Executive Summary	Specialty Medication Prior Authorizations (R020)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2022
Reviewed By	Retiree Health Plan Advisory Board
Review Date	September 9, 2021

1) Background

The AlaskaCare Defined Benefit Retiree Health Plan (Plan) provides coverage for outpatient drugs for treatment of illness, disease, or injury if dispensed upon prescription of a provider acting within the scope of their license. Similar to Plan requirements for precertification for certain intensive, complex, or high-cost medical services, the Plan currently includes provisions that allow for a prior authorization review of certain medications to evaluate if the person utilizing the medication meets the medical necessity guidelines and clinical criteria established by the FDA and other evidence-based resources for safe and effective use.

Specialty medications are typically highly complex, high-cost, or high-touch drugs that often must be administered in a very specific manner. Many specialty medications are prescribed to treat chronic conditions, meaning that utilizers are likely to use that medication for a long time. In 2020, specialty costs for less than 1% of prescriptions (associated with 3.7% of utilizers) made up 37%, or $110 million, of the total Plan prescription drug spend.

Currently the Plan does not have a prior authorization process in place for specialty medications. In a review of over 60 public health plans, the AlaskaCare retiree plan was the only plan without this process in place. As a result, the Plan's Pharmacy Benefit Manager (OptumRx) does not have a means to receive and review the information necessary (*e.g.*, basic diagnostic information) to ensure the patient meets the specific FDA and clinical criteria associated with appropriate and effective use of the specialty medication.

2) Objectives

a) Promote safe and effective use of medications in accordance with evidence-based clinical standards.
b) Employ prudent pharmacy management strategies to curtail unnecessary or unsafe medication utilization.

3) Summary of Proposed Change

Prior authorization requires prescribers to provide patient-specific medication treatment information for review prior to approval and dispensing to the patient. This review ensures that a prescription drug is appropriately prescribed, meets FDA and other clinical guidelines for the condition being treated, and is eligible for coverage.

The Division proposes implementing prior authorization requirements for specialty medications through OptumRx's specialty prior authorization program. Prescribers would need to provide certain clinical data to OptumRx for a review prior to approval for coverage. In most cases these reviews are completed within 72 hours and prescribers can submit the request electronically. A list of specialty medications requiring prior authorization is available here: OptumRx Specialty Pharmacy Drug List.

4) Actuarial and Financial Impacts of Proposed Change

This proposal will not result in a change to members' cost share for their covered prescriptions, nor will it remove coverage for any drugs currently being covered by the plan. Therefore, implementing prior authorizations for specialty medications will not have an impact on the actuarial value of the Plan.

Savings accrue to the plan via increased drug manufacturer rebates associated with implementing prior authorizations, denials of medication due to inappropriate use of the drug, abandoned prior authorization requests, and alternative prescriptions being dispensed.

The anticipated financial impact to the plan associated with implementing prior authorizations is a reduction in costs of approximately $7.7 million for 2022, and a potential $100.8 million reduction in the healthcare Accrued Actuarial Liability associated with the plan.