IHS RPMS eLearning Training

Pharmacy Point of Sale

Prior Authorizations

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August 11, 2020

Pharmacy—POS
Benefits Management (ABSP)

Version 1.0
Patch 51

Introduction

This class will cover the techniques and resources available to initiate and complete a prior authorization for a prescription medication.

- **Presenter**: Michael Hunt
  - 7 years working as a Point of Sale (POS) pharmacist in the RPMS system
  - 16 years of retail pharmacy experience

This Course Is Suitable for the Following Roles

- Pharmacy Technicians
- Pharmacists
- Business office personnel performing POS duties

Prerequisites

Users must have access to:

- Point of Sale functions within RPMS
- Access to Electronic Health Record (EHR)

Pharmacy Point of Sale eLearning Sessions

Date	Session
5/12/2020	• Pharmacy Pont of Sale Setup • Daily Task Checklist
6/9/2020	• Identification and Entry of Third-Party Insurance
7/14/20	• Correcting Rejections
8/11/20	• **Prior Authorizations**

*Continued POS Office Hours trainings monthly on the second Tuesday of each month. Live demonstrations. Not recorded.

Watch the LISTSERV-Pharmacy billing for advertisements.

Indian Health Service

Mission:

The overall mission of the Indian Health Service (IHS) is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level.

Goal:

The main goal of IHS is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.

*It is impossible to achieve these without sufficient funding.

Retail Pharmacy vs. Indian Health Service

Retail: Prior Authorization completion is the responsibility of the doctor's office, with the patient being the driving force to urge the completion of the Prior Authorization. If not approved, the patient is responsible for paying the full amount or having the prescription changed.

Indian Health Service: Prior Authorization completion is usually the responsibility of the pharmacy with the driving force being the third-party collections. Point of Sale collections are increasingly important to funding clinics.

Learning Objectives

1. Defining terms related to Prior Authorization

2. Identifying which rejected claims need Prior Authorization

3. Initiating and completing a Prior Authorization

Learning Objectives #1

Defining terms related to Prior Authorization

Terms Related to Prior Authorization

- Prior Authorization (PA)

- Insurer or Third-Party Payer

- Formulary and Non-Formulary medications

- Formulary Tiers

- Diagnosis Code

Prior Authorization (PA) (1)

The approval by an insurer or other third-party payer of a health care service before the service is rendered. This approval is required in order for the insurer to pay the provider for the service.

Reference:

https://medical-dictionary.thefreedictionary.com/prior+authorization

Prior Authorization (PA) (2)

The approval by an insurer or other third-party payer of a **health care service** before the service is rendered. This approval is required for the insurer to pay the provider for the service.

- Health care services needing prior authorization could include:
    - Medical procedures
    - Unique lab work
    - Prescription medications

Prior Authorization (PA) (3)

The approval by an insurer or other third-party payer of a health care service **before** the service is rendered. This approval is required for the insurer to pay the provider for the service.

*Obtaining the PA **before** the medication is ordered is not always an option.

Insurer or Third-Party Payer

An entity (other than the patient or the health care provider) that reimburses and manages health care expenses.

Third-party payers include insurance companies, governmental agencies, and employers.

Reference:

https://medical-dictionary.thefreedictionary.com/third-party+payer

Common Third-Party Payers for Prescriptions

- Medicaid
- Medicare Part D
  - D-Humana
  - D-Silverscript
- Private Insurance
  - Blue Cross/Blue Shield
  - Caremark
  - Cigna
- Workman's Compensation

Formulary and Non-Formulary Medications (1)

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Reference:

https://www.healthcare.gov/glossary/formulary/

Formulary and Non-Formulary Medications (2)

Non-Formulary Medication: Not approved for use. The term is applied to a drug whose prescription is not usually reimbursed by a health insurer because it is absent from its formulary.

Reference:

https://medical-dictionary.thefreedictionary.com/nonformulary

Reasons a Medication Might be Non-formulary

- Expensive brand name medication that does/does not have a generic equivalent

- Expensive generic medications that have cheaper alternatives within their drug class

- Medications that are not approved for use by the Food and Drug Administration (FDA)

- FDA approved medications that are being used for a non-approved use

- Repackaged medications: do not offer rebates to third party payers

Formulary Tiers

A formulary generally lists many drugs and ranks them in groups described as tiers. Tier 1 drugs generally do not require pre-authorization and often will cost you little, if any, co-pay. Higher tiers may require approval from your insurance and may cost you a high co-pay.

Insurance formularies will usually have four (4) tiers.

Reference:

https://www.verywellhealth.com/drug-formulary-tiers-pricing-health-insurance-plans-2615042

Formulary Items: Tier 1 or Tier I

Tier 1 drugs are usually limited to generic drugs, which are the lowest cost drugs. Sometimes lower price branded drugs will fall into this tier as well. Tier I drugs are generally automatically approved by your insurance and cost you the lowest co-pays that your plan offers.

