Pharmacy Processing Information Frequently Asked Questions

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

A formulary is a list of all the drugs that are covered by an insurance plan. In general, the drugs listed in the formulary are covered as long as the drug is medically necessary, the prescription is filled through a network pharmacy or network mail order facility (when applicable) and other coverage rules are followed. For some drugs, there may be additional requirements or limits to coverage.

Superior Medicaid (STAR, STAR+PLUS, STAR Health, STAR Kids) and Children's Health Insurance Plan (CHIP) programs must adhere to the Preferred Drug List (PDL) and clinical criteria determined by the Texas Vendor Drug Program (TXVDP). Medications on the Medicaid PDL are described as preferred and non-preferred.

- **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.

The Texas Drug Utilization Review (DUR) Board meets quarterly to recommend products for the TX VDP 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.

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

Not all drugs are included on the various formularies. Each formulary is reviewed by independent physicians and pharmacists on Superior's Pharmacy Therapeutics Committee, similar to the Corporate P&T members, for any recommendations to state DUR board or to Corporate P&T committees for their consideration. 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: https://www.TXVendorDrug.com/formulary/prior-authorization/preferred-drugs • **PDL Clinical Criteria**, found at: https://www.SuperiorHealthPlan.com/providers/resources/pharmacy/clinical-prior-authorization.html • **Quantity Limits**, found at: https://www.SuperiorHealthPlan.com/providers/resources/pharmacy.html	**Medicaid/CHIP Prior Authorization Request Forms**, found at: https://www.SuperiorHealthPlan.com/providers/resources/forms.html **Superior's Pharmacy Benefit Manager (PBM), Envolve Pharmacy Solutions:** • Phone: 1-800-460-8988 **Prior Authorization:** • Phone: 1-866-399-0928 • Fax: 1-866-399-0929
Medicare: Allwell HMO Allwell HMO SNP	• **Allwell HMO & HMO SNP Formulary,** found at: https://Allwell.SuperiorHealthPlan.com/prescription-drugs-formulary/formulary.html	**Allwell HMO & HMO SNP Coverage Determination and Redetermination Forms**, found at: https://Allwell.SuperiorHealthPlan.com/prescription-drugs-formulary/coverage-determinations.html **Allwell Pharmacy Help Desk:** • Phone: 1-888-865-6567 **Allwell Coverage Determination Team:** • Phone: 1-800-867-6564 • Fax: 1-866-226-1093

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Medicaid-Medicare: STAR+PLUS MMP	• **STAR+PLUS MMP Formulary,** found at: https://MMP.SuperiorHealthPlan.com/mmp/prescription-drug-part-d.html	**STAR+PLUS MMP Coverage Determination and Redetermination Form** , found at: https://MMP.SuperiorHealthPlan.com/mmp/prescription-drug-part-d/coverage-determinations-exceptions.html **MMP Pharmacy Help Desk:** • 1-888-865-6567 **MMP Coverage Determination Team:** • Phone: 1-800-867-6564 • Fax: 1-877-941-0480
Marketplace: Ambetter	• **Ambetter Formulary,** found at: https://Ambetter.SuperiorHealthPlan.com/provider-resources/pharmacy.html	**Ambetter Prior Authorization Form,** found at: https:// Ambetter.SuperiorHealthPlan.com /provider-resources/pharmacy.html **Envolve Pharmacy Solutions:** • Phone: 1-800-460-8988 **Prior Authorization:** • Phone: 1-866-399-0928 • Fax: 1-866-399-0929

What is Prior Authorization (PA)?

Prior authorization is when a physician is required to obtain approval from Superior in order to prescribe a specific medication. Superior will need to ensure they are covered within the patient's plan (Medicaid, Medicare, etc.), as well as ensure the medication is medically necessary and appropriate for the situation.

Clinical prior authorization criteria which 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:

- Hepatitis C
- Orkambi
- Promethazine utilization (patients two years of age and younger)
- 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, Allwell (HMO, HMO SNP) and MMP

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 medication 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.

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- 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 must be submitted within 60 days from the date of the denial notice letter.

- 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.

Allwell (HMO, HMO SNP) and 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.

What is a Point of Sale message?

Point of Sale (POS) messages are rejection messages received by the local pharmacy during claim adjudication. Messages will generally provide the solution or direction to the best contact for claim concerns/prior authorization requests.

