

## Pharmacist Comments:

1. Please inform MD's of their role in this process. You have to explain everything to them or send them updated formularies so they will prescribe only from the list.
2. Need but medical.
3. I find that the prior authorization plus website is a great tool, because it allows us as the pharmacy to start the prior authorization paperwork for the doctors office.
4. I feel the PA process is inadequate. The prescriber seldom has to substantiate why a non-PDL drug is required. The check off box of medically appropriate should be eliminated unless Medicaid requires clinical notes to substantiate that the PDL drugs have failed. In other words, it is way too easy for prescribers to have a non-PDL drug approved with the current system.
5. Frequently provide the prescribers updated formularies so they can be aided in choosing the medication they provide.
6. When a PA is approved, the pharmacy where the reject was processed should be notified by the system. We are always the last to know and typically, the only way we find out is by trying to submit the claim again when the patient inquires.
7. Need message to state brand name drug preferred, for example. This is due to rebating program. Why does reject say prior authorization required when it is, in fact, not covered because of a rebating agreement?
8. We are a long term care pharmacy and almost always the doctor is not available to complete prior authorizations the same day we send the form out. It would be a great if you would allow prior authorization approvals to be backdated to the date of dispense once approved. Thank you.
9. Prior authorization for Medicaid in a long term care setting is extraordinarily difficult and slow. In attempts to cut costs by adding more prior authorizations, etc. the quality of care plummets in the LTC setting. Doctors are hard to find, often find dealing with Medicaid difficult due to constantly changing the formularies and oddities such as covering brands and not generics. Prior authorizations that take an enormous amount of time also lead to more Medicare A stays at facilities and hospitals as patients are routinely shipped back and forth as their care slides with issues. A constant culprit of this is the coverage procrit and aranesp and other various IV's. These types of drugs require immediate dispensing and use and without them sometimes the patients care deteriorates quickly. Medicaid needs to allow transitional fills or at least enable the LTC pharmacy to do the PA with appropriate information they can obtain from the Doctor or LTC facility.
10. I actually think it works very well. I just wish the doctors would fill out the forms faster.
11. We should try and make prior authorization requests all electronic.
12. Some packaging cannot be broken down to a 14 day supply. If you are going to permit a one-time fill, it would be more appropriate to allow a one month supply so that pharmacies are not put in a position of having to enter an incorrect day supply to fill the prescription. If a 30 day supply is not allowed then it should be clearly stated by Medicaid how we are to process such claims so that the patient is not unnecessarily inconvenienced.
13. Some medications that require PA are only available in quantities greater than 14 day supply (i.e., inhaler or eye drops) and therefore, cannot be submitted for a 14 day supply since the calculated days supply is greater than 14 days. This should be addressed. One minimum unit should be allowed in this case.
14. Medicaid is the easiest 3<sup>rd</sup> party to deal with. Nearly everything is covered – policies are very liberal. The 14 day supply is a bad design (especially for unnecessary medications like acne treatment); the switch to the preferred agent should happen on day 1. MD needs to consult the preferred/non-preferred drug list before the patient leaves the office. It would seem that is part of their job?
15. If a medication needs prior authorization, it would help if you would provide the name of alternatives that are covered. What is extremely confusing is when Husky requires a generic medication to get prior authorization, but Husky will pay for the brand name of said medication such as with Valcyclovir and Valtrex.

16. It would be helpful to list the alternative drug covered that is on the PDL on the electronic prior authorization rejection that we get instead of having to always refer back to the PDL on line.
17. System works very well.
18. Pharmacist should have limited prescriptive authority to intervene and provide patients much needed medication in a timely manner when physician cannot be reached.
19. My biggest challenge is Subutex when prescribed for pregnant women. There should be some sort of exception for this particular group of clients who are trying to end drug addiction but cannot get ongoing medications because sometimes it takes too long to get the PA. Is there a way in the system we could enter due date or some documentation of pregnancy to override at our end? Suboxone (which Husky pays for) is contraindicated in these patients...otherwise I usually find fast response to MD requests.
20. Enable requests via email. Have DSS automatically assign a 'transaction number' (for each claim requiring PA) which refers to all pertinent information for the affected claim (client ID, quantity, days supply, etc.). Pharmacy can then contact the physician with a unique PA incident number. The physician can then enter the number into a dedicated DSS PA website and add any information required for authorization. A system such as this would greatly facilitate authorization requests.
21. Physicians do not respond quickly/or at all and we are in the middle when the patient has no medication. We often have to take a loss on the next fill because the MD or the process is not working quick enough and we will not let the patient go with the med. There needs to be another override to allow these patients to get medication when the system is being inefficient.

## Prescriber comments:

1. The TXIX PA process is very easy.
2. It should be electronic rather than paper.
3. Short and simple because providers are so busy that time is the essence, we need to provide quality care instead of worrying whether it is covered by insurance. We can't speak for others, but our doctors are genuinely dedicated to patients. If the authorization can be done online in a very easy and simple way, that will make us very happy.
4. We try to use what is on the formulary unless the patient has had a problem with the formulary drug.
5. This is the most cumbersome and nonsensical system that only further delays the most vulnerable members of the healthcare system from getting care. The state should be ashamed of itself!
6. When medication is approved a fax should be sent to the ordering physicians office so we are aware, often we have to call back to verify if approved.
7. Should not have to go through the prior authorization system when someone has been taking a specific medication for many years.
8. Computerized process with a more efficient turn around time would be wonderful. Additionally, after hours are an issue if seeing a patient later in the day, or on the weekend, as we so often do.
9. Providers should be notified of the outcome of the prior authorization. There is never any feedback.
10. The process takes too much time and required info is excessive. Even generic prescriptions need prior authorization.
11. I believe that many prescriptions are being kicked back over into prior authorization simply because the prescriber did not tick off 'dispense as written' for certain medications that the state will not cover as generic. Examples would be Augmentin suspension, or Concerta, or Pulmicort Respules. Unless we tick DAW, the pharmacy automatically attempts to fill the generic version, which is rejected, thereby resulting in prior authorization paperwork and additional delays to the family. Obviously, the prescribers are expected to keep up-to-date with the Preferred Drug List; however, I would think that the pharmacists would be able to alert us that a DAW error is the problem and not simply send the prescriber a non-specific rejection message stating that prior authorization is required. It costs the state time and money to process prior authorizations, so I would hope that simple DAW errors could be identified appropriately and treated as a separate category of error.
12. Never notified if PA is approved or rejected. This is a MAJOR problem.
13. We are Pediatricians. We do not prescribe anything exotic. Pharmacists should automatically switch to, for example, your preferred (name brand) Pulmicort if we accidentally prescribe (the generic) budesonide. This begs the question: is the state getting a better price on the brand name Pulmicort than on a generic?
14. The providers feel they can write whatever they want and the drug reps add to this by telling the providers that their products are now formulary for Medicaid, which is sometimes true and sometimes not.