

THE PA PROCESS

FOR PRESCRIPTIONS

INFORMATION
REGARDING YOUR
PRESCRIPTION
PRIOR
AUTHORIZATION

Prior authorization (PA) is a procedure in which specific medications need pre-approval before they can be dispensed. MedOne Pharmacy Benefit Solutions implements this process to ensure appropriate and cost-effective medication utilization. Below are steps outlining the process for when your prescription requires a prior authorization.

First Time Prescription PA Process

1. Your prescriber writes the prescription.
2. Your preferred pharmacy attempts to fill the prescription and process a claim, receiving a "rejection" from the prescription coverage plan (MedOne) indicating a prior authorization needed.
3. A prior authorization request is sent directly to your prescriber from the pharmacy or MedOne requesting additional information about your medical history and the need for the medication.
4. The prescriber submits the necessary clinical documentation and chart notes directly to prescription coverage plan via fax or electronic submission through CoverMyMeds®.
5. MedOne reviews the submitted information and moves forward with an approval or denial of prescription request (usually 3-5 business days, however duration may vary). PA decisions are then faxed to prescriber and pharmacy, and a written decision will be mailed to you.
6. If prescription is approved, the pharmacy will successfully process the claim and fill the medication.

If PA is denied for any reason, information regarding the denial reason and the appeal process will be sent to prescriber.



Renewal Prescription PA Process

1. Prescriber's manage renewal requests through CoverMyMeds®. They are alerted when authorizations will expire and are prompted to submit updated information through CoverMyMeds® to MedOne.
2. Your prescriber submits any necessary clinical documentation directly to MedOne via fax or electronic submission through CoverMyMeds®.
3. MedOne reviews the submitted information for approval or denial of prescription request.
4. The prior authorization decision is then faxed to your prescriber and pharmacy, and a written decision will be mailed to you.
5. If the prescription is approved, your pharmacy will process the claim and fill your medication.

Questions?

Our Member Advocate team can also assist with any questions you may have regarding your prescription benefit. Call **888-884-6331** or check out our LIVE chat feature on our website at www.medone-rx.com.

PERFORMANCE | Fail First Requirements | Effective January 1, 2025

CLINICAL REVIEW PROGRAM

MEMBER GUIDELINES

The Clinical Review Program includes medications which have certain requirements to try and fail more cost-effective treatments prior to less cost-effective treatments. The last 18 months of claims history available is reviewed to confirm prior treatments used. MedOne will work with prescribers to identify any gaps in the claims history to make sure the most appropriate and most cost-effective medication is covered as quickly as possible. Certain Step-One medication may be accessed without additional fail-first requirements. This document does not guarantee coverage of any drug. Additional plan specific limitation may apply.

PHYSICIAN GUIDELINES¹

Claims history from the prior 18 month period is reviewed. Historical review timeframe and compliance requirements may change based on therapy class or client request. Contact MedOne Pharmacy Benefit Solutions at **888-884-6331** to begin the Clinical Review Process. This document does not guarantee coverage of any drug. Certain Category A medication may be accessed without additional fail-first requirements. To access a medication on the clinical review program guide, the medication must be on formulary. Additional plan specific limitations may apply.

Clinical review program guidelines may be updated on an ongoing basis due to changes in the pharmacy industry. Failure to accurately complete the PA form or submit required documentation may result in a delay in the member's therapy.

