SIMPLIFY PRIOR AUTHORIZATION
WE ALL BENEFIT

I am a Plan Sponsor/Advisor

PA Stakeholders, You, and the Prior Authorization Claims Process

Earlier we explained how and why a prescription drug becomes a specialty drug, and why specialty drugs are subject to a process called prior authorization (PA), sometimes also called special authorization.

Prior authorization is a series of administrative steps in the claims process defined by a group benefits insurer, and sometimes administered by a pharmacy benefits manager (PBM), that must be followed before they will consider a prior authorization claim for reimbursement. Once all the required information is submitted, the plan member will be advised whether the claim is approved, usually by mail.

In this section we will give you an overview of the PA claims process. You may also want to review the list of prior authorization stakeholders on this site for details on the people and organizations that may be able to help plan members prepare and submit their prior authorization claim for the specialty drug(s) they have been prescribed.

We have also developed some tips for patients in Do You Have Prescription Drug Coverage.

Physicians

The prior authorization claims process begins when a drug is prescribed to a plan member. The prescriber, usually a physician, may or may not know that the drug they are prescribing will require PA by the member's group benefits provider. If it is a drug(s) they have prescribed to other patients, they should have a good idea whether the drug(s) will be covered by one of the following:

- A public drug program in their province
- The group benefits provider
- Or whether the patient will need to apply to a compassionate program offered directly by the pharmaceutical manufacturer.

If the drug prescribed is not covered by any provincial drug plan and requires that the plan member submit a prior authorization claim for reimbursement, then the prescriber will also be required to prepare documentation that will support the claim. The plan member will also need to provide written information for their claim including:

- The name of their insurer
- Policy, and certificate number
- Patient signature

If the plan member is not sure where to locate them, you will be able to help with their policy and possibly their certificate number.

Insurers can advise what claim forms are necessary. They may also refer plan members to one of the PSP organizations in the Resources page for assistance in completing forms and submitting the plan member's drug(s) claim.

If the physician is familiar with the prior authorization process, they will probably have easy access to the claim form the plan member requires. They may also have staff to help the plan member and the physician complete the claim form, and attach the necessarily medication documentation, or they may refer the plan member to outside assistance to help with preparing their claim through a patient support program (PSP).

If the physician is not familiar with the prior authorization process, they can use the physician section of this website for more information on prior authorization or they can use the Resources page on this site to access links to each insurer.

Help from outside the physician's office - even with some guidance from a physician's office, prior authorization and drug coverage for specialty drugs can be difficult to navigate. Most plan members will probably need some help from an expert in prior authorization who will work with a patient's best interest in mind to achieve a timely and fair reimbursement decision.

Patient support program (PSP) - are services delivered by dedicated PSP companies and funded by pharmaceutical manufacturers. The programs are designed to provide features and support for patients on specific medications. As advocates they help patients navigate the complexities of reimbursement.

PSPs may also have funds available to them through a patient assistance program to help with the cost of medication if the plan member does not have coverage elsewhere or if your drug is not completely covered either through a provincial drug plan or a group benefits plan. Programs that exist can be very specific in terms of criteria for enrollment. As such, the prescribing physician will be engaged to ensure that only those that qualify are referred.

The prescribing physician should be able to direct the plan member to the PSP for the drug they have prescribed.

If it is unclear whether there is a PSP for the drug that has been prescribed, you can:

- Contact the pharmaceutical manufacturer's general information/medical information phone number
- Look online through the product name you have been prescribed or on the manufacturer's Canadian website
- Look online at the patient organization for your condition. Some patient organizations are listed on the Resources page of this website.
- There are more tips on this under the Resources page of this website.

For oncology drugs, the physician may also refer the plan member to a drug access navigator (DAN), who are publicly funded, and will be able to help with enrollment if a manufacturers program does exist.

Drug access navigator (DAN) - in the case of cancer therapies - also known as drug access facilitator or medication reimbursement specialist, DANs work to connect a patient with the medication or treatment they require.

Currently DANs are mostly found in cancer clinics but are increasingly found in other diseases like Multiple Sclerosis and Cystic Fibrosis. If the plan member is being treated at a cancer centre, they should ask their physician if there is a DAN or someone in a similar role that can help them through the claims process. A pharmacist or social worker may do the role of the DAN even by a different title. You can find out more about DANs through their provincial associations.

Specialty pharmacy - a specialty pharmacy may work closely with physicians and patients on preparing a prior authorization claim. If the physician works closely with a specialty pharmacy, the plan member for assistance in preparing their claim.

The local pharmacy - if the prescribing physician does not tell the plan member or they are not aware that the drug prescribed requires prior authorization, then the plan member's local pharmacy may be the one to tell them that the drug requires prior authorization. In that case the plan member should contact their physician's office and tell them that the drug prescribed requires prior authorization.

The physician or their staff may either assist the plan member or direct them to a specialty pharmacy and/or PSP or DAN as noted. Remember, you can find out more about the roles of these PA Stakeholders here and patient organizations on this site.

Submitting a claim for review and approval

Once the plan member is working with an individual or organization for help with their prior authorization claim, they will act as an advocate to prepare and submit the plan member's prior authorization claim. They will:

- Coordinate all the information required from the prescribing physician and plan member
- Submit the claims documentation for review to the insurer, or the organization reviewing the claim on their behalf.

Today there is no electronic mechanism in place to submit prior authorization claims, which means that the claim form and any other documentation will be sent by mail or fax for review. If any further information is required, then the plan member of the prescribing physician, or the organization who helped the plan member prepare and submit their claim will be contacted by mail or fax.

The timeline for receiving a decision on whether the claim has been approved will vary, but the plan member can expect to wait at least 7 – 10 days. The plan member may receive a letter in the mail, or if the drug prescribed is urgently needed, then they may receive a decision more quickly. If they have been working with a drug access navigator for their oncology drug(s) and the treatment is urgently needed, then they could receive a decision more quickly and you could receive a phone call from them.

Receiving medication after approval

Once the claim has been approved, the plan member may be directed to one of several locations by the insurer to receive their drug(s):

- **The local pharmacy** – If the approved drug is an oral medication the insurer may allow the medication to be dispensed by a local pharmacy.
- **A specialty pharmacy chosen by the insurer** – The specialty pharmacy may be chosen either because the drug prescribed is an injectable or infused therapy, or the insurer may have negotiated preferred pricing because the specialty pharmacy offers a discount.
- **In hospital** – If the drug prescribed is an injectable or infused therapy normally administered in hospital, particularly for oncology products, the drug may be administered in hospital.

Where the plan member will receive their medication may depend on several factors, including whether the drug is taken orally or infused.

- If the drug is an oral medication – then the plan members is likely to be directed either to their local pharmacy or a specialty pharmacy. If a specialty pharmacy is not near their home, the prescription may be delivered to them.
- If the drug is an infused medication – then the plan member may be directed to their local pharmacy and then an infusion clinic, a specialty pharmacy that can administer the medication onsite, or even the plan member's local hospital.

If a claim is denied

If the claim is not approved, the plan member will either receive written notice or they may receive a call from the group that helped them submit their claim. Their prescribing physician's office or the group that helped them submit their claim will discuss appeal options or alternative medications for their condition.

Review the next section for more information on what to do if the drug is not approved by the plan member's insurer.