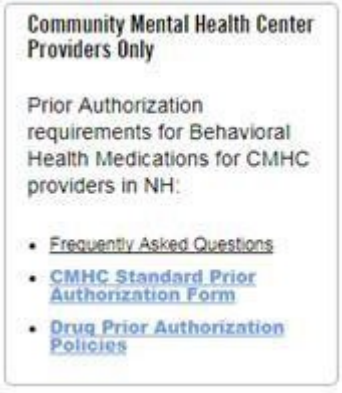
Frequently Asked Questions
Community Mental Health Center (CMHC) Prior Authorizations

Q: What is changing on September 5th, 2017?
A: Effective September 5th, 2017, Well Sense formulary requirements will resume including prior authorization, quantity limits, and step therapy for certain behavioral health medications. Prior authorization forms and clinical policies with drug-specific criteria are available at www.wellsense.org/providers.

Q: How will a Provider know what requires prior authorization?
A: The Well Sense drug list provides information on all drugs that are covered by the Plan. It also includes information on restrictions, such as prior authorization, quantity limits, or step therapy. Please refer to www.wellsense.org/providers to see what drugs are covered.

Well Sense will mail out to each Provider a notice that contains their impacted patients.

Q: What form should be used to submit the prior authorization request?
A: Effective September 5th, 2017, CMHC Providers must use the approved universal PA form to submit prior authorization requests to Well Sense for drugs used to treat mental illness. The universal PA form and link to our pharmacy policies are available on our website at www.wellsense.org/providers. Providers may also request a copy of the PA form to be faxed to their office by calling 1-877-957-1300, option 3 then option 4. Completed prior authorization request forms should be faxed to 1-877-251-5896.



Q: How can a Provider request assistance with completing the universal PA form?
A: Assistance with completing the universal PA form or accessing the Clinical Policies can be requested by contacting Well Sense Provider Services at 1-877-957-1300, option 3 then option 4 and a Well Sense representative can assist the provider in filling out the necessary information on the form.

Q: How much information is needed on the prior authorization form?
A: In order to ensure all prior authorization requests can be reviewed timely, all prior authorization forms must be reasonably complete. A reasonably complete form includes complete Member and Provider information (Sections I and II) as well as complete explanations for each clinical question checked off in Section III of the universal PA form.

Q: How long will it take to do the prior authorizations?
A: A reasonably complete prior authorization form will be reviewed with a decision to approve or deny the request by the close of the next business day.

Q: What is the process if a decision is not made by the close of the next business day?
A: Well Sense monitors turnaround time for all prior authorization requests throughout the day. If a request has not been reviewed with a decision made within the required turnaround times, the request will be automatically approved. An approval letter will be sent to the Provider.

Q: What if the member needs to take the medication soon and can't wait for a PA?
A: Well Sense allows for a 72-hour emergency supply of medication should a Member require urgent treatment that cannot wait for the completion of a prior authorization request. The dispensing pharmacist can call ESI at 1-800-753-2851 to request a 72 hour emergency fill for the requested medication. If the pharmacist or Provider is aware that a member requires an emergency supplying exceeding 72 hours, a request can be made to the Plan for approval of a 96 hour emergency supply.

Q: What happens if the prior authorization request is denied?
A: The Provider can contact Well Sense to request a peer to peer review with a psychiatric specialist who has prescribing privileges within one (1) business day. The Plan will outreach and conduct the peer-to-peer review by the close of the next business day. Please contact Well Sense at 1-877-957-1300, option 3 then option 4 to request a peer- to-peer review.

Q: What is the process if the timeline to request a peer-to-peer under HB517 is missed?
A: The Provider can contact Well Sense to request a peer to peer review following Well Sense's standard peer to peer process. The standard process provides for a discussion with a Clinical Pharmacist or Plan Medical Director, as needed. Standard peer to peer requests are responded to within 24-48 hours of receipt of request.

Q: Can the Member appeal the denial?
A: The Member or Provider on the Member's behalf can submit an appeal request by telephone, in writing or in person, within 60 calendar days from the date of the denial letter.

To Appeal by Telephone: Member or healthcare provider may appeal by telephone, by calling the Well Sense Member Services Department at 1-877-957-1300 (TTY/TDD 711) Monday through Wednesday between the hours of 8:00 a.m. and 8:00 p.m. or Thursday through Friday between the hours of 8:00 a.m. and 6:00 p.m. (except holidays).

To Appeal in Writing: Member or healthcare provider may appeal in writing, by sending a letter explaining the reason for filing the Appeal, a copy of the denial letter, and any additional information that supports the Appeal and mail it to:

Well Sense Health Plan
ATTN: Appeals & Grievances Specialist
529 Main Street, Suite 500
Charlestown, MA 02129.

To Appeal in Person: To submit an Appeal in person, Member may visit us at the location above.

Q: How can a Provider file a complaint regarding the prior authorization or peer to peer review process?
A: Complaints regarding the prior authorization or peer-to-peer review process can be sent to the Plan at pharmacy@BMCHP-Wellsense.org.

For other questions about various pharmacy coverage issues, please contact the Well Sense Pharmacy Department via email at pharmacym@bmchp.org.