Pharmacy Processing Information Frequently Asked Questions

Who determines the formulary, how does it affect me and where can I find the formulary?

Superior Medicaid (STAR, STAR+PLUS, STAR Health, STAR Kids) and Children's Health Insurance Plan (CHIP) programs must adhere to the Medicaid and CHIP formularies and clinical criteria determined by the Texas Vendor Drug Program (TXVDP). The Medicaid formulary includes a Preferred Drug List (PDL). Drugs on the Medicaid formulary (PDL) are described as preferred and non-preferred. Drugs on the CHIP formulary do not have a status of preferred or non-preferred. If drugs are listed on the formulary, Medicaid, and CHIP formularies, they are covered, but if they are not listed, they are not covered.

- **Preferred:** Products are listed on the TXVDP PDL and are considered covered. *Please note: some products may require review of clinical criteria through submission of a prior authorization in order to obtain approval.*
- **Non-preferred:** Products are listed on the TXVDP PDL, however are only covered through prior approval. A review must be completed before the product is provided to make sure the product is appropriate and medically necessary.

The Texas Drug Utilization Review (DUR) Board meets quarterly to recommend products for the TXVDP PDL and review medical/therapeutic criteria. Additional information about the Texas DUR Board can be found at https://www.txvendordrug.com/resources/drug-utilization-review-board.

Ambetter from Superior HealthPlan (Marketplace), and STAR+PLUS Medicaid-Medicare Plan (MMP) each follow their own formulary. These formularies are determined by the Centene Corporate Pharmacy and Therapeutic Committee, who utilize clinical and economic criteria to determine which drugs to cover on each formulary.

Not all drugs are included on the various formularies. Each formulary is reviewed by independent physicians and pharmacists on Centene's Pharmacy and Therapeutics (P&T) Committee. For any recommendations to state Drug Utilization Review (DUR) board or to Corporate P&T committees for their consideration, this is completed by Superior HealthPlan Pharmacy Department and/or Superior HeatlhPlan Medical Directors. Please reference the table below for formularies and pharmacy resources for each product.

Formulary and Prior Authorization Information

Product	Formulary/Criteria	Forms/Phone/Fax
Medicaid/CHIP: STAR STAR Health STAR Kids STAR+PLUS CHIP	• **TXVDP Preferred Drug List** found at: www.TXVendorDrug.com/formulary/prior-authorization/preferred-drugs • **PDL Clinical Criteria** found at: SuperiorHealthPlan.com/ClinicalPriorAuth • **Quantity Limits** found at: SuperiorHealthPlan.com/Pharmacy	**Medicaid/CHIP Prior Authorization Request Forms** found at: SuperiorHealthPlan.com/ProviderForms **Pharmacy Relations and Pharmacy Services Prior Authorization and Coverage Determination Department:** • Phone: 1-866-768-7147 • Fax: 1-833-423-2523
Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP)	• **STAR+PLUS MMP Formulary** found at: mmp.SuperiorHealthPlan.com/mmp/prescription-drug-part-d/formulary.html • *Please note: Most drugs on the MMP formulary are covered under Medicare Part D listed as tier 1&2, Medicaid coverable drugs are listed as tier 3.*	**STAR+PLUS MMP Coverage Determination and Redetermination Form** found at: mmp.SuperiorHealthPlan.com/mmp/prescription-drug-part-d/coverage-determinations-exceptions.html **Pharmacy Solutions Coverage Determination:** • Phone: 1-800-867-6564 • Fax: 1-877-941-0480

Marketplace: Ambetter	• **Ambetter Formulary** found at: Ambetter.SuperiorHealthPlan.com/provider-resources/pharmacy.html	**Ambetter Prior Authorization Form** found at: Ambetter.SuperiorHealthPlan.com/provider-resources/pharmacy.html **Pharmacy Relations and Pharmacy Solutions Prior Authorization and Coverage Determination Department:** • Phone: 1-877-725-7749 (option 3) • Fax: 1-800-977-4170

What is Prior Authorization?

Prior authorization is when a physician is required to obtain approval from Superior before we agree to cover a drug. Superior will need to ensure they are covered within the patient's plan (Medicaid, Medicare, etc.), as well as ensure the drug is medically necessary and appropriate for the situation.

Superior Medicaid/CHIP programs must follow clinical prior authorization criteria are based on Food and Drug Administration (FDA)-approved product labeling, national guidelines and peer-reviewed literature established by the Texas Health and Human Services Commission (HHSC). All state Managed Care Organizations (MCO) are required to implement the following clinical criteria:

- Promethazine Agents
- Synagis

What happens when a prior authorization is denied?

