

Exceptions Policy for Non-Formulary Drug Access

Purpose:

This policy establishes the procedures through which an enrollee, their designee, or their prescribing provider may request an exception to the Plan's drug formulary to obtain coverage for a non-formulary drug. EHO is committed to ensuring that enrollees have access to medically necessary medications while maintaining a cost-effective formulary.

Scope:

This policy applies to all enrollees of and their prescribing providers.

Definitions:

- **Formulary:** A list of prescription drugs covered by Plan.
- **Non-Formulary Drug:** A prescription drug that is not included on Plan's formulary. **Medical**
- **Necessity:** The requested drug is needed to prevent, diagnose, or treat the enrollee's medical condition(s) and meets accepted standards of medical practice. **Clinical Appropriateness:** The
- requested drug is considered the most suitable treatment option for the enrollee's medical condition, considering their specific health circumstances and potential alternatives.
- **Prescribing Provider:** A licensed healthcare provider who is authorized to prescribe the requested medication.
- **Designee:** A person authorized to act on behalf of the enrollee.

General Principles:

- All non-formulary drug exception requests will be evaluated based on medical necessity and clinical appropriateness.
- The prescribing provider is responsible for providing adequate clinical documentation to support the request.
- Plan will review all exception requests in a timely manner.
- Enrollees have the right to appeal adverse coverage determinations through Plan's standard appeal process.
- The exception process does not guarantee approval.

Standard Exception Procedure: 1.

Request Submission:

- The enrollee, designee, or prescribing provider must submit a written request to EHO.
- The request must include the following information:
 - Enrollee's name and identification number.
 - Name, dosage, and frequency of the requested non-formulary drug. Prescribing provider's name, contact information, and signature.
 - A detailed statement of medical necessity and clinical appropriateness, including:
 - The enrollee's specific medical condition and diagnosis.
 - A comprehensive medical history, including relevant treatments and medications.

- Documentation that formulary alternatives have been tried and failed, are contraindicated, or are not as likely to be effective as the requested non-formulary drug. This should include specific details about the enrollee's response to previous treatments (e.g., lack of efficacy, adverse effects).
- Clinical rationale for why the requested non-formulary drug is superior to available formulary alternatives, including supporting evidence from medical literature, clinical practice guidelines, or expert opinion.
- Any other relevant information that supports the request.

2. Initial Review:

- EHO will review the request for completeness within 7 business days of receipt.
- If the request is incomplete, Plan will notify the requesting party and specify the missing information.

3. Clinical Review:

- A qualified healthcare professional, such as a pharmacist or physician, will review the complete request.
- The reviewer will evaluate the medical necessity and clinical appropriateness of the requested drug based on the submitted documentation, evidence-based guidelines, and relevant medical literature.
- The reviewer may contact the prescribing provider for additional information or clarification, if necessary.

4. Determination and Notification:

- EHO will make a determination on the request within 7 business days of receiving the complete request.
- EHO will provide written notification to the enrollee and the prescribing provider. The notification will include:
 - Whether the request is approved or denied.
 - If approved, the terms of the approval, including any limitations on quantity or duration.
 - If denied, the specific reasons for the denial, the applicable plan policy or contract provision, and information about the enrollee's right to appeal the decision through EHO's standard appeal process.

Expedited Exception Procedure:

1. Request for Expedited Review:

- An expedited review may be requested if the standard review timeframe could seriously jeopardize the enrollee's life, health, or ability to regain maximum function.
- The enrollee, designee, or prescribing provider may request an expedited review.
- The request must include a clear statement of the exigent circumstances that necessitate an expedited review and supporting clinical information.

2. Initial Assessment for Expedited Review:

- EHO will determine whether the request qualifies for expedited review within 48 hours of receipt.

3. Expedited Clinical Review:

- If the request is approved for expedited review, a qualified healthcare professional will conduct an expedited review of the request.

4. Expedited Determination and Notification:

- EHO will make a determination as soon as possible, and no later than 48 hours, after receiving the request for expedited review.
- EHO will notify the enrollee and the prescribing provider of the determination. Initial notification may be provided verbally, but will be followed by a written notification.
- The written notification will include the same information as in the standard exception procedure. If the request is denied, the notification will also include information about any available expedited appeal options.

Documentation and Record Keeping:

- EHO will maintain records of all exception requests, including the request, supporting documentation, review process, determination, and notification.

Policy Review:

- This policy will be reviewed and updated periodically to ensure compliance with applicable laws and regulations and to reflect current clinical practice.

Contact Information:

- For questions about this policy, please contact EHO Member Services at 800-650- 1817.