Gateway Health℠ It's Wholecare.

Updated: 07/2021
PARP Approved: 07/2021

Prior Authorization Criteria

Covid-19

This policy addresses potential for extending existing authorization lengths, 90-day medication supplies, RTS edit overrides, and potential removal of prior authorization criteria as outlined below. While a valid disaster declaration by the Governor related to the COVID-19 virus remains in effect this policy supersedes policy CP-215-MD-PA Access to Pharmaceuticals During Disasters.

1. If a decision is made by either DHS or the Plan to extend existing authorizations, reporting will be pulled to identify existing authorizations. The request for coding of the authorization extensions, including end-dates will be sent to the PBM for activation.

2. Members may obtain a 90-day supply of medication while a valid disaster declaration by the Governor related to the COVID-19 virus remains in effect.
    - The following medications are excluded:
        - short acting beta agonist metered dose inhalers
        - Medications designated as specialty drugs

3. One Refill-Too-Soon (RTS) Edit override will be allowed every 30 days per medication.
    - Pharmacies can override a RTS edit by using a Submission Clarification Code (SCC) of "13".

4. If DHS requires removal of any or all authorization requirements, Gateway will follow DHS guidance.

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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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COVID-19
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

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

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a 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-10 Code: _____

Request type:
☐ Refill Too Soon
☐ 90 day supply

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date