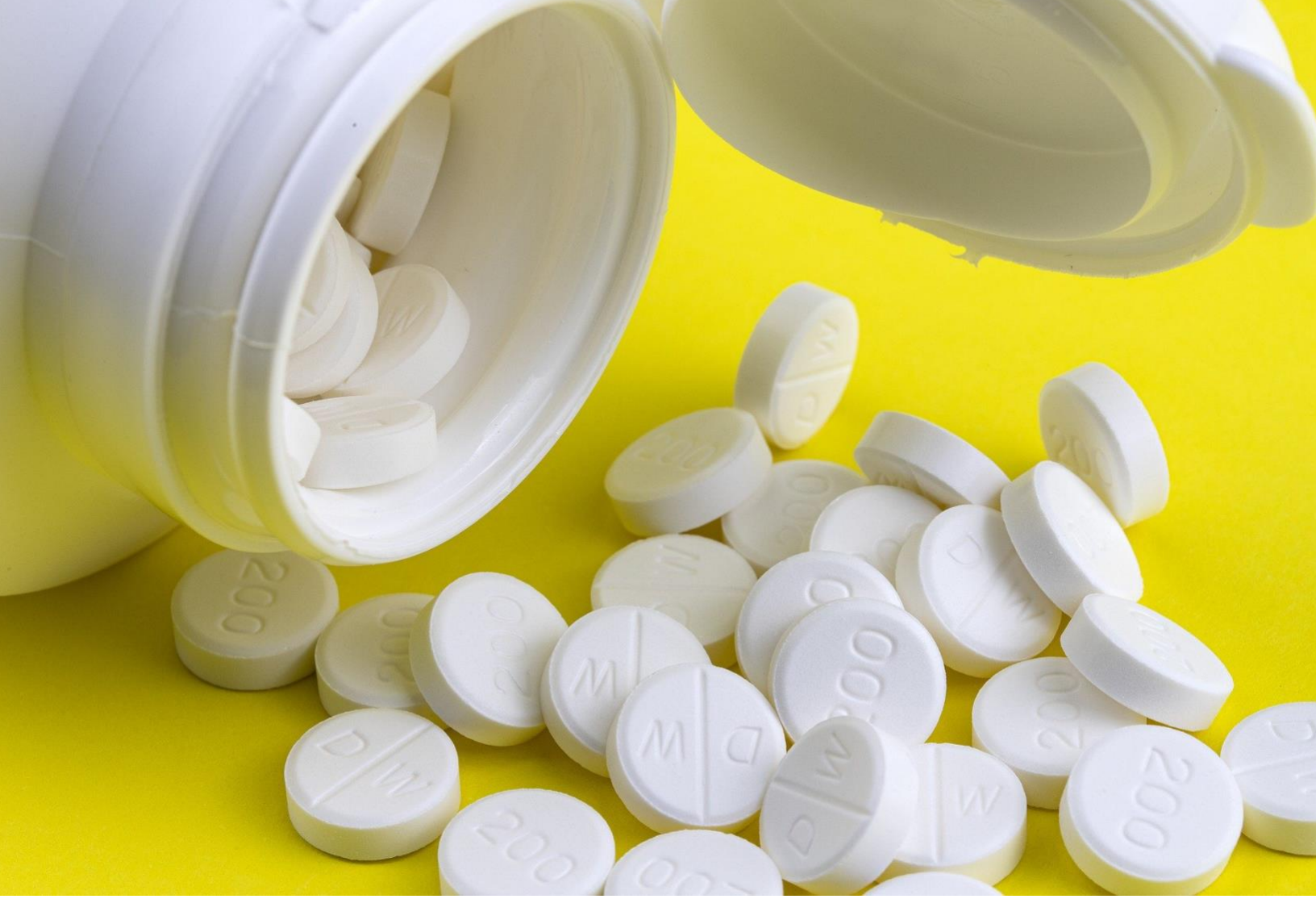

Texas Department of Insurance: Advisory Committee for the Standard Request Form for Prior Authorization of Prescription Drug Benefits, October 21st, 2020

1. Call to order, Introductions and welcome, Antitrust statement. The meeting was convened by Debra Diaz Lara. This is a second meeting to address the benefit and take member comments. The Committee moved directly to agenda item 4. **Reference**: Insurance Code 1369.305(d).

2. Staff update regarding instructions for completing the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standardized Prior Authorization Request Form for Prescription Drug Benefits if the plan requires prior authorization of a prescription drug or device. In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization by fax or mail when an issuer requires prior authorization of a prescription drug, a prescription device, formulary exceptions, quantity limit overrides, or step-therapy requirement exceptions. An Issuer may also provide an electronic version of this form on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a prescription drug benefit.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a prescription drug or device requires prior authorization; or 6) request prior authorization of a health care service.

Additional Information and Instructions:

Section I – Submission: Enter the name and contact information for the issuer or the issuer's agent that manages or administers the issuer's prescription drug benefits, as applicable. An issuer or agent may have already prepopulated its contact information on the copy of this form posted on its website.

Section VI – Prescription Compound Drug Information: List the quantities of ingredients in units of measure (mg, ml, etc.).

Section VIII – Patient Clinical Information: Enter ICD Version 9 or 10, as applicable.