PA CATEGORY	STEP-ONE	STEP-TWO	STEP-THREE
ADD/ADHD^{PA}	PA may be required for authorization: dexamethylphenidate IR/ER, lisdexamfetamine, methylphenidate ER / CD / XR, methylphenidate IR, mixed amphetamine salts ER / XR, mixed amphetamine salts IR	Only after failure with two preferred generic treatments of similar duration of action: Brand ADD/ADHD medications: METHYLPHENIDATE ER, MYDAYIS	
ANKYLOSING SPONDYLITIS^{PA}	ADALIMUMAB-ADB ^M *, oral diclofenac, oral ibuprofen, oral meloxicam, oral naproxen YUSIMRY* <small>*Failure of preferred generic will be required prior to authorization of YUSIMRY or ADALIMUMAB-ADB^M</small>	After failure with one preferred generic and YUSIMRY or ADALIMUMAB-ADB ^M : CIMZIA, ENBREL®, RINVOQ®, SIMPONI®, XELJANZ®	Only after failure with one preferred generic, YUSIMRY or ADALIMUMAB-ADB ^M , and one Step-Two medication: COSENTYX®, TALTZ®
ANTIDEPRESSANTS^{PA}	bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine IR/ER tabs, venlafaxine ER caps ² , vilazodone	Only after failure with one SSRI, one SNRI, and one other antidepressant class: FETZIMA®, TRINTELLIX®	
ANTIPSYCHOTICS Injectable^{PA}	fluphenazine, haloperidol, olanzapine, risperidone	Only after failure with one Step-One medication: ABILIFY MAINTENA/ARISTADA®	Only after failure with one Step-One and one Step-Two medication: INVEGA SUSTENNA, ZYPREXA RELPREV®

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This document is for informational use only and does not guarantee coverage, lack of coverage, or coverage requirements for any specific drug therapy. Information within this document is subject to change. Additional plan limitations and requirements may apply. If you have questions regarding the medications covered under your prescription drug benefit, please call MedOne Pharmacy Benefit Solutions at 1-888-884-6331.

Clinical Review Continued

PA CATEGORY	STEP-ONE	STEP-TWO	STEP-THREE
ANTIPSYCHOTICS Oral ^{PA}	aripiprazole, chlorpromazine, clozapine, fluphenazine, haloperidol, loxapine, lurasidone, olanzapine, paliperidone, perphenazine, quetiapine IR/ER, risperidone, thiothixene, trifluoperazine, ziprasidone	After failure with two Step-One medications: CAPLYTA®, REXULTI®, VRAYLAR®	
CROHN'S DISEASE^{PA}	ADALIMUMAB-ADB ^M *, azathioprine, Corticosteroid, Injectable methotrexate, Mesalamine, sulfasalazine, 6-mercaptopurine, YUSIMRY* <small>*Failure of preferred generic will be required prior to authorization of YUSIMRY or ADALIMUMAB-ADB^M</small>	After failure with one preferred generic and YUSIMRY or ADALIMUMAB-ADB ^M : CIMZIA, RINVOQ, SKYRIZI®, STELARA®	Only after failure with one preferred generic, YUSIMRY or ADALIMUMAB-ADB ^M , and one Step-Two medication: ENTYVIO®
DIABETES DPP4V Inhibitors ^{PA}	generic sulfonylureas, generic thiazolidinediones, Insulin, metformin IR/ER, repaglinide	Only after failure with metformin, recommend trial of another generic Step-One medication: JANUMET IR/XR, JANUVIA, JENTADUETO IR/XR, TRADJENTA	
DIABETES GIP/GLP-1 Agonists ^{PA}	generic sulfonylureas, generic thiazolidinediones, Insulin, metformin IR/ER, repaglinide	Only after failure with metformin, consider trial of another generic Step-One medication: MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY	Only after failure with metformin, recommend another generic Step-One medication, and failure of one Step-Two medication: BYDUREON, BYETTA
DIABETES SGLT2 Inhibitors ^{PA}	generic sulfonylureas, generic thiazolidinediones, Insulin, metformin IR/ER, repaglinide	Only after failure with metformin, recommend trial of another generic Step-One medication: FARXIGA/XIGDUO XR, JARDIANCE/SYNJARDY, TRIJARDY	
INTRANASAL STEROIDS	intranasal budesonide, intranasal fluticasone, intranasal mometasone, intranasal triamcinolone	Only after failure with three Step-One medications: QNASL®	Only after failure with two Step-One & one Step-Two medications: FLONASE®, NASACORT® AQ, XHANCE®
JUVENILE IDIOPATHIC ARTHRITIS^{PA}	ADALIMUMAB-ADB ^M *, azathioprine, hydroxychloroquine, leflunomide, methotrexate, YUSIMRY* <small>*Failure of preferred generic will be required prior to authorization of YUSIMRY or ADALIMUMAB-ADB^M</small>	After failure with one preferred generic and YUSIMRY or ADALIMUMAB-ADB ^M : ENBREL®, RINVOQ®, XELJANZ®	Only after failure with one preferred generic, YUSIMRY or ADALIMUMAB-ADB ^M , and one Step-Two medication: ACTEMRA®
MIGRAINE TREATMENT^{PA} CGRP	amitriptyline, nortriptyline, duloxetine, metoprolol, propranolol, nadolol, divalproex sodium, valproic acid, topiramate, pregabalin, gabapentin, lamotrigine, venlafaxine, verapamil	Only after failure with three Step-One medications: AIMOVIG®, AJOVY®, QULIPTA®, EMGALITY 100mg®	Only after failure with Aimovig or Ajoyv: EMGALITY 120mg®
PLAQUE PSORIASIS^{PA}	ADALIMUMAB-ADB ^M *, acitretin, cyclosporine, methotrexate, sulfasalazine, YUSIMRY*	Only after failure with preferred generic and YUSIMRY or ADALIMUMAB-ADB ^M :	Only after failure with one preferred generic, YUSIMRY or ADALIMUMAB-ADB ^M ,

