

PromptPA Quick Tips Guide

Your employer has partnered with RxBenefits for Prior Authorization services.



What You Can Expect:

With RxBenefits' independent Prior Authorization reviews, there is an actual person following the process. Because of our hands-on approach, you can rest assured knowing your members' medications are reviewed individually by a team of professionals, not an automated system.

- In-House Pharmacy and Providers should use PromptPA to send Prior Authorizations (PAs) to RxBenefits for review. PromptPA offers two ways to submit PAs:
 - online via the website RxB.PromptPA.com
 - by faxing the PA form to **888.610.1180**
- RxBenefits will review the Prior Authorization and relay determination and next steps to the prescriber and member.
- RxBenefits is only able to receive prior authorizations through **PromptPA**. We **do not** integrate with CoverMyMeds due to the independent clinical review process required.

You should not submit the Prior Authorization request to any Pharmacy Benefit Manager (PBM).

Follow directions below for the prior authorization process.

How to Submit a Prior Authorization using PromptPA

- Method 1 (Preferred)**
 - Utilize the online portal at RxB.PromptPA.com.
 - Initiate a review, complete the drug-specific question set, and submit chart notes electronically.
 - Check the coverage determination within the portal.
- Method 2**
 - Utilize the attached PA form (pg.3 below) and fax to **888.610.1180**.
 - For most PAs, the standard turnaround time is 1-3 business days.

How Do I Check the Status of a Prior Authorization?

- 1 Visit the online portal at RxB.PromptPA.com.
- 2 Select the **Check Status** tab across the top. All required fields (identified by a red *) must be completed to search for an existing review.
- 3 The **Status** will show **In Progress** until the review is finalized. Once the review is finalized it will show a coverage determination of either **Approved**, **Partially Approved**, **Cancelled** or **Denied**.
- 4 If additional information is needed, the **Progress Note** will indicate RxBenefits has reached out to the prescriber for additional information by saying "Waiting on additional information from prescriber."
- 5 The **Est. Time of Completion** field provides the estimated time to completion, including additional time added to allow for prescriber outreach and response.
- 6 To answer criteria questions (Questionnaire), click the **Complete Existing Request** tab at the top of the screen. These questions are specific to this PA review request. Answer all applicable questions accurately.

 **Average turnaround time for reviewing Prior Authorization is 1-3 Business days.**

Questions?

In-House Pharmacies

can contact Pharmacy Accelerated Call Experience (PACE) at

855.391.5746

*7 a.m. - 6 p.m. CT,
Monday through Friday*

clientservices@rxbenefits.com

Providers

can contact RxBenefits Member Services at

800.334.8134

*7 a.m. - 8 p.m. CT,
Monday through Friday*

customercare@rxbenefits.com



RxBenefits.com

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Fax completed form to **888.610.1180** or email to **PASupport@RxBenefits.com**

Electronic version available at <https://rxb.promptpa.com>

**Incomplete form will delay the coverage determination. Please fill out all sections completely and legibly.
Documentation is required for all requests.**

Request Date:		<input type="checkbox"/> Request to expedite review
<i>If the prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request, please mark above the request to expedite this review process.</i>		
Patient Information		
This section must be filled out completely to ensure HIPAA compliance		
First Name:	Last Name:	Phone Number:
Address:	City:	State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height (in/cm): _____ Weight (lb/kg): _____ (Include If Applicable)
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:
Prescriber Information		
First Name:	Last Name:	Specialty:
Address:	City:	State: Zip Code:
NPI Number (individual):	Phone Number:	
Fax Number (in HIPAA compliant area):		
Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Fax Number (in HIPAA compliant area):	
Medication and Medical Information		
Medication Name and Strength:	<input type="checkbox"/> Dispense as written <input type="checkbox"/> Generic substitution permitted* <i>*default is generic substitution permitted</i>	
Directions for Use:	Quantity / day supply:	
<input type="checkbox"/> New Therapy	<input type="checkbox"/> Continuation of Therapy - Start Date: _____	Duration of Therapy:
If the patient has tried other medication(s) for this condition, please provide a list of previously tried and failed agents, including dates and reason(s) for failure		
Reason for use of medication:	ICD 10 codes(s) and diagnosis:	
Has documentation (i.e., chart notes, pertinent lab values, medical history, etc.) been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prescriber attests that the provided information is complete and accurate and understands that RxBenefits, Inc. reserves the right to perform an audit requesting the medical information necessary to verify accuracy at any time.		
Prescriber Signature:	Date:	
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