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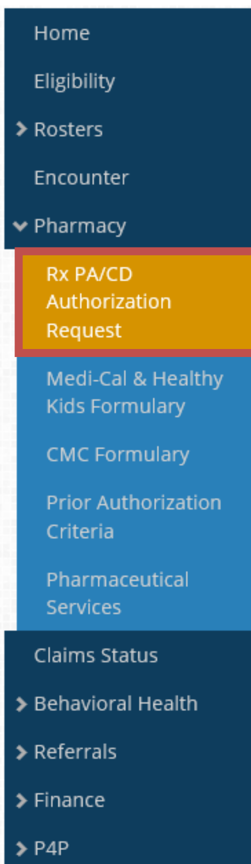
This guide is to assist with submitting a prior authorization electronically to the **IEHP Pharmaceutical Services Department**. For more information regarding any other functions of the Provider Portal, please reach out to your Provider Services Representative.

What you should know before you start:

1. For those prescribing providers that currently submit UM E-Authorizations online, that process will not change, AND they can now also submit select Rx HCPCS via the new Prescription Drug Authorizations (RxPA/CD) online request form (refer to HCPCS Submission page 12 in this guide). All other online submissions for UM HCPCS remain the same.
2. One NDC per submission (multiple NDC requests will require multiple submissions).
3. Fields with a red asterisk (*) are required.
4. RxPA: Prescription Drug Prior Authorization for Medi-Cal line of business
5. CD: Coverage Determination Authorization for Medicare line of business
6. If system is on XP, it is recommended Google Chrome or Firefox be used as your internet browser.
    a. *Google Chrome is preferred for this form's submission, Chrome is a universal compatible browser type across operating systems.*

Guidelines to successfully completing an online Prescription Drug Prior Authorization Request (RxPA/CD):

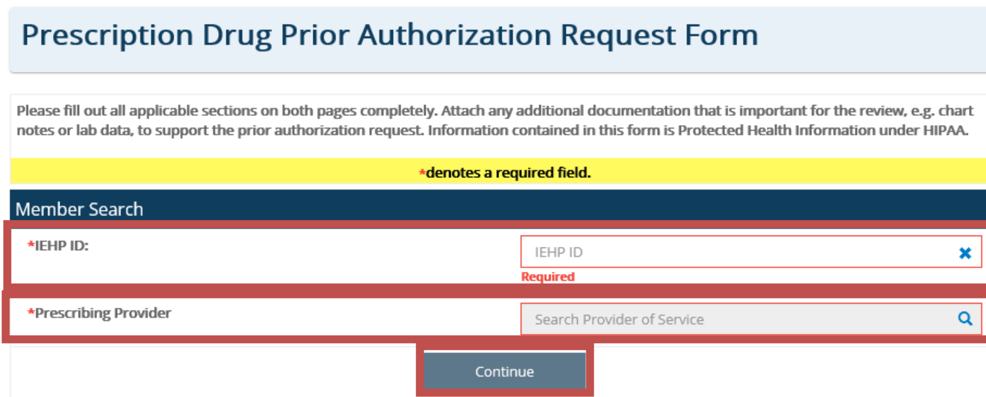
- Navigate to www.iehp.org, click Provider login, enter your **Login ID** and **Password** and click **Submit**



