

BeneCard PBF Clinical Programs Explained

Clinical Programs are designed to ensure patient safety and assist in reducing pharmacy spend. Here is detailed information on how each program works:

Clinical Review – A process where additional information is required from the prescriber to ensure a medication is safe and appropriate for the member.

Drug Utilization Review (DUR) – A safety check that evaluates drug interactions, dosage limits, and prescription history to promote safe medication use.

Step Therapy – A requirement where a patient must try lower-cost or preferred medications before approval of a more expensive or alternative option.

Formulary – A list of covered medications that are reviewed regularly to include the most effective and lowest net cost options.

Frequently Asked Questions

Clinical Review	
Program/Topic	Response/Information
Who Can Initiate a Clinical Review?	A member, prescriber, pharmacy, or authorized representative can initiate a review by calling the number on the member's ID card at 1-888-907-0070. Prescribers can initiate electronic prior authorizations (ePA). BeneCard PBF partners with CoverMyMeds to facilitate the ePA process.
Why does BeneCard PBF need to review some prescriptions?	Certain medications have known safety issues or side effects, which can be severe or life-threatening. During a Clinical Review, BeneCard PBF's clinical staff will determine if a medication is appropriate and safe for a member based on factors such as the member's diagnosis, other medications the member may be taking, and other health conditions the member may have.
Doesn't the dispensing pharmacist verify that the medication is okay to provide for the member?	Dispensing pharmacists serve many patients each day. A prescriber or dispensing pharmacist doesn't always have a patient's complete medical profile at their fingertips. It is our job to help them make sure all possible safety concerns are addressed. BeneCard PBF's clinical review process provides a crucial safety check to help support both the prescriber and the dispensing pharmacist in making sure the medication is appropriate for an individual's unique needs.
What does it mean when BeneCard PBF states additional information is needed from the prescriber?	Sometimes, we don't initially receive all the information we need from a prescriber to verify that a medication is both safe and clinically appropriate for the member. When this happens, our clinical team reaches out to the prescriber to try to obtain the necessary information.
How frequently do I need a clinical review?	The duration of approval depends on the medication. Most medications are approved for one year, but some may be for a shorter or longer duration. Prior to an override expiring, BeneCard PBF will make proactive outreach to the member's prescriber to obtain all necessary information. Members may also receive a letter in the mail reminding you that your override is expiring.
How can I monitor my clinical review status?	You can monitor the status of your clinical review in real time on the member portal, or you can call Member Services 24/7 at 1-888-907-0070.
What are the next steps if my clinical review is denied?	The member will receive a notice of claim denial, which will identify the reason for which the claim was denied. If the claim is denied, the letter will also provide the member with instructions on how to appeal the decision if they do not agree.

How is the member's privacy protected when information is requested from a doctor for Clinical Review?	Information requested by BeneCard PBF for Clinical Review is considered Protected Health Information (PHI). The request for PHI for Clinical Review is a covered use under the Healthcare Insurance Portability and Accountability Act (HIPAA), and BeneCard PBF only asks the doctor for information pertinent to the claim being reviewed. BeneCard PBF takes its obligation to protect member privacy seriously, and strictly follows the procedures laid out by HIPAA to ensure that privacy.
Turnaround Time for Clinical Review	Initial Request: Standard: 96 hours; Expedited: 24 hours. Appeals: Standard: 15 days; Expedited: 3 days.
What happens when my override approval expires?	Our Clinical Operations team proactively makes outreach to providers to ensure members obtain their medications. Letters are mailed to members approximately 45 days prior to the overrides expiring. Members are not required to initiate these requests since our team proactively starts the process. Members can monitor the status of the request on the member portal.

Step Therapy

Program/Topic	Response/Information
What is Step Therapy? Why does it require a member to try another medication if the doctor prescribed something else?	Step Therapy requires trying lower cost clinically appropriate medications (first-line) before more expensive ones (second-line). First-line medications are often generic versions of brand-name drugs and may have fewer risks. This approach helps save the member money and allows members to begin therapy with a lower risk alternative.
What steps can be taken following a denial due to Step Therapy requirements?	Members can request an alternative lower-cost option or have their prescriber request a medical exception if the first-line medication was tried and ineffective.

Quantity Limit

Program/Topic	Response/Information
What does it mean when a claim is rejected for Quantity Limit?	Quantity limits are in place for member safety. They ensure that the amount of medication being filled is in accordance with manufacturer guidelines, U.S. Food and Drug Administration (FDA) guidelines, and standard quantities based on currently accepted medical practice. If the claim rejects for quantity greater than what is allowed, the number of medication units (pills or liquid measure) being dispensed will need to be adjusted or the member or prescriber can initiate a clinical review. Additionally, some medications are available in multiple strengths. Our Quantity Limit program allows us to coordinate with the prescriber to lower the pill burden on members.

Starter Dose

Program/Topic	Response/Information
What is the Starter Dose Program?	Starter dose allows members to test a new medication for 10–30 days to monitor side effects before committing to a full supply. This allows for monitoring of any problematic side effects the member may experience and reduces medication waste.

For onsite support, the BeneCard team is available Monday, Tuesday, Thursday, and Friday from 9AM to 4PM in the Benefits & Wellness office #1-182B at 5775 Osceola Trail, Naples, FL 34109. To schedule an appointment, please email us at collieronsitesupport@benecard.com.