

HEADER INFORMATION

Owner Department:	Health Alliance Medical Plans contracts H1417, H1463
Subject:	Transitioning Process for Medicare Part D Members, including members in Long Term Care Facilities
Owner:	Pharmacy
Affected Departments:	
Effective Date:	01/01/2010
Revision Date:	
Review Date:	01/01/2011
Policy #:	1232
Policy Applies To:	Medicare members with Part D

PURPOSE OF THE POLICY

To define the transition process for members joining a Health Alliance Medicare Advantage Part D Benefit Plan that are currently utilizing medications covered by Part D, but which may not be coded on the Part D formulary or which may have restrictions such as Prior Authorizations or Step Edits.

STATEMENT OF THE POLICY

Health Alliance will follow this policy for members joining the Medicare Advantage Part D Benefit who are currently on medications which may not be coded on the Medicare D Formulary or have restrictions. This transition process will allow members to continue their current maintenance medication therapy without interruption.

Implementation Statement: Health Alliance Medical Plans in conjunction with our Pharmacy Benefits Manager (PBM), MedImpact, uses electronic systems to allow appropriate claims adjudication for transitioning Medicare Part D Beneficiaries so that they are allowed to obtain their medications without interruption, whether the medication is non-formulary, has utilization management (UM) edits, or the members are in a Long Term Care (LTC) Facility. The Health Alliance formulary is considered an “Open Formulary.” There are few drugs that would not automatically go through at the point of sale (POS) for these beneficiaries. Any prescription which goes through the PBM’s electronic adjudication process and is noted to be a transition prescription will automatically be given a 30 day override or 31 day override in the case of LTC members. The pharmacy will see a message that the drug is not on the formulary, but the claim will continue to adjudicate. The PBM generates a daily transition report for the health plan, and those transition claims are manually given an override for the rest of the plan year. The only exceptions are prescriptions for drugs which require Prior Authorization criteria to be met. These claims would be picked up on the daily transition report, a letter would be sent to the member, and a review for continuation of that drug with the appropriate criteria submitted by the member or physician would be initiated. This implementation statement is in accordance with the PBM’s implementation statement, attached below in Bullet 5 of this policy and Section 1.3 of the MedImpact policy.

PROCEDURES

1. Transition Process for medications not currently coded on the Medicare Part D Formulary for 2010 for Retail and Long Term Care Prescriptions

- 1.1 Health Alliance will have an Open Formulary for our Medicare Advantage Part D Members. This means that drugs, which are not otherwise coded, currently listed on the most recent printed formulary document, or posted on the Health Alliance Medicare website will adjudicate at Tier 3, whether generic or brand, in accordance with any Prior Authorization or Step Edits that are in place. This does not include drugs deemed excluded by the Centers for Medicare and Medicaid or by Health Alliance.
- 1.2 In the event that a Medicare Advantage Part D member gets a rejection denial for “drug not on formulary” when at point of sale at the pharmacy, the following process needs to be followed, so Health Alliance Pharmacy Dept., can make a systems update and get the drug coded appropriately thru the Pharmacy Benefit Manager (PBM), Medimpact.
 - At point of sale, if a rejection code appears for “drug not on formulary,” the pharmacist should call the Health Alliance Pharmacy Department and request an override so the member’s prescription will adjudicate.
 - A pharmacy coordinator will put in an override, which will allow the prescription to adjudicate at Tier 3 for whatever supply is written.
 - Time frame for the override should be within 24hrs
 - In the event, that the pharmacy does not call into the health plan for an override, the claim will still go through at the point of sale due to the electronic system edits put in place by our PBM. The system allows for the one-time, temporary 30-day fill or 31-day fill for LTC members.
 - Prior Authorization or Exceptions request forms can be obtained through the Health Alliance Pharmacy Department by calling 1-800-851-8078. The department will mail, fax or email the form.
 - The Prior Authorization Form is attached at the end of this document for printing.
 - The Transition Policy link is also viewable through the Medicare Plan Finder Website.
 - The Transition Policy extends across contract years in accordance with the PBM attached policy section 1.2
- 1.3 Long Term Care pharmacies who come across the same rejection code should follow the same process

2. Transition Process for new members and Long Term Care residents on maintenance medications which have restrictions such as Step Edits

- 2.1 If a member is transitioning to Health Alliance and has been maintained on a medication, which has restrictions such as Step Edits, they will be allowed to continue on their medication without fulfilling the Step Edit.
- 2.2 If the prescription is for a brand new medication that the member has not been maintained on, the member will be required to fulfill the requirements before being able to obtain the new medication.