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*Failure of preferred generic will be required prior to authorization of YUSIMRY or ADALIMUMAB-ADBDM

CIMZIA, ENBREL®, OTEZLA®, SKYRIZI®, STELARA®, TREMFYA®

and **one** Step-Two medication:

COSENTYX®, TALTZ®

Clinical Review Continued

PA CATEGORY	STEP-ONE	STEP-TWO	STEP-THREE
PSORIATIC ARTHRITIS^{PA}	ADALIMUMAB-ADBDM*, azathioprine, hydroxychloroquine, leflunomide, methotrexate, YUSIMRY* *Failure of preferred generic will be required prior to authorization of YUSIMRY or ADALIMUMAB-ADBDM	After failure with one preferred generic and YUSIMRY or ADALIMUMAB-ADBDM: CIMZIA, ENBREL®, OTEZLA®, RINVOQ®, SIMPONI®, SKYRIZI®, STELARA®, TREMFYA®, XELJANZ®/XELJANZ XR®	Only after failure with one preferred generic, YUSIMRY or ADALIMUMAB-ADBDM, and one Step-Two medication: COSENTYX®, TALTZ®
RHEUMATOID ARTHRITIS^{PA}	ADALIMUMAB-ADBDM*, azathioprine, hydroxychloroquine, leflunomide, methotrexate, sulfasalazine, YUSIMRY* *Failure of preferred generic will be required prior to authorization of YUSIMRY or ADALIMUMAB-ADBDM	Only after failure with preferred generic and YUSIMRY or ADALIMUMAB-ADBDM CIMZIA®, ENBREL®, RINVOQ®, SIMPONI®, XELJANZ®/XELJANZ XR®	Only after failure with one preferred generic, YUSIMRY or ADALIMUMAB-ADBDM, and one Step-Two medication: ACTEMRA®, KEVZARA®, RITUXAN®
ULCERATIVE COLITIS^{PA}	ADALIMUMAB-ADBDM*, azathioprine, corticosteroid, mesalamine, sulfasalazine, 6-mercaptopurine, YUSIMRY* *Failure of preferred generic will be required prior to authorization of YUSIMRY or ADALIMUMAB-ADBDM	Only after failure with preferred generic and YUSIMRY or ADALIMUMAB-ADBDM SIMPONI®, SKYRIZI®, STELARA®, RINVOQ®, XELJANZ®/XELJANZ XR®	Only after failure with one preferred generic, YUSIMRY or ADALIMUMAB-ADBDM, and one Step-Two medication: ENTYVIO®, OMVOH®, ZEPOSIA®

1. Additional plan limitations or exclusions may apply
2. Coverage requires trial and failure of venlafaxine ER capsules, prior to authorization

★: Plan benefit may restrict use of multiple medications per category at the same time
OTC: Over-the-counter product coverage is subject to plan allowance. Use of non-formulary OTC products may be required prior to authorization of formulary prescription products.
PA: Prior Authorization may be required.
APA: Auto-Prior Authorization applies in patients who meet auto-PA criteria

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