NEBRASKA MEDICAID PRIOR AUTHORIZATION PROCESS

1. Drug Coverage information is listed on the Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care Pharmacy Program website at https://nebraska.fhsc.com . There is a drug search function if a provider wants to look up a specific drug. Information available includes coverage status as well as limitations related to such things as age or quantity. In addition, the Preferred Drug List is available online which indicates the medications in each therapeutic class that are preferred and available without prior authorization. Clinical criteria for many drug classes and prior authorization forms are also available.

   Criteria and claim limits are developed from recommendations made by the Drug Utilization Review Board and the Pharmaceutical and Therapeutics Committee. Both of these professional advisory boards are made up of pharmacists and physicians. DHHS makes the final decision when setting criteria or limits.

2. If a prescription claim is denied during the prescription filling process, the pharmacy receives a message regarding the reason(s) for denial. Typically, the pharmacy will resolve issues if they can (for example a quantity limit) or notify the prescriber that prior authorization is required.

3. The majority of initial prior authorization requests are submitted to the contracted claims processor, Prime Therapeutics State Government Solutions (Fax: 866-759-4115 or Phone: 800-241-8335). Prime evaluates the request based on criteria set by the Department of Health and Human Services Division of Medicaid and Long-Term Care. Many of the criteria used come from recommendations of professional advisory boards made up of pharmacists and physicians. When a prior authorization form is submitted, a response is sent back to the pharmacy (if a fax number has been provided) and provider within one business day. There are times when Prime requests additional information from the provider to determine if the patient meets the criteria. Once all necessary information is received, the prescriber and pharmacy typically receive the approval or denial within 24 hours. All requests are resolved as CIT (Change in Therapy) or Approve or Deny.

4. If the request is denied, the prescriber can provide additional documentation to Prime for "Special Consideration". A Pharmacy Consultant, who is a Registered Pharmacist, will then review material submitted and consult DHHS if needed. If additional information is needed, the pharmacy would be notified or an approval or denial would be sent to the prescriber and the pharmacy within one business day.

   If the request is again denied, the prescriber may then request a peer-to-peer review. The peer-to-peer review is done by the Medicaid Medical Director or designee. In order to provide background for the Medicaid Medical Director or

designee, we recommend providers send a minimum six months chart notes and other information to establish medical necessity. The Medicaid Medical Director then makes a determination on denial, approval or to request further information from the prescriber.

5. If the request is denied by the Medicaid Medical Director or designee, the client or the provider has the right to request a State Fair Hearing. Requests for State Fair Hearing must be submitted in writing to:

   DHHS, Legal Services Hearing Office
   P.O. Box 98914
   Lincoln, NE 68509-8914

   If you need help filing your State Fair Hearing you may call 1-844-385-2192 or email DHHS.HearingOffice@nebraska.gov.