2.3 The Health Alliance P&T Committee will not be involved in overseeing the transition process other than approving policies, because the process allows transitioning beneficiaries to continue their medications without limits.

3. Transition Process for medications which are listed as “Specialty Medications” or need Prior Authorization on the Medicare Part D Formulary for Retail and Long Term Care Prescriptions

- 3.1 Members which require a medication listed as a Specialty Medication or need a Prior Authorization on the Medicare Part D Formulary will be able to have their Specialty medication continue for one month, at which time patient and patient’s physician are required to send in the requested prior authorization material to Health Alliance to meet Health Alliance’s coverage criteria for continuation of therapy, which is supplied by Health Alliance’s Specialty Pharmacy provider, when appropriate.
- 3.2 Current Specialty Medications listed on the Medicare Part D Formulary are at a Tier 4 level.
- 3.3 The Health Alliance Pharmacy Department will ensure the member receives appropriate written notice within three business days of a temporary fill.

4. Health Alliance Medical Plans Transition Policy Web Address:
<https://healthalliance.org/HA20/Policies/Med%20D%20Transition%20Policy.pdf>

5. MedImpact’s Supporting Transition Policy:



Document Title	Transition Process Requirements for Medicare Part D				
Document #	900-PL-103	Version	3.0	Supersedes	None
Process owner (title)	Product Manager I, GPS			Effective Date:	01-01-2010

Approver Name	Title	Signature	Date Approved
Carine Scherlippens	Director, Medicare Programs	Carine Scherlippens	06/18/2010

Purpose	The purpose of this policy is to describe MedImpact’s process for transitions and ensure that continued drug coverage is provided to new and current Part D members. The transition process allows for a temporary supply of drugs and sufficient time for members to work with their health care providers to select a therapeutically appropriate formulary alternative, or to request a formulary exception based on medical necessity. Transition processes will be administered by MedImpact in a manner that is timely, accurate and compliant with all relevant CMS guidance and requirements as per 42 CFR §423.120(b)(3)
Quality Records	Transition of Care Notification File Implementation Questionnaire (IQ)

Related Documents	42 CFR §423.120(b)(3) Chapter 6 Medicare Part D Manual Medicare Marketing Guidelines 400-PD-011 Medicare Part D Coverage Determinations
--------------------------	--

Doc Type	<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Work Instruction
Usage and Scope	<input type="checkbox"/> Used within Dept only <input type="checkbox"/> Used inter-department or all Business Unit <input type="checkbox"/> Used Enterprise-Wide <input checked="" type="checkbox"/> Cross-functional - used by 2 or more Business Units <p>Scope: This policy is necessary with respect to: (1) new enrollees into prescription drug plans at the beginning of a contract year; (2) the transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year; (3) the transition of individuals who switch from one plan to another after the beginning of a contract year; (4) enrollees residing in long-term care (LTC) facilities; and (5) in some cases, current enrollees affected by formulary changes from one contract year to the next. Applicable personnel in Government Programs, Health Services and Operations follow this policy. This document is intended to describe processes necessary to meet regulatory requirements as of the effective date above.</p>
External Sharing	<input type="checkbox"/> No, do not share externally Yes, may share with: <input checked="" type="checkbox"/> Client <input checked="" type="checkbox"/> Regulatory agencies Other:
Document Protection	Is password required for viewing? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Is printing allowed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Change Control

Versio n	Review date	Status	Author/Reviewer	Approval Review Date
3.0	03/01/2010	Approved	Carine Scherlippens	06/18/2010

Printed copies of this document may not be current. Verify for latest version check the electronic source document in the Process Library on the I drive.

1. Policy

Overview

MedImpact supports Plans in administering a transition process that is in compliance with the established CMS transition requirements. MedImpact will ensure that its transition policy will apply to non-formulary drugs, meaning both (1) Part D drugs that are not on a plan's formulary; and (2) Part D Drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules. MedImpact will ensure that its policy addresses procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

Also in accordance with CMS requirements, MedImpact ensures that drugs excluded from Part D coverage due to Medicare statute are not eligible to be filled through the transition process. However, to the extent that a Plan covers certain Part D excluded drugs under an Enhanced benefit, those drugs should be treated the same as Part D drugs for the purposes of the transition process.

