HIGHMARK HEALTH OPTIONS

Updated 01/2025
DMMA Approved 01/2025

Request for Prior Authorization for Non-Formulary/Non-Preferred/Medical Necessity Review
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Non-Formulary/Non-Preferred/Medical Necessity Medications require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Non-Formulary/Non-Preferred/Medical Necessity Review Prior Authorization Criteria:

For all requests for non-formulary medications, non-preferred medications, and medications that require medical necessity review all of the following criteria must be met:

- The requested medication has a diagnosis that is one of the following:
  - An FDA-approved indication or
  - A medically accepted indication that is supported by nationally recognized pharmacy compendia defined as one of the following:
    - American Hospital Formulary Service Drug Information (AHFS-DI): "supportive"
    - Drugdex (Micromedex): level of evidence Class I, Class IIa, or Class IIb
    - United States Pharmacopeia Drug Information (USP-DI)
  - Peer-reviewed medical literature:
    - Use supported by clinical research that appears in at least 2 Phase III clinical trials that definitively demonstrate safety and effectiveness
    - If no Phase III trial evidence is available, at least 2 Phase II clinical trials with reasonably large patient samples showing consistent results of safety and efficacy.
    - Phase II or Phase III trials must come from different centers and be published in national or international peer-reviewed journals.
    - Literature including scientific and medical publications. This does not include in-house publications of pharmaceutical manufacturing companies or abstracts (including meeting abstracts).
- The medication is aligned with pertinent clinical treatment modalities based on current national treatment guidelines or peer reviewed literature.
- If an FDA approved companion diagnostic test for the requested agent exists, documentation that the test was performed to confirm the diagnosis
- If a test with adequate ability is necessary to confirm a disease mutation exists, documentation that the test was performed to confirm the diagnosis
- The requested medication is being prescribed by or in consultation with an appropriate specialist (when applicable)
- Must have a therapeutic failure, contraindication, or intolerance to the biosimilar agent(s) approved or medically accepted for the member's diagnosis
- Documentation of all pertinent clinical information related to the request from

available sources (i.e., Primary Care Physician, Facility Utilization Review Department, Medical Record Department) including but not limited to:

- Age
- Complications
- Progress of treatment
- Diagnosis/co-morbidities
- Medical History
- Current medications
- Previous test results
- Current laboratory results
- Physical exam findings
- Psychosocial situation
- Home environment/social situation when applicable
- Any other data or rationale to support the medical necessity of the request

- The request cannot be for an experimental, cosmetic, or investigational treatment
- The dose and frequency of the requested medication is appropriate based upon the FDA-approved package insert nationally recognized compendia or peer-reviewed medical literature
- Formulary alternative(s) were adequately tried and failed.
  - Documentation must be provided to support the following:
    - Whether or not the member was recently hospitalized and if so, whether or not the requested medication was initiated during this hospital stay. (While hospitalization will not guarantee approval of the medication, it will be factored in to the medical necessity review.)
    - Medication name(s) and dose(s)of the formulary alternative(s) tried
    - Dates of trial of the formulary alternative(s)
    - Documentation of reason for failure /discontinuation of formulary alternative(s)
      - If the discontinuation of formulary alternative(s) was due to side effect(s), documentation of the nature of the side effect(s)
      - If inadequate response to a formulary alternative(s) is noted, documentation that shows whether or not the dose was increased in an attempt to achieve a greater level of efficacy
    - The member has exhausted the possible formulary alternatives for their diagnosis(es) OR reasonable rationale has been provided to indicate why other formulary alternatives cannot be tried
    - If a BRAND medication is requested and a generic version of that medication is available, and both BRAND and GENERIC are non-preferred or non-formulary, the GENERIC formulation will be authorized if the BRAND is requested and all other applicable criteria is met
    - If a BRAND medication with a generic version of that medication is available and changes to non-preferred or non-formulary status due to a PDL change, the GENERIC formulation will be authorized if the BRAND is requested and all other applicable criteria is met

- If the provider requests a BRAND name product where the GENERIC is preferred, a MedWatch form must be submitted with the request
- If a non-preferred/non-formulary combination product is being requested and the individual components of that combination product are available documentation that the member has tried and failed the individual products together first
- The requested medication does not interact with other medications which may result in a serious or life threatening adverse reaction.
- The member does not have a contraindication to the requested medication

- **Initial Duration of Approval:** Up to 12 months dependent upon clinical discretion with consideration given to if the requested medication is classified as a maintenance drug. Drugs with specific authorization criteria may have approval durations for less than 1 year
- **Reauthorization criteria:**
  - Documentation from the provider the member had a positive clinical response and is able to tolerate therapy.
- **Reauthorization Duration of Approval:** Benefit is approved for the requested duration or up to 12 months dependent on clinical discretion. All medications for chronic or long-term conditions will be reauthorized for 12 months.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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NON-FORMULARY/NON-PREFERRED/MEDICAL NECESSITY REVIEW
MEDICATION PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8am to 7pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
Is the member currently or recently hospitalized? ☐ Yes ☐ No	Date of discharge:

Is a BRAND name product where the GENERIC is preferred being request?
☐ Yes, must attach completed Med Watch Form ☐ No

Additional clinical or supporting information (please include office notes, lab data, and applicable supporting medical literature):

_____

_____

_____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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