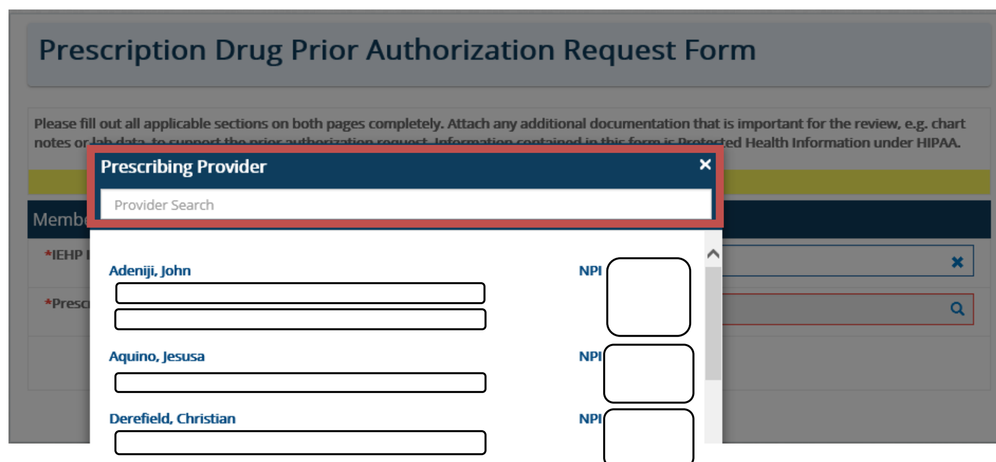
- Click the **Pharmacy** Tab
    - **Rx PA/CD Auth Request**: Link to the Prescription Drug Prior Authorization/Step Therapy Exception Request Form

Member Search

- **Enter Member *IEHP I.D #** (14-digits) in the member search field



- ***Prescribing Provider** click in the **Search Provider of Service** field and select the prescribing provider and office address; click **Continue**



Member Information

- Verify Member Information to ensure accuracy. If incorrect Member generated, click the "X" in the member box to **Reset Form** and repeat steps above.
  - Confirm pre-populated member's demographic information
  - Enter the member's allergies, one ***Allergy** at a time to the Allergies field and click Add. You can add multiple allergies by repeating this process.
  - Enter Member's Height and click in/cm to determine proper metric
  - Enter Member's Weight and click lbs/kg to determine proper metric
    - Height and Weight are not required fields, however should be completed when applicable (i.e. nutritional or weight loss request).
  - Enter **Patient's Authorized Representative** (*applies to Medicare Members only)*
  - Enter **Authorized Rep Phone Number** (*applies to Medicare Members only)*

Member Information
Name: Gender: DOB: Age:
Address: City: State-Zip: Phone:
IEHP ID: CIN: MediCare: Medi-Cal:
County: Aid Code: LOB: Group:
Selected Allergies:
sulfa
*Allergies: Add
Height: Height in
Weight: Weight lbs
Patient's Authorized Representative
Representative Name
Authorized Representative Phone Number (e.g. 9098902000)

Member's Insurance Information

- ***Is IEHP the Primary Insurance for Member?***
  - If Yes, proceed to Prescriber Information
  - If No, enter Primary Insurance Information and Insurance ID number.
    - If Member does not have IEHP as a primary insurance, please submit prior authorization to Member's primary pharmacy benefits provider.

Member's Insurance Information
*Is IEHP the Primary Insurance for Member? Yes No

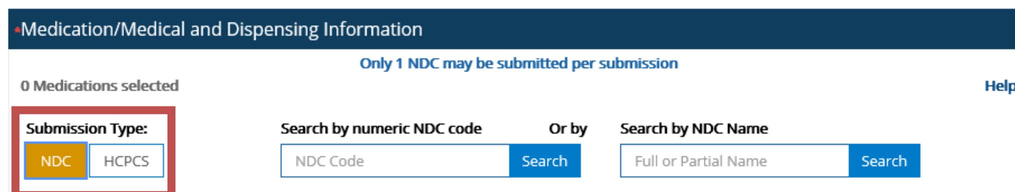
Prescriber Information

- Auto-populates based on **Prescriber Provider** selection above.
- If the prescriber information is different than the pre-populated information, please notate the correct address, phone/fax for the office under the ***Medical Justification** free-form field below (see page 7).
- ***Prescriber's Full Name**: the full name of the prescriber needs to be populated even if it matches the pre-populated information.
- ***Name of the Submitter**: place to input the name of the person to contact if the reviewer has questions about the submission.

