when a prior is started? priors shouldn't be limited to a pharmacy, but maybe there could be a spot for "pharmacy to notify when decision is reached"?
- Compounds - Inactive ingredients used in compounds should be automatically included with a prior request, unless pharmacies are allowed to apply for the prior directly. Prescribers shouldn't have to list all the ingredients in a multi-ingredient compound, just the actives should be approved and the inactives on that script should be automatically approved.
- Multiple PA's needed on same script. If a PA is applied for, all associated limits for the same script should be implied. For instance, if a drug needs a non-formulary exception approval, once approved we should not have to turn around and apply for a quantity limit approval as a separate PA. These should be all on the same initial request or be implied. Sometimes we only get one rejection at a time and cannot tell the prescriber to apply for both until the first rejection is approved and the second denies.