If Superior denies a prior authorization request for a prescription drug, the member and requesting provider will receive a written notification detailing the outcome, including member appeal rights for any requests that have been denied.

Medicaid, Ambetter, and CHIP

If an authorization is denied for lack of medical necessity, a formal letter of denial will be sent to both the member and the provider. The letter offers providers the right to discuss the decision with the reviewer, along with additional rights for the member to file an appeal.

- If during this discussion new information is provided, and it is determined that the request should be approved, the original reviewer may overturn their decision.
- If no discussion takes place or it is determined that the information is insufficient, the request will remain denied and the member, a member representative or the provider may request an appeal.

CHIP and Ambetter

Before an adverse determination is made and an authorization is denied, the pharmacy benefit manager or Superior will outreach to the requesting provider to offer a peer-to-peer discussion regarding the potential denial.

- If during the discussion new information is provided, and it is determined that the member meets criteria, then the drug may be approved.
- If there is continued disagreement, a formal letter of denial will be sent to both provider and member in which additional rights will be provided.
- If following receipt of the formal denial notification, additional information is provided and it is determined that the request should be approved, the original reviewer may overturn their decision.
- If no discussion takes place or it is determined that the information is insufficient, the request will remain denied and the member, a member representative or the provider may request an appeal.

What is the appeal process?

The member, a member representative, the pharmacy or the provider may ask for an appeal. A Medical Director who has not previously reviewed the case, practices in the same specialty as a health-care provider who manages the member's condition and is not a subordinate of the original reviewer renders the determination for the appeal.

Medicaid and CHIP

The appeal may be requested verbally or via written request within 60 days from the date of the denial notice letter. All verbal requests require a written confirmation of appeal.

- For standard appeals, decisions are made within 30 calendar days.
- For expedited appeals, decisions are completed within 72 hours of receipt of the appeal or within 1 business day for ongoing emergencies.

Upon completing Superior's internal appeal process, if the appeal decision is upheld the member, a member representative or the provider may request a review of the denial through a State Fair Hearing from HHSC for Medicaid, or through an External Review from an Independent Review Organization (IRO), for CHIP.

STAR+PLUS MMP
A Level 1 appeal must be submitted within 60 days of the initial denial decision. If the redetermination is also denied, the member or member representative and the provider will be sent a notice that gives you specific reason(s) for the denial. A Level 2 appeal may be submitted with 60 days, which will be sent to the Medicare Independent Review Entity (IRE). The Medicare IRE will send written notice of their decision.

Ambetter
The appeal must be submitted within 180 days from the date of the denial notice letter.

- For standard appeals, decisions are made within 30 calendar days of receipt of the appeal.
- The time for resolution of an expedited appeal may not exceed 1 working day from the date all information necessary to complete the appeal is received. Upon completing Superior's internal appeal process, if the appeal decision is upheld, the member, a member representative or the provider may request review of the denial through an External Review from an IRO.

Where do I go for questions or additional resources?

For more information regarding the drug formulary, prior authorization, and rights to discuss or appeal, please review **Superior's Provider Training and Manuals** webpage found at SuperiorHealthPlan.com/ProviderTrainings.

For questions, please contact Pharmacy Services at:

- **STAR, CHIP, STAR+PLUS, STAR Kids and STAR Health**
  Phone: 1-866-768-7147
  Fax: 1-833-423-2523

- **Ambetter**
  Phone: 1-877-725-7749 (option 3)
  Fax: 1-800-977-4170

- **STAR+PLUS MMP**
  Provider Services Phone: 1-877-391-5921

For questions, or to submit an appeal, please contact Superior's Appeals Department at:

- **STAR, CHIP, STAR+PLUS, STAR Kids, STAR Health, and Ambetter**
  Superior HealthPlan
  ATTN: Appeals Department
  5900 E Ben White Blvd
  Austin, TX 78741

  Phone: 1-877-398-9461
  Fax: 866-918-2266

- **STAR+PLUS MMP**
  Part C Appeals:
  Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP)
  ATTN: Appeals and Grievances - Medicare Operations
  7700 Forsyth Blvd.
  St. Louis, MO 63105

  Phone: 1-866-896-1844 (TTY: 711)
  FAX: 1-844-273-2671

  Part D Appeals:
  Superior HealthPlan
  ATTN: Medicare Part D Appeals
  P.O. Box 31383
  Tampa, FL 33631-3383

  Phone: 1-866-896-1844 (TTY: 711)
  FAX: 1-866-388-1766