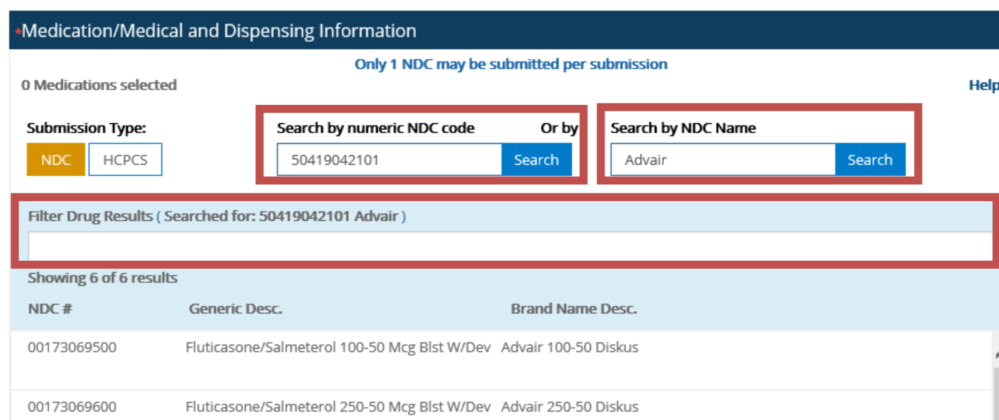
Prescriber Information
Name: Desert Aids Project Fax #: (760) 416-1651 NPI: 1568439081 Tel #: (760) 323-2118
Address: 1695 N Sunrise Way City: Palm Springs State: CA Zip Code: 92262
*Prescriber's Full Name: Prescriber's Full Name
*Name of Submitter: Name of Submitter
DEA #: D.E.A. number

Medication/Medical and Dispensing Information

- Select **Submission type**
  - NDC: select for medications being dispense by the pharmacy
  - HDCPCS: select for office stock medications (see page 10)



- Select NDC/Medication Submission
  - Only one NDC/Drug per submission
  - Enter the 11-digit NDC number (no dashes) or the Name of the medication and click **Search**
    - **Search by numeric NDC code**: enter the National Drug Code (NDC) to search for the medication
    - **Search by NDC Name**: enter the name of the medication if NDC is unknown
      - If multiple search results display, you may enter a second search item in the **Filter Drug Results** field to refine your search and narrow the results
        - Select the appropriate drug by clicking on the drug of choice



- ***Brand Only:** Select Brand or Generic.
  - If Brand is selected, provide why brand name medication is being requested in the **Medical Justification** section. Consult the **IEHP Brand Name Drug Policy** for details
- ***SIG:** Enter directions including frequency for the medication
- ***# of Refills:** Enter the number of additional refills
- ***Quantity:** total quantity needing to dispense
- ***Therapy:**
  - Select **New Therapy** if medication is new to Member.
  - Select **Renewal of Therapy** if Member was previously on medication
    - When selecting **Renewal of Therapy**, the form will prompt you to enter the ***Date Initiated**, ***From** and ***Through** date.
      - Note: **Date Initiated** must be prior to **From** date
      - The form will prompt How did the patient receive the medication? Enter **Paid Under Insurance Name** i.e. IEHP, Medi-Cal, Private Insurance, or Cash
  - Select **Step Therapy Exception Request** if requesting an exception to step therapy.
- Select **Administration** and **Administration Location**

Pharmacy as Service Provider

- Click magnifying glass symbol and **Select Pharmacy as Service Provider** window will appear
- Enter Pharmacy information (Name, City and/or Zip Code) and click **search** (only 1 search criteria is necessary for search)

- Scroll and Click on the Pharmacy to populate. When Pharmacy Service Provider is not on file, click the '**Pharmacy not found?'** link and the "Select Pharmacy Service Provider" window will appear
    - Enter information manually and Click **Search**.
        - Pharmacy Name and Phone are the minimum fields required for submission of request

Patient Medications

- Answer the following question
  - ***Has the patient tried any other medication for this condition**?
    - If Yes, enter ***Medication/Therapy, *Duration From, *Duration Through** and ***Response/Reason of Failure/ Allergy**. Medication can either be searched by using the magnifying glass or entered as free text. Add another medication by clicking **Add+**, max of 10 medications.
    - If No, proceed to **ICD Code**

ICD Codes

- Enter **ICD codes** in the ***Primary Diagnosis** field then click **Add ICD Code**
  - When applicable enter **Secondary Dx** and **Tertiary Dx**
    - If diagnosis is off label, include any supporting information for use of the medication in treating the member's diagnosis in the Medical Justification section (see page 8)
    - Selected ICD codes will populate. Description of diagnosis will populate below the code.

Medical Justification

- ***Please provide all relevant clinical information to support a prior authorization review**
  - Please document all relevant clinical information in the field provided
    - Enter any changes to the pre-populated prescriber office information (see page 4)
    - Enter any justification for off label diagnosis (see page7)

*Medical Justification

*Medical Justification - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review. If a brand medication is requested, please provide medical justification why a brand name medication is medically necessary. (2000 char max)

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent (urgent) circumstances or required under state and federal laws.

Clinical Information or Comments

Required

Additional Medi-Cal Information

- *Applies to Medi-Cal Members only.*
- Select the priority– **Urgent Request, Non-Urgent Request**
  - Urgent Request – **Urgent (exigent circumstance)** or **Urgent Concurrent**

*Additional Medi-Cal Information

Urgent Request | Non-urgent Request

Urgent (exigent circumstance) | Urgent Concurrent

Request for Urgent (exigent circumstances) Review: By checking this box and signing below, I certify that applying the 24 hours standard review timeframe may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

*Additional Medi-Cal Information

Urgent Request | Non-urgent Request

Urgent (exigent circumstance) | Urgent Concurrent

A request for coverage of pharmaceutical services made while a Member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.

  - Non-Urgent Request – **Pre-Service** or **Post Service**

*Additional Medi-Cal Information

Urgent Request | Non-urgent Request

Pre-Service | Post-Service

A request for coverage of pharmaceutical services that the organization must approve in advance, in whole or in part.

*Additional Medi-Cal Information

Urgent Request | Non-urgent Request

Pre-Service | Post-Service

A request for coverage of pharmaceutical services that has been received.

Additional Medicare CD Information

- *Applies to Medicare Members Only*
- Check statement(s) that apply to Member Medical Justification

Additional Medicare CD Information

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure [Specify in previous therapy: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]
- Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change [Specify in medical justification: Anticipated significant adverse clinical outcome]
- Medical need for different dosage form and/or higher dosage[Specify in medical justification: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]
- Request for formulary tier exception [Specify in medical jusitifcation: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]

- Read the **Request for Expedite Request** section and check only when 72-hour standard review timeframe would jeopardize Member's health.

Request For Expedited Review

Request For Expedited Review:
By Checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Request for expedited review

Legal Agreements

- Read and confirm understanding of ***Attestation** by checking the box
- Read and confirm understanding of ***Confidentiality Notice statement** by checking the box

Legal Agreements

*Attestation:
I electronically attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

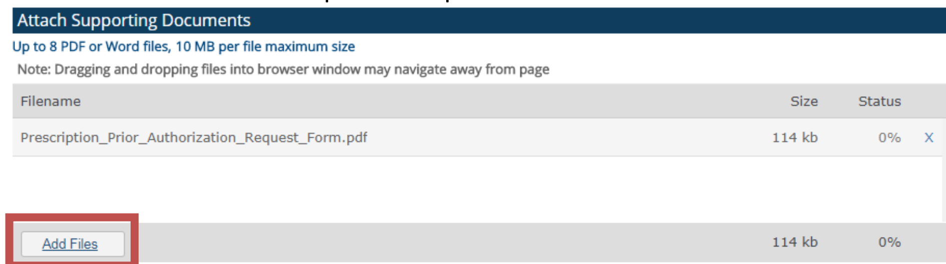
I understand the Attestation statement written above.

*Confidentiality Notice:
The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

I understand the Confidentiality Notice written above.

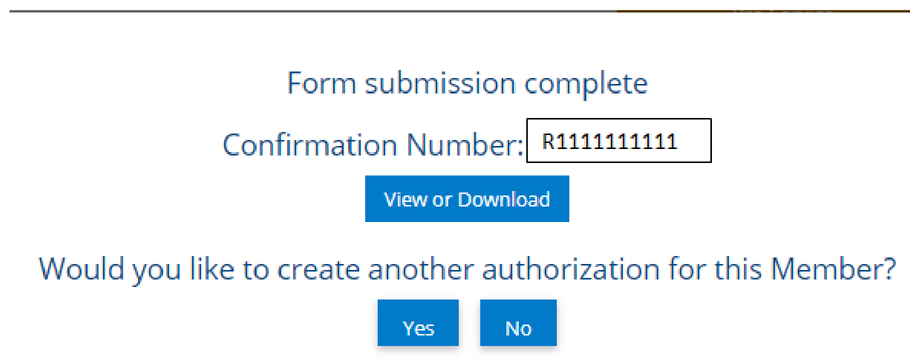
Attach Supporting Documents

- Click **Add Files** and attach files (PDF and MS Word files only)
  - Please do not submit files that are password protected



- Review all information prior to submitting
- Click on **Submit Authorization Request** button

  - System will generate a **Prescription Identification Number** and give the option for the user to View or Download a copy of the Submitted Request for their files
  - The user will be given the opportunity to enter another request for the same member by clicking on Yes to "Would you like to create another authorization for this member?"
    - Clicking **Yes** will direct user to next Prescription Drug Prior Authorization Request for the same member
    - Clicking **No** will end the submission request for the member



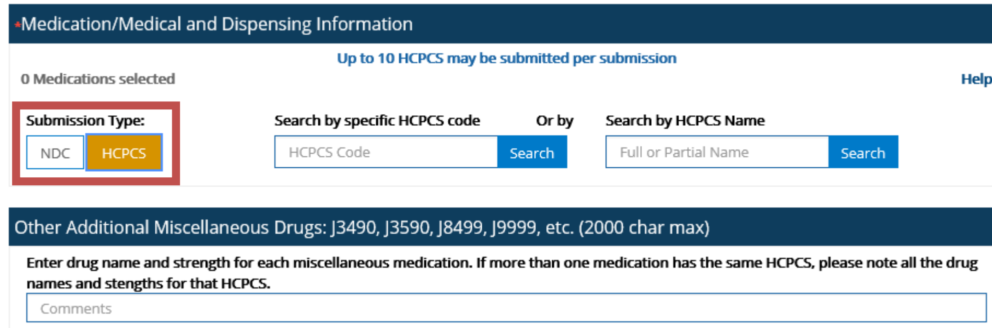
HCPCs Submission

What you should know before you start:

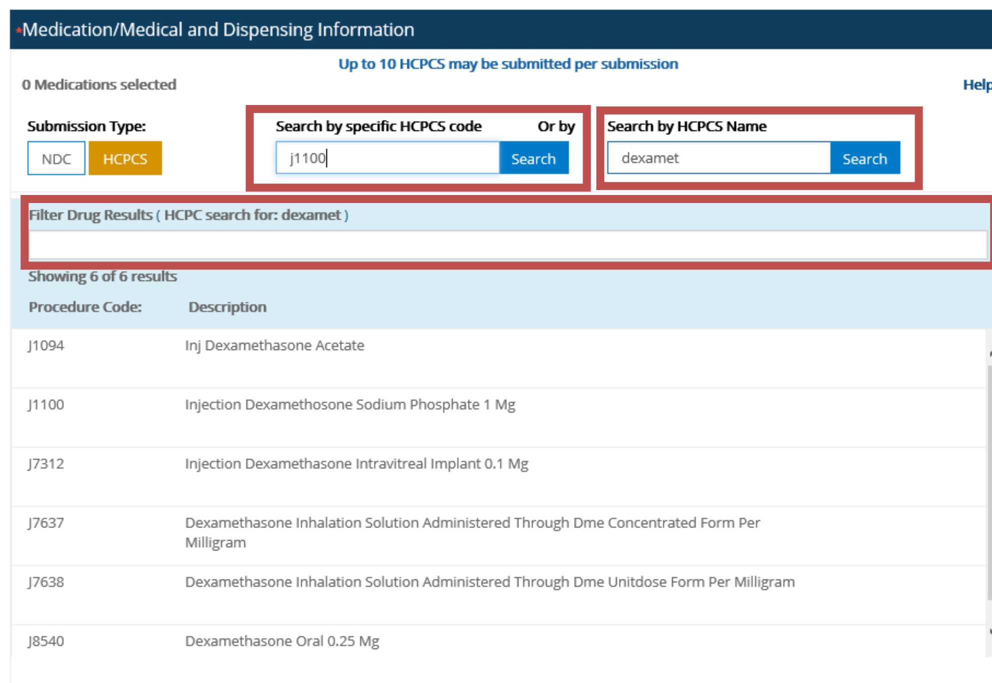
1. Only Direct providers can submit HCPCS requests.
2. Up to 10 HCPCS codes per submission (Internet Explorer 8 will only allow 3 HCPCS codes per submission)
3. Fields with a red asterisk (*) are required.
4. If system is on XP, it is recommended Google Chrome or Firefox be used as your internet browser.
5. Follow the steps outlined on pages 3-4 for entering Member and Prescriber information.

Medication/Medical and Dispensing Information

- **Submission Type**: Select HCPCS



- Enter the HCPCS code or the Name of drug and click **Search**.
  - If multiple search results display, enter a second search item in the Filter Drug Results field to refine your search and narrow the results
  - Select appropriate item by clicking on it in the list of results



- Enter ***Dosage** to be administered
- Click ***Frequency** drop down menu and select appropriate frequency
- Enter ***Quantity**
- Select the appropriate ***Units** from the drop-down menu
  - Click **New** or **Renewal of Therapy***
    - If **New Therapy** selected, proceed to **Administration** and **Administration Location**
    - If **Renewal of Therapy** selected, enter ***Date Initiated**, ***From**, and ***Through** dates (click calendar icon to select date)
      - Note: **Date Initiated** must be prior to **From** date
  - Select appropriate drop down under **Administration** and **Administration Location,** if known

*Medication/Medical and Dispensing Information
Up to 10 HCPCS may be submitted per submission
1 Medications selected
Help

Medication 1:
J1100 INJECTION DEXAMETHOSONE SODIUM PHOSPHATE 1 MG
*Dosage/Admin: *Frequency: *Quantity: *Units:
*Therapy: New Therapy Renewal of Therapy
Administration:
Administration Location:

New Therapy Renewal of Therapy
*Date Initiated MM/DD/YYYY *From MM/DD/YYYY *Through MM/DD/YYYY

- Additional HCPCS codes can be added (up to 10, if needed) by repeating steps above
    - If using Internet Explorer 8, a maximum of 3 HCPCS can be entered per submission
    - The system will number each item being requested

*Medication/Medical and Dispensing Information
Up to 10 HCPCS may be submitted per submission
2 Medications selected
Help

Medication 1:
J1100 INJECTION DEXAMETHOSONE SODIUM PHOSPHATE 1 MG
*Dosage/Admin: *Frequency: *Quantity: *Units:
*Therapy: New Therapy Renewal of Therapy

Medication 2:
J0696 INJECTION CEFTRIAXONE SODIUM PER 250 MG
*Dosage/Admin: *Frequency: *Quantity: *Units:
*Therapy: New Therapy Renewal of Therapy

- HCPCS codes J3490, J3590, J8499, J999, etc. will trigger a message indicating additional required information in the Other Additional Miscellaneous Drug box

Medication 1:
J3490 UNCLASSIFIED DRUGS
*Enter drug name and strength for each miscellaneous medication in the "Other Additional Miscellaneous Drugs" section below

Other Additional Miscellaneous Drugs: J3490, J3590, J8499, J9999, etc. (2000 char max)
Enter drug name and strength for each miscellaneous medication. If more than one medication has the same HCPCS, please note all the drug names and strengths for that HCPCS.
Comments

Pharmacy as Service Provider

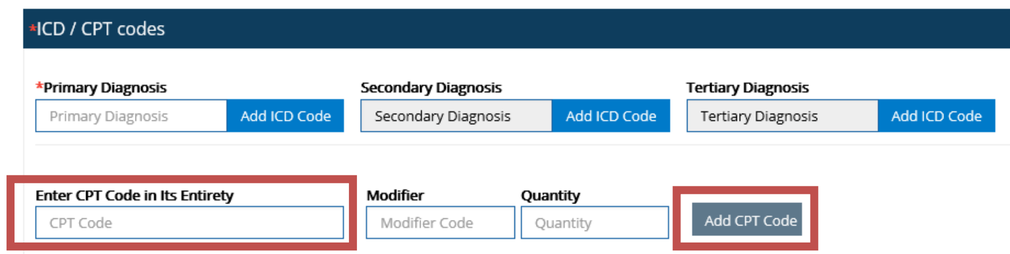
- See page 6 *if pharmacy is supplying medication*

Patient Medications

- See page 7

ICD Codes

- See page 7 *for ICD codes*
- Enter the **CPT Code**, Modifier and Quantity and click on **Add CPT Code**
  - You may enter up to 8 CPT codes

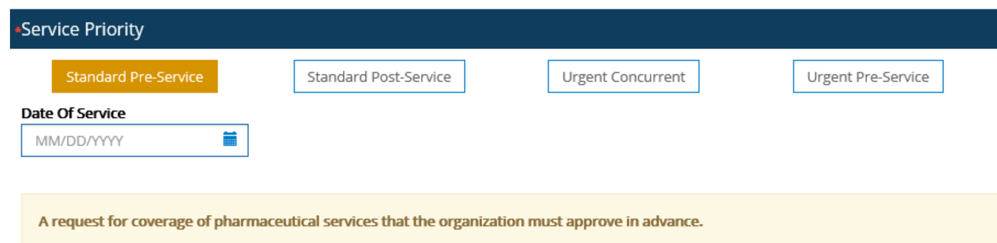


Medical Justification

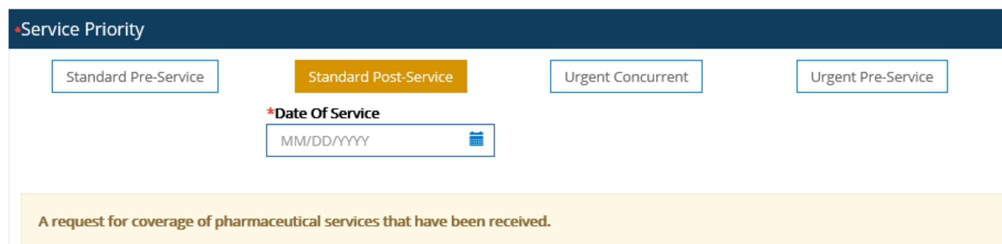
- See page 8

Service Priority

- Select the ***Service Priority**
  - **Standard Pre-Service**: Enter pre-service date



  - **Standard Post-Service**: Enter ***Date of Service**



- **Urgent Concurrent**

*Service Priority

Standard Pre-Service | Standard Post-Service | Urgent Concurrent | Urgent Pre-Service

A request for coverage of pharmaceutical services made while a Member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approved the earlier care.

- **Urgent Pre-Service**

*Service Priority

Standard Pre-Service | Standard Post-Service | Urgent Concurrent | Urgent Pre-Service

A request for pharmaceutical care or services where application of the time period for making a non-urgent decision could result in the following:
• Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state.
• In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request (e.g. retrospective review)

Legal Agreements

- See page 9

Attach Supporting Documents

- See page 10

For all questions, comments, or concerns regarding RxPA/CD Authorization Web Submissions, please call (888) 860-1297.