1.1. Transition Population

MedImpact will maintain an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how, for enrollees whose current drug therapies may not be included in their new Part D plan's formulary, it will effectuate a meaningful transition for: (1) new enrollees into prescription drug plans at the beginning of a contract year; (2) the transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year; (3) the transition of individuals who switch from one plan to another after the beginning of a contract year; (4) enrollees residing in long-term care (LTC) facilities; and (5) in some cases, current enrollees affected by formulary changes from one contract year to the next.

1.2. Transition Period

MedImpact allows Plans to choose the number of transition days offered under their transition policy. CMS requires a minimum of 90 days from the start of coverage under a new plan. The 90 days are calculated from the member's Part D plan start date. MedImpact will extend its transition policy across contract years should a beneficiary enroll in a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply. This 90 day timeframe applies to retail, home infusion, LTC and mail-order pharmacies. Plans may choose to enhance their transition policy to provide coverage beyond the CMS minimum requirements.

With the exception of MedImpact's Transition Across Calendar Years processes described later in this policy, it is ultimately the responsibility of the Plan to indicate which of their members should be in a transition period. Plans must place their members into a transition period by populating the appropriate Member Plan Part D Start Date in Segment Code 5 of the Type 24 File (Member Attribute Load File). The transition period (90-day minimum) is then calculated from the Member Plan Part D Start Date with the Plan.

MedImpact will ensure that it will apply all transition processes to a brand new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

1.3. Implementation Statement

a) Claims Adjudication System: MedImpact has systems capabilities that allow MedImpact to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

b) Pharmacy Notification at Point-Of-Sale: Until such time as alternative transactional coding is implemented in a new version of the HIPAA standard, MedImpact will promptly implement either: (1) appropriate systems changes to achieve the goals of any additional new messaging approved by the industry through NCPDP to address clarifying information needed to adjudicate a Part D claim (see the 5.1 Editorial Document), or (2) alternative approaches that achieve the goals intended in the messaging guidance.

c) Edits During Transition: During an enrollee's transition period, the only edits that are enforced by MedImpact's claims adjudication system are: (1) edits to help determine Part B vs. Part D coverage, (2) edits to help prevent coverage of non-Part D drugs (i.e., excluded drugs); and (3) edits to help promote safe utilization of a Part D drug (i.e., quantity limits based on FDA maximum recommended daily dose, early refill edits).

MedImpact will ensure that the transition policy provides refills for transition prescriptions dispensed for less than the written amount due to quantity limits for safety purposes or drug utilization edits that are based on approved product labeling.

d) Pharmacy Overrides at Point-Of-Sale: During the member's transition period, all edits (with the exception of those outlined in part c above) associated with non-formulary drugs are automatically overridden by MedImpact's claims adjudication system at the point-of-sale. MedImpact will ensure that pharmacies can override step therapy and prior authorization edits - other than those that are in place to determine Part B versus Part D coverage, prevent coverage of non-Part D drugs, and promote safe utilization of a Part D drug (e.g., quantity limits based on FDA maximum recommended dose, early refill edits) - during transition at point-of-sale. Pharmacies can also contact MedImpact's Pharmacy Help Desk directly for immediate assistance with point-of-sale overrides. MedImpact can also accommodate overrides at point-of-sale for emergency fills as described in section 1.6.

1.4. Transition Fills for New Members in the Outpatient (Retail) Setting

MedImpact will ensure that in the retail setting, the transition policy provides for at least a one-time, temporary 30-day fill (unless the enrollee presents with a prescription written for less than 30 days in which case the Part D sponsor must allow multiple fills to provide up to a total of 30 days of medication.) anytime during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage.

1.5. Transition Fills for New Members in the LTC Setting

MedImpact will ensure that in the long-term care setting: (1) the transition policy provides for a 31-day fill (unless the enrollee presents with a prescription written for

less than 31 days), with multiple refills as necessary, up to a 93 days supply during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage; (2) in the long-term care setting, after the 90 day transition period has expired, the transition policy provides for a 31-day emergency supply of non-formulary Part D drugs (unless the enrollee presents with a prescription written for less than 31 days) while an exception or prior authorization is requested; and (3) for enrollees being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge.

