
11. PHARMACY

A. Formulary Management

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. The IEHP formulary is a continually updated list of medications immediately available to practitioners and Members. It contains information on co-payment requirements and the procedures for obtaining non-formulary medications.
- B. The IEHP Pharmacy and Therapeutics (P&T) Subcommittee makes decisions regarding which medications are included on the formulary.
- C. The IEHP P&T Subcommittee evaluates the clinical use of drugs, develops policies for managing drug use and drug administration, and manages the formulary system. The Quality Management (QM) Committee has final approval of P&T Subcommittee decisions.
- D. The P&T Subcommittee objectively appraises, evaluates, and selects pharmaceutical products for formulary inclusion and exclusion. This is an ongoing process to ensure the optimal use of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use, and cost.
- E. IEHP provides direct written notice to affected Members at least 60 days prior to the date the change becomes effective; or at the time affected Members request a refill of the Part D drugs (with a 60 day supply of the drug).
- F. The P&T Subcommittee will make reasonable effort to review a new chemical entity within 90 days, and will make a decision on each new chemical entity within 180 days of its release onto the market, or a clinical justification will be provided if this timeframe is not met.
- G. IEHP does not accept any incentives to use a specific drug on a preferred status; therefore, the IEHP formulary does not contain any drugs with preferred status.
- H. Due to the multiplicity of drugs on the market and the continuous introduction of new drugs into the market, IEHP P&T Subcommittee meets regularly (up to six times a year) to update the formulary.
- I. The P&T Subcommittee provides recommendations regarding protocols and procedures for the use of non-formulary medications as outlined in Policy 11B, “Prior Authorization for Non-Formulary Medications.”
- J. The P&T Subcommittee provides recommendations regarding educational materials and programs about drug products and their usage to all IEHP practitioners and providers.

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- K. The P&T Subcommittee develops and monitors quality issues in regards to correct drug use for IEHP and its Members. This includes drug utilization review (DUR) and drug use evaluation (DUE) programs.
- L. The P&T Subcommittee recommends disease state management or treatment guidelines for specific diseases or conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions.
- M. The treatment guidelines are evidence based guidelines from recognized sources or developed by board-certified practitioners from appropriate specialties.
- N. The current treatment guidelines include Depression, Attention Deficit/Hyperactivity Disorder (ADHD), Diabetes, Asthma, Hyperlipidemia, Allergic Conjunctivitis, Anti-Infective Guide, Respiratory Syncytial Virus (RSV), Multiple Sclerosis, Migraine, Pulmonary Arterial Hypertension, Hepatitis C, and Hypertension.
- O. All treatment guidelines are reviewed annually. IEHP sends written notification to IEHP Providers regarding the availability of new guidelines. All current guidelines are available through our website at www.iehp.org.
- P. IEHP distributes the formulary to all new practitioners.

PROCEDURES:

- A. IEHP P&T Subcommittee's membership consists of the IEHP Director of Pharmaceutical Services as designee or Chairperson, the Chief Medical Officer, Medical Director (Health Plan), Medical Director (Direct), five clinical pharmacists (representative of the overall IEHP network) and five practicing physicians (representative of the overall IEHP network) as voting members. The IEHP staff includes the Director of Quality Management, Director of Health Administration, and Clinical Pharmacist. The Pharmaceutical Services Administrative Assistant acts as secretary to the Subcommittee. The Subcommittee meets on a quarterly basis at IEHP offices.
- B. Factors related to optimal pharmacotherapy and considered in formulary deliberations include:
 - 1. Pharmacologic considerations (e.g., drug class, similarity to existing drugs, side effect profile, mechanism of action, therapeutic indication, drug-drug interaction potential, clinical advantages over other products in the specific drug class);
 - 2. Unlabeled uses and their appropriateness;
 - 3. Bioavailability data;
 - 4. Pharmacokinetic data;
 - 5. Dosage ranges by route and age;

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6. Risks versus benefits regarding clinical efficacy and safety of a particular drug relative to other drugs with the same indication;
 7. Patient risk factors relative to contraindications, warnings and precautions;
 8. Special monitoring or medication administration requirements;
 9. Cost comparisons against other drugs available to treat the same medical condition(s); and
 10. Pharmacoeconomic data.
- C. The P&T Subcommittee meets up to six times a year or as needed to update the formulary by reviewing:
1. Medical literature including clinical trials (i.e., MEDLINE search, and Cumulated Index Medicus database search),
 2. Relevant findings of government agencies, medical and pharmaceutical associations, national institutes of health, and regulatory body publications,
 3. Relevant patient utilization and experience,
 4. Current therapeutic guidelines and the need for revised new guidelines and,
 5. IEHP provider and practitioner recommendations for addition or deletion of drugs to the formulary,
 6. Reviews the top 10 therapeutic classes and top 10 medications that were submitted for prior authorization. IEHP P&T Subcommittee determines if any of the medications or criteria need modifications to improve access, quality and safety of pharmaceutical care.
- D. IEHP is a generic mandatory plan. Brand name products, when generics exist, are available through the Pharmacy Exception Request (PER) form along with justification of use and proven failure of the generic version.
- E. Selected medications have FDA-approved generic equivalents available. IEHP mandates generic dispensation for all quality generic products. Quality generic medications are those medications that have received an “AB” rating by the FDA. IEHP only allows payment for “AB” rated generic medications. Lower quality generics are not covered by the IEHP formulary. This mandate is enforced by the use of an NDC block at the point of sale.
- F. Exceptions to the mandatory generic formulary are as follows:
1. Carbamazepine (Tegretol, Digoxin (Lanoxin));
 2. Levothyroxine (Levothroid, Levoxyl, Synthroid);
 3. Oral Contraceptives;

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4. Phenytoin (Dilantin);
 5. Valproic Acid/Divalproex Sodium (Depakene/Depakote); and
 6. Warfarin (Coumadin).
- G. Exceptions to the Part D Covered Drugs are as follows (Some exceptions below may be covered benefits under Medi-Cal, please refer to the IEHP Medi-Cal Formulary Management Policy):
1. Barbiturates
 2. Benzodiazepine
 3. Over-the-counter Drugs
 4. Fertility drugs and cosmetic drugs
 5. Drugs to treat anorexia
 6. Weight loss agents
 7. Agents that are used for the symptomatic relief of cough and cold
 8. Prescription vitamins and mineral products (except prenatal vitamins and fluoride)
- H. Selected medications have step-therapy protocols. Step-therapy protocols are built under clinical evidence based review and are approved by the IEHP P&T Subcommittee. Such medications are non-formulary, and if the prerequisite criteria are met, the claims are allowed without prior authorization. Angiotensin Receptor Blockers, and COX-2 Inhibitors are examples of medications that have built-in step-therapy protocols.
- I. The IEHP Formulary and Treatment Guide is published in a booklet format annually and mailed to practitioners. It can also be found on the IEHP website at www.iehp.org.
- J. When a formulary drug is deleted, IEHP provides direct written notice to affected members at least 60 days prior to the effective date of the change; or IEHP may provide the members with a 60-day supply of the drugs under the same term as previously allowed and provide written notice of the formulary change. The written notice shall contain the following information:
1. The name of the affected covered Part D Drug;
 2. Describe the change of the formulary status;
 3. The reason for the change;
 4. Alternative drugs in the same therapeutic category or class; and
 5. The means by which Members may obtain a coverage determination or exception.

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- K. When necessary, between annual publications, IEHP notifies its practitioners and Providers in writing about the formulary additions, deletions, and policies and procedures modifications.
- L. Requests for formulary additions should be submitted to the P&T Subcommittee in writing, on the IEHP Request for Addition/Deletion of a Drug to the Formulary (see Attachment 11-1 in Section 11, “Attachments”).
- M. A request should be submitted to the Chief Medical Officer, or IEHP pharmaceutical services staff, for placement on the agenda of the next Subcommittee meeting.
- N. IEHP Formulary can also be found on our website at www.iehp.org. Copies of the Formulary may also be obtained by contacting the following:
1. For Members – IEHP Member Services Department at 1-877-273-IEHP (4347); or
 2. For Providers and Practitioners – IEHP Pharmaceutical Services Department at (909) 890-2049.
 3. The Formulary is also available to Providers and Members through the IEHP website (<http://ww2.iehp.org/IEHP/Providers/Pharmaceutical+Services>).
- O. IEHP periodically publishes information regarding IEHP Formulary on Providers and Members Newsletter.
- P. All new IEHP practitioners and pharmacists receive a copy of the formulary in their orientation materials.

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B. Prior Authorization For Non-Formulary Medications

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. All non-formulary medications exception requests require the submission of a Pharmacy Exception Request (PER) form (see Attachment 11-2 in Section 11, “Attachments”). Requests that are attempting to satisfy prior authorization requirements or to demonstrate that the Member has met prior authorization requirements associated with a formulary drug require the submission of the Coverage Determination Form (see Attachments 11-3 and 11-4 in Section 11, “Attachments”). The PER form and the Coverage Determination form can be faxed to IEHP.
- B. Prior Authorizations are not required when medications are used in emergent or urgent circumstances.
- C. A Member, Member’s appointed representative, pharmacist (on behalf of the Member), or the prescribing physician (on behalf of the Member) may file an exception request. Member or Member’s appointed representative may file an exception request by contacting IEHP Member Services Department (see Attachment 11-2 in Section 11, “Attachments”). A pharmacist or prescribing physician may file an exception request by contacting IEHP Pharmaceutical Services Department (see Attachment 11-2 in Section 11, “Attachments”).
- D. A prescribing physician must provide an oral or written supporting statement that the requested prescription drug is medically necessary to treat the Member’s disease or medical condition because:
1. All of the covered Part D drugs on IEHP Formulary for treatment for the same condition would not be as effective for the Member as the non-formulary drug, would have adverse effects for the Member, or both.
 2. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements has been ineffective, or has caused or based on sound clinical evidence, is likely to cause an adverse reaction or other harm to the Member.
 3. The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the disease or medical condition.
 4. All PERs or Coverage Determination Forms must contain information that supports the medical necessity of a non-formulary drug that does not meet criteria. In addition, all PERs must include previous successful or failed therapies, any allergies, or any other clinical condition when applicable.

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B. Prior Authorization For Non-Formulary Medications

- E. If an oral supporting statement is provided by the physician, IEHP may require the physician to subsequently provide a written supporting statement.
- F. A decision by IEHP concerning an exception request constitutes a Coverage Determination as described in Policy 11H, "Coverage Determination".
- G. All requests are reviewed and acted on in accordance to the time frame in Coverage Determination Section in Policy 11H, "Coverage Determination".
- H. If IEHP fails to make a decision on an exceptions request and provide notice of the decision within the timeframe required under this Policy and the failure constitutes an adverse coverage determination, IEHP must forward the request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe (see Attachment 11-7 in Section 11, "Attachments").
- I. Request for cash reimbursements are considered as Pharmacy Exception Requests. The request may be considered up to one year from the date of service.
- J. If IEHP approves the exceptions request, IEHP may not require the Member to request approval for a refill, or a new prescription to continue using the Part D prescription drug after the refills for the initial prescription are exhausted, as long as:
 - 1. The Member's prescribing physician continues to prescribe the drug;
 - 2. The drug continues to be considered safe for treating the disease or medical condition;
 - 3. The enrollment period has not expired. If the Member renews his or her membership after the plan year, IEHP may choose to continue coverage into the subsequent plan year
- K. Member Transitions - A one (1) time transition supply for up to thirty (30) calendar days supply (30-day fill in retail setting; 31-day fill in long-term care setting) during the first 90 days of the enrollment can be provided to the new Member if the Member has been using a non-formulary drug prior to enrollment in IEHP. During this period of time, the Member should request a Coverage Determination or transition to another covered drug.
- L. If there is a formulary change during the year, IEHP provides direct written notice (see Attachment 11-13 in Section 11, "Attachments") to affected Members at least 60 days prior to the date the change becomes effective; or at the time an affected Members requests a refill of the Part D drugs (with a 60 day supply of the drug).
- M. IEHP provides continuous coverage of the affected Part D prescription drugs to the affected Members for reasons other than safety or because the Part D prescription drug cannot be supplied by or was withdrawn from the market by the drug's manufacturer.
- N. The continuous coverage applies to the formulary changes related to the deletion of a drug from the formulary, changes in step therapy, dosage limitations, or therapeutic substitution.