Reference:

https://www.verywellhealth.com/drug-formulary-tiers-pricing-health-insurance-plans-2615042

Formulary Items: Tier 2 or Tier II

Tier II is usually comprised of brand-name drugs or more expensive generics. Your payer will have a list of branded drugs it prefers, which are typically on the lower end cost-wise. Tier II drugs may require a pre-authorization from your insurance company.

Reference:

https://www.verywellhealth.com/drug-formulary-tiers-pricing-health-insurance-plans-2615042

Formulary Items: Tier 3 or Tier III

The more expensive brand-name drugs cost more and are considered non-preferred. Tier III drugs usually require a pre-authorization, with your doctor explaining to your health insurer why you need to take this drug instead of a cheaper option. These drugs will cost you a higher co-pay than the lower tiers.

Reference:

https://www.verywellhealth.com/drug-formulary-tiers-pricing-health-insurance-plans-2615042

Formulary Items: Tier 4 or Tier IV

Tier 4 or Tier IV, also called specialty drugs: These are usually newly approved pharmaceutical drugs that your payer wants to discourage because of their expense. These drugs almost always require a pre-authorization, and evidence from your doctor that you do not have any less expensive option. Each insurer has their own policy regarding your rate when it comes to Tier 4.

Reference:

https://www.verywellhealth.com/drug-formulary-tiers-pricing-health-insurance-plans-2615042

Diagnosis Code (1)

- Diagnostic coding is the translation of written descriptions of diseases, illnesses and injuries into codes from a particular classification.

- ICD-10 (International Classification of Diseases, Tenth Revision)
  - A medical classification list by the World Health Organization (WHO)

Reference:

https://en.wikipedia.org/wiki/ICD-10#:~:text=ICD-10%20is%20the%2010th%20revision%20of%20the%20International,abnormal%20findings%2C%20complaints%2C%20social%20circumstances%2C%20and%20external%20causes

Diagnosis Code (2)

- ICD-10 codes:
- Listed under **Problem Management** tab within EHR
  - Where we get the codes that we will include on prior authorizations to indicate which medical condition the medication is being used.

Diagnosis Code Example

An example of an IDC-10 code for Essential Hypertension is I10.

The ICD-10 code is a letter/number combination that represents a specific disease state.

Objective 1 Knowledge Check #1

Which medication is **more** likely to require a prior authorization?

A. Ibuprofen (Tier 1)

B. Methotrexate (Tier 1)

C. Enbrel (Tier 4)

D. Sulfasalazine (Tier 1)

Objective 1 Knowledge Check #2

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits is called:

A. Menu

B. Formulary

C. Wish List

D. Inventory

Objective 1: Questions?

Are there any questions for Objective 1?

Learning Objective #2

Identifying which rejected claims need Prior Authorization

Rejection Types that Might Require a Prior Authorization

- 22:M/I Dispense As Written(DAW)/Product Selection

- 569:Provide Beneficiary with CMS Notice of Appeal (The product is not typically covered on a Medicare Part D plan.)

- 608:Step Therapy, Alt Drug Therapy Required

- 70:Product/Service Not Covered (Not on the plan's approved formulary.)

- 75:Prior Authorization Required

- 76:Plan Limitations Exceeded (An example is when a doctor has ordered a medication to be give twice daily when it is normally given once daily.)

Rejection Types that Might Require a Prior Authorization (cont.)

- AG:Days Supply Limitation For Product/Service (An example is a product that the plan will pay for 90 days, but after the 90 days, a PA is required.)

- MR:Product Not On Formulary

- R6:Product/Service Not Appropriate For This Location (Either the patient is locked into filling at a mail order service, which a PA will not help with, or it could also be a higher priced medication that the insurer wants the patient to fill at mail order. A PA will sometime help with this, at least a one-time override.)