What are some common pharmacy POS codes, messages/rejections and solutions?

POS Code	POS Message	Reason and Recommended Next Steps
POS 41	Submit bill to other processor or primary	Medicare Part D is always primary and Medicaid is the payer of last resort. 1. Verify with the member if they have other primary insurance. If so, obtain their primary insurance information and process first. 2. Process Superior as secondary through coordination of benefits. *Please note: For Medicaid/CHIP members only, if the primary insurance pays for the product, but Superior rejects the secondary COB claim, contact Superior's PBM.* 3. If the member does not have any other insurance or says this other coverage is no longer effective, contact Superior's PBM to request a temporary override. 4. Advise the member to contact their local Medicaid office to update their eligibility status.
POS70	NDC not covered	Products are not listed on the formulary and are considered excluded benefits. 1. Change the product to a preferred NDC. Verify the preferred NDC is in stock. If the product is not in stock, verify that it is available to order. 2. If the preferred NDC is not available (backorder, discontinued, etc.), contact Superior for assistance. *Please note: Superior does not determine which manufacturers or NDCs are covered by the TXVDP.*

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POS75	Prior authorization required	Generally used when a non-preferred was prescribed. Use preferred product. May be used for clinical criteria not met and requires prior authorization. 1. Contact provider's office to change the prescription to a preferred product. Preferred products are listed on the formulary that can be accessed online or by contacting Superior's PBM, Envolve Pharmacy Solutions. If clinical criteria is not met pursue prior authorization. 2. If the provider decides not to change medication to a preferred product, a prior authorization may be submitted to request approval. 3. For Medicaid and MMP Tier-3 medications, a 72-hour emergency supply may be considered if the drug would prevent a detrimental health decline if not provided in 72 hours. For assistance with a 72-hour emergency supply, please contact Superior's PBM to request the override. Hepatitis C medication is not eligible for a 72 hour supply. This is not applicable to Ambetter or Allwell plans.
POS76	Plan limitations exceeded	Quantity limits are set for safety reasons and to limit excess use of a product. 1. Review POS secondary message (additional details) which indicates max dosage/quantity allowed. 2. Contact the provider to request a change in directions or dosage to be within quantity limitations. If the provider decides not to change directions or dosage, a prior authorization is required. 3. During the prior authorization process for Medicaid, pharmacies are able to process *certain* products for one 15-day supply override for excessive quantity. This is not applicable to Ambetter, Allwell or MMP plans. 4. To process a 15-day supply override, change the quantity to a 15-day supply. Enter "1" in PA Code Type and resubmit the claim. *Please note: A 15-day supply override will only allow for a member to receive a 15-day supply of the product. A prior authorization must be submitted for additional quantities.*
POS78	Cost exceeds maximum	This is a cost edit override, please contact Superior's Pharmacy department at 1-800-218-7453, ext. 22080 (STAR, CHIP or Ambetter) or 22272 (Medicare, STAR+PLUS, STAR Health, STAR Kids).
POS85 or others	Claim not processed	Clinical prior authorization criteria is not met. Primarily, this may be due to clinical edit steps such as age, diagnosis, claim requirements, etc. 1. Notify the provider's office that a prior authorization is needed to obtain approval. Direct the provider to Superior for additional questions and/or concerns. *2.* For Medicaid and MMP Tier-3 medications, a 72-hour emergency supply may be considered if the drug would prevent a detrimental health decline if not provided in 72 hours.. For assistance with a 72-hour emergency supply, please contact Superior's PBM to request the override. Hepatitis C medication is not eligible for a 72 hour supply. This is not applicable to Ambetter or Allwell plans. *Please note: More information about each specific clinical edit requirement can be found at: https://www.SuperiorHealthPlan.com/providers/resources/pharmacy/clinical-prior-authorization.html.*

Where do I go for questions or additional resources?

For more information regarding the drug formulary, prior authorization, and rights to discuss, please review **Superior's Provider Training and Manuals** webpage found at https://www.SuperiorHealthPlan.com/providers/training-manuals.html.

For questions, please contact Superior's Pharmacy department at:

- **STAR, CHIP, Ambetter**
  Phone: 1-800-218-7453, ext. 22080
  Fax: 1-866-683-5631
- **Allwell, STAR+PLUS, STAR Health, STAR Kids**
  Phone: 1-800-218-7453, ext. 22272
  Fax: 1-866-683-5631