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B. Prior Authorization For Non-Formulary Medications

- O. If IEHP approves an Exception request for a non-formulary drug, the costs incurred by the Member for the approved drug shall be included for purposes of calculating and meeting the Member's TrOOP Expenditure.
- P. Both the Member and the prescribing physician may request a redetermination if the Member has received a coverage determination.

PROCEDURES:

- A. IEHP supplies all providers with the Pharmacy Exception Request (PER) form, the Coverage Determination Form and instructions for its use (see Attachments 11-2, 11-3 and 11-4 in Section 11, "Attachments").
- B. PER forms are used for the following:
 - 1. Drugs or dosage forms not included in the IEHP formulary
 - 2. Branded drugs when generic is available. Exceptions are:
 - a. Carbamazepine (Tegretol)
 - b. Digoxin (Lanoxin)
 - c. Levothyroxine (Levothroid, Synthroid)
 - d. Phenytoin (Dilantin)
 - e. Valproic Acid/Divalproex Sodium (Depakene/Depakote)
 - f. Warfarin (Coumadin)
 - 3. Prescriptions for formulary drugs that do not comply with Dose/Duration/or Quantity guidelines (as outlined in the IEHP formulary).
- C. PER and Coverage Determination forms are submitted via the IEHP website (www.iehp.org).
- D. "White out" or any other type of correction fluid(s) is not to be used on any part of the PER form.
- E. Members on medications that are deleted from the formulary by the Pharmacy and Therapeutics Subcommittee may continue to receive the medications if the prescribing physicians continue to prescribe the medications for the Members.
- F. IEHP staff reviews individual medication requests; thoroughly surveys the Member's existing medication regimen, previous successful or failed therapies, any allergies, or any other clinical condition when applicable; and either approves, modifies, defers, or denies the request.

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B. Prior Authorization For Non-Formulary Medications

1. **Request Approved:** An approval code is entered into the claims processing system to allow the claim to adjudicate on-line for the span of the approval period (maximum 12 months).
 2. **Request Modified:** Exception request approved with modifications as indicated. Approval code is entered into the claims processing system to allow the claim to adjudicate on-line within the modified IEHP approved parameters.
 3. **Request for More Information:** There is insufficient information to make a judgment as to the appropriateness of the request. The submitting provider is required to forward the documentation required within 72 hours or the request is denied.
 4. **Misdirected:** Exception request was submitted to IEHP by mistake.
 5. **Request Denied:** Documentation provided did not meet approval guidelines.
- G. The IEHP Clinical Pharmacist consults with the appropriate specialists as part of the decision process for requests involving unusual or clinically complicated conditions.
- H. Prior to denying a request, the IEHP Clinical Pharmacy staff consults with the prescribing physician to offer an alternative pharmacotherapeutic regimen, and to discuss the specific reason for the denial.
- I. For transition members, a thirty-day (30) supply of drug may be supplied. During this period of time, an alternative medication should be discussed and prescribed by the physician, or if the medication is clinically indicated, a Coverage Determination or Pharmacy Exception Request should be submitted to IEHP Pharmaceutical Services Department for review.
- J. The IEHP Clinical Pharmacy staff discusses the requests that are found to be medically unjustifiable with the Clinical Pharmacist prior to denying them. The IEHP Director of Pharmaceutical Services and/or the Clinical Pharmacist sign all denied PERs.
- K. A copy of the response is faxed back to the requesting practitioner.
- L. The IEHP compensation plan for Clinical Pharmacy staff who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.
- M. In the event that timely completion of the written PER form by the practitioner is not possible, IEHP clinical pharmacy staff authorize the request over the telephone and document the information for logging into the database.
- N. After business hours, on weekends, and holidays, pharmacy providers should dispense a sufficient supply of formulary and non-formulary medication to IEHP Members when medically necessary. IEHP reimburses pharmacies for any doses dispensed even in the event of a denial of the PER.

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B. Prior Authorization For Non-Formulary Medications

- O. The final authority for obtaining medications not included in the IEHP formulary rests with the IEHP Chief Medical Officer. All documents and written materials are forwarded to the Chief Medical Officer for review if the prescribing physician, IPA, pharmacist, Member, or Member's responsible party files an appeal.
- P. IEHP may authorize Member reimbursement for payment of Covered Part D drugs in excess of the co-payment:
1. Member may contact IEHP Member Services Department for information regarding the reimbursement. IEHP Member Services Department obtains all necessary information in regards to the reimbursement request.
 2. IEHP Pharmaceutical Services Department evaluates and records the information provided by the Member or related parties, and determines if the request is approved or denied. All denials are considered to be Coverage Determination as described in Policy 11H, "Coverage Determination."
 3. IEHP may not reimburse Member's reimbursement request if the Member chose not to follow the PER process, or chose not to follow the procedure described in this Policy and Policy 11H, "Coverage Determination."
- Q. IEHP may approve the payment request by approving drugs retrospectively. The Pharmacy processes the approved medication and provides refund to the Member. IEHP may approve payment directly to the Member if the Member is unable to return to the dispensing pharmacy.

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C. Medication Handling Requirements at PCP Sites

APPLIES TO:

- A. This policy applies to all Primary Care Physicians who treat IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP requires that the staff at any PCP site dispensing medication follow all applicable policies and procedures. The PCP is responsible for monitoring and tracking all dispensing of medications performed on-site.
- B. To ensure proper handling and storage of pharmaceuticals at Primary Care Physician (PCP) offices.
- C. To ensure that all applicable statutory or regulatory standards regarding medication handling and storage are followed and maintained at the PCP offices.

PROCEDURES:

- A. All stock and sample drugs must be checked monthly for their expiration dates.
- B. A physician who dispenses drugs must store all drugs to be dispensed in an area that is secure (CA Business and Profession Code § 4172).
 - 1. A secure area must be a locked storage area within the physician's office.
 - 2. The area must be secure at all times.
 - 3. The keys to the locked storage area must be available only to staff authorized by the physician.
- C. All records for dispensing of medications must be open to inspection at all times during business hours by authorized individuals, and must be preserved for at least three years.
- D. Storage areas must meet the following requirements:
 - 1. Drug storage areas must be neat and clean.
 - 2. All medications must be properly labeled with expiration date and lot number.
 - 3. Oral and injectable medications must be stored separately from medications intended for external use.
 - 4. All medications must be stored in a locked cabinet with access only by authorized persons.

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C. Medication Handling Requirements at PCP Sites

- E. Physicians dispensing medications to Members in their offices must meet the following requirements (CA Business and Profession Code § 4172, 4170 and Title 16, CCR § 1356.3):
1. The medication is dispensed to the physician's own patient and the drugs are not furnished by a nurse or attendant.
 2. The medications are necessary in the treatment of the condition for which the physician is attending the patient.
 3. Physicians must record the disposition of medications and keep them for at least three years.
- F. Any medication stored in a refrigerator must be completely separate from food or other items in the refrigerator. This can be accomplished by having a separate refrigerator for medications, or by storing medications in a separate container within the refrigerator.
- G. The temperature of a refrigerator should be maintained at 35 to 46 degrees F or 2 to 8 degrees C.
- H. The temperature of a freezer must be maintained at 7 degrees F or -14 degrees C.
- I. The temperature of a freezer must be maintained at 5 degrees F or -15 degrees C if storing varicella vaccine (Varivax).
- J. Daily temperature logs for freezer and refrigerator must be maintained.
- K. Needles and syringes must be kept in locked secure cabinets.
- L. All medication is considered good through manufacturer's expiration date; however, physician offices must consider the integrity of the vial and its effect on the potency, and/or sterility of the medication before each use.
- M. Compliance with IEHP medication handling requirements is monitored during Department of Health Care Services (DHCS) required facility reviews, as described in Policy 6A, "Site Review and Medical Records Review Survey Requirements and Monitoring."

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D. Physician Profiling Program

APPLIES TO:

- A. This policy applies to all physicians who treat IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP has developed a program to monitor prescribing patterns according to clinically efficacious, cost-effective principles.
- B. The Physician Profiling Program increases the physician's awareness of their own performance relative to peers or established goals.
- C. IEHP distributes quarterly physician profiling reports to the top 100 prescribers by prescription volume.

PROCEDURES:

- A. The Physician Profile contains information on prescription utilization, prescription cost, utilization by specific high volume drug agents, and therapeutic classes.
- B. IEHP Clinical Pharmacist evaluates the top 100 highest volume prescribers.
- C. Each physician profile indicates whether or not that physician is an outlier compared to peers and overall prescribing partners.
- D. Physician outliers are defined as follows:

Bottom 10%	in terms of...	% Generic Rx's
Top 10%	in terms of...	% Code 1 Drugs
		% DEA Controlled Rx's
		% Prior Authorization Rx's
Top 10%	in terms of...	% Patients with > 8 Rx's
- E. To improve performance, IEHP highlights the meaning of the profiles for the prescribers by defining all the terms in the profile and including sample reports in the mailing packets.
- F. IEHP's Clinical Pharmacist provides an educational outreach program designed to reduce inappropriate drug prescribing. Higher-volume prescribers are targeted through utilization reports.
- G. IEHP's Clinical Pharmacist conducts academic detailing (one-to-one visits) to providers to disseminate information and increase knowledge in an attempt to change behavior patterns.

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D. Physician Profiling Program

- H. IEHP reinforces the visits by mailing printed materials to providers after each academic detailing.

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E. Pharmacy Reports

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP reviews specific pharmacy reports on a monthly basis.
- B. The purpose of these reports is to identify high-risk IEHP patients through pharmacy data.
- C. IEHP Clinical Pharmacist contacts Members identified through the pharmacy reports and perform clinical intervention. Clinical intervention includes consultation, evaluation, and communications with the members and/or providers.

PROCEDURES:

- A. Pharmacy reports include:
1. Max dose reports;
 2. Members who use 3 or more pharmacies;
 3. Member who use 3 or more physicians;
 4. Members who obtain same therapy from 3 or more pharmacies/physicians; and
 5. Therapeutic duplication reports on all major therapeutic classes.
- B. Medication Therapy Management report includes:
1. Members who use 5 or more chronic medications, including anti-diabetics, anti-convulsants, cardiac, anti-hypertensives, anti-asthmatics, and biologics.
- C. All reports include patient's last and first name, IEHP ID number, gender, date of birth, physician National Provider Identifier (NPI) number, medication brand name, dosage form, drug strength, service date and quantity.

