PRIOR-AUTHORIZATION PROTOCOL

FOR CANCER TREATMENT AND/OR GENETICAL STUDIES SERVICES

Prior authorization, also frequently referred to as preauthorization, is a utilization management practice that requires certain procedures, tests and medications prescribed by healthcare clinicians to first be evaluated to assess the medical necessity and cost-of-care ramifications before they are authorized. To help ensure our Vital Plan Enrollees' benefit coverage is medically appropriate, FMHP regularly evaluate its medical policies, clinical programs and health benefits based on the latest scientific evidence.

To support these goals, FMHP require a prior authorization for injectable outpatient chemotherapy and related cancer therapies administered in an outpatient setting, including but not limited to intravenous, for a cancer diagnosis. This information only applies to Vital Plan Enrollees who are receiving Cancer treatment (Chemotherapy and Radiotherapy) and/or Genetic studies services. For other services, please refer to FMHP's Provider Guidelines 2021 at www.firstmedicalvital.com.

PROGRAM REQUIREMENTS

First Medical Health Plan, Inc. (FMHP) Prior authorization requirements include the following services and procedures:

1. Neurosurgical Procedures, Injection of Anesthetic Agents for Neurologic Block, and Neurostimulators;
2. Radiation Therapy;
3. Computerized Tomography;
4. Magnetic Resonance Imaging;
5. Nuclear Imaging;
6. Single-photon Emission Computed Topography ("SPECT") test;
7. Impedance Plethysmography (IPG);
8. Diagnostic Endoscopies;
9. Genetic Studies;

10. Physical Therapy- Limited to a maximum of fifteen (15) treatments per Enrollee condition per year, unless Prior-Authorization of an additional fifteen (15) treatments is indicated by an orthopedist or physiatrist;
11. General Anesthesia;
12. Hyperbaric Chamber;
13. Mammoplasty;
14. ERCP;
15. Colonoscopy and Virtual Colonoscopy;
16. Stereotactic Radiosurgery;
17. EEG; and
18. Prosthetics, including the supply of all extremities of the human body including therapeutic ocular prosthetics, segmental instrument tray, and spine fusion in scoliosis and vertebral surgery;
19. Non-emergency Transportation;
20. J Codes;
21. Direct Medical Equipment and Supplies: Case by Case Review;
22. Wound Care
23. Oral chemotherapy and anti-emetic drugs, not included in the FML of Vital Plan
24. Use of chemotherapy drugs for non-cancer diagnosis

All physicians who perform pre-selected oncology-related injection/infusion procedures are required to obtain a prior authorization for services prior to the service being rendered. Physicians and facilities who render oncology-related injection/infusion procedures within the scope of this protocol must confirm that prior authorization has been obtained, or payment for their services may be denied. Adding a new injectable chemotherapy drug to a regimen will require new authorization.

HOW TO REQUEST PRIOR AUTHORIZATION

To submit a request for prior authorization, use the Prior Authorization Formulary. You must complete all the requested fields prior submitting to FMHP your request. If you have questions

about preauthorization, please call Provider's Service Line at 1-844-347-7802 from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday.

SUBMITTING YOUR PA REQUEST

- **Medical Affairs**

You can start the prior authorization process by sending your service request via fax to the following number (787) 626-2189. Requesting services related to Discharge Planning shall be send to (787) 629-2113.

Any other service request that requires pre-authorization shall be sent to the following fax number (787) 626-2110.

- **Pharmacy**

The medical provider or the pharmacy staff selected by the beneficiary will be responsible for sending the information required for the assessment by the Pharmacy Department to the following fax number 1-844-347-7807.

TIMEFRAMES TO RESPOND A PA REQUEST

For services that require Prior-Authorization, the Service Authorization request shall be submitted promptly by the Provider for FMHP evaluation. FMHP will ensure that Prior-Authorization is provided for the Enrollee in the following timeframes, including on holidays and out of normal business hours:

- The decision to grant or deny a Prior-Authorization will not exceed seventy-two (72) hours from the time of the Enrollee's Service Authorization Request for all Covered Services.
- In cases where the Enrollee's Provider determines that the Enrollee's life or health could be endangered by a delay in accessing services, the Provider must notify FMHP that the services is "URGENT" and demonstrate medical necessity by providing the appropriate clinical documentation. In those cases, the Prior-Authorization must be provided as expeditiously as the Enrollee's health requires, but no later than twenty-four (24) hours from the receipt of the request. Urgent care decisions will be made when following the standard timeframe could result in seriously jeopardizing the member's life, health, or ability to regain maximum function.
- FMHP can request an extension, of up to fourteen (14) calendar days, to the PRHIA when Medical Affairs justifies a need for the extension to collect additional information. The

extension must be in the Enrollee's best interest. The Enrollee or the Provider can also request an extension.

- If an extension is granted, FMHP must provide the Enrollee a written notice of the reason behind granting the extension and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision. The notice of the determination must be sent as expeditiously as the Enrollee's health condition requires and no later than the expiration date of the extension.
- Providers will be notified of the determination via fax.

Any denial, unreasonable delay, or rationing of medically necessary services to Enrollees is expressly prohibited.

DENIAL PROCESS

FMHP's employees are licensed and trained professionals to supervise all Prior-Authorization decision Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, is made by a clinician who possesses the clinical expertise for treating the Enrollee's condition.

FMHP will evaluate all Prior-Authorization requests. If the medical information related to the request indicates that it does not meet with the applicable criteria for approval the Utilization Management Review Specialist will refer it to the Medical Director for the medical review process. The Medical Director may:

- Approve the request;
- Contact the care physician or attending physician for additional medical information;
- Contact the care physicians or attending physician to discuss an alternative treatment plan; or
- Deny the request.

FMHP will assure that all denial notifications are handled in a timely manner. Enrollees, Authorized Representatives, and Physicians are informed by an outbound call and are explained their appeal rights. The Enrollee and Provider will receive a written denial notice whether coverage is denied in whole, in part, or discontinued. The notification will include the appeal rights, reconsideration process and timeframes.

APPEALS PROCESS

Enrollees or their Authorized Representatives may file an appeal to an adverse determination verbally by calling the following number 1-844-347-7800 or in writing by sending a fax to 787-300-3931 with all the pertinent information supporting the appeal or any new information not provided during the initial prior-authorization process.

If you have questions and need more information, please contact us to address your concern at: call Provider's Service Line at 1-844-347-7802.