POS Tutorial: Reject List Tab

569:Provide Beneficiary with CMS Notice of Appea	Could be many different reasons. Must look at the receipt to determine cause. 1. billing Medicare part B product to Medicare part D plan (i.e. test strips,lancets, nebulizer solution); must bill Medicare part B. 2. quantity may exceed daily limit (i.e. billing bupropion XL 150mg as 2 daily, but limit is 30 per 30 days; must change order to bill for just #30) 3. Could be product that requires a Prior Authorization.(even though it does not say 'PA required', many times a PA can be obtained).
60:Product/Service Not Covered For Patient Age	Patient exceeds maximum or minimum age accepted by insurance. (i.e. aspirin 81mg may not pay for certain ages, tretinoin cream may not pay for over age 18-25, adult inhaler (Amanex) may not pay for pediatric use. PA is possible, but unlikely.
608:Step Therapy, Alt Drug Therapy Required	1. Medication may require prior authorization to show patient has tried preferred medications.
619:Prescriber Type 1 NPI Required	NPI may not be added in Provider's record. If you have the keys, go to ^NPI in RPMS, and select Add/Edit NPI values for Providers. Enter that provider's name and hit enter. If entered, the NPI will appear. If not it will allow you to enter it. Once entered, resubmit claim as NEW.
62:Patient/Card Holder ID Name Mismatch	Patient name submitted does not match Third Party file. (i.e. Oklahoma Medicaid requires exact match for patient name. Can verify name that Medicaid has on file at the OHCA website.(see SEARCH FOR ELIGIBILITY tab at the bottom of this document) If it is different than patient chart you can enter the MEDICAID NAME on #3 when editing the medicaid plan on page 4.
645:Reject Code description not entered,See NCPD	Reject because of the use of a repackaged medication. Similar to 21:M/I Product/Service ID. Usually receive this from BC/BS, PRIME THERAPEUTICS, and some Medicare part D plans. Consider ordering non-repackaged med, if cost allows.
65:Patient Is Not Covered	Patient coverage may be terminated, or DOB/person code/ID number may be entered incorrectly. Verify eligibility. See SEARCH FOR ELIGIBILITY tab.
68:Filled After Coverage Expired	Coverage may be terminated. Verify eligibility through Emdeon Cardfinder, Availity, or OHCS website. See SEARCH FOR ELIGIBILITY tab.
69:Filled After Coverage Terminated	Coverage may be terminated. Verify eligibility through Emdeon Cardfinder, Availity, or OHCS website. See SEARCH FOR ELIGIBILITY tab.
70:Product/Service Not Covered	Could be many reasons. 1. Product may require Prior Auth or formulary exception request through Cover My Meds. 2. Oklahoma Medicaid patient may have Family Planning benefits only. 3. product may be excluded from plan (True Metrix test strips not covered on OK medicaid). 4. Route of administration may not be covered (Depo Provera injections on Prime Therapeutics). 5. OTC medication not covered.
71:Prescriber Is Not Covered	Doctor is not an eligible provider. Patient's plan may require them to use a PCP designated by the insurance. Call insurance to verify.
73:Refills Are Not Covered	May vary with insurer. At our site, we have a Medco/Express Script plan that allows only 2 refills at retail. Patient must then use the mail order pharmacy, or call to "opt out" of the mail order option and get a PA on file to continue filling at retail level.
75:Prior Authorization Required	Fill out appropriate Prior Authorization form. (Medicaid or Cover My Meds)
76:Plan Limitations Exceeded	Could be many reasons. Must check claim receipt. 1. Oklahoma Medicaid: may have already used their limit 6 fills for the month. If receiving OMB rate, make sure that you have a $391 payment for each date of service during the month. 2. Too may pills per day (simvastatin 20mg dosed at 2 daily;insurance only covers 1 daily. Have order changed to higher strength, if possible.) 3. receipt will say "Max 2 fills then action required". Patient must call number provided to opt out of mail order service. 4. Claim may be submitted for greater than the allowable day supply (i.e. Max day supply allowed is 30). 5. Actual day supply on insulin may exceed 30 day limit by insurance. On these, we enter the prescription order as the ACTUAL DAY SUPPLY for the quantity being dispensed. 6. Patient may have already received their TRANSITION FILL, and a prior authorization may need to be filled

POS Tutorial: Reject List Tab (cont.)

The POS tutorial Reject list tab (slide 34) lists the most common solutions to most rejections. The image on the previous slide has some of the rejections highlighted that might require prior authorization. Again, one rejection type can have many different solutions. Looking at the claim receipt will normally help tell you which route to go. As you work these claims more and more, you will start to more easily identify which ones need prior authorization.

22:M/I Dispense As Written(DAW)/Product Selection

- Will initially need to be overridden with the proper DAW code.

  (Usually DAW of 5 in field 408)

- Claim may then reject stating:
  - 70:Product/Service Not Covered
  - 75:Prior Authorization Required

  Common medications:

  Proair Inhaler, Toprol XL, K-Tab, Synthroid, Rocaltrol

569:Provide Beneficiary with CMS Notice of Appeal

Must look at the receipt to determine cause.

1. Billing Medicare part B product to Medicare part D plan (i.e., test strips, lancets, nebulizer solution); must bill Medicare part B.

2. Quantity may exceed daily limit (i.e., billing bupropion XL 150mg as 2 daily, but limit is 30 per 30 days; must change order to bill for just #30 or get quantity limit override)

3. Could be product that requires a Prior Authorization. (Even though it does not say "PA required", many times a PA can be obtained.)

Common medications:

Dulera Inhaler, Levemir insulin, Asmanex inhaler, Wixela inhaler

608:Step Therapy, Alt Drug Therapy Required

- Medication is not on plan's preferred list
- May require prior authorization to show patient has tried preferred medications.

Common medications:

Rasuvo Injection

70:Product/Service Not Covered

Must look at receipt to identify how to fix it

1. Product may require Prior Auth or formulary exception request through Cover My Meds.
2. Oklahoma Medicaid patient may have Family Planning benefits only.
3. Product may be excluded from plan (True Metrix test strips not covered on OK Medicaid).
4. Route of administration may not be covered (Depo Provera injections on Prime Therapeutics).
5. OTC medication not covered.

Common Medications:

Levemir, Novolog, alogliptin, Wixela

75:Prior Authorization Required

Needs Prior Authorization initiated.

Common medications:

Diclofenac gel, Jardiance, Humira, Enbrel, Chronic Pain Medications

76:Plan Limitations Exceeded

1. Oklahoma Medicaid: may have already used their limit 6 fills for the month. If receiving OMB rate, make sure that you have a $479 payment for each date of service during the month.
2. Too may pills per day (simvastatin 20mg dosed at 2 daily; insurance only covers 1 daily. Have order changed to higher strength, if possible.)
3. Receipt will say "Max 2 fills then action required." Patient must call number provided to opt out of mail order service.
4. Claim may be submitted for greater than the allowable day supply (i.e., Max day supply allowed is 30).
5. Patient may have already received their TRANSITION FILL, and a prior authorization may need to be filled out.

Common medications:

Ondansetron, pantoprazole, omeprazole, diazepam, quetiapine, Jardiance

AG:Days Supply Limitation For Product/Service

- View claim receipt to see the limitation for the product. (i.e., MAX OF 90 PER 30 DAYS).

- Can try to get a PA or QUANTITY LIMIT OVERRIDE through Covermymeds or by calling insurance. Otherwise, the prescription may need to be changed by the provider to the maximum allowable amount to get paid.

Common medications:

Bupropion XL (when ordered for greater than 1 per day)

MR:Product Not On Formulary

Product is not covered, without approval. Try to get a PA FORMULARY EXCEPTION or TIERING EXCEPTION through Cover my meds.

Common medications:

Proair HFA, alogliptin

R6:Product/Service Not Appropriate For This Location

Receipt may say SPECIALTY DRUG: PRODUCT/SERVICE NOT APPROPRIATE FOR THIS LOCATION. This is when the insurance wants the patient to use their specialty pharmacy (usually high cost meds). Can possibly get override to fill locally by calling insurance (maybe at least a one-time override until Specialty pharmacy order can be processed).

Common meds:

Rasuvo, Enbrel, Humira

Special procedure for Caremark claims to fill specialty meds at IHS

Override to fill Specialty Meds at IHS: CAREMARK ONLY

Can receive override by sending the following information via secure e-mail:

- Email Address: SpecialtyIHSrequests@cvshealth.com

Information To include:

- RxClaim Number

- Rx Number (for RPMS sites, be sure you are using the billable Rx number)

- Date of Service

- Member ID

- Date of Birth

- NCPDP of Dispensing Pharmacy (if known)

Identifying Claims for PA: Recap

So far, we have:

• Looked at different rejection types that may need a PA

• Identified common medications that need a PA

Now, how do we get our list of claims?

• Rejected claims report (RCR) imported into RRIP

RRIP (RPMS Report and Information Processor)
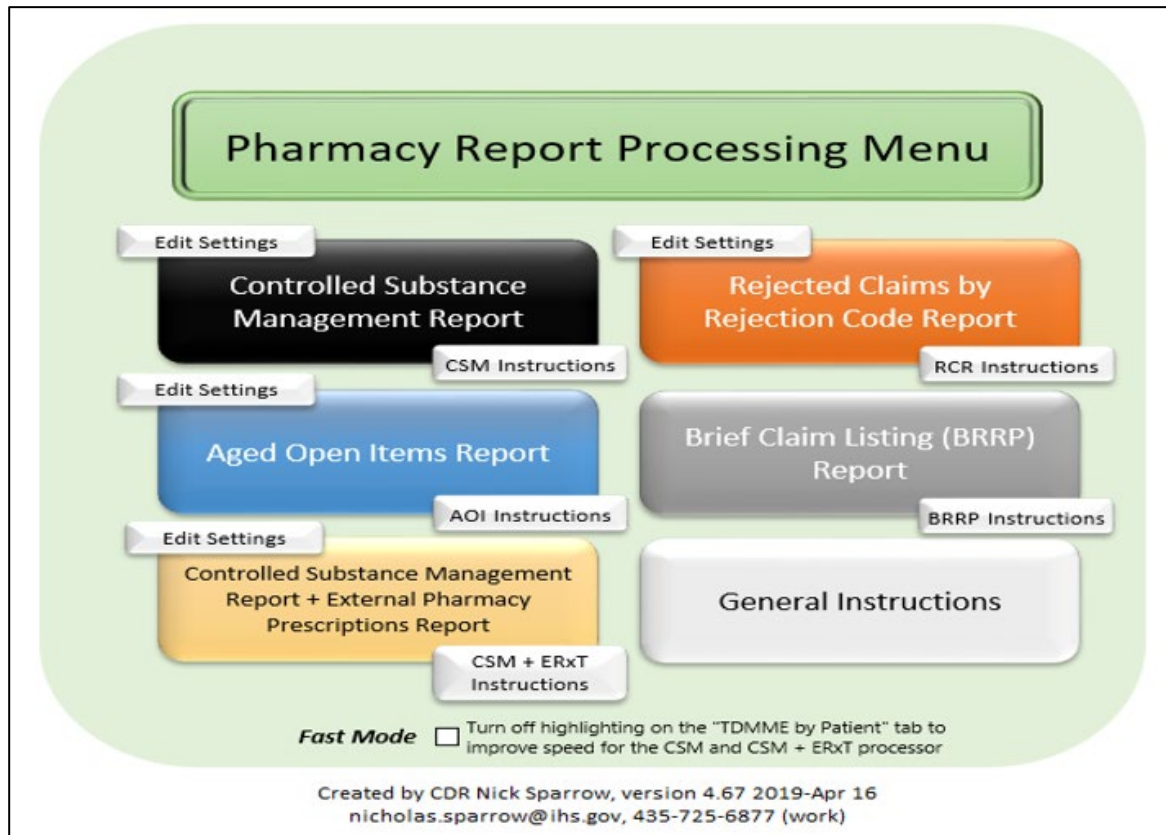
The RRIP, or RPMS Report and Information Processor, is an Excel document created by Nick Sparrow. It changes the RCR report into an easy to use Excel form. It comes with its own user manual and directions.

RCR Report Loaded into RRIP

RCR Report Loaded into RRIP (cont.)

Slide 48 (previous slide) is an example of what the claims will look like once loaded into the RRIP. The claims can be sorted by any of the headings, whether by reject code, medication, or dollar amount.
The system used at Clinton is that if a claim needs a Prior Authorization filled out, the claim can be labeled in the comments section for later attention. We color code all those that need PAs completed or that need additional work yellow, and those PAs that have been sent off but are awaiting a response, in green. Whatever system the site decides to use, the utilization of the RRIP will greatly improve the efficiency which should increase the collections.

Learning Objective #2: Knowledge Check #1

True or false.

Reject code 75:Prior Authorization Required is the only reject code that needs attention when initiating prior authorizations

Learning Objective #2: Knowledge Check #2

Which tab on the POS Tutorial can you find an explanation of different rejection types to see which ones might benefit from a PA?

A. Daily Tasks

B. Fixing a Rejected Claim

C. PA log

D. Reject list

Indian Health Service
Office of Information Technology

Learning Objective #3

Initiating and completing a Prior Authorization

Options for Initiating a Prior Authorization

- Contact individual third-party directly by phone. The number is usually included in the RPMS rejection receipt.
- Go to each third-party insurance's website
  - Caremark (ePA)
  - United Healthcare
  - Express Scripts/Medco
  - OHCA – Oklahoma Medicaid
- **Covermymeds–PREFERRED**

Covermymeds

- Free website for Prior Authorization completion for most third-party plans.
- Search for forms by entering BIN, PCN, and GROUP numbers.
- Website stores patient, prescriber, and pharmacy information once it is entered.
- Greatly speeds the PA process through online completion. May receive immediate response in some cases.
- Stores outcomes of PA's to show trends of which meds are normally approved/denied.

POS Tutorial: PRIOR AUTHORIZATIONS Tab
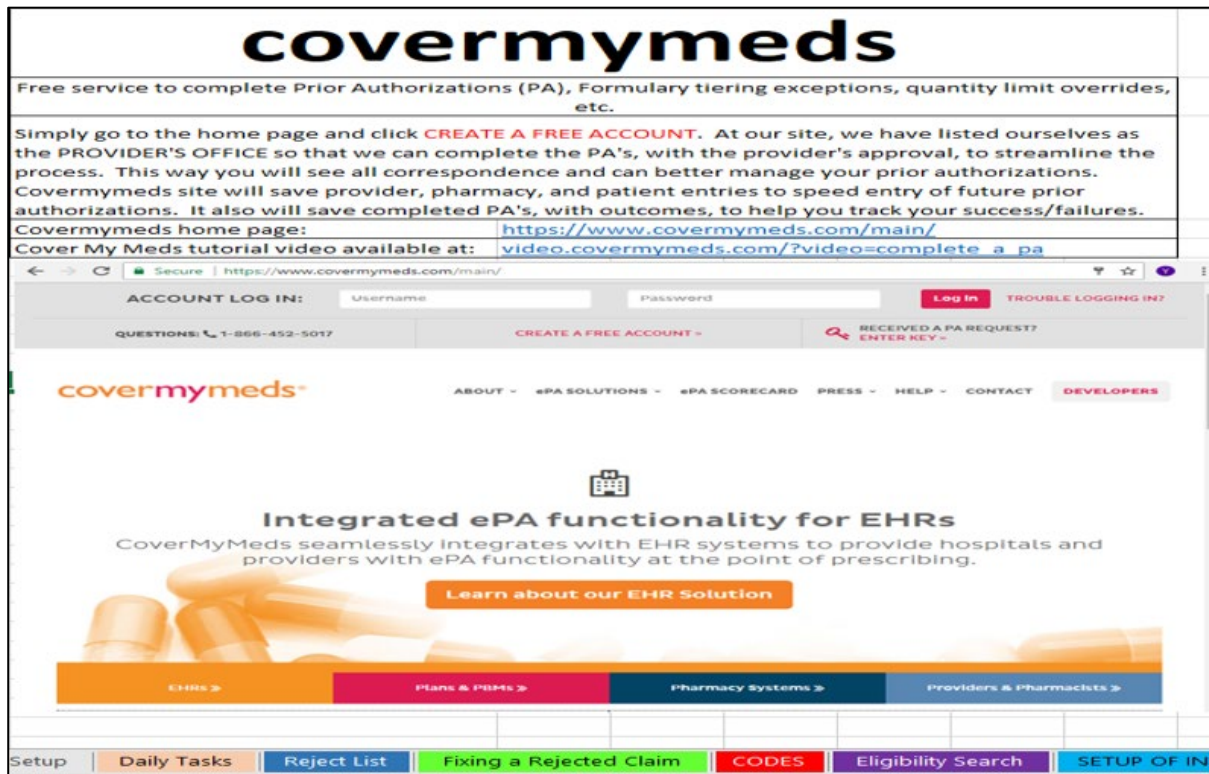
Click the **Prior Authorizations** tab of the POS tutorial to locate website information and a link to a video tutorial on how to use Covermymeds.

Covermymeds – Getting Started

1. To get started, navigate to https://www.covermymeds.com/main/.
2. Click **Create A Free Account**.
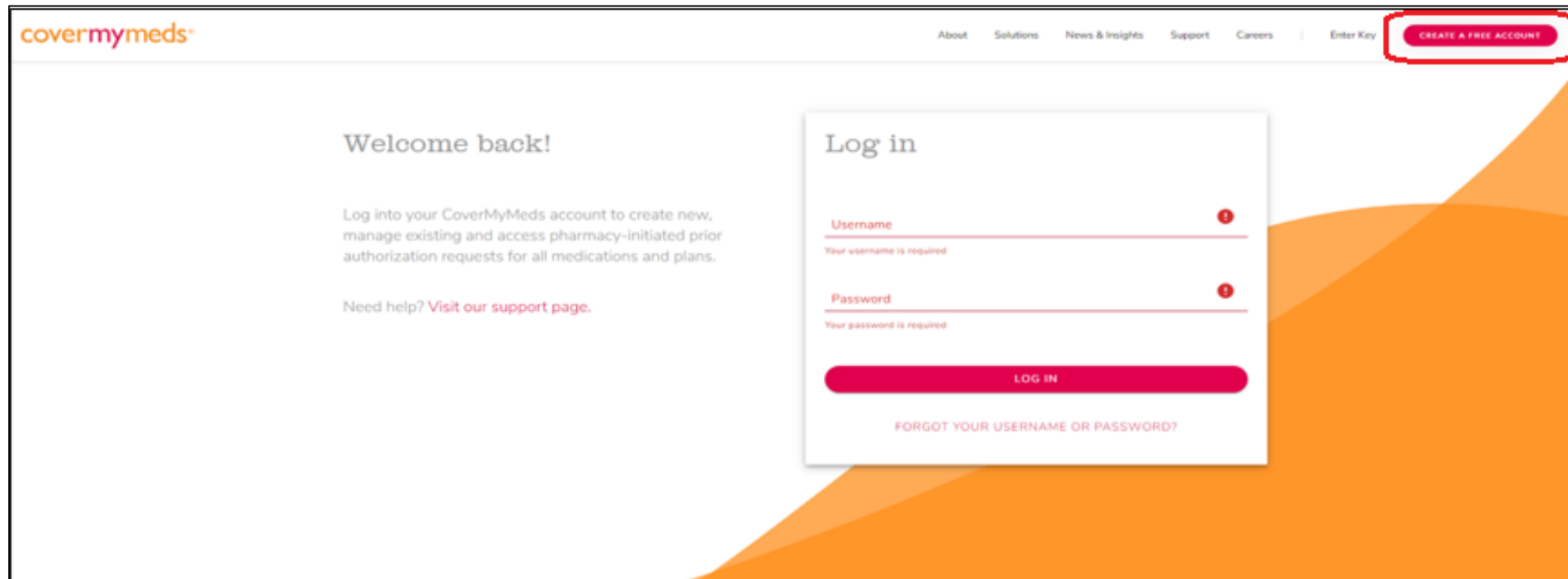
Create Your Account Form

- To create your account, enter your site's information.
- It is best to have one account for your site and have everyone use the same account.
- This consolidates everyone's efforts, so it is easy to find out if others have already submitted a PA in the past.

Creating Your Covermymeds Account

Set up account with you listed as a **PRESCRIBER** instead of Pharmacist/Technician

• Benefit: PA responses will come directly to you to speed the process

• Meet with your providers to verify that they approve of your completing the PA on their behalf

Accessing Information to Complete PA Request

Most information can be obtained from patient's EHR.

- Medication list: shows dates and history of using preferred meds
- Problem list: shows diagnosis and ICD-10 codes
- Chart notes: view note from date medication was started

Prior Authorization Example (1)

- Highlighted in yellow is the Mometasone inhaler that was rejected for this patient: 70:PRODUCT SERVICE NOT COVERED.

- At this point, log onto Covermymeds and locate which PA for to use.

Prior Authorization Example (2)

1. Navigate to the Covermymeds homepage.

2. Click **Login** and enter the Username and Password.

Prior Authorization Example (3)

New Request: New PA

This page also shows:

- Current requests

- PAs sent to plan

- Search function
  - Search by patient first name/last name/medication name

Prior Authorization Example (4)

- Enter Medication
  - By name and strength
  - By NDC number: Enter the NDC from your RRIP report to select the correct medication. (PREFERRED)
  - Copy and paste the NCD number in the **Name of the Medication** field and it will populate the correct medication.
  - Double-click the medication.

Find Your Medication

Name of Medication

00085134107

Asmanex (30 Metered Doses) 220MCG/INH aerosol powder

Prior Authorization Example (5)

- To Select Insurer form enter from RRIP:
  - BIN
  - PCN
  - GROUP
- Once entered, the choices will populate at the bottom of the screen. The top of the list is usually correct.
- Click **Start** to launch the form.

Prior Authorization Example (6)

Enter the patient information:

Prior Authorization Example (7)

Enter Medication Info:

- Name will Prepopulate
- Enter Dosage Form
- Enter Quantity
- Enter Day Supply

Prior Authorization Example (8)

- Enter Provider Info
    - Once a provider is entered, pull up their info by clicking the **Provider address book**.

Prior Authorization Example (9)

- Send to Plan
- Will receive a reply where you can enter additional info (if you set up account as prescriber)
  - Diagnosis
  - Medication history
  - Other information supporting request
  - "Magic Paragraph"

▼ Prescriber Next Steps

? Click the "Send to Plan" button to submit this information to OptumRx. (If it is disabled, be sure all required fields have been completed.) This electronic submission does not require a signature.

OptumRx will respond automatically with your next steps.

Send to Plan

Prior Authorization Example (10)

Completing additional info request

- Directions: Meds tab

- Timeframe

- Diagnosis: Problem Mngt tab

- Dose: Meds tab

Please provide the directions for use:
1 PUFF DAILY

Does the prescriber attest that applying the standard timeframe for review of this coverage determination will not seriously jeopardize the enrollee's life, health, or ability to regain maximum function?
- ◉ Yes - apply standard timeframe for review of this coverage determination
- ○ No - the patient's life/health/or ability to regain maximum function is in jeopardy

What is the requested quantity?
- ◉ Less than or equal to 0.040000 per day
- ○ Greater than 0.040000 per day

What is the diagnosis for the medication being requested?
- ◉ Asthma
- ○ Other

The following alternatives are the preferred alternative: Arnuity Ellipta or Flovent Diskus or Flovent HFA. Would you like to switch to the provided preferred alternatives?
- ○ Yes
- ◉ No

Prior Authorization Example (11)

Directions for use:
- Navigate to the **Medications** tab in EHR.
- The SIG will show directions for use.

Prior Authorization Example (12)

Diagnosis and Diagnosis Code

Problem Mngt > **Chronic** > diagnosis and **ICD-10** code

Prior Authorization Example (13)

- Diagnosis Code

- Visible in Rx Order

- ^PPP (Patient Prescription Processing)

- Only visible if entered on the original Rx order


```
---------------------------------------------------------
          Rx #: ████
(1) *Orderable Item: MOMETASONE 220MCG 30 INHL,ORAL
(2)       CMOP Drug: MOMETASONE 220 MCG/PUFF ORAL INHL PWDR-30 (E)
             Verb: INHALE
(3)       *Dosage: 1 PUFF
          *Route: ORAL INHALATION
       *Schedule: QDAY
(4)Pat Instructions: FOR BREATHING
             SIG: INHALE 1 PUFF BY MOUTH EVERY DAY FOR BREATHING
Clinical Indication: Asthma |   J45.909  ←
(5)  Patient Status: OUTPATIENT
(6)      Issue Date: 04/24/20          (7)  Fill Date: 04/24/20
     Last Fill Date: 07/17/20 (Window)
  Last Release Date: 07/17/20          (8)      Lot #:
+---------Enter ?? for more actions-----------------------
DC   Discontinue       PR   Partial          RL   Release
ED   Edit              RF   (Refill)         RN   Renew
```

Prior Authorization Example (14)

Dose per day calculation

Quantity/day supply = Quantity per day

1/30 days = 0.03 per day

Prior Authorization (15)

The following alternatives are the preferred alternative: Arnuity Ellipta or Flovent Diskus or Flovent HFA. Would you like to switch to the provided preferred alternatives?

○ Yes
◉ No

Formulary options are normally not available at IHS.

May require an explanation to Insurers concerning the limited formulary and special circumstances surrounding the Indian Health Center.

Magic Paragraph

Other formulary alternatives are not available at our FEDERAL INDIAN HEALTH CENTER. Patient receives their care at our INDIAN HEALTH SERVICE CLINIC (FEDERAL FACILITY). We have a closed formulary, and the preferred medications are not available for use. The patient can try the preferred meds through retail or mail order service; however, they would be responsible for the copay amount, which they cannot afford. Our clinic does not charge the patient their copay. We bill insurance, recover what we can to fund our clinic, and waive the patient copay. The patient pays nothing.

Attach Paragraph Explanation

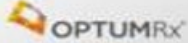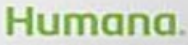To attach the paragraph explanation, select the **Yes** button in the **Additional Documentation** pane.

Checking PA for Approval or Denial

- Denials can be appealed to possibly get an approval
- Approvals: keep track of your successful PA attempts

PA LOG Tab on Pharmacy POS Tutorial

- Keeps track of successful Prior Authorizations
- Gives an estimated collection for the Year
- Gives Reminders when the PA is about to expire

Total from column "I":	$46,944.00					How many fills to assume per year:		12	
Date	Chart #	PT. NAME	Starting Date	Ending Date	Needs update?	MEDICATION	Amount/month	Estimate/year	ACTION
1/1/2015	3333	DOE,JOHN	1/1/2018	12/31/2018	TRUE	ENBREL	$3,900.00	$46,800.00	
1/1/2019	4444	DOE,JANE	1/1/2019	12/31/2019	TRUE	TRUE METRIX TEST	$12.00	$144.00	

Backdating an Approved Prior Authorization

Since we often submit for PAs after the actual fill date has passed, we may need to call insurance to backdate to the actual fill date

- Call the phone number on the PA approval that you receive by fax

- Some insurers (Caremark) automatically backdate PAs 30 days

- Others will backdate up to 7, 14, or even 30 days, depending on the plan

Special Situations

1. Specialty meds covered through Caremark (discussed earlier)
   - Email Address: SpecialtyIHSrequests@cvshealth.com
2. Federal Blue Cross/Blue Shield BIN: 610239 PCN: FEPRX
   - If PA is denied, call and ask to speak to the **Plan Manager**
   - Special provisions in place for Prior Authorizations to be approved for IHS
     - Phone number: 800-345-5413
     - Ask for Plan Manager
     - Follow up if the claim does not go through

Learning Objective #3: Knowledge Check #1

When setting up your Covermymeds account it should list you as the_____ so you can see all correspondence.

A. Pharmacist

B. Pharmacy Tech

C. Provider

Learning Objective #3: Knowledge Check #2

When filling out a PA on Covermymeds, you can find the ICD-10 code under the _____ tab in _____.

A. Wellness, EHR

B. Patient Goals, EHR

C. POS User Menu, RPMS

D. Problem management, EHR

Creating Opportunities

With your work in pharmacy point of sale, you can **create opportunities** all around you.

The work that is done to increase collections can create new treatment opportunities for our patients. It can also create new job opportunities by the **addition of new services**. Never underestimate the **impact** that you can have on your site and on the **lives of the patients** that your site serves.

Our **IHS goal** cannot be reached without your **hard work** and dedication.

What Questions Do You Have?

Contact for Questions or Comments

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