TheHealthPlan

Chapter 9

Pharmacy

Provider Manual

Introduction

The Health Plan (THP) shall promote optimal therapeutic use of pharmaceuticals by encouraging the use of cost effective generic and/or brand drugs in certain therapeutic classes.

THP has processes in place that explain how members, pharmacists, and practitioners and physicians determine which medications are covered under the members' pharmacy benefit, any utilization management requirements and where members can fill medications.

1. THP publishes a prescription formulary at least annually for Commercial, Exchange, Medicare and Self-Funded/Administrative Services Only (ASO) lines of business on the corporate website, healthplan.org. The formulary indicates a drug's copay tier and utilization management requirements including prior authorization, step therapy, or quantity limit requirements.

   THP has drug policy coverage criteria to encourage the use of preferred drugs in the therapeutic class for the treatment of certain diseases. THP publishes the drug policy coverage criteria on the provider portal (myplan.healthplan.org "Policies"). . Select drugs require prior authorization based on specific plan requirements of some groups.
   Physicians and practitioners shall be informed of service and authorization requirement changes (including site of service changes) 30 days prior to the implementation of changes.

2. Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the Food and Drug Administration (FDA) "orange book" as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug. This is also known as "AB" rated.
   THP pharmaceutical management program allows consideration of medical necessity exceptions for members in obtaining coverage for non-preferred drugs and brand drugs when a generic is available.

3. Prescriptions can be filled at any participating THP pharmacy within the member's pharmacy network. THP does reserve the right to redirect medications to a specific pharmacy such as a specialty pharmacy for certain medications. Any medication redirection will be communicated to providers via the authorization notification letter.

Clinical Criteria for Pharmaceutical Management Program

THP utilizes both external clinical vendor and internal utilization management policies to perform medical necessity reviews for pharmaceuticals. Drug policy coverage criteria are developed based on reasonable medical evidence and guidelines using one or more of the following: FDA label literature, national accepted treatment guidelines, and/or Standard medical reference compendia adopted by the United States Department of Health and Human Services.

Additional factors take into consideration include: individual member circumstances and medical history, West Virginia Bureau for Medical Services (BMS) Preferred Drug List, Coverage Details and Criteria/Policy Manual (for WV Medicaid policies only), preferred covered drugs for the condition, preferred formulary agents in the drug class and cost analysis.

Policies are reviewed at least annually by the clinical vendor or THP using the aforementioned development criteria and additional factors. Recommendations are reviewed by

the respective Pharmacy and Therapeutics Committees.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee serves as an advisory committee that is responsible for providing multi-disciplinary oversight and review of new and evolving pharmaceuticals for possible inclusion in the benefit structure for THP's pharmaceutical management program. The P&T Committee also works to ensure compliance with FDA label literature, national accepted treatment guidelines, Standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

Specialty Pharmacy Program

Specialty drugs are used to treat complex, chronic conditions and/or rare diseases. Extensive management for safety and effectiveness is often needed along with dosage monitoring and adjustment for optimal treatment of the member's condition.

Specialty drugs require prior authorization to ensure appropriate utilization of the drug. Dispensing may be limited to pharmacies with specific services and distribution programs to ensure proper management and delivery of these medications. Diseases targeted to receive therapy include, but are not limited to, rheumatoid arthritis, severe chronic psoriasis, multiple sclerosis, hepatitis C, hemophilia, certain cancers, growth deficiency, cystic fibrosis, Crohn's disease, and organ transplant.

To verify if a medication is considered a specialty drug, please refer to the formulary (list of covered drugs). Specialty drug names will be followed by a "SP" for specialty drug and listed as a tier 4, 5, or 6 in the formulary.

Pain Management Program and Opiate/Opioid Management

THP limits the acute use of opioid medications for moderate to severe pain from acute injury, medical treatment, or surgical procedure for fully insured and employer funded members. The first fill of an opioid medication will be limited to a 5-day supply. This limit is for the first fill of an opioid medication for a member who has no history of opioid usage in the past 130 days.

For THP members needing further management of their pain, a prior authorization will be required if:

- The opioid exceeds 80 morphine milligram equivalents
- Is taken for greater than 90 consecutive days
- Is a long-acting opioid
- Use of more than one immediate release and one extended-release opioid

A clinical pharmacist will review the coverage review to evaluate that the opioid is being utilized in accordance with the utilization management policy. Additionally, if necessary, the member can be limited to one prescriber and one pharmacy.

Formulary medications will be preferred over non-formulary medications. Step therapy rules may be applied when reviewing a request for non-formulary medications. Also, dosing and quantities may be limited. If the prescribing physician does not bill The Health Plan for services, no coverage of opioids will be provided through pharmacy benefit.

THP's Pharmacy Network

A THP member may obtain a prescription at any participating THP pharmacy. For the location of a participating pharmacy, call Express Scripts, THP's prescription benefit manager at 1.800.988.2262 or expressscripts.com. The member's THP ID card must be presented to the pharmacy to allow dispensing of the prescription. The member may be required to pay a copayment which will be collected at the time of service based on the prescription drug plan of the member.

Formulary

THP formularies are a listing of prescription medications that are preferred for use. Formulary drugs will be a covered benefit when dispensed at participating pharmacies. Drugs not listed are not covered without written medical statements of necessity by the prescribing physician. Coverage requests may be requested non-urgently or urgently. Requests for non-urgent coverage determinations received after 5 p.m. will be processed the next business day. All requests for coverage determinations will be processed within the applicable state, federal or accrediting agency timeframes.

Multi-source drugs must be dispensed as the generic. Failure to dispense the generic will subject the member to a higher copayment. This higher copay consists of the brand copayment plus the cost difference of the brand drug and generic drug.

Choosing a Preferred Drug Formulary

Formulary Tier Definitions

- Prescription – Drugs that can only be dispensed upon order (prescription) by a qualified provider of care. Additionally, only drugs which are labeled "Caution: Federal law prohibits dispensing without a prescription" will be considered eligible.
- Generic – A drug available as a chemically and therapeutically equivalent copy of a brand name drug. It is usually available from several manufacturers. Generics must meet federal standards for potency and bioavailability.
- Brand Drug – A prescription item only available from a single source supplier.
- Multi-Source Brand Drugs – Brand name drugs which are manufactured by more than one producer. These agents are usually available as generic equivalents.
- Over-the-Counter Drugs (OTC) – Drugs which are not restricted to prescription-only status. These agents are available for purchase without physician approval and are not covered by THP.
- Home Delivery Service – Certain group benefit designs allow members to receive medications at home via the mail. (See your specific benefits for details).

Pharmaceutical Substitution and Interchange Program

Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the FDA "orange book" as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug.

Generic Difference Policy

If a prescription order specifies that a brand name drug must be dispensed when the generic equivalent is available, or the prescription order allows for generic substitution and the member elects to have the prescription filled with a brand name drug instead, the member must pay the brand copayment plus the difference between The Health Plan cost of a brand name and its generic equivalent (i.e., The Health Plan only pays for the generic cost.) *Please note non-formulary brand versions of generic drugs require coverage review.*

Non-Formulary Requests (Exception Policy)

Certain non-formulary medications are eligible for coverage only after a patient-specific approval has been authorized. Patient-specific criteria may include age, gender, and clinical conditions determined by the physician for authorization to be granted for a specific drug. A non-formulary exception request can be made by the member, member's representative, or physician. A Formulary Exception Request Form may be accessed on THP's secure provider portal myplan.healthplan.org "Forms," "Other Forms" or by contacting Pharmacy Services at 1.800.624.6961, ext. 7914. Exception requests may be requested non-urgently or urgently. Requests for non-urgent exceptions received after 5 p.m. will be processed the next business day. All requests for exceptions will be processed within the applicable state, federal or accrediting agency timeframes.

The Health Plan Pharmacy Service Department is available Monday through Friday 8 a.m. to 5 p.m. and after hours via telephonic auto attendant's emergency option seven days a week, including holidays. They may be reached at 1.800.624.6961, ext. 7914; fax 304.885.7592.

Requests will be reviewed according to the following criteria:

1. The request for the non-formulary drug is for a condition or medical need not met by existing drugs on The Health Plan formulary.
2. In the physician's medical judgment, the formulary alternatives have been ineffective in the treatment of the member's disease or condition (documentation in the member's clinical record is required).
3. The formulary alternative causes, or is reasonably expected by the prescriber to cause, a harmful or adverse reaction in the member (documentation in the member's clinical record is required).

Authorization for Coverage

Authorization for coverage consists of criteria-based programs for determining whether members qualify for coverage of a requested drug based upon the plan's drug policy coverage criteria. Drug policy coverage criteria are based on recommendations of The Health Plan's Pharmacy and Therapeutics Committee. These criteria are periodically reviewed for alignment with FDA label literature, national accepted treatment guidelines, Standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

Mandatory Generic Policy and Formulary Override Procedure

Pharmacy benefits with a mandatory generic component require that if the prescription item ordered is available from a generic supplier, The Health Plan will cover the maximum allowable cost of the generic. Any additional costs of brand name medication will be the responsibility of the member. This is regardless of any dispense as written indicators (DAW).

Exemption Review Request Procedure

At the time of dispensing, the pharmacy will transmit a claim to The Health Plan claims processor. If the item submitted is available as a generic, the claims processor returns the cost of the prescription in the following manner:

Brand submitted	Generic submitted
The brand copay is assessed + the difference in the cost of the generic and brand product to arrive at a brand penalty copayment. Copay = brand copayment + penalty	The generic copayment is assessed, and it is the member's responsibility to pay at the time of dispensing

Exemptions

The following agents are exempt from mandatory criteria:

Generic drugs not listed in the FDA "orange book" of generic equivalents with an "AB" rating. "AB" rating is defined as therapeutic and generic equivalent.

In cases of defined medical necessity, an exemption to the mandatory generic policy may be authorized. Exemption requests can be called to pharmacy services at 1.800.624.6961, ext. 7914 or faxed to 304.885.7592.

The requests must include:

- Supporting medical literature describing treatment failures of the generic.
- Defined allergic potential to a specific component in a generic NOT found in the brand product. (i.e., fillers, dyes, preservatives)
  - Documented treatment failure of a specific member with supporting clinical assessment and appropriate lab readings.
  - Member refusal to take the generic is not acceptable.

Pharmacy Prior Authorizations

Program Description

THP's Pharmacy Services Department handles customer service calls and coverage review determinations as well as eligibility and prior authorization updates.
THP's pharmacy prior authorization form can be found on THP's secure provider portal

Traditional Prior Authorization (TPA)

A program where The Health Plan Pharmacy Services Department adjudicates coverage review determinations as well as authorization updates. This program criteria are developed and conforms to plan coverage conditions for client review and selection and in administering prior authorization policies. Traditional prior authorization rules require coverage review for all claims presented for a given drug to determine if the member meets drug policy coverage criteria.

Smart Rules – Automated Prior Authorization Processes at the Point of Sale

Smart rules in pharmacy benefit manager's system use sophisticated logic in conjunction with available drug history, patient reported health information, and medical claims information to automatically determine whether a member qualifies for coverage of a drug based on the plan's drug policy coverage criteria. As a result, smart rules limit coverage reviews to only those claims where the member's information is least likely to meet drug policy coverage criteria.

Quantity Per Dispensing Event

Quantity per dispensing event rules set dispensing quantity thresholds that reduce client exposure to unnecessary cost, without creating obstacles to access for most members. Drugs that are subject to quantity per dispensing event rules usually have specific quantity limitations approved by the FDA. Through traditional prior authorization, members can be approved for an additional quantity exception.