

Health Net: Medical/Surgical Prior Authorization Process

Prior authorization or notification is limited to procedures where interventions are proven to be successful.

1. Prior authorization review is the utilization management process of data collection, evaluation/analysis and determination of medical necessity by Health Net that occurs prior to rendering a health care service.
2. The prior authorization review process is applied to requests for outpatient surgery, admissions to an inpatient facility and selected ambulatory procedures. Services subject to prior authorization are governed by Health Net's benefit plan.

Prior authorization helps ensure:

- Hospital admissions are medically necessary
 - Planned services are performed safely and effectively in the most appropriate setting
 - Services to be rendered are covered benefits
 - The Health Net care management team is notified of admissions so that they can facilitate the member's care when needed
3. Prior authorization is not required for emergency care.
 4. Health Net licensed nurses use nationally recognized criteria when evaluating a prior authorization request. Cases that do not meet this criteria are forwarded to a Health Net medical director for further review and determination. Only medical directors have the authority to deny services.
 5. Participating providers must obtain prior authorization for certain services indicated on the Prior Authorization Requirements list. Changes to the prior authorization list are sent to all participating providers 90 days prior to the effective date.
 6. Providers should obtain prior authorization before referring a member to a non-participating provider for consultation or treatment.
 7. In the event Health Net receives incomplete clinical information, a letter will be sent to the requesting provider and the member indicating the clinical information needed to make a determination. If the requested information is not received, the determination is made on the available information. The member and provider are notified in writing with appeal information.
-

Pharmacy Prior Authorization Process:

1. If a participating provider determines that a Medicaid Healthy *Options* member needs a medication not on the Connecticut Healthy *Options Preferred Drug List (PDL)* or more than the usual recommended amount of a medication, the provider can complete the Prior Authorization/Medication Exception form.
2. Certain medications require prior authorization due to utilization, safety concerns or medical policy guidelines. These agents are restricted for use under conditions approved by the Pharmacy & Therapeutics (P&T) Committee. Other medications have a benefit determination requirement to establish if the medication is covered according to the member's *Schedule of Benefits*. Before these medications can be authorized for coverage, the prescribing provider must forward the diagnosis to Health Net so that a determination can be made.
3. The prior authorization should also be used to request a dosing regimen that is outside the usual recommended length of therapy or dosage limits.

4. Requests are accepted by faxing the prior authorization form to the Health Net Pharmaceutical Services (HNPS) prior authorization line. Urgent prior authorization requests may also be submitted by calling the HNPS prior authorization department.
5. Pharmacy prior authorization requests are processed 12 hours a day (9am to 9pm EST), five days a week (Monday through Friday), with a standard turnaround time of less than 24 hours or one business day. Urgent requests (such as for an antibiotic needed for infection treatment) are processed within two hours. An approval is faxed back to the physician or, in the case of a denial, a letter is faxed with documented reasons for the denial and suggestions for formulary alternatives. Copies of the prior authorization forms are available on the provider portal of Health Net's Web site at www.healthnet.com or by calling HNPS.
6. Prior authorization may also be requested through the dispensing pharmacy. The prescribing provider may indicate on the script the specific documented justification for the medication requested based on specific criteria, such as the member's diagnosis or previously-used unsuccessful or contraindicated medications. The dispensing pharmacist may obtain prior authorization from Health Net if the pharmacist has the necessary patient information.