1.6. Emergency Supplies and Level of Care Changes for Current Members

An Emergency Supply is defined by CMS as a one-time fill of a non-formulary drug that is necessary with respect to current members in the LTC setting. Current members that are in need of a one-time Emergency Fill or that are prescribed a non-formulary drug as a result of a level of care change can be placed in transition by the Plan via Segment Code 5 of the Type 24 File. MedImpact can also accommodate a one-time fill in these scenarios via a manual override at point-of-sale, if authorized by the Plan to do so.

1.7. Optional Medicare Part D LTC Notification Report

The MedImpact Medicare Part D LTC Notification Report is designed to assist Plans by notifying them when a member who is not Low Income Cost-Sharing (LICS) Level 3 has a prescription filled while in a Nursing Home, LTC Facility or a Rest Home. Plans may use this report to identify members that may be in need of a one-time emergency fill or that qualify for transition due to a level of care change.

1.8. Transition Across Contract Years

For current enrollees whose drugs are no longer on the Sponsor's formulary, Sponsor will effectuate a meaningful transition by either: (1) providing a transition process consistent with the transition process required for new enrollees beginning in the new contract year; or (2) effectuating a transition prior to the beginning of the new contract year.

MedImpact POS logic is able to accommodate option 1 by allowing current members to access transition supplies at the point-of-sale when their claims history from the previous calendar year contains an approved claim for the same drug that the member is attempting to fill through transition. This process only applies to current members that are not otherwise placed in transition by the Plan via Segment Code 5 of the Type 24 File. To accomplish this, POS looks for Part D claims in the member's claim history that were approved prior to January 1 of the new plan year, and that have the same HICL, Product and Indicator values as the transition claim.

1.9. Transition Extension

Sponsor will make arrangements to continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, to the extent that their exception requests or appeals have not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request)..The Plan can extend the member's transition period by populating a new Member Plan Part D Start Date in Segment Code 5 of the Type 24 File. On a case-by-case basis, point-of-sale overrides can also be entered by the Plan or by MedImpact (if authorized by the Plan to do so) in order to provide continued coverage of the transition drug(s).

1.10. Cost-sharing for Transition Supplies

MedImpact will ensure that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-LIS eligible enrollees, MedImpact will ensure that cost-sharing for a temporary supply of drugs provided under its transition process is based on one of the sponsor's approved cost-sharing tiers (if the sponsor has a tiered benefit design) and is consistent with cost-sharing the sponsor would charge for non-formulary drugs approved under a coverage exception.

1.11. Six Classes of Clinical Concern

Per CMS guidance, members transitioning to a Plan while taking a drug within the six classes of clinical concern must be granted continued coverage of therapy for the duration of treatment, up to the full duration of active enrollment in the Plan.

Utilization management restrictions and/or non-formulary status, which may apply to new members naïve to therapy, are not applied to those members transitioning to the Medicare Part D plan on agents within these key categories. The six classes include:

- 1) Antidepressant;
- 2) Antipsychotic;
- 3) Anticonvulsant;
- 4) Antineoplastic;
- 5) Antiretroviral; and
- 6) Immunosuppressant (for prophylaxis of organ transplant rejection).

1.12. Member Notification

MedImpact provides Plans (via FTP) with a daily file called the Transition Notification File. The Transition Notification File, which contains claims data and other member information, provides Plans with all of the information needed to contact members and providers regarding transition fills. Sponsor will send written notice via U.S. first class mail to enrollee within three business days of adjudication of a temporary fill. The notice must include (1) an explanation of the temporary nature of the transition supply an enrollee has received; (2) instructions for working with the plan sponsor and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary; (3) an explanation of the enrollee's right to request a formulary exception; and (4) a description of the procedures for requesting a formulary exception. Sponsor will use the CMS model Transition Notice via the file-and-use process or submit a non-model Transition Notice to CMS for marketing review subject to a 45-day review.. Providing written notification to the member and/or provider in accordance with CMS requirements is ultimately the responsibility of the Plan. Plans also have the option to contract with MedImpact's print vendor to receive the Transition of Care Notification File and facilitate the fulfillment process of member notification on Plan's behalf.