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F. Emergency Department and Hospital Inpatient Discharge Medication Requirement

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP ensures that Members have timely access to pharmacy services upon discharge from the Emergency Department (ED) or Hospital in-patient unit.
- B. Discharge medications (starter pack) may be provided by the Hospital or ED, or be accessed in one of the 24 hours pharmacies within the IEHP Pharmacy Network.
- C. IEHP allows pharmacists to provide short term supply of formulary medications until the next business day without risk.
- D. IEHP monitors grievance cases and reports (under Access/medication – “Emergency discharge meds” report) to ensure coverage is adequate.
- E. IEHP monitors 24 hours pharmacy geo-access report annually to ensure coverage is adequate.

PROCEDURES:

- A. When the course of treatment provided to an IEHP Member in the ED requires the use of medications, a sufficient quantity of such medications may be provided to the Member to last until the Member can reasonably be expected to have a prescription filled at an IEHP network pharmacy. In the event such pharmacy service is not available in the hospital or ED, IEHP Member may obtain the medication through one of the 24 hour Pharmacies.
- B. To monitor compliance, on a quarterly basis, IEHP will report grievances related to medication access upon discharge to the Grievance Committee.
- C. On an annual basis, IEHP monitors the Geo Access report to ensure adequate 24-hour Pharmacies coverage around the contracted hospitals and EDs.
- D. The starter-pack medication label must include the following information:
 - 1. Patient name;
 - 2. Medication name, dosage, and quantity;
 - 3. Direction for use;
 - 4. Date;
 - 5. Name of the prescribing physician;
 - 6. Physician’s signature; and

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F. Emergency Department and Hospital Inpatient Discharge Medication Requirement

- 7. Medication expiration date
- E. Members receiving starter-pack or other medications must receive medication counseling prior to discharge.
- F. Pharmacy Exception Request (PER) forms are not required when medications are used in emergent or urgent circumstances. Please refer to Policy 11B “Prior Authorization for Non-Formulary Medications,” for further details.

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G. Coverage Determination

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP ensures timely Coverage Determinations are made in accordance with the terms and conditions of this policy.
- B. The following actions are considered to be Coverage Determinations:
1. A decision not to provide or pay for a Part D drug (including a decision not to pay because the drug is not on the plan's formulary because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because IEHP determines that the drug is otherwise excludable under the Social Security Act § 1862 (a) of the Act if applied to Medicare Part D that the Member believes may be covered by IEHP);
 2. Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the Member; and
 3. A decision concerning a Pharmacy Exception Request.
- C. IEHP notifies a Member and a Member's prescribing physician, if the physician requested the Coverage Determination, of a favorable Coverage Determination.
- D. The following individuals may request a standard or expedited Coverage Determination:
1. A Member;
 2. A Member's Authorized Representative on behalf of the Member; or
 3. A prescribing physician on behalf of the Member.
- E. Member Transitions
1. A one (1) time transition supply for up to thirty (30) calendar days supply can be provided to the new Member if the Member has been using a non-formulary drug prior to enrollment in IEHP. During this period of time, the Member should request a Coverage Determination or transition to another covered drug.
- F. If IEHP removes a Covered Part D drug from the IEHP Formulary or makes any changes in the IEHP Formulary, IEHP shall provide notice (see Attachment 11-13 in Section 11, "Attachments") to the affected Members at least sixty (60) calendar days prior to effective date of the change made on the IEHP Formulary. IEHP shall provide the following information to the affected Members:
1. The removed Covered Part D Drug;
 2. The reason for the change;

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3. Alternative drugs in the same therapeutic category or class; and
 4. The means by which Members may obtain a Coverage Determination set forth in this policy
- G. IEHP shall provide the Member a sixty (60) calendar day supply of the affected drugs and the notice of change at the time the refill is requested if IEHP fails to notify the changes to the Member in accordance with this section.
- H. Pharmacists and other providers are encouraged to exercise appropriate professional and clinical judgment when determining whether to dispense medications pending final Coverage Determination. IEHP reimburses pharmacies that dispense a sufficient supply of medication to last until final Coverage Determination is made.
- I. IEHP documents all exceptions requests activities in our Medical Management System. IEHP Pharmaceutical Services Department evaluates and monitors all exceptions requests daily to ensure compliance to the timelines requirement of the exceptions process. IEHP generates and presents monthly reports to the IEHP Pharmacy and Therapeutic (P&T) Subcommittee for review.
- J. All clinical criteria for authorization of non-formulary medications are reviewed and updated at least annually or more often, as needed. Most common non-formulary medications, prior authorization trends and approval/denial statistics, are reviewed at P&T Subcommittee to ensure the formulary is up-to-date, and all commonly-used medications are accessible to patients.

PROCEDURES:

- A. A Member, a Member's Authorized Representative, or a pharmacist, or a prescribing physician may request an Exception under the following circumstances:
1. The Member is using a drug that has been removed during the Benefit Year for reasons other than safety or because the drug cannot be supplied by, or was withdrawn from the market by, the drug's manufacturer;
 2. The Member's drug regimen exceeds IEHP limitations for quantity, refill frequency, duration of therapy, or does not meet on-line step therapy restriction; or
 3. The Member's physician prescribed a non-formulary drug for the Member that the physician believes is medically necessary.
- B. A prescribing physician must provide an oral or written supporting statement that the requested prescription drug is medically necessary to treat the Member's disease or medical condition because:
1. All of the covered Part D drugs on IEHP Formulary for treatment for the same condition would not be as effective for the Member as the non-formulary drug, would have adverse effects for the Member, or both.

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2. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the Member's disease or medical condition, or based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
 - b. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the Member
 3. The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the Member's disease or medical condition, or based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
- C. All PERs must contain information that supports the medical necessity of a non-formulary drug that does not meet criteria. In addition, all PERs must include previous successful or failed therapies, any allergies, or any other clinical condition when applicable.
- D. For members transitioning from another Health Plan, a sixty (60) day supply of drug may be supplied. During this period of time, an alternative medication should be discussed and prescribed by the physician, or if the medication is clinically indicated, a Coverage Determination or Pharmacy Exception Request should be submitted to IEHP Pharmaceutical Services Department for review.
- E. IEHP grants an Exception to a Member's request for a non-formulary drug if the following IEHP clinical review criteria are met:
1. The requested drug is medically necessary based on the medical justification statement submitted by the prescribing physician. Medical justification should include information described in Procedure B. 1-3 of this policy.
 2. The requested drug is FDA approved.
 3. The request is for an indication covered by the Evidence of Coverage.
 4. Treatment is not investigational or experimental.
 5. Evidence of clinical studies (published in nationally recognized medical journal, or findings/studies that are conducted by nationally recognized federal research institutes) that an improvement in clinical outcome was achieved in the clinical situation for which the drug is being prescribed

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6. The safety record for the treatment, determined by reviewing the contraindications, precautions, warnings, adverse effects, and drug interactions associated with the use of the drug, is acceptable in relation to the prognosis of the condition.
- F. If there is a formulary change during the year, IEHP provides direct written notice to affected Members at least 60 days prior to the date the change becomes effective; or at the time an affected Member requests a refill of the Part D drugs (with a 60 day supply of the drug).
 - G. IEHP provides continuous coverage of the affected Part D prescription drugs to the affected Members for reasons other than safety or because the Part D prescription drug cannot be supplied by or was withdrawn from the market by the drug's manufacturer.
 - H. The continuous coverage applies to the formulary changes related to the deletion of a drug from the formulary, changes in step therapy, dosage limitations, or therapeutic substitution.
 - K. If IEHP approves the exceptions request, IEHP may not require the Member to request approval for a refill, or a new prescription to continue using the Part D prescription drug after the refills for the initial prescription are exhausted, as long as:
 1. The Member's prescribing physician continues to prescribe the drug;
 2. The drug continues to be considered safe for treating the disease or medical condition;
 3. The enrollment period has not expired. If the Member renews his or her membership after the plan year, IEHP may choose to continue coverage into the subsequent plan year.
 - L. A Coverage Determination will be made if a Covered Part D Drug is dispensed at a Non-participating Pharmacy if:
 1. IEHP cannot reasonably expect the Member to obtain such drugs at a Participating Pharmacy in a timely manner; and
 2. The Member does not access Covered Part D drugs at Non-participating Pharmacies on a routine basis.
 3. IEHP may require the Member to assume financial responsibility for any differential between the Non-participating Pharmacy's Usual and Customary (U&C) price and IEHP's allowance for such Covered Part D Drug.
 - M. When a non-formulary medication is requested through the point-of-sale system, a message will be transmitted to the Pharmacy indicating that the drug is not covered. Pharmacy should notify the Member, the Member's Authorized Representative, or the prescribing physician to request a Coverage Determination. Pharmacists are allowed to dispense sufficient amount of medications in emergent situation based on Pharmacist's clinical judgment.

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G. Coverage Determination

N. Standard timeframe for Coverage Determination

1. Timeframe for requests for drug benefits:
 - a. If the authorized person requests a Coverage Determination for a drug benefit, IEHP shall notify the Member and the prescribing physician involved expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receipt of the request.
2. Timeframe for requests for payment:
 - a. If the authorized person requests a payment for the furnished drugs, IEHP shall notify the Member of its determination no later than 72 hours after receipt of the request.
 - b. All payments will be made within 14 calendar days after approval.

O. Expedited Coverage Determination

1. The authorized person may request IEHP to expedite a Coverage Determination if applying the standard timeframe may seriously jeopardize the Member's life, health, or ability to regain maximum function.
2. The expedited Coverage Determination cannot be made for the payment of Covered Part D Drugs that are already furnished to the Member.
3. To request an expedited Coverage Determination:
 - a. A Member, or a Member's Authorized Representative may submit a request for an expedited Coverage Determination orally or in writing to the IEHP Member Services Department
 - b. A prescribing physician may submit a Pharmacy Exception Request and supporting statement indicating the request as "expedited" for an expedited Coverage Determination to IEHP Pharmaceutical Services Department. A prescribing physician may provide oral or written support for a Member's request for an expedited Coverage Determination.
4. IEHP documents all oral requests and maintains the documentation in the case file.
5. The request will be expedited and responded within twenty-four (24) hours after receipt of the request, or for an Exceptions request, with the physician's supporting statement, if the physician indicates that the member's life or health will be seriously jeopardized by waiting for a standard decision.
6. If a Member, or Member's representative requests expedited Coverage Determination, IEHP will respond within twenty-four (24) hours of receipt if IEHP determines that the member's life or health will be seriously jeopardized by waiting for a standard decision.

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G. Coverage Determination

7. If IEHP denies a Member's or a Member's Authorized Representative's request for an expedited Coverage Determination, the request will be processed under the standard Coverage Determination procedures under this policy.
 - a. IEHP provides prompt oral notice to the Member that the request will be processed under the Standard Coverage Determination
 - b. Informs the Member of the right to file an expedited Grievance if he or she disagrees with IEHP's decision not to expedite the Coverage Determination
 - c. Informs the Member of the right to resubmit a request for an expedited Coverage Determination by the prescribing physician
 - d. Provides instructions on IEHP's Grievance process and timeframes
 - e. IEHP mails a written confirmation to the Member within three (3) calendar days after the oral notification.

