Specialty Medication Notification/Prior Authorization

Frequently Asked Questions

Key Points
• We require notification/prior authorization for certain specialty medications. • Notification/prior authorization requirements may vary depending on the member's benefit plan. • For information on which medications and services require notification/prior authorization, go to UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > Plan Requirement Resources.

Overview

UnitedHealthcare requires notification/prior authorization for certain specialty medications to help ensure our members have access to medically appropriate care. Coverage review requirements and their effective dates vary by plan and are generally announced in the *Network Bulletin* or through letters to care providers.

To see which medications and services currently require notification/prior authorization for a specific plan, go to UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > Plan Requirement Resources.

Frequently Asked Questions and Answers

Q1. Where can I view the coverage policies for a specific medication?

A1. To view the coverage policy for a specific medication, go to UHCprovider.com/policies, then select the following based on health plan:

- For **UnitedHealthcare commercial plans**, select Commercial Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines
- For **UnitedHealthcare Community Plan**, select Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines
- For **UnitedHealthcare Medicare Advantage plans**, select Medicare Advantage Plan Policies > Coverage Summaries for Medicare Advantage Plans > Medications/Drugs (Outpatient/Part B) – Medicare Advantage Coverage Summary

Q2. How does the notification/prior authorization process work for specialty medications?

A2. When we receive notification for the medication, we'll determine if the member's benefit plan includes coverage for it and whether the plan requires covered services to be medically necessary. If so, we'll conduct a clinical coverage review as part of our prior authorization process.

These clinical coverage reviews evaluate whether the drug is appropriate for the individual member, taking into account:

- The terms of the member's benefit plan
- Our drug coverage policy
- Applicable state Medicaid guidelines
- Applicable Medicare guidance

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- Applicable state and federal regulatory requirements
- The member's treatment history
- Dosage recommendations from the U.S. Food and Drug Administration-approved labeling

Additional criteria also may be considered. We encourage you to submit any information you would like us to review as part of your prior authorization request.

When a coverage determination is made, we'll inform you and the member of the decision. If an adverse determination is made, we'll provide appeal information in the determination notice.

Q3. Is notification/prior authorization required for any of these medications to be administered in an inpatient or emergency setting?

A3. No. Notification/prior authorization requirements don't apply for services that take place in an emergency room, observation unit, urgent care facility or during an inpatient stay.

Q4. How can I submit a notification/prior authorization request for these medications?

A4. Please use one of the following methods to begin the notification/prior authorization process:

- **Go to UHCprovider.com/priorauth** > Submit a Request for Notification or Prior Authorization.
- **Call the Provider Services phone number** on the member's health plan ID card.

Q5. What turnaround time can I expect for my request?

A5. Standard processes apply, taking into account federal and state regulatory requirements. Please refer to the UnitedHealthcare Administrative Guide or UnitedHealthcare Community Plan Care Provider Manual for standard and urgent turnaround times for prior authorization requests.

- For commercial plans, go to UHCprovider.com/guides.
- For Community Plan, go to UHCprovider.com > Menu > Administrative Guides and Manuals > Community Plan Care provider Manuals.
- For Medicare Advantage plans, go to UHCprovider.com/guides > View Online Version > Chapter 6: Medical Management > Coverage and Utilization Management Decision.

Q6. Can I appeal an adverse decision?

A6. If an adverse determination is made, we'll include appeal information with the determination notice, so you'll know which steps to take.

If you have any questions, please contact your Provider Advocate or call the Provider Services phone number on the member's health plan ID card. Thank you.

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