MedImpact and MedImpact's print vendor adhere to all CMS Marketing Guidelines as set forth in Chapter 3 of the Medicare Managed Care manual.

Sponsor will make their transition policy available to enrollees via link from Medicare Prescription Drug Plan Finder to Sponsor web site and include in pre-and post-enrollment marketing materials as directed by CMS.

1.13. PDE Reporting

Since this is a CMS required process, any drugs dispensed that qualify under the transition period are reported as covered Part D drugs with appropriate Plan and member cost sharing amounts on the Prescription Drug Event (PDE).

1.14. CMS Submission

Sponsor will submit a copy of its transition process policy to CMS.

1.15. Pharmacy and Therapeutics Committee Role

For MedImpact’s standard formulary Plans only, the MedImpact Pharmacy and Therapeutics Committee (P&T) maintains a role in the transition process in the following areas:

- 1) The MedImpact P&T committee reviews and recommends all MedImpact formulary step therapy and prior authorization guidelines for clinical considerations; and
- 2) The MedImpact P&T committee reviews and recommends procedures for medical review of non-formulary drug requests, including the MedImpact exception process.

1.16. Exception Process

MedImpact follows an overall transition plan for Medicare Part D members; a component of which includes the exception process. MedImpact’s exception process integrates with the overall transition plan for these members in the following areas:

- 1) MedImpact’s exception process complements other processes and strategies to support the overall transition plan. The exception process follows the guidelines set forth by the transition plan when applicable.
- 2) When evaluating an exception request for transitioning members, the Plan’s exception evaluation process considers the clinical aspects of the drug, including any risks involved in switching, when evaluating an exception request for transitioning members.
- 3) The exception policy includes a process for switching new Medicare Part D plan members to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

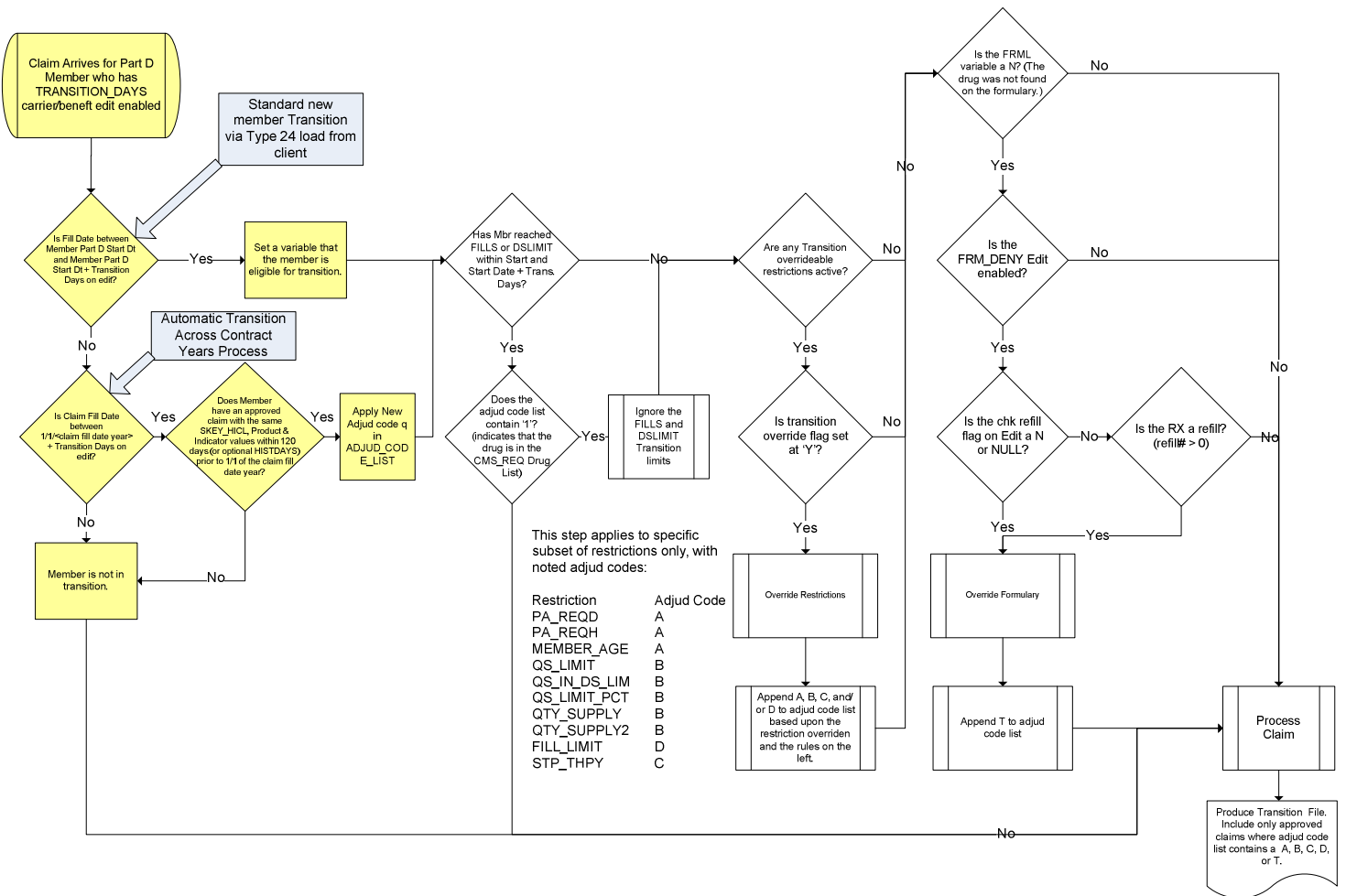
Sponsor will make available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on plan web sites.