- P. Timeframes for expedited coverage determination
 1. Timeframe for requests for drug benefits:
 - a. If the authorized person requests an expedited Coverage Determination for a drug benefit, IEHP shall notify the Member and the prescribing physician involved expeditiously as the Member's health condition requires, but no later than twenty-four (24) hours after receipt of the request.

- Q. If IEHP denies a drug benefit, in whole or in part, a denial letter shall be issued to both Member and the prescribing physician. The denial letter shall include the following information:
 1. Approved notice language in a readable and understandable form
 2. Criteria used in the review process
 3. Provide procedures for obtaining additional information about criteria used in the review process
 4. Inform the Member of his or her right to a Redetermination:
 - a. If IEHP denies drug coverage, the notice shall describe both the standard and expedited Redetermination processes, including the Member's right to, and conditions for, obtaining an expedited Redetermination and the Appeals process
 - b. If IEHP denies payment, the notice shall describe the standard Redetermination process and the Appeals process
 - c. Other notice requirements as specified by the Centers for Medicare and Medicaid Services (CMS)

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G. Coverage Determination

- R. If IEHP denies, in whole or in part, a denial letter shall be issued to both Member and the prescribing physician. The denial letter shall include the following information:
1. Approved notice language in a readable and understandable form
 2. Criteria used in the review process
 3. Provide procedures for obtaining additional information about criteria used in the review process
 4. Inform the Member of his or her right to a Redetermination:
 - a. If IEHP denies drug coverage, the notice shall describe both the standard and expedited Redetermination processes, including the Member's right to, and conditions for, obtaining an expedited Redetermination and the Appeals process
 - b. If IEHP denies payment, the notice shall describe the standard Redetermination process and the Appeals process
 - c. Other notice requirements as specified by the Centers for Medicare and Medicaid Services (CMS)
- S. Notice requirements for Coverage Determination
1. If the request for a drug benefit is approved or denied, in whole or in part, IEHP gives the Member or Submitter written notice of the determination within 3 calendar days.
 2. The denial letter shall include the following information:
 - a. Approved notice language in a readable and understandable form
 - b. Criteria used in the review process
 - c. Provide procedures for obtaining additional information about criteria used in the review process
 - d. Inform the Member of his or her right to a Redetermination:
 - e. If IEHP denies drug coverage, the notice shall describe both the standard and expedited Redetermination processes, including the Member's right to, and conditions for, obtaining an expedited Redetermination and the Appeals process
 - f. If IEHP denies payment, the notice shall describe the standard Redetermination process and the Appeals process
 - g. Other notice requirements as specified by the Centers for Medicare and Medicaid Services (CMS)
 3. If IEHP fails to notify the Member of its determination in the appropriate timeframe under this policy, the failure constitutes an adverse coverage

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determination, and IEHP must forward the Member's request to the Independent Review Entity (IRE) within twenty-four (24) hours of the expiration of the adjudication timeframe.

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Chief Title: Chief Medical Officer	Revised Date:	January 1, 2008

11. PHARMACY

H. Co-Payment Requirement

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP requires that all IEHP Medicare DualChoice (HMO SNP) Members pay a co-payment for prescriptions until a total drug cost of \$ 4,700 for 2012 has been reached.

PROCEDURES:

- A. Co-payment requirements for IEHP Medicare DualChoice (HMO SNP) Members:
1. For prescription medications
 - a. Acute supply (30 day supply)
 - 1) Brand: \$3.30 per prescription by year 2012
 - 2) Generic: \$1.10 per prescription by year 2012
 - b. Maintenance supply (90 day supply)
 - 1) Brand: \$3.30 per prescription by year 2012
 - 2) Generic: \$1.10 per prescription by year 2012
 - c. Mail Order (90 day supply)
 - 1) Brand: \$3.30 per prescription by year 2012
 - 2) Generic: \$1.10 per prescription by year 2012
 - B. Exceptions to the Part D Covered Drugs are as follows (Some exceptions below may be covered benefit under Medi-Cal, please refer to the IEHP Medi-Cal Formulary Management Policy):
 1. Barbiturates
 2. Benzodiazepine
 3. Over-the-counter Drugs
 4. Fertility drugs and cosmetic drugs
 5. Drugs to treat anorexia
 6. Weight loss agents
 7. Agents that are used for the symptomatic relief of cough and cold
 8. Prescription vitamins and mineral products (except prenatal vitamins and fluoride)

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H. Co-Payment Requirement

9. Drugs to treat Erectile Dysfunction such as Sildenafil

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11. PHARMACY

I. True Out-Of-Pocket (TrOOP) Expenditures

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP's Contracted Pharmacy Benefit Company shall track all Members' True out-of-pocket (TrOOP) Expenditures during a program year on covered Part D drugs.
- B. IEHP provides coordination of benefits information with the Pharmacy Benefit Management Company, Centers for Medicare and Medicaid Services (CMS) contracted COB Contractor, and the TrOOP Facilitators. Please see Policy 11J, "Coordination of Benefits."
- C. IEHP shall send an Explanation of Benefits (EOB) to a Member on a monthly basis. Member shall be informed of how much the Member has spent during the calendar year on Covered Part D Drugs, and where the Member stands in relation to the TrOOP Threshold.
- D. A Member may call IEHP Member Services Department at 1-877-273-IEHP (4347) to find out the current TrOOP Expenditure status.
- E. IEHP shall collect the Other Health Coverage information (i.e. AIDS Drug Assistance Programs and the Indian Health Service) and submit electronically to the Pharmacy Benefit Management Company. IEHP shall maintain connectivity with CMS systems to allow direct access to Other Health Coverage status information. The data shall be used in a Member's TrOOP Expenditures calculation.
- F. IEHP reports quarterly TrOOP expenditures calculations for Members to CMS according to the guidelines and instructions set by CMS.

PROCEDURES:

- A. The following payment sources for Covered Part D Drugs CAN be counted toward a Member's TrOOP Threshold:
1. The Member
 2. Another individual (i.e. a family member or friend)
 3. A bona fide charity unaffiliated with employers or unions
 4. Medicare's low-income cost sharing subsidy
- B. The following payment sources for Covered Part D Drugs CANNOT be counted toward a Member's TrOOP Threshold:
1. Group Health Plan
 2. Government programs (i.e. Tricare, Veterans Affairs)

11. PHARMACY

I. True Out-Of-Pocket (TrOOP) Expenditures

3. Workers' compensation
 4. Automobile, no-fault, or liability insurances
 5. Supplemental benefit portions of a Medicare Part D plan
- C. Payments made for the following drugs CANNOT be counted towards a Member's TrOOP Threshold:
1. Drugs that are not Covered Part D Drugs, and that have not been approved for use through an Appeals or Grievance process
 2. Drugs purchased outside the United States
 3. Over-the-counter drugs and other Part D excluded drugs
- D. IEHP will coordinate with the Pharmacy Benefit Management Company on the TrOOP Expenditure calculation. Any adjustment notice received through the coordination of benefits process will be transferred to the PBM for recalculation of the Member's TrOOP Expenditures.
- E. In case if an erroneous payment is made due to inaccurate or incomplete information regarding a Member's TrOOP Expenditures, IEHP may recover the costs directly from the Member.
- F. An Explanation of Benefits (EOB) will be provided to the Member when a Member disenrolls from IEHP. The EOB should contain information of TrOOP Expenditures status and gross drug spend balances as of the effective date of the disenrollment, and periodically thereafter as required to provide updates on late claims.
- G. IEHP's Contracted Pharmacy Benefit Management Company will process claims and track TrOOP in real time.

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11. PHARMACY

J. Coordination of Benefits (COB)

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP's Coordination of Benefits (COB) program prevents duplication of payments for the same health care services, and to prevent Medicare from paying primary when it is the secondary payor. It serves as a mechanism to collect information from a Member regarding Other Health Coverage. It also serves to support the tracking and calculating of beneficiaries' "true out-of-pocket" (TrOOP) expenditures.
- B. IEHP provides coordination of benefits with the Pharmacy Benefit Management Company (PBM), Centers for Medicare and Medicaid Services (CMS) contracted COB Contractor, and the TrOOP Facilitators.
- C. The coordination of benefits includes: 1) enrollment file sharing; 2) claims processing and payment; 3) claims reconciliation reports; 4) third-party reimbursement of out-of-pocket cost; 5) application of protection against high out-of-pocket expenditures; and 6) other processes that CMS determines.
- D. IEHP shall update Member records regarding the Other Health Coverage information according to the monthly member eligibility file sent by Department of Health Care Services. Beneficiaries are legally obligated to report information about Other Health Coverage or reimbursement for prescription drugs costs that they have or expect to receive under the Medicare Modernization Act (MMA).
- E. IEHP and the contracted PBM comply with all administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between IEHP and Other Health Coverage for:
1. Payment of premiums and coverage
 2. Payment for supplemental prescription drug benefits for Members enrolled in IEHP and an entity that provides other prescription drug coverage
- F. IEHP shall collect the COB information and submit electronically to the COB Contractor. IEHP shall maintain connectivity with CMS systems to allow direct access to Other Health Coverage status information.
- G. IEHP may impose user fees to Other Health Coverage for costs related to coordination of benefits between IEHP and Other Health Coverage under the provision of MMA. The user fees must be reasonable and related to the IEHP's actual costs of COB with the Other Health Coverage.

11. PHARMACY

J. Coordination of Benefits (COB)

PROCEDURES:

- A. IEHP utilizes the monthly member eligibility file sent by Department of Health Care Services on information regarding the “Other Health Coverage” for the Medi-Cal Medicare Members.
- B. A Member is legally obligated to report information about Other Health Coverage
- C. A Member shall disclose all expenditures for Covered Part D Drugs made by the Other Health Coverage to IEHP.
- D. IEHP shall retroactively adjust claims and True Out-of-Pocket (TrOOP) balances based on prescription drugs event and claims records.
- E. IEHP’s Contracted Pharmacy Benefit Management Company will process claims and track TrOOP in real time.

