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Utilization Review Policy

Purpose and Definitions
To ensure the safe, effective, and cost-efficient use of medications by conducting structured, ongoing review of pharmacy claims, while maintaining compliance with regulatory standards and providing transparent appeal mechanisms.

PBM clients of RxPreferred Benefits, LLC, ("RxPreferred") are referred to herein as "Client(s)" or "Plan(s)." As of the date of this Utilization Review Policy ("Policy"), RxPreferred services only self-funded ERISA plans and does not service Medicaid or Medicare plans or state equivalents. RxPreferred's "Prior Authorization" and "Step Therapy" criteria are drug-specific and are developed and reviewed by board-certified licensed pharmacists employed by RxPreferred (the "Clinical Team").

Standards

- **Clinical Standards:** All utilization review (UR) decisions are based on current, evidence-based clinical guidelines and national standards of care.
- **Regulatory Compliance:** UR activities must comply with federal and state regulations. As of the date of this Policy, RxPreferred services only self-funded ERISA plans and does not service Medicaid or Medicare plans or state equivalents.
- **Transparency:** Clinical criteria, coverage decisions, and appeal processes must be transparent and accessible to providers and members.
- **Non-Discrimination:** Decisions are not based on cost alone; clinical appropriateness and patient safety are prioritized.

Criteria

- **Plan Design:** UR requirements are driven by the plan design established by the Client at onboarding, including Prior Authorization dollar limits and whether the Client has elected to apply RxPreferred Step Therapy formulary. Clients may add additional requirements to specific drug categories.
- **Clinical Appropriateness:** Claims are reviewed for medical necessity, alignment with approved indications, and adherence to step therapy or prior authorization requirements.
- **Safety:** Reviews ensure patient safety by identifying potential drug interactions, contraindications, and therapeutic duplication.
- **Cost-Effectiveness:** Where clinically equivalent options exist, cost-effective alternatives are encouraged.
- **Quality Indicators:** Reviews may include monitoring for optimal use, such as adherence to preferred drug lists, generic utilization, and outcomes-based metrics.

Policies

- **Staff Roles:**
  - **Unlicensed Staff:** May perform initial screening, data entry, and administrative functions under the supervision of licensed clinicians.
  - **Licensed Staff:** Board-certified pharmacists make clinical determinations, including approvals, denials, and complex case reviews.
- **Help Desk and Support:** RxPreferred's toll-free support line is fully staffed during normal business hours and reduced staff are designated to be available after-hours and on weekends.
  - Support phone number, 888-666-7271.
  - Limited staff available Monday through Friday from 6 pm to 8 pm and Saturday from 10:30 am to 3:30 pm Central Standard Time.
- **Decision-Making:** Only licensed clinicians determine denial of coverage criteria or make medical necessity determinations.
- **Education:** Initial and ongoing training is provided for all staff on clinical criteria, regulatory changes, and ethical standards.
- **Documentation:** All review decisions, supporting documentation, and communications are maintained in accordance with confidentiality and HIPAA-compliant record-keeping requirements.

Procedures

1. **Claim Submission:** Pharmacy claims are submitted electronically or via other approved means. When a pharmacy submits a claim for a mediation that exceeds the Plan's dollar limit or requires Prior Authorization, the pharmacy is notified via a rejection message stating PA Required, Cost Exceeds, or NDC Not Covered. The reject message includes RxPreferred's phone number and requests a call from the pharmacy. The pharmacy calls RxPreferred's member support line to notify the RxPreferred team that Prior Authorization is needed.
2. **Initial Screening:** Unlicensed staff perform initial screening for completeness, eligibility, and simple coverage criteria. For Prior Authorization, upon receiving a call from a pharmacy, the RxPreferred team initiates the Prior Authorization request for the prescriber via fax, which includes a Prior Authorization form containing the member, prescriber, and drug information. The form requests the most recent supporting documentation (office visit notes), including any supporting lab work. The RxPreferred team cannot move forward with the review until all supporting documentation is received. RxPreferred provides and electronically documents three fax attempts to obtain complete documentation. Once all necessary documentation is received, RxPreferred completes the review within 48 to 72 hours, depending on volume. For Step Therapy, the RxPreferred team follows RxPreferred Step Therapy criteria as a guideline during the review.
3. **Clinical Review:** Complex or flagged claims are escalated to board-certified pharmacists employed by RxPreferred for medical necessity and clinical appropriateness review.
4. **Decision Notification:** Prescribers and members are notified of coverage decisions immediately upon determination, including approval effective dates, reasons for denial, and process for appeal, in writing. Pursuant to the notification, prescribers may contact RxPreferred to discuss UR determinations with the RxPreferred Clinical Team. [The RxPreferred team calls the pharmacy to help obtain a paid claim.]
5. **Intervention:** Identified issues (e.g., inappropriate prescribing, safety concerns) are addressed through provider outreach, academic detailing, or other corrective actions.
6. **Monitoring and Reporting:** Ongoing monitoring of UR outcomes, provider performance, and adherence to clinical guidelines.