Appendix A. Glossary

Term	Description
CMS	Centers for Medicare and Medicaid Services – The agency within the US Federal Government that is charged with the execution and maintenance of the law defining the prescription drug program for senior citizens, the disabled, and the infirm.
FTP	File Transfer Protocol – One of the methods used by MedImpact and its clients to transfer electronic files via the Internet. The first two bits of the file indicate the type of file.
HICL	An FDB data warehouse term that is an alpha-numeric code used to describe drugs ingredients. The HICL codes have been sequenced

	according to an ingredient sequence table. The HICL sequence table establishes relative importance to each ingredient, relative to other ingredients. The relative importance of an ingredient is based on its clinical and therapeutic use. The most important ingredients are sequenced first and the least significant are sequenced last.
Level of Care Changes	<p>Level of care changes include the following changes from one treatment setting to another:</p> <ul style="list-style-type: none"> • Enter LTC facility from hospitals or other settings; • Leave LTC facility and return to the community; • Discharge from a hospital to a home; • End a skilled nursing facility stay covered under Medicare Part A (including pharmacy charges), and revert to coverage under Part D; • Revert from hospice status to standard Medicare Part A and B benefits; and • Discharge from a psychiatric hospital with medication regimens that are highly individualized.
LTC	Long Term Care
MSB	Multi-source Brand – A branded drug that through cross-licensure is sold under more than one brand name.
NCPDP	A 7-digit number assigned to a pharmacy by the NCPDP, with the first 2 identifying the state and the last 5 identifying the pharmacy.
PA	Prior Authorization - The process undertaken to make a benefit determination that is made prior to the intended delivery of the healthcare service, treatment or supply under review (e.g., a Pre-Service Claim). Prior Authorization includes requests for coverage determination for medications that are designated on the client part D formulary as “Prior Authorization Required”, “Step Therapy”, “Quantity Restrictions” or for requests for exception for non-formulary medications or co-insurance amount.
PDE	Prescription Drug Event. File that reports all claims transactions to CMS for inclusion in the annual financial reconciliation between CMS and the plans.
Plan	Medicare Part D Plan Sponsors who are MedImpact clients.
POS	The acronym given to MedImpact’s point-of-sale prescription transaction processing computer system. Also indicates that the actual retail transaction occurs when the claim is submitted electronically by the pharmacy.
P&T Committee	Pharmacy & Therapeutics Committee – An independent group of external & internal health care practitioners that are responsible for evaluating the efficacy, safety and cost effectiveness of medications to determine potential additions, subtractions and other changes to a formulary.
SSB	Single Source Brand – This drug has a single source of manufacturing.
UM	Utilization Management – A set of guidelines that can be applied independently or jointly that otherwise restrict access to the dispensing or consumption of prescription drugs. The four basic restrictions are prior authorization (PA), quantity limits (QL), step therapy (ST) and tier placement. UM is a tool used by health plans to ensure safe, efficacious and cost-effective use of medication by beneficiaries.