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11. PHARMACY

K. Pharmacy Access Standards

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP delegates all pharmacy contracting responsibilities to the Pharmacy Benefit Management Company.
- B. IEHP contracts with any willing pharmacy that meets the standard terms and conditions, without any time restriction.
- C. IEHP ensures the Pharmacy Access Standards are in accordance with requirements set by Centers for Medicare and Medicaid Services (CMS), which includes:
1. In urban areas, at least 90% of enrollees in a plan must, on average, live within two miles of a retail pharmacy;
 2. In suburban areas, the requirements is 90% of enrollees within five miles; and
 3. In rural areas, it is 70% of enrollees within 15 miles.
- D. IEHP contracts with over 450 pharmacy providers, including chains and independents. IEHP also contracts with multiple long term care pharmacies, home infusion pharmacies, and specialty pharmacies to provide various pharmacy services to IEHP Members.
- E. IEHP contracts with one Mail Order Pharmacy to process mail order requests. Drugs that are on the Maintenance Lists are available through the Mail Order Pharmacy. All mail order requests must be a 90-day supply of the drug.
- F. IEHP Members may receive 90-day supply of the Maintenance medications through retail pharmacies or mail order pharmacies.
- G. IEHP Members can call the IEHP Member Services Department at 1-877-273-IEHP (4347) to locate one of the contracted pharmacies in the local area.
- H. IEHP ensures Members have adequate access to covered Part D drugs at out-of-network pharmacies. IEHP contracts with chain pharmacies that have pharmacies nationwide.
- I. Members are able to have access to covered Part D drugs dispensed at out-of-network pharmacies when the Members:
1. Cannot reasonably be expected to obtain such drugs at a network pharmacy; and
 2. Do not access covered Part D drugs at an out-of-network pharmacy on a routine basis

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K. Pharmacy Access Standards

PROCEDURES:

- A. IEHP Members may go to any one of the pharmacies in our pharmacy network for pharmacy services. IEHP Members may call IEHP Member Services Department at 1-877-273-IEHP (4347) to find the nearest pharmacy provider in our network.
- B. IEHP does not limit access of Part D drugs to a limited distribution through a subset of network pharmacies, except when necessary to meet FDA limited distribution requirements or to ensure the appropriate dispensing of Part D drugs that require extraordinary requirements cannot be met by a network pharmacy.
- C. IEHP may specify, on a drug by drug basis, reasonable requirements for network pharmacies to ensure appropriate handling and dispensing of a particular Part D drug that requires special attention.
- D. IEHP may arrange delivery of medications from specialty pharmacies if a referral is made by a physician and approved by IEHP. Member will be notified upon delivery by the specialty pharmacy.
- E. IEHP Members may receive home infusion pharmacy services for infusion drugs if a referral is made by a physician and approved by IEHP.

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11. PHARMACY

L. Pharmacy Claims Processing

APPLIES TO:

- A. This policy applies to network and non-network Pharmacies who provide service to IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP contracts with Pharmacy Benefit Management Company (PBM) to handle all on-line claims transactions. The contracted PBM develops and operates an on-line claims processing system that operates in real time to ensure accurate and timely payment of all claims submitted by network pharmacies.
- B. IEHP and the contracted PBM develop and operate a paper claims processing system designed to pay claims submitted by non-network pharmacies.
- C. IEHP and the contracted PBM develop and have available for inspection by the Centers for Medicare and Medicaid Services (CMS) a complete description of the claims adjudication system.
- D. The contracted PBM develops and makes available to CMS upon request policies and procedures that include a complete description and flowchart detailing the claims adjudication process, claims detail management, access to claims information, and the claims data retrieval process.
- E. IEHP or the contracted PBM develop and have available to CMS upon request policies and procedures that include a description of how overpayments and underpayments to pharmacies, as well as Members, are handled and recovery procedures, and procedures surrounding disputed claims.
- F. The contracted PBM has a robust testing process that identifies and corrects any plan configuration errors prior to implementation.
- G. The contracted PBM accepts eligibility files and any prior claims data electronically in NCPDP format.
- H. The contracted PBM documents the manner and extent to which it has tested benefit designs such as drug exclusions or quantity limitations and plan parameters such as co-payments or benefit maximums.

PROCEDURES:

- A. The contracted PBM develops and operates an on-line claims processing system that operates in real time to ensure accurate and timely payment of all claims submitted by network pharmacies. System operates according to the following standards:
 - 1. 98% response within 4 seconds
 - 2. 99% of all claims paid with no errors

11. PHARMACY

L. Pharmacy Claims Processing

3. 99% system availability
- B. IEHP and the contracted PBM develop and operate a paper claims processing system designed to pay claims submitted by non-network pharmacies. IEHP and the contracted PBM process claims according to the following standards:
1. 100% of claims requiring no intervention handled within 15 calendar days
 2. 100% of claims requiring intervention handled within 30 calendar days
 3. 99% of all manually keyed claims paid with no errors
- C. IEHP and the contracted PBM develop and have available for CMS inspection a complete description of the claims adjudication system including:
1. Hardware and software;
 2. Operating system;
 3. MediSpan or First Data Bank database, including number of iterations saved;
 4. Number of sites processing claims (including disaster recovery back-up system); and
 5. System volume in covered lives, including the number of transactions the system can support per day and per hour.
- D. IEHP and the contracted PBM develop and have available to CMS upon request policies and procedures that include a complete description and flow chart detailing the claims adjudication process for each:
1. Contracted network pharmacies
 2. Out-of-network pharmacies
 3. Paper claims
 4. Batch-processed claims
 5. Manual claim entry
- E. IEHP and the contracted PBM develop and have available to CMS upon request policies and procedures that include a complete description of claim detail management, including:
1. The length of time that detailed claim information is maintained online (not less than 12 months);
 2. The data storage process after it is no longer online; and
 3. The length of time that detailed claim information is stored when it is no longer online (not less than 10 years)

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L. Pharmacy Claims Processing

- F. IEHP and the contracted PBM develop and have available to CMS upon request policies and procedures that include a complete description of the accessibility of this information for data capture purposes and flow chart of the claims data retrieval process for each:
1. Entire claims history file
 2. Encounter data required by state mandates
 3. Encounter data required by alternate funding sources
 4. Out-of-pocket maximum/deductible files

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11. PHARMACY

M. Medication Quality Assurance Program

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP maintains policies and systems to assist in preventing over-utilization and under-utilization of prescribed medications.
- B. IEHP provides the Centers for Medicare and Medicaid Services (CMS) with information concerning the procedures and performance of its drug utilization management program, according to guidelines specified by CMS.
- C. IEHP ensures that participating pharmacies comply with the minimum standards for pharmacy practice as established by the State of California in accordance with the California Business and Professions Code, Section 4000.
- D. IEHP monitors patient safety by developing appropriate Drug Utilization Review Process (DUR). IEHP designs and administers the patient safety programs by using on-line Drug Utilization Review (DUR), DUR conducted by Pharmaceutical Services staff via the prior authorization process, and quality assurance services. IEHP staff also prepares monthly and quarterly utilization reports for the IEHP Pharmacy and Therapeutics (P&T) Subcommittee's review. All clinical criteria for authorization of non-formulary medications are reviewed and updated at least annually or more often, as needed.
- E. IEHP ensures patient safety by analyzing medication data to identify problematic prescription use patterns. The contracted Pharmacy Benefit Management (PBM) Company provides on-line adjudication ability and transmits alerts to pharmacists to prevent adverse outcomes. The PBM Company utilizes the First Data Bank Drug Interaction Module Version 3.2 to identify drug interactions at the point of sale. Severity level 1 drug-drug interactions (defined as "This drug combination is contraindicated and generally should not be dispensed or administered to the same patient") are identified by the system and returned to the pharmacy. The point-of-sale system also screen for potential drug therapy problems due to therapeutic duplication, age/gender-related contraindications, over-utilization and under-utilization, drug-drug interactions, incorrect drug dosage or duration of drug therapy, and Drug-allergy contraindications. Additional DUR edits predetermined by IEHP according to the clinical practice standards assist pharmacists at the point-of-sale and allow pharmacists to correct any potential adverse events. The DUR edits are implemented according to the clinical guidelines and programs approved by the IEHP P&T Subcommittee. Appropriate interventions discovered by DUR reports are also integrated into the system to increase safety measures.
- F. IEHP Clinical Pharmacist reviews all potential clinical abuse/misuse cases and communicates with the prescribing physician accordingly.

11. PHARMACY

M. Medication Quality Assurance Program

- G. IEHP Clinical Pharmacist reviews RxFocus clinical reports. The reports are designed to identify unusual trend, or cases that are related to the conditions specified.
- H. The Pharmaceutical Services staff intervenes with prescribers, pharmacists and patients to correct any medication-related problems.
- I. The program ensures that the prescribers are thoroughly educated about the medication-related problems, and utilize best practices associated with the use of prescription drugs.
- J. In addition, IEHP develops clinical programs to enhance quality of care for patients, particularly those with chronic conditions on maintenance medications. All utilization reports related to conditions such as Asthma, Diabetes, Chronic pain, Hypertension are reviewed.
- K. Most common non-formulary medications are reviewed at P&T Subcommittee to ensure the formulary is up-to-date, and all commonly-used medications are accessible to patients.
- L. When a medication is withdrawn by the FDA (such as Baycol), or voluntarily withdrawn by the manufacturer (such as Vioxx), IEHP will communicate the message to the providers by mail or fax. Identified members who were on the withdrawn medication by the FDA will be notified by mail.

PROCEDURES:

- A. The IEHP Medication Quality Assurance Program (Patient Safety) includes prospective and retrospective drug utilization review (DUR). Prospective DUR includes online drug utilization review, which consists of drug/drug interactions, duplication of therapy, known allergies, under and over dosing, or inappropriate therapy. It occurs at point-of-sale and assists pharmacists to perform prescription screening process and make appropriate clinical decision. Concurrent prospective DUR includes prior authorization conducted by IEHP Pharmaceutical Service staff (Procedure C & D). Utilization analysis is a retrospective analysis, which reviews the prescribing, and dispensing practices. This review detects inappropriate patterns in prescribing, dispensing, or administering medications, and serves as the framework for developing prospective standards and targeted interventions. IEHP Clinical Pharmacist reviews monthly and quarterly utilization reports to ensure the DUR edits are working and monitor the trend. The reports are presented during the IEHP P&T Subcommittee meeting.
- B. Online DUR edits are constantly updated to reflect the latest clinical practice standards. The DUR messaging maintains the unique advantage of simultaneously screening all the medications that a patient receives from all pharmacies. It allows pharmacists to identify and resolve problems of therapeutic duplications, drug/disease contraindications, drug-drug interactions, incorrect dosage or duration of therapy, drug-allergy interactions, and clinical abuse/misuse. This system increases the safety and effectiveness of drug therapy.

11. PHARMACY

M. Medication Quality Assurance Program

- C. Prior authorization programs are used to encourage proper use of medication and discourage inappropriate prescribing of complex medications. When pharmacists receive DUR alerts through the online system, upon pharmacists' verification, pharmacist may submit Pharmacy Exception Request (PER) to IEHP for approval. All medication requests that are not standard clinical practices will require prior authorization process.
- D. The IEHP Pharmaceutical Services staff ensures that all requests are screened and verified with sound clinical justifications. Justification is needed on issues such as "off-label" use, dosage that exceeded the maximum daily dosage allowed, duplicate therapy, use of medication without following the standard treatment guideline. The IEHP Clinical Pharmacist contacts the providers to discuss the safety and appropriateness of certain drug treatment as needed. The IEHP Pharmaceutical Services staff approves/modify/deny according to IEHP clinical practice guidelines and protocols approved by the IEHP P&T Subcommittee. The decision is always made after discussing with the providers and documented.
- E. The IEHP Pharmaceutical Services staff ensures that medications that require laboratory-based monitoring for dosage adjustment or adverse drug reactions are used appropriately.
- F. Retrospective utilization analysis and studies identify those prescribing, dispensing, and drug use practices, which may be out of conformance with accepted standards and or may result in medically unjustified costs. The analyses include, but are not limited to, "Analysis of eight prescription per member per month, "Narcotics Utilization Review", "Utilization of different drug classes-SSRI, TZD, COX-2 inhibitors, ACE inhibitors, Statins, and other drug classes", and "Analysis of Respiratory Syncytial Virus Immunoprophylaxis in high-risk infants."
- G. IEHP Clinical Pharmacist reviews RxFocus clinical reports. These DUR reports include: Max Dose Report, Multiple Pharmacy and Physician Summary, Medication Compliance Report, Drug Utilization Comparison, Therapeutic Duplication, Same therapy with more than 3 of Physicians, Same therapy with more than 3 of Pharmacies. Other clinical reports include: Asthma Utilization Report- a. Long Acting B2 Agonist with No Concomitant Anti-inflammatory; b. Long Acting B2 Agonist with No Quick Relief B2 Agonist; c. Utilization of MDI by Children less than 2; Diabetes Utilization Report, Diabetes Utilization Report; Antidepressant Utilization; ADHD medication Utilization; Chronic Pain –Narcotic Utilization Report; and Member profile report.
- H. Quality assurance programs are created to enhance patient safety and improve the ways in which patients use medications.
- I. The Director of Pharmaceutical Services and Clinical Pharmacist present utilization data, studies, scientific evidence, and clinical literatures on new drugs, and clinical programs in the IEHP P&T Subcommittee meeting. These studies and programs measure the safety and efficacy of the studied (class of) drugs; the efficacy of a clinical program and its effect on prevalence of a disease state; and provide update on the newest treatment

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M. Medication Quality Assurance Program

guidelines. All new drug additions, clinical programs, and clinical guidelines are approved by the IEHP P&T Subcommittee.

