Specialty pharmacy programs — Medical benefit

Frequently asked questions

This document reviews information for UnitedHealthcare commercial plans specialty pharmacy programs for drugs covered under the medical benefit.

Review at Launch

What is Review at Launch?

The **Review at Launch (RAL) program** allows us to proactively respond to new drug launches, while minimizing member disruption. The program helps ensure coverage for clinically appropriate drugs, while enabling providers to better serve their patients as new therapies become available.

What is Exclude at Launch?

Our Exclude at Launch (EAL) program builds on RAL. It excludes drugs on the RAL drug list from coverage until clinical criteria are fully developed and implemented, and other strategies are evaluated. This process generally takes up to 6 months and allows us to develop comprehensive clinical management strategies prior to approving coverage for the drug.

Questions?

If you have questions, call the Provider Services number on the member's ID card. For more information, visit our **Specialty Pharmacy – Medical Benefit Management** page.

What does it mean if a drug is on the RAL medication list?

If providers wish to prescribe drugs on the RAL medication list, we encourage requesting pre-determination reviews. These reviews take into consideration the terms of the member's benefit plan, FDA-approved labeling, available clinical evidence and any applicable medical drug policies.

What if a provider doesn't request a pre-determination review?

We review submitted claims against our medical drug policy. We may deny a claim if the services aren't consistent with clinical guidelines or if the member's benefit plan doesn't allow for coverage while in the RAL period.

What medications are on the RAL drug list?

Please see our **Review at Launch for New to Market Medications** medical benefit drug policy. We regularly update this policy as new drugs are approved by the U.S. Food and Drug Administration.

Notification and prior authorization

What do I need to know about notification and prior authorization?

We require notification or prior authorization for certain specialty drugs to help ensure our members have coverage for medically appropriate care. Coverage review requirements vary by plan.

To view which drugs and services require notification or prior authorization for a specific plan, visit our **Prior Authorization and Notification** page. Sign in to the UnitedHealthcare Provider Portal and select Plan Requirements for Advance Notification/Prior Authorization.

Where can I view the coverage policies for a specific medication?

To view the coverage policy for a specific drug, visit our **UnitedHealthcare Commercial Medical & Drug Policies** page.

How does the notification or prior authorization process work for specialty drugs?

When we receive a notification or prior authorization request for a drug, we'll determine if the member's benefit plan includes coverage for it and whether the plan requires covered services to be medically necessary. If so, we'll conduct a clinical coverage review as part of our notification or prior authorization process.

Clinical coverage reviews evaluate whether the drug is appropriate for the individual member, considering:

- The terms of the member's benefit plan
- Our drug coverage policy
- Applicable state and federal regulatory requirements

We may also consider additional criteria. We encourage you to submit any information you'd like us to review as part of your notification or prior authorization request.

How can I submit a notification or prior authorization request for these drugs?

You have 2 options for requesting pre-service coverage reviews and submitting prior authorization and notification requests:

- Online:
  - Go to **UHCprovider.com** and click Sign In at the top-right corner
  - Enter your One Healthcare ID
    - New users who don't have a One Healthcare ID: Visit **UHCprovider.com/access** to get started
  - From the left-hand tabs, select Prior Authorizations & Notifications. Then, click "Create a new request."
  - Select the appropriate prior authorization type from the dropdown
  - Enter the required information and click Continue
- Phone: Call the Optum Intake Team at 888-397-8129

Can I appeal an adverse determination?

We'll inform you and the member of our coverage determination. If we make an adverse determination, we'll provide appeal information in the determination notice.

Site of care

What is site of care?

We're focused on achieving better health outcomes and lowering the cost of care. To continue this important work, we evaluate the site of care for the administration of certain specialty drugs and whether the patient needs more intensive services or can be moved to a lower-cost alternate site of care.

Under the medical benefit, certain specialty drugs may not need to be administered at an outpatient hospital level. For those drugs, we require you to use an alternative site of care. By changing to an alternative location, providers can help our members receive effective and convenient care, while also lowering costs.

How does site of care work?

During the prior authorization process, we review the clinical evidence submitted by the provider and consider the member's specific condition.

If we determine that the drug doesn't need to be monitored in an outpatient hospital setting after we review the clinical data and medical necessity criteria, we'll require the provider to change to an alternate site of care for the drug to be covered. The alternate site of care will be a participating infusion provider (home infusions), physician office or freestanding infusion center. This is in place of the higher-cost location, such as an outpatient facility.

Members may be eligible for a grace period as they transition to an alternate site of care.

For more information, see our **Provider Administered Drugs – Site of Care** medical benefit drug policy.

Preferred product

What is a preferred product?

We're committed to providing our members with access to high-quality products at the lowest possible costs. In some cases, we ask you to prescribe lower-cost options when there are multiple drugs used to treat the same condition. As part of the prior authorization review, we'll require documentation to support the medically necessary clinical requirement that members must try the preferred drug(s) and fail the maximum tolerated dosage, experience an adverse reaction, or have a contraindication to receive coverage approval for the non-preferred drug(s).

Which drugs require providers to prescribe a preferred product?

You can find the preferred product strategies on our **UnitedHealthcare Commercial Medical & Drug Policies** page. For more information related to biosimilars and clinical programs, see our **Biosimilars: Frequently asked questions.**

Medical Benefit Therapeutic Equivalent Medications – Excluded Drugs Policy

What is the Medical Benefit Therapeutic Equivalent Medications – Excluded Drugs Policy?

The Medical Benefit Therapeutic Equivalent Medications – Excluded Drugs Policy is a long-term exclusion program for certain targeted medical benefit medications administered by a health care professional. All excluded medications have a therapeutically equivalent alternative option available for coverage. Therapeutic equivalence is defined as having essentially the same efficacy and adverse effect profile to another covered medication/product. This determination is made by the UnitedHealthcare Pharmacy & Therapeutics (P&T) Committee.

What drugs are included in this policy?

For more information, see our **Medical Benefit Therapeutic Equivalent Medications - Excluded Drugs** policy.

Medication sourcing

What is medication sourcing?

Medication sourcing, otherwise known as white bagging, requires the provider (physician or facility) administering/infusing the medication to obtain it from a participating specialty pharmacy and the patient visits the physician's office or infusion facility for administration.

How does medication sourcing work?

When the specialty drug is obtained through the participating specialty pharmacy, the pharmacy will bill UnitedHealthcare directly for the drug under the member's medical benefit. Providers can only seek reimbursement from UnitedHealthcare for administration of the drug and not for the drug itself and can't seek any reimbursement from the member for the drug.

For additional information on medication sourcing, visit the Medication Sourcing section on our **Specialty Pharmacy – Medical Benefit Management (Provider Administered Drugs)** page.

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