Reasonable Target Review Periods

- **Standard Claims:** Initial screening and reviews are completed within 48–72 hours of receipt of necessary documentation.
- **Complex or Manual Reviews:** Clinical reviews requiring pharmacist input are completed within 5 business days.
- **Urgent Requests:** Expedited reviews for urgent or emergency situations are completed within 24 hours.

Appeal Mechanisms

- **Provider and Member Notification:** All adverse decisions are communicated in writing, with clear instructions for appeal.
- **Appeal Process:** Providers or members may appeal within 180 days of denial. Appeals are reviewed by a licensed clinician. Standard appeal requests are reviewed within 7 business days. Member or prescriber may request an expedited appeal if the member's health status is jeopardized by the standard processing time. Expedited appeal requests will be reviewed within 72 hours. Members or prescribers wishing to appeal must complete the form provided by RxPreferred and available on its member portal and fax it to 888-631-0862, along with any additional supporting evidence. For questions regarding appeals, provider services is available at 888-666-7271.
- **External Review:** If the internal appeal is denied, members may be eligible to request an external review by an independent, board-certified pharmacist, pursuant to the requirements of applicable law.
    - If a member has exhausted the internal appeal process for an adverse benefit determination, the member may request an external review of the Plan's final adverse determination for certain health benefit claims.
    - The Plan will provide for an external review process in accordance with federal law. Note that the federal external review process is not available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan.
- **Transparency:** Appeal statistics, including approval and denial rates, are made available to the appropriate authorities upon request or through other accessible means.

Complaint Procedure

Members and prescribers may lodge a complaint regarding RxPreferred UR Policy by calling RxPreferred and submitting the complaint in writing to the address below:

RxPreferred Benefits, LLC

PO Box 396

Mt. Juliet, Tennessee 37121
Attn: Support or General Counsel

An acknowledgement letter will be sent within ten (10) business days of receipt of the complaint. Complaints must be confirmed received by RxPreferred prior to the applicability of any timelines herein. RxPreferred will work with the complainant to gather all pertinent facts regarding the complaint and attempt to resolve the complaint as soon as reasonably possible. RxPreferred will endeavor to resolve the complaint, and the complainant will be notified in writing

within thirty (30) calendar days of RxPreferred's receipt of the complaint, except for good cause in which case a written estimated extension of time shall be provided to the complainant.

Written complaints shall be retained by RxPreferred for a period of five (5) years from the date of written confirmation of receipt.

Program Evaluation and Quality Assessment

Quality process improvement is a disciplined approach to maintain consistent application of UR processes. It is designed to provide objective and systematic assessment of the UR Policy by measuring the adherence to policies and procedures, licensing/regulatory standards, and customer services. Process improvement reviews include:

- **Ongoing Assessment:** RxPreferred performs, at least annually or as necessary for new pharmaceutical technology or treatment guidelines, evaluation of UR program effectiveness, including review of outcomes, provider feedback, and regulatory compliance.
- **Quality Improvement:** Continual process improvements based on findings from program evaluation and audit results.

As directed or based upon relevant findings during quality review, RxPreferred may also provide:

- Process audits conducted by the clinical team;
- Member surveys conducted by an external vendor;
- Participation in activities to meet accreditation and regulatory requirements; and
- Development of targeted, relevant action plans for continuous process improvement activities.

Confidentiality

RxPreferred UR activities are privileged and confidential and are conducted in a manner that ensures the confidentiality of member and prescriber information. Staff are required to handle data responsibly and carefully and take the necessary steps to protect the privacy of the involved individuals in compliance with HIPAA regulations. The information collected for purposes of utilization review is limited to the information necessary for RxPreferred to adjudicate the claim and used solely for the purposes of utilization review and quality management. Information obtained for purposes of utilization review will be shared only with those agents of RxPreferred who have a need to know such information for the purposes herein. RxPreferred employs all data and system security procedures required under applicable HIPAA and privacy regulations and maintains Service Organization Control Type 2 (SOC2) cybersecurity certification to prevent unauthorized release of member information to the public. Information pertaining to the diagnosis, treatment or health of an enrollee shall be disclosed only to authorized persons. Release of information otherwise shall only be permitted with the express written consent of the member, or pursuant to court order for the production of evidence or discovery, or as otherwise provided by state or federal law. All employees are subject to a confidentiality agreement as a term of employment with RxPreferred. Any breach in confidentiality will result in disciplinary action as described in the employee manual.

Last Reviewed: May 13, 2026
Department: Legal