- J. IEHP provides educational interventions, which include both written and oral presentations to physicians and pharmacists regarding clinically important, drug specific therapy problems.
- K. Monthly reports are prepared by the IEHP staff that allows the ongoing assessment of data on the clinical quality of the use of drugs. Non-formulary medications are reviewed and added as clinically appropriate.
- L. When a medication is withdrawn, either by FDA or voluntarily by the manufacturer, IEHP will communicate with the providers by fax or mail. IEHP will also identify the members who were on the withdrawn medications by mail.

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Chief Approval: <i>Signature on file</i>	Effective Date:	January 1, 2007
Chief Title: Chief Medical Officer	Revised Date:	January 1, 2011

11. PHARMACY

N. Medication Therapy Management Program

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. The Medication Therapy Management (MTM) Program is designed to ensure that covered Part D drugs prescribed to targeted Members are appropriately used to optimize therapeutic outcomes through improved medication use. It is also designed to reduce the risk of adverse events, including adverse drug interactions, and to increase Member adherence with prescription medications.
- B. The MTM Program may be furnished by a pharmacist or other qualified provider, provided that he or she attends an IEHP MTM education/certification or equivalent training program as determined by IEHP.
- C. The MTM Program may distinguish between services in ambulatory and institutional settings.
- D. IEHP determines and identifies the targeted Members for the MTM Program. Targeted Members must have multiple chronic diseases, who are taking multiple Part D drugs, and are likely to incur annual costs for covered Part D drugs that exceed seven hundred and fifty dollars every quarter.
- E. The MTM Program is voluntary. IEHP shall not deny a Member's access to prescription drugs based on the Member's failure to participate in the MTM Program. IEHP enrolls all targeted beneficiaries using an opt-out method of enrollment only.
- F. IEHP shall target beneficiaries for enrollment at least quarterly during each year.
- G. The MTM Programs are developed and administered by the contracted PBM.
- H. The MTM Programs are coordinated with the care management plan established for a targeted member under a chronic care improvement program.
- I. IEHP shall disclose to the Centers for Medicare & Medicaid Services (CMS) the amount of the management and dispensing fees and the portion paid for MTM Program services to pharmacists and others upon request. Reports of these amounts are protected under the Social Security Act § 1927 (b)(3)(D).
- J. IEHP provides CMS with information regarding the procedures and performance of its MTM Program, according to guidelines specified by CMS.
- K. IEHP reimburses pharmacists participating in the MTM Program for the resources used and the time required to implement the MTM Program. A list of reimbursement fees schedule is provided on the IEHP MTM Intervention Form and in the IEHP Pharmacy Program Manual.

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N. Medication Therapy Management Program

PROCEDURES:

- A. IEHP MTM Programs are available for Members who meets the following criteria:
1. At least three or more of the following chronic diseases:
 - a. Respiratory Disease – COPD
 - b. Chronic Heart Failure
 - c. Diabetes
 - d. Hyperlipidemia
 - e. Hypertension
 - f. Bone Disease – Arthritis - Osteoporosis
 - g. Mental Health – Depression
 2. Currently receives 8 or more covered medications for the chronic diseases;
 - a. Inhaled Corticosteroids
 - b. ACE-Inhibitors
 - c. Beta-Blockers
 - d. Bronchodilators
 - e. Angiotensin II Receptor Blockers
 - f. Calcium Channel Blockers
 - g. Diuretics
 - h. Antihyperlipidemics
 - i. Antihypertensives
 - j. Insulin
 - k. Antidepressants
 - l. Selective Serotonin Reuptake Inhibitors (SSRIs)
 - m. Oral Hypoglycemics
 - n. Bisphosphonates
 3. Member is likely to incur annual costs for Covered Part D drugs that exceed seven hundred and fifty dollars every quarter.
 - a. Members are identified on a quarterly basis.
 - b. Members who incur at least seven hundred fifty dollars (\$750) in paid claims for the quarter are considered as potential candidates.

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N. Medication Therapy Management Program

- B. IEHP identifies the qualified Members on a quarterly basis according to the procedure described in A. IEHP notifies the potential candidates regarding the voluntary MTM Program by mail or phone.
- C. The MTM Program includes the following components:
1. Annual Comprehensive Medication Review Process
 - a. Medication review at a minimum on an annual basis
 - b. Interactive, person-to-person consultation
 - c. Individualized, written summary of consultation
 - d. Additional quarterly targeted medication review (individualized written “take-away” materials such as personal medication record, reconciled medication list, action plan, recommendations for monitoring, education, or self-management)
 2. Medication therapy review
 - a. Assesses the appropriateness of the current medication therapy
 - b. Interviews with Members to ensure the adherence and appropriateness of the dose and dosing regimen of each medication
 - c. Check for therapeutic duplications
 - d. Interprets, monitors and assesses patient laboratory results
 - e. Check for drug to disease, and drug-drug interactions
 - f. Check for contraindications, and adverse effects
 - g. Check for over-utilization and under-utilization
 3. A personal medication record-assesses all relevant clinical information with the medication record obtained, interviews with Members.
 4. A medication action plan
 - a. Develops a modification/recommendation plan based on the interviews, medication record evaluation and patient assessment
 5. Intervention and referral
 - a. Provides education and training on the appropriate use of medications and monitoring devices
 - b. Emphasizes the importance of medication adherence and understanding of the treatment goals
 - c. Communicates with the physician or other health care providers on the findings when appropriate

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N. Medication Therapy Management Program

6. Documentation and follow up
 - a. MTM Program providers should document all interventions on the IEHP MTM Program Intervention Form, and submit the form to IEHP Pharmaceutical Services Department
- D. IEHP evaluates and measures the effectiveness of the MTM Program through
 1. Beneficiary health statistics on individual Members according to the Member medication profiles- the adoption of recommended treatment regimen, the number of chronic medications, and projected annual pharmacy expenditures per Member.
 2. Drug utilization statistics on the overall MTM Program- Number of changes in medication regimens, average number of chronic medications per Member, average projected annual pharmacy expenditures per Member
 3. Financial impact – pharmacy cost changes
 4. Customer satisfaction
- E. IEHP reports the following data on the MTM Program to CMS semi-annually:
 1. Number of Members identified for the MTM Program
 2. Number of Members participating in the MTM Program
 3. Number of Members who are eligible, but declined to participate in the MTM Program
 4. Total drug costs for Members in MTM on a per MTM-enrolled Member per month basis.

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11. PHARMACY

O. Transition Process

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP adopted this transition process for new Members who are transitioning to IEHP Medicare DualChoice (HMO SNP) from other prescription drug coverage, including other Part D plans, and whose current drug therapies may not be included in the IEHP Medicare Formulary.
- B. The transition process applies to: (1) new Members into IEHP Medicare DualChoice (HMO SNP) on January 1 of the new year following the previous year's annual coordinated election period; (2) the transition of newly eligible Medicare beneficiaries from other coverage in the new year; (3) the transition of individuals who switch from one plan to another after January 1 of the new year; and (4) enrollees residing in long-term care (LTC) facilities.
- C. The transition policy will apply to non-formulary drugs, meaning both (1) Part D drugs that are not on IEHP Medicare Formulary, and (2) Part D Drugs that are on IEHP Medicare Formulary but require prior authorization or step therapy under IEHP utilization management rules.
- D. IEHP contracts with Pharmacy Benefit Management (PBM) Company to handle all point-of-sales transactions. IEHP ensures the contracted PBM has systems capabilities that allow a one-time, temporary supply of non-formulary Part D drugs, or to override step therapy and prior authorization edits during transition at point-of-sales transactions, in order to accommodate the immediate needs of an enrollee, as well as to allow IEHP and/or the Member sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.
- E. IEHP assures that the transition policy provides refills for transition prescriptions dispensed for less than the written amount due to a plan edit (quantity limits).
- F. IEHP assures that in the retail setting, the transition policy provides for at least a one-time, temporary 30-day fill (unless the Member presents with a prescription written for less than 30 days) anytime during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage.
- G. IEHP assures that in the long-term care setting, the transition policy provides for a 31-day fill (unless the Member presents with a prescription written for less than 31 days), with multiple refills as necessary, during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage.

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O. Transition Process

- H. IEHP assures that in the long-term care setting, after the 90 day transition period has expired, the transition policy provides for a 31-day emergency supply of non-formulary Part D drugs (unless the Member presents with a prescription written for less than 31 days) while an exception is being processed.
- I. IEHP assures that all transition processes are applied to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.
- J. IEHP and the contracted PBM adopt a work-around process for using structured payment coding in the message field of the NCPDP 5.1 billing transaction indicating that a particular fill is a transition supply. IEHP assures that the trading partners (including pharmacies) use and implement such messaging until such time as such messaging is superseded by a new HIPAA-approved standard with appropriate coding.
- K. IEHP will ensure Members receive adequate supply of drug during the transition of care at time of discharge to home from Long Term Care (LTC) facilities (covered under Part A; for IEHP, it is coordinated internally).
- L. IEHP makes the transition policy available to Members via link from Medicare Prescription Drug Plan Finder to IEHP web site and include in pre-and post-enrollment marketing materials as directed by CMS.
- M. IEHP assures that for Members being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and that they are allowed to access a refill upon admission or discharge.
- N. IEHP shall provide a full outpatient supply of therapy under Part D to continue therapy once the Member's limited Part A supply is exhausted.

