PRO/ACT
PHARMACY BENEFIT MANAGEMENT

■ **What's the difference between a prescription and a prior authorization? My provider already sent in a prescription, isn't that authorization enough?**

A prescription is an instruction written by a medical practitioner that authorizes a patient to be provided a medication.

A prior authorization (PA) is a process for some medications, due to cost, type, or prescription benefit plan that require review before they are covered. PAs are designed to help prevent you from being prescribed medications you may not need, those that could interact dangerously with others you may be taking, or those that are potentially addictive. PAs are a way to help ensure that you are getting the most cost-effective drug for your condition.

■ **What do I do if my prescription requires a prior authorization?**

First, DON'T LEAVE THE PHARMACY. In order to provide a smooth transition and prevent members from experiencing a lapse in therapy, ProAct has a ONE-TIME OVERRIDE policy for claims that may reject for a PA or a similar edit. Follow the workflow below.

Yes · · · · · · | **HAVE YOU BEEN ON THIS MEDICATION BEFORE?** | · · · · · · · *No*

CALL THE PROACT HELP DESK
1-877-635-9545
ProAct will verify that you've been on the medication previously and it is covered by your plan.

CONTACT YOUR PROVIDER
Notify them that your prescription has been denied due to a PA requirement.

PROACT WILL GRANT A ONE-TIME OVERRIDE
(up to a 30-day supply).

YOU WILL STILL NEED TO CONTACT YOUR PROVIDER
to initiate the PA process.

1 | VALIDATION
Upon receiving notification of rejection at a local or mail order pharmacy, due to a PA request, ProAct will validate with the pharmacist or provider's office that you have previously been on this medication. To ensure that you are not without medication, YOU MUST CALL THE PROACT HELP DESK.

2 | OVERRIDE
Once confirmed, we will grant a ONE-TIME OVERRIDE for you to fill UP TO A 30-DAY SUPPLY. Although the one-time courtesy override is the standard practice, claims that exceed certain dollar thresholds or dose/frequency/duration limits may be subject to additional review before being allowed to process.

3 | FURTHER REVIEW
After the one-time override has been placed, you will need to contact your provider to have them initiate a PA request. The easiest way for them to do this is by visiting our PA portal at https://proactrx.promptpa.com.

REMINDER:
This process does not apply to any excluded medications due to the Advantage formulary. If a drug is not included within your formulary, it is strictly excluded. You must speak with your provider regarding possible alternatives.

■ **How do I check the status of my prior authorization?**

1. Contact your pharmacy to rerun your prescription through your insurance.
2. Contact your provider's office as they will be notified via fax if the PA has been approved or denied.
3. Contact ProAct's Help Desk.
4. Check status through PromptPA Online Portal with Episode of Coverage (EOC) Number.

■ **Who handles the prior authorization review process?**

ProAct's Clinical team consists of clinical pharmacists, clinical care coordinators, clinical services specialists, and clinical services clerks who review each PA request.

■ **What are they reviewing?**

Prior authorization requests are reviewed against both member-specific prescription drug coverage and evidence-based clinical criteria guidelines for the medication requested.

■ **How long does it take to review a prior authorization? What can cause a delay in getting the review finalized?**

Standard requests are completed within 3 business days and urgent requests within 1 business day once all required information is received from your provider. Reviews can be delayed if we do not receive all information needed to make a determination from your provider. The most efficient way for a provider to initiate a prior authorization request is through our online portal: https://proactrx.promptpa.com. Drug-specific information is incorporated into this process to help reduce the need for subsequent outreach to your provider after the request is initiated. Manual faxing of these requests can cause delays in the initiation and turnaround time of the determination.