Section IX — Justification: In the space provided or on a separate page:

- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency.
- Explain any comorbid conditions and contraindications for formulary drugs.
- Provide details regarding titration regimen or oncology staging, if applicable.
- Provide pertinent information about any step-therapy exception, if applicable.

Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed. Note:

Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.

TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

Clear Form | Print

SECTION I — SUBMISSION

Submitted to:	Phone:	Fax:	Date:

SECTION II — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:	
BIN # (if available):	PCN (if available):	Rx ID # (if available):	

SECTION IV — PRESCRIBER INFORMATION

Name:	NPI #:	Specialty:	
Address:	City:	State:	ZIP Code:
Phone: / Fax:	Office Contact Name:	Contact Phone:	

SECTION V — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated: _____)

For Provider Administered Drugs Only:

HCPCS Code: _____ NDC #: _____ Dose Per Administration: _____

SECTION VI — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:

Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VII — PRESCRIPTION DEVICE INFORMATION

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION VIII — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION IX — JUSTIFICATION (SEE INSTRUCTION PAGE SECTION IX)

~~**3. Review of adopted Texas Standard Prior Authorization Request Form for Prescription Drug Benefits**~~

4. Receive committee members' comments and recommendations, and take possible action, regarding:

(A) the effectiveness and impact on patient safety of the Standard Prior Authorization Request Form; and

The group wanted to update the instructions to include ICD 10 or successive codes since ICD 11 will be out in 2021. The instructions should include current coding instructions. There was no objection to this proposal.

The form has been effective with only a couple of implementation issues. The time taken to fill out this form is lengthy. The authorization process in general also takes too long but that is not a form issue.

From a PBM perspective, additional outreach can be required, and thus taking more time.

Texas Medicaid also agrees. Addendums to the form have had to be added. Specific drugs that require additional information require an addendum. HHSC asked about leaving off the provider signature.

With numerous reasons provided, there was a consensus to leave off the provider signature.

Is a signature required on the addendum? HHSC answered in the affirmative.

The reason that the signature was not required was because many physicians may be involved, and it is the staff that are usually filling out the form.

(B) suggested changes to the Standard Prior Authorization Request Form to increase effectiveness and patient safety.

Is it possible for the signature of the prescriber's authorized agent (nurse or other staff)? It was agreed that that is something that could be looked into. This would be specifically about opioids. There would have to be a rule change to add that requirement.

There have not been any complaints about the form to-date.

I would not want to increase administrative burdens on staff. Who signs the addendum? The form is accessible on the web. It is a publicly accessible form.

Section V of the above form— 80 percent of the time, patients miss dosages because of the time it takes for renewals. Is there a way to get qualified before? This is a patient safety issue. The change would involve checking the box that it is a continuation drug, then the process for approval has been completed already. The delay is because of the cost of the drug, not a change in formulary. The PBMs are the ones causing the delay, requiring reauthorization every six months to a year. Continuation therapy should not have to be redone. This would be a rule change for patient safety.

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Where would the information be captured if the drug has not been effective if we go with the proposal? You could add language asking a question about effectiveness. Physicians would not be proposing to continue a medication that was not working. Section 8 would accommodate that with the relative laboratory dates and other information.

The fast track really only pertains to reauthorization. The effectiveness has already been proven. There is no need to redo the form. The PBM should have this information already on file.

Many programs have fast-track renewals. You would not want to auto-approve an opioid, for instance. Looking back at previous cases, privacy is an issue, especially if patients choose a new provider.

We also look at the claims history and sometimes duplicate therapies can be discovered. Some members also change plans. Their prescriptions then go through a new PBM.

(Informal) MOTION: *Open the rule to address continued therapy - prevailed.*

What was the consensus regarding the signature? As long as it can be a designated person, then this might not be a problem.

(informal) MOTION: *for a rule change to require a signature from the prescriber or their designee - prevailed. (In box 2, make it an expedited or regular and a signature from prescriber or designee.)*

Other states use this approach.

SB1742 is addressed also in a new rule proposal that is being published in the Texas Register this week.

The continued therapy issue was brought back up. A fast track continuous medication would now place the responsibility on the PBM, which would not have to provide the reasoning why they need the form filled out. This way, it does not become a regulatory change. If a medication has been authorized it should not be treated as a new medication.

HHSC stated that they would be concerned about removing information that might make the PBM deny a medication because it does not have enough information. This could prolong the process.

Opioids perhaps should be a carve-out. It is hard to justify filling out Section 8 every six months, especially for chronic diseases.

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There was a question brought up about Section 3 and the need for the **BIN #** and whether it's necessary for that to be on the form. This might not be necessary if the policy change on Section 5 is implemented. For prior authorization, the PBM would not need this. This is used by pharmacies.

There was consensus to remove the BIN# and PCN and RX ID number from section three.

The proposals will be taken back to TDI rules committee.

5. Discuss future meeting schedule.

If the task is to review the form, then annually would be fine. Also if action items are brought up, then a special called meeting could occur.

As decisions are made about the rule change, **the committee should get back together.**

(Informal) MOTION: *continue biannual meetings and ad hoc meetings as necessary - prevailed.*

6. Adjournment. There being no further business, the meeting was adjourned.

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