Appendix B. POS Transition Flow Diagram



Health Alliance Prior Authorization Form Template:

REQUEST FORM

Section 1—To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay review process.

Date

Patient Name Patient Health Alliance ID Number Patient Birth Date

(())

Requesting Physician's Name Requesting Physician's Phone Number Requesting Physician's Fax Number

Diagnosis:

SERVICES REQUIRING PRE-AUTHORIZATION

Services Requested Procedure Code Date Scheduled

(())

Facility Practitioner Provider Phone Number Provider Fax Number

Physician Signature Date

TERTIARY/OUT-OF-NETWORK REFERRALS

Referred to:

Physician Facility

Physician Phone Number () Physician Fax Number ()

The patient has been encouraged to contact Health Alliance to verify coverage for visiting this provider.

Explanation of Services Requested

Physician Signature Date

PHARMACY MEDICAL EXCEPTION/RX PRE-AUTHORIZATION

(Fax to 217-255-4598)

Drug Requested Strength Diagnosis

List [1] Therapy failure on two or more formulary drugs in the same therapeutic/disease class.

[2] Why failed, and [3] Medical rationale

for requesting non-formulary drug.

1)

2)

3)

Physician Signature Date

Health Alliance · 301 S. Vine Street · Urbana, Illinois 61801

(217) 337-8061 · Fax (217) 337-8440

Health Alliance Main Office-Urbana

Fax (217) 337-8440 (Medical Management)

Pharmacy Fax (217) 255-4598

Southern IL Fax (217) 337-8440

Ottawa Fax (217) 337-8440

Dekalb Fax (217) 255-4671

Decatur Fax (217) 255-4671

Peoria Fax (217) 255-4671

Sterling-Rock Falls Fax (217) 255-4671

Springfield Fax (217) 698-8679

Macomb Fax (217) 698-8679

Quincy Fax (217) 698-8679

Ames Fax (515) 296-2545

Quad Cities Fax (515) 296-2545

For office use only:

Disapproved Approved Consult only Consult & Treatment

Date received at Health Alliance Reference No. Number of visits

Comments: Staff initials:

HISTORY

T.Howerton RPh revised for 2007 -1.1.07

Thowerton RPh-took out language stating LTC facility had to recv spec meds from a specialty pharmacy 1.1.08

SMadigan-clarify wording in section 3.3 -1.1.09

Thowerton RPh-1.1.2010 no chngs

Thowerton RPh- 4.12.2010 added Medimpact's Transition Policy under our policy

THoweton RPh- 6.17.2010- added Implementation Statement, CMS pts addressing attestations #4,10,12,14,& 17 & MI revised policy

APPROVED BY

Signature(s): _____
(Signature copies are kept in Compliance)

Date: _____



Health Alliance

REQUEST FORM

Medical Management Department
Fax (217) 337-8440
 Pharmacy Department
Fax (217) 255-4598

MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS

Section 1—To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay the review process.

Date _____

Reason for Request:
 Not Available in Network Unable to Schedule in Timely Manner Member Request
 Other [please specify] _____

Patient Name _____

Patient Health Alliance ID Number _____

Patient Birthdate _____

Requesting Physician's Name _____

()
Requesting Physician's Phone Number _____

()
Requesting Physician's Fax Number _____

Diagnosis: _____

Services Requiring Preauthorization

Services Requested _____

Procedure Code _____

Date Scheduled _____

Facility _____

Practitioner _____

()
Provider Phone Number _____

()
Provider Fax Number _____

Physician Signature _____

Date _____

Tertiary/Out-of-Network Referrals

Referred to: _____
Physician

Physician Phone Number () _____

Facility _____

Physician Fax Number () _____

Service Reason:
 Consult Consult and Treatment
Visits: _____ Length of Referral: _____

The patient has been encouraged to contact Health Alliance to verify coverage for visiting this provider.

Explanation of Services Requested _____

Physician Signature _____

Date _____

Pharmacy Medical Exception/Rx Preauthorization (Fax to (217) 255-4598)

Drug Requested _____ Strength _____ Diagnosis _____

- List [1] Therapy failure on formulary drugs in the same therapeutic/disease class, [2] Why failed, and [3] Medical rationale for requesting non-formulary drug.
- 1) _____
2) _____
3) _____

Physician Signature _____

Date _____