PROCEDURES:

- A. Under circumstances where the transition policy does not apply, all non-formulary medications are subject to prior authorization process. Please refer to Policies 11B, "Prior Authorization for Non-Formulary Medications" and 11G, "Coverage Determinations."
- B. IEHP assures that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts
- C. IEHP sends written notice via U.S. mail to enrollee within three business days of a temporary fill. IEHP uses the CMS model Transition Notice (see Attachment 11-5 in Section 11, "Attachments") which includes:
 - 1. An explanation of the temporary nature of the transition supply an enrollee has received;

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O. Transition Process

2. Instructions for working with the plan sponsor and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary;
 3. An explanation of the enrollee's right to request a formulary exception; and
 4. A description of the procedures for requesting a formulary exception.
- D. IEHP makes available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via mail, fax, email, and on IEHP's web sites.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective Date:	January 1, 2007
Chief Title: Chief Medical Officer	Revised Date:	January 1, 2011

11. PHARMACY

P. Pharmacy Program to Control Fraud, Waste and Abuse

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP adopts a comprehensive Part D Program to Control Fraud, Waste and Abuse in accordance to the Guidance issued in the Prescription Drug Benefit Manual by the Centers for Medicare and Medicaid Services (CMS). This comprehensive program includes the following requirements:
1. Written Policies and Procedures and Standards of Conduct (Please refer to IEHP Compliance Plan Manual)
 2. Compliance Officer and Compliance Committee (Please refer to IEHP Compliance Plan Manual)
 3. Training and Education (Please refer to IEHP Compliance Plan Manual)
 4. Effective Lines of Communication (Please refer to IEHP Compliance Plan Manual)
 5. Enforcement of Standards through well publicized disciplinary guidelines (Please refer to IEHP Compliance Plan Manual)
 6. Monitoring and Auditing
 7. Corrective Action Procedures
 8. Comprehensive Fraud and Abuse Plans- Procedures to voluntarily self-report potential fraud or misconduct (Please refer to IEHP Compliance Plan Manual)
- B. IEHP Part D Program to Control Fraud, Waste and Abuse is incorporated into the IEHP's existing Compliance Program structure. All activities described in this policy will be reported to the IEHP Compliance Committee.
- C. IEHP identifies Members' fraud, waste and abuse through:
1. Pharmacy Audits (IEHP contracts with Third-Party entity to perform monthly in-store and desktop audits);
 2. Complaint of fraud by Members, Pharmacy or Medical Providers;
 3. Utilization Management monitoring activities;
 4. Claims Audits and monitoring activities; and/or
 5. Quality Management monitoring activities
- D. IEHP identifies Providers' fraud, waste and abuse through:

11. PHARMACY

P. Pharmacy Program to Control Fraud, Waste and Abuse

1. Pharmacy Audits (IEHP contracts with Third-Party entity to perform monthly in-store and desktop audits);
 2. Medical Management Audits;
 3. Complaint of fraud by Members or related parties;
 4. Monitoring of Member grievances;
 5. Monitoring of Provider grievances;
 6. Claims Audits and monitoring activities;
 7. Utilization Management monitoring activities; and/or
 8. Quality Management monitoring activities
- E. Pharmacy Audits
1. IEHP conducts a comprehensive audit process to assure pharmacy, Member, and prescriber compliance with IEHP program policies and procedures.
 2. The IEHP Pharmacy Audit Program is designed to build adherence with the pharmacy program and provides a sentinel effect to deter possible future fraud and or noncompliant activities or procedures.
 3. The IEHP Pharmacy Audit Program adheres to and follows the General Accounting Government Auditing Standards (GAGAS).
 4. All Pharmacy Audit Programs are reviewed to determine compliance with applicable managed care organization parameters and integration with other quality assurance programs within IEHP.
- F. All suspected complaints or reports are forwarded to the Compliance Officer. Investigations will be conducted in accordance to the policy and procedures set forth in the IEHP Compliance Plan Manual.
- G. IEHP contracts with Third-Party entity to perform annual Pharmacy Benefit Management (PBM) Company audit to ensure proper reimbursements were made at any level within IEHP network. The audit includes, but are not limited to, areas such as benefit design, reimbursement rates, MAC pricing, formulary implementation, invoice review, and performance guarantee report.
- H. All Pharmacy claims are adjudicated electronically in a real-time basis. All Part-D excluded drugs, prescriptions that are prescribed by excluded providers, or non-contracted providers will be denied at the time the claim is transmitted.
- I. IEHP ensures all records related to the Part D Program are retrievable for 10 years for auditing purposes from the end of the final contract period or completion of an audit, whichever is later.

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P. Pharmacy Program to Control Fraud, Waste and Abuse

- J. IEHP monitors all requirements and standards regarding the process of Prior Authorization and Coverage Determination. The result is reported to the IEHP Pharmacy & Therapeutics (P&T) Subcommittee quarterly. IEHP Healthcare Analytics and Reporting Department periodically performs quality assurance audits on selected Prior Authorization Request or Coverage Determination.

PROCEDURES:

- A. IEHP identifies possible fraud, waste and abuse cases through different approaches as listed in the Policies A-I above. Once identified, all necessary documentations are collected and forwarded to the Chief Compliance Officer and Compliance Department. Please refer to Compliance Manual for follow up Policy and Procedure.
- B. Pharmacy Audits:
1. The IEHP Pharmacy Audit Program consists of two major components: computerized DeskTop audits and Pharmacy In-Store audits.
 2. The DeskTop audit program is an analysis of pharmacy provider prescription claims.
 - a. All prescription claims are subjected to specific edits such as high dollar value, unusual quantities, unusual days supply, prescriptions requiring code 1 overrides, high number of DUR overrides, and many others.
 - b. All prescriptions identified through this reporting process are individually selected for in-depth scrutiny.
 - c. All suspect prescriptions are tagged and request for information letters are generated and mailed to the pharmacy providers. Pharmacy providers are requested to provide photocopies and documentation to substantiate the questionable prescription(s).
 - d. Pharmacies are given a second notice if they do not comply with the first request.
 - e. After receiving the prescription information, all information for program compliance is checked and a decision is made.
 - f. If the prescription(s) is determined to pass program compliance, no further action is taken. If the prescription(s) does not pass program compliance, the pharmacy is notified.
 3. The initial 60 days after the initiation of the audit program is an educational process identifying areas that need improvement.
 4. The In-Store audit program includes the compliance audit and a general overview and examination of the pharmacy's practices, procedures and general overall facility requirements. Selection criteria used may include, but not be limited to:

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P. Pharmacy Program to Control Fraud, Waste and Abuse

- a. Number of Claims - The total number of claims is an indication as to the total volume relative to the pharmacy.
 - b. Total Amount Due - Indicates the total dollars paid to the pharmacy and is an indication of the total volume of the pharmacy.
 - c. Average Dollars per Brand Claims - If a pharmacy is to submit fraudulent claims, they may do this with high cost single source drugs. An auditor utilizes this statistic in conjunction with a detail report to identify possible fraudulent prescriptions.
 - d. Average Dollars per Generic Claims - Used as an indicator of overall pharmacy productivity.
 - e. Average Number of Claims per Patient - A high number of claims per patient may indicate the fraudulent submission of claims. This number may be high depending on the type of pharmacy facility (i.e., LTC or SNF).
 - f. Average Quantity - May indicate a pharmacy that is not aware of the program parameters or fraudulently submitting claims with low quantities in order to increase their number of claims submissions, which in turn increases their dispensing fee revenue.
 - g. Average Days Supply - May indicate a willingness to “split” prescriptions in order to increase their claims count, thus increasing their dispensing fee revenue. This statistic is also contingent on the pharmacy type.
 - h. Unique Number of Patients - Most pharmacies maintain a “healthy” mix of patients and physicians. This indicator, used in conjunction with the Amount Due and Total Number of Claims, may indicate the fraudulent submission of claims.
 - i. Number of Claims greater than \$100.00 (Number and Percentage) - Indicates a pharmacy dispensing high cost claims. May also indicate a pharmacy submitting fraudulent prescriptions.
 - j. Reversed Prescriptions (Number and Percentage) - The number and percentage of reversed prescriptions indicate both the understanding of the program and or the adherence to a Return to Stock (RTS) policy. A low percentage rate may indicate that the pharmacy is not “RTSing” claims when not picked up, and a high percentage may indicate either a misunderstanding of the program or may indicate that the pharmacy is out of compliance with their contract.
5. Throughout the selection process the name of the pharmacy, pharmacy type and pharmacy location is not disclosed to the auditor until the final determination for

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P. Pharmacy Program to Control Fraud, Waste and Abuse

audit is made. Prior to visiting these pharmacies, an appointment is scheduled with the pharmacy managers.

6. All IEHP In-Store audits are performed by a licensed pharmacist or technician.
7. In addition to the review of prescriptions and signature logs, the auditor provides comments regarding the general cleanliness of the pharmacy. The auditors also ensure that state and federal guidelines are adhered to, such as posting of licenses and consumer guidelines. Auditors observe the pharmacy staff to ensure that counseling, according to Omnibus Budget Reconciliation Act (OBRA) guidelines, is followed.
8. The auditors are available to the pharmacy staff to answer questions regarding the IEHP program. The compliance audits provide excellent educational value and a long lasting sentinel effect.
9. IEHP requests corrective action plans from pharmacies with quality or noncompliance issues identified during the audit process.
10. Pharmacies failing to submit adequate corrective action plans (CAPs), or failing to fully implement CAPs, are subject to contract compliance actions up to termination from the IEHP network.
11. Pharmacies with poor compliance audit findings, numerous complaints from IEHP members, or gross deviations from the IEHP pharmacy network normal standards receive focused fraud audits.
12. A Focused Fraud Audit incorporates the following:
 - a. Pharmacy Location Surveillance - This is done to determine the member traffic utilizing the pharmacy.
 - b. Requests of Wholesaler Purchase Records (directly from the wholesaler) - It has been recorded that many pharmacies have gone to the extent of falsifying or manufacturing wholesaler records. For this reason, IEHP obtains purchase records directly from the pharmacies' wholesaler.
 - c. In-depth Analysis of Prescription Records - IEHP analyzes at a minimum 12 to 16 months of pharmacy prescription records.
 - d. Review of Signature Logs - As with the prescription records, IEHP requests, at a minimum 12 to 16 months of pharmacy signature logs.
 - e. Pharmacy Stock Analysis - Review pharmacy stock to determine if stock is appropriate for the amount and type of prescriptions being filled.
 - f. Visits with Prescribing Physicians- We determine the top 10 or 20 physicians utilizing the target pharmacies. Our auditors meet with the physicians and request specific patient charts.

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P. Pharmacy Program to Control Fraud, Waste and Abuse

- g. Review / Communicate with Patient Charts / Records - Review of patient charts and visit with patients to determine if medications/supplies were received.
 - 13. Upon completion of a focused fraud audit, IEHP submits reports to the California State Board of Pharmacy, and other agencies, if necessary. Pharmacies that are found to be practicing in such a manner that is unsafe for IEHP Members are removed from the IEHP network.
 - 14. The audit result is presented to the Compliance Committee quarterly.
- B. Pharmacy Benefit Management (PBM) Company Audits:
- 1. IEHP contracts with Third Party Entity to perform monthly audits on PBM.
 - 2. The contracted PBM Company processes all Pharmacy claims electronically on behalf of IEHP.
 - 3. Audit areas include, but are not limited to, benefit design, reimbursement rates, MAC pricing, Formulary implementation, invoice review, and performance guarantee report.
 - 4. PBM audit results are presented to the Compliance Committee annually.
- C. Internal Quality Assurance Process:
- 1. All Prior Authorization Requests and Coverage Determinations are processed in IEHP Pharmaceutical Services Department.
 - 2. All Prior Authorization Requests and Coverage Determinations are processed according to CMS requirements as outlined in Policies 11B, "Prior Authorization for Non-Formulary Medication," and 11G, "Coverage Determination".
 - 3. IEHP Pharmaceutical Services Department monitors and ensures all Prior Authorization Requests and Coverage Determinations submitted by the Members and Providers are processed within the timeframe set forth in Policy 11G, "Coverage Determination."
 - 4. IEHP Quality Management Department performs monthly quality assurance audits on randomly selected Prior Authorization Requests or Coverage Determinations.
 - 5. IEHP monitors and reports the number of Prior Authorization Requests, Coverage Determinations and the time-turn-around statistics to the IEHP P&T Subcommittee quarterly.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective Date:	January 1, 2007
Chief Title: Chief Medical Officer	Revised Date:	

11. PHARMACY

Q. Insulin Administration Devices and Diabetes Testing Supplies

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. Insulins and Glucagon Emergency Kit are covered by the IEHP pharmacy benefit.
- B. Syringes and needles are the insulin administration devices covered under the IEHP pharmacy benefit. Insulin pen devices require the submission of a pharmacy exception request (PER).
- C. Insulin pumps fall under IPA/Hospital's financial responsibility.
- D. Diabetes testing supplies are covered under the IEHP pharmacy and medical benefit. This includes blood glucose meters, test strips, lancets, urine test tape and tablets, ketone test strips and acetone tablets.

PROCEDURE:

- A. For Members with special medical needs, a pharmacy exception request (PER) must be submitted for all insulin pen devices (see Attachment 11-2 in Section 11, "Attachments"). See Policy 11B, "Prior Authorization for Non-formulary Medications."
- B. Diabetes testing supplies, including glucometer, test strips and lancets may be obtained through retail pharmacies or through IEHP Diabetes Care Program.
- C. IEHP covers diabetic testing supplies using the criteria approved by the IEHP Pharmacy and Therapeutics Subcommittee.
- D. IEHP Members may participate in IEHP Diabetes Care Program. The program provides test strips, and lancets through mail order vendor. The selected vendor provides comprehensive diabetes care program (diabetes educational materials, outreach program, health fair) to the participants. The selected vendor is required to perform monitoring measures at least on a quarterly basis. The selected vendor is also required to report all measures to IEHP.

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11. PHARMACY

R. Medicare DualChoice (HMO SNP) Vaccine Coverage

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) established a permanent policy for payment by Medicare for administration of Part D-covered vaccines, beginning in 2008. Specifically, the policy states that, effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of "covered Part D drug" under the Part D statute.
- B. This policy does not affect Part B covered vaccines.
- C. The Part D vaccine program generally covers those vaccines not available under Part B. The following vaccines are covered under the Part B Program:
1. Pneumococcal pneumonia vaccine
 2. Influenza virus vaccine
 3. Hepatitis B vaccine for individuals at high or intermediate risk
 4. Other vaccines (i.e. tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition
- D. IEHP Medicare DualChoice (HMO SNP) Members receive both Part B and D vaccine coverage through IEHP.
- E. All Part D covered vaccines are listed in the IEHP DualChoice Formulary. No prior authorization is required for covered Part D vaccines. All covered Part D vaccines are restricted to be used according to the latest CDC recommended Adult Immunization Schedule. <http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#print>

PROCEDURES:

- A. Members may receive Part D vaccine coverage through one of the following options:

Option 1: Out-of-Network Approaches-IEHP reimburses the Members directly

When you receive a Part-D covered vaccine through your doctor or other health care provider, pay them directly for the cost of the vaccine and the administration of the vaccine. Bring the Part D Vaccine Member Reimbursement Form to your health care provider, complete all the required information and send the Member Reimbursement Form along with the receipt to IEHP. Your deductible, coinsurance and co-pay will apply.

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R. Medicare DualChoice (HMO SNP) Vaccine Coverage

Option 2: Out-of-Network Distribution-Receive vaccination through the physician provider

The physician provider may submit claims on behalf of the Members when they provide Part D covered vaccines. The Member may also obtain the vaccine from the pharmacy and transport the vaccine to the physician's office for administration. No Member Reimbursement form is required. The deductible, coinsurance, and co-pay will apply.

Option 3: In-Network Approaches-Use a Vaccine Network Pharmacy

Pharmacy Providers who register with the Pharmacy Benefit Manager (PBM) as the vaccine providers may provide service and submit claims online as a single claim (both the vaccine serum and the administration cost). Pharmacy Providers should collect any applicable cost-sharing on the vaccine and its administration. No Member Reimbursement form is required. Your deductible, coinsurance, and copay will apply.

- B. One cost-sharing amount should be applied to both the vaccine ingredient cost and the administration. If the vaccines are distributed.
- C. IEHP's contracted PBM accepts Part D vaccine administration claims from participating pharmacies in the NCPDP-approved 5.1 format effective January 1, 2008. IEHP reimburses any pharmacy that has agreed to provide vaccine administration services. (Administration fee-incentive amount submitted field; DUR/PPS code-Medication administration field).
- D. IEHP provides all enrollees with a vaccine-specific notice that the Members could bring to their physicians. This notice would provide information necessary for a physician to contact IEHP to receive authorization of coverage for a particular vaccine, reimbursement rates, Member cost-sharing to be collected by the physician, and instructions on how to submit the out-of-network claim on the Member's behalf.
- E. IEHP and the contracted PBM will monitor the Part D vaccine claims. When administration is billed separately from the dispensing of the vaccine, IEHP and the contracted PBM will review existing claims for the presence of a vaccine charge. Should no vaccine charge be present in the claims history, IEHP will work with the Member to ensure the Member did not forget to submit a paper receipt for the vaccine and that appropriate reimbursement has been paid.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective Date:	January 1, 2009
Chief Title: Chief Medical Officer	Revised Date:	

11. PHARMACY

S. Best Available Evidence (BAE)

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP shall provide access to Part D drugs at the correct Low Income Subsidy (LIS) cost-sharing level when presented with evidence of LIS eligibility, even if IEHP's system and Centers for Medicare and Medicaid Services' (CMS) systems do not yet reflect that eligibility.
- B. IEHP shall accept BAE at point-of-sale and update the system within 48-72 hours of the receipt of the documentation.
- C. IEHP must update the systems to reflect the LIS status indicated by the BAE, and submit a request to CMS for update.
- D. If the case is urgent, IEHP shall allow a minimum of 72 hours worth of medications until the case is resolved.
- E. This process only applies to Members who are "deemed" eligible for LIS, and may not be used for LIS applicants.

PROCEDURES:

- A. IEHP accepts the following documentation to validate the correct LIS cost-sharing level and effective date for Members who should be deemed eligible for LIS. The document must show that the Member was eligible for Medicaid (IEHP Medi-Cal) during a month after June of the previous calendar year.
1. A copy of the Member's Medicaid card which includes the Member's name and eligibility date;
 2. A copy of a state document that confirms active Medicaid status;
 3. A print out from the State electronic enrollment file showing Medicaid status;
 4. A screen print from the State's Medicaid systems showing Medicaid status;
 5. Other documentation provided by the State showing Medicaid status;
 6. A report of contact, including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the State staff person who verified the Medicaid status;
 7. A remittance from a long term care facility showing Medicaid payment for a full calendar month for that individual;

11. PHARMACY

S. Best Available Evidence (BAE)

8. A copy of a state document that confirms Medicaid payment to a long term care facility for a full calendar month on behalf of the individual;
 9. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month's stay for Medicaid payment purposes;
 10. Supplemental Security Income (SSI) Notice of Award with an effective date;
 11. An Important Information letter from SSA confirming that the beneficiary is automatically eligible for extra help.
- B. Upon receipt of one of the documentation above, IEHP shall update the PBM's system to allow point-of-sales transaction to go through with the correct LIS cost-sharing level.
- C. IEHP submits the appropriate documentation obtained per the above list and submits to IntegriGuard to provide and update for the Member.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective Date:	January 1, 2010
Chief Title: Chief Medical Officer	Revised Date:	

11. PHARMACY

T. Pharmacy Provider Policies and Procedures Summary

APPLIES TO:

- A. This policy applies to all IEHP Contracted Pharmacy Providers.

POLICY:

- A. In addition to the Provider Manual- Pharmacy section, IEHP Contracted Pharmacy Providers must provide pharmacy services according to the policies and procedures listed on the Quick Reference Guide.

PROCEDURE:

- A. The following Quick Reference Guide is distributed to the IEHP Contracted Pharmacy Providers:

11. PHARMACY

T. Pharmacy Provider Policies and Procedures Summary

Pharmacy Provider Quick Reference Guide

- A. Member Eligibility Verification- Contracted pharmacies are required to verify eligibility and provide pharmacy services to IEHP Members in accordance with the Pharmacy Agreement with IEHP's contracted Pharmacy Benefit Management (PBM) Company.
1. Pharmacy staffs should ask for Members' ID card to verify eligibility
 2. If the Member is shown not eligible via online transmission (point-of-sales), call the Medi-Cal Automated Eligibility Verification System (AEVS) at 1-800-456-2387, or IEHP IVR hotline at 1-800-440-4340.
 3. If the Member is eligible according to the Eligibility verification system, contact IEHP Pharmaceutical Services Department
- B. Prior Authorization
1. Pharmacy Provider may submit Pharmacy Exception Request Form to IEHP (All required information must be provided, including medical justification).
 2. PERs may be submitted online at www.iehp.org (please call IEHP to obtain login password).
 3. PERs are reviewed and determined (approved, denied or misdirected) within 1 business day if all necessary information is provided.
- C. Emergency supplies- pharmacists are allowed to dispense up to 72 hours of supplies of any non-formulary medications under emergent situation. Pharmacist should document the "emergent situation" and submit the information to IEHP for approval.
- D. Newborns- Newborns are covered for the month of birth and the following month, provided their mother is an eligible IEHP Member. Pharmacies may submit claims for the Newborns by using mother's IEHP Member ID Number, the mother's full name, and date of birth. Newborns' eligibility after one month will be determined by Medi-Cal eligibility requirements.
- E. Coordination of Benefits (other primary payors)- IEHP Members may have prescription coverage through other payment sources. If Member has other primary health insurance coverage, pharmacy providers must submit claims to the other payment source first. IEHP is the payer of last resort for coordination of benefits claims. IEHP is responsible for co-insurance, and co-payments only after all prior authorization processes through the primary payer have been exhausted. All COB claims must be submitted electronically to the PBM. Please refer to the PBM's payer sheet for instruction.
- F. Coordination of Benefits (Medicare) - Medicare is the primary payer for Medi-Medi patients. Medicare crossover claims (from Part B) must be submitted electronically to the PBM.

11. PHARMACY

T. Pharmacy Provider Policies and Procedures Summary

- G. IEHP cannot cover co-payments for covered Medicare Part D drugs (from any Medicare Part D plans or IEHP Medicare DualChoice (HMO SNP)). IEHP is responsible for excluded Part D Drugs only.
- H. The State law requires Medi-Cal Members and Providers to notify the Department of Health Care Services (DHCS) if they believe a member has “other health coverage.” Providers may also contact IEHP Pharmaceutical Services Department regarding the coverage information.
- I. Under no circumstances may a Medi-Cal recipient (including IEHP Members) be billed or charged directly for after hours or delivery services.
- J. California Children’s Services - The California Children’s Services (CCS) Program covers children with certain physical limitations and chronic health conditions or disease through their 21st birthday. Covered services include physician services, drugs, and specialty medical care. The CCS authorization (SAR- service authorization request) includes coverage for prescribed medications used to treat the CCS eligible condition. All CCS covered services (services or medications) for CCS eligible conditions must be submitted to CCS as the primary payor.
- K. