PURPOSE:

To provide a prior authorization drug request process for injectable and non-injectable medication in line with the Department of Health Services (DHS) P&T Committee with the purpose of ensuring safe and appropriate use of prior authorization medications.

DEFINITIONS:

1. Prior authorization medication request (PAMR) –defined as a request form for approval for drugs to be dispensed or administered to patients that are either:
   a. Non-formulary
   b. Formulary with pre-approved established criteria for use
   c. Formulary prescribed outside of approved restrictions
2. Formulary-list of safe and efficacious drugs approved for use at all DHS institutions.
3. Injectable medication-drug that is administered intravenously, subcutaneously, intradermally, or intramuscularly by the provider to the patient.
4. Outpatient-a patient who is not hospitalized, but who visits a DHS institution for diagnosis or treatment.
5. Pre-approved drug specific PAMR-request form for DHS Core Formulary medications with P&T Committee approval criteria for authorization.
6. Urgent-requires immediate action to prevent a serious deterioration of a patient's health, jeopardize the ability of the individual to regain maximum function, or delay would subject the patient to severe pain that cannot be adequately managed.

POLICY:

The PAMR form must be filled out completely by the physician prescribing a prior authorization Medication, reviewed by the facility pharmacy department, central DHS pharmacy department, and approved by the facility Chief Medical Officer (CMO) or designee prior to issuance of the drug. Approved requests must be reviewed no later than every 6 months.

Time Frames

1. Standard (non-urgent) request- review and decision within 24 hours of receipt by the pharmacy department.
2. Urgent request-review and decision within 6 hours of receipt by the pharmacy department.

Reviewed: 10/2/15bj, 7/12/2018bdk, 4/19/2022 TT

Approved By:

PROCEDURE:

The PAMR form is to be completed for both new patients and patients who have previously used the requested prior authorization drug. Patients who are currently receiving prior authorization medications will be permitted to continue therapy through the duration of the authorization. A renewal authorization is required to continue the medication beyond the authorized duration.

PAMR Review and Decision Steps:

1. The PAMR form must be completed by the prescriber and submitted with a prescription order to the facility pharmacy department.
2. The PAMR form must be adequately reviewed for completeness and clinical appropriateness by the facility pharmacy department.
3. For all pre-approved drug specific PAMR forms submitted, the facility pharmacy department shall approve if all criteria elements are met. For pre-approved drug specific PAMR forms that do not meet all established criteria, the facility pharmacy department will provide a recommendation to the facility CMO or designee for decision. A copy of the pre-approved drug specific PAMR form for an outpatient injectable medication with time stamps will be forwarded to the central DHS pharmacy department for tracking.
4. The outpatient pharmacy department is to forward the PAMR form to the central DHS pharmacy department for a clinical review by fax or e-mail.
   a. Fax number: (323) 832-5861
   b. E-mail: priorauth@dhs.lacounty.gov
5. The central DHS pharmacy department will provide a recommendation to the facility CMO or designee and copy to the facility pharmacy department.
6. Based on the information submitted and the recommendation from the facility pharmacy department the facility CMO or designee will approve or deny the prior authorization medication request.
7. The facility CMO or designee is to notify the facility pharmacy department of the decision of the prior authorization request.
8. The facility pharmacy department shall notify the prescriber and procure medication if necessary. A copy of the decision is to be provided to the central DHS pharmacy department.
9. In the event the PAMR is:
   a. Approved: the prescriber and patient will be granted access to the requested medication for up to 6 months.
   b. Denied: the prescriber and patient will not have access to the requested drug and will be required to use a medication currently on the approved DHS Core Formulary.

10. The prescribing physician may appeal the PAMR decision. A formal appeal request must be submitted to the facility CMO or designee.
11. PAMR records will be maintained by both the facility pharmacy department and the central DHS pharmacy department.
12. After-hours urgent PAMRs shall be reviewed in a timely manner. If the initial PAMR meets facility approval, then the facility pharmacy shall submit for official approval on the next business day. For after-hour urgent PAMR approvals, the facility pharmacy will provide no more than a 72-hour supply of medication until an official approval is finalized.

Inpatient Pharmacy Urgent Prior Authorization Procedure:

1. The receipt of an urgent PAMR triggers the following:
    a. Communication between the pharmacist and the provider as to alternative formulary medication available.
    b. If it is determined that the medication is urgently needed and no available alternative formulary medication can be substituted, the pharmacist will ensure that the medication becomes available as soon as possible via the following mechanisms:
        i. Patient's own medication.
        ii. Borrow from a sister hospital or neighboring hospital.
        iii. Order through Pharmacy Procurement. (Note: It may take up to 48 hours to order a medication Mondays-Thursdays and longer on Fridays, weekends, and holidays).

APPENDIX:
1. Appendix A: Prior Authorization Medication Request Form
2. Appendix B: DHS Prior Authorization Medication Request Process Flowchart

REFERENCE:
1. DHS Process for Outpatient Prior Authorization Medication Requests, Policy 329.007, October 9, 2012.

Health Services

DHS PRIOR AUTHORIZATION MEDICATION REQUEST FORM

INSTRUCTIONS

1. THIS FORM IS NOT A SUBSTITUTE FOR A PRESCRIPTION ORDER. ANY FORM SUBMITTED WITHOUT A PRESCRIPTION ORDER WILL BE CONSIDERED INCOMPLETE AND NOT REVIEWED.
2. COMPLETE ALL THREE PAGES OF THIS PRIOR AUTHORIZATION FORM.
3. SUBMIT COMPLETED PAGES AND PRESCRIPTION ORDER TO LOCAL FACILITY DHS PHARMACY.
4. LOCAL FACILITY PHARMACY WILL REVIEW FOR COMPLETENESS/ACCURACY, AND THEN FORWARD TO DHS CENTRAL PHARMACY FOR PROCESSING VIA FAX 310-669-5609 OR EMAILING PRIORAUTH@DHS.LACOUNTY.GOV
5. FINAL APPROVAL WILL BE PROVIDED BY FACILITY CHIEF MEDICAL OFFICER OR DESIGNEE.

*** NOTE: FOR CLINICALLY URGENT CASES THAT CANNOT WAIT TYPICAL REVIEW TIMEFRAMES (~2-3 DAYS FROM SUBMISSION TIME), FACILITY CMO OR DESIGNEE MAY APPROVE THERAPY IF PRIOR AUTHORIZATION FORMS ARE COMPLETE.

DHS FACILITY (CHECK ONE)	☐ EL MONTE CHC	☐ HUMPHREY CHC	☐ OV/UCLA MC
☐ LAC+USC MC	☐ H/UCLA MC	☐ MLK MACC	☐ MID-VALLEY CHC
☐ HUDSON CHC	☐ LONG BEACH CHC	☐ HIGH DESERT MACC	☐ SAN FERNANDO HC
☐ ROYBAL CHC	☐ WILMINGTON HC	☐ RANCHO LA NRC	☐ OTHER:_____

PATIENT NAME (PLEASE PRINT): LAST, FIRST, MI	DHS MEDICAL RECORD NUMBER	PLEASE SELECT ONE		
		☐ INPATIENT	☐ OUTPATIENT INFUSION CLINIC	☐ OUTPATIENT

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#:** (_____)_____
Plan/Medical Group Fax#: (_____)_____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Patient's Home ☐ Long Term Care
☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

New 08/13