THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

☒ Imperial
☒ Riverside/San Bernardino
☒ Los Angeles
☒ Orange
☒ Sacramento
☒ San Diego

LINES OF BUSINESS:

☒ Molina Medi-Cal Managed Care
☐ Molina Medicare Options Plus
☐ Molina Dual Options Cal MediConnect Plan (Medicare-Medicaid Plan)
☒ Molina Marketplace (Covered CA)

PROVIDER TYPES:

☒ **Medical Group/ IPA/MSO**

Primary Care
☒ IPA/MSO
☒ Directs

Specialists
☒ Directs
☒ IPA

☒ **Hospitals**

Ancillary
☒ CBAS
☒ SNF/LTC
☒ DME
☒ Home Health
☐ Other

FOR QUESTIONS CALL PROVIDER SERVICES:
(855) 322-4075, Extension:

Los Angeles/Orange Counties
X111113 X123071
X127657

Riverside/San Bernardino Counties
X127684 X128010
X120618

Sacramento County
X121360 X126232

San Diego County
X121805 X121401
X127709 X121413
X123006 X121599

Imperial County
X125682 X125666

STATE LEGISLATION SENATE BILL 282

This is an advisory notification to Molina Healthcare of California (MHC) network providers regarding **State Legislation Senate Bill (SB) 282.**

REQUIREMENTS

Effective January 1, 2018 SB, 282 requires all health plans, risk-bearing organizations, physicians or physician groups to use only the Prescription Drug Prior Authorization Request Form 61-211 for a medically necessary non formulary prescription drug.

Prescription Drug Prior Authorization Request Form No. 61-211 is attached to this notification, as well as available on the MHC website.

Medi-Cal:
https://www.molinahealthcare.com/providers/ca/PDF/Archive/Medication_PA_Form.pdf
Marketplace:
https://www.molinahealthcare.com/providers/ca/PDF/Archive/Medication_PA_Form.pdf

Completed forms may be submitted via the Cover My Meds Webpage (https://www.covermymeds.com/main/) or by fax to (866) 508-6445.

MHC will notify the prescribing provider within two (2) business day of receipt of a prescription prior authorization request that either:

- The prescribing provider's request is approved; or
- The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or
- The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the prescription drug prior authorization request;
- The patient is no longer eligible for coverage; or
- The prescription prior authorization request was not submitted on the required form and needs to be submitted using Form No. 61-211.

QUESTIONS

If you have any questions regarding the notification or regarding your submission, please contact (888) 665-4621.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#: (_____)_____**

Plan/Medical Group Fax#: (_____)_____ **Non-Urgent** ☐ **Exigent Circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:

Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____Weight (lb/kg):_____	Allergies:

Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:

Address:	City:	State:	Zip Code:

Requestor (if different than prescriber):	Office Contact Person:
NPI Number (individual):	Phone Number:
DEA Number (if required):	Fax Number (in HIPAA compliant area):

Email Address:

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?

☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:	☐ Patient's Home	☐ Long Term Care
☐ Physician's Office	☐ Home Care Agency	☐ Other (explain):_____
☐ Ambulatory Infusion Center	☐ Outpatient Hospital Care	_____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

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 circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I 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.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

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.

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number (_____)_____

☐ Approved ☐ Denied Comments/Information Requested: _____