SIMPLIFY PRIOR AUTHORIZATION
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When is a Prescription Drug a Specialty Drug?

Most prescription drugs, particularly those that have been available for a long time will be listed on almost all group plan prescription drug formularies. These are not usually specialty drugs.

Plan members may receive a generic drug instead of a name brand drug when a pharmacist dispenses their prescription medication, but a brand drug and generic are essentially the same, although they may look a little different.

These prescriptions can typically be filled at a local pharmacy using a prescription drug card as identification to confirm coverage, including the insurance company, policy number and the plan member's certificate number, whether they are the primary plan member or the insured spouse or dependent of the primary plan member.

Newer, more expensive specialty prescription drugs, typically drugs whose price is $10,000 or more annually per patient, may not be available at a local pharmacy. They may be one of a list of drugs identified by an insurer that are not available without a prior or special authorization. They are typically used in the treatment of more complex conditions such as cancer, rheumatoid arthritis, Crohn's disease, multiple sclerosis, and other diseases.

It is common for insurers to restrict access to these drugs so that only plan members with a specific medical history, disease profile, or those who have tried and failed to respond to other less expensive therapies, have access to more expensive drugs.

The drug a plan member has been prescribed is probably a specialty drug requiring prior authorization if one or more of the following applies:

- If they have been told that the drug is not immediately available to them because it is a specialty drug
- If they have been told that the drug is not immediately available to them because it requires prior or special authorization
- If the plan member and the prescriber must both complete a claim form(w) and provide medical evidence to support the claim before the payer, the insurer or pharmacy benefit manager, will agree to consider reimbursement of the drug(s) prescribed.

If the plan member is not sure if the drug they have been prescribed is a specialty drug requiring prior authorization they can check with their insurer that manages their group benefits plan. You may also be able to check for them by contacting their insurer on their behalf. Be sure to have the group policy number and certificate number handy and the drug name and what condition the drug has been prescribed to treat.

Finding Claim Forms

The insurer will be able to tell you how to find the right claim form for the drug the plan member has been prescribed and the condition that the drug will be used to treat. Knowing the condition is important because claim forms can vary by condition for specialty drugs.

Depending on who you contact, they may be able to confirm that the drug the plan member has been prescribed is listed in the plan's formulary. You may have a contact you already use at the plan member's insurer. If not, you can find links to insurers and their PA claim form lists under Resources on this site. Drug Access Canada also links to prior authorization forms for private insurers as well as other resources related to prior authorization.

If the drug(s) prescribed require prior authorization the plan member will probably need help with the process of submitting their claim for reimbursement. This website contains information that will explain the claims process, the stakeholders in the process, and who can help them prepare and submit their claim, including who can help if their claim is not approved by their insurer. You can refer them to the Patient section of the Information tab on this site.

If you need further information, you can contact Simplify Prior Authorization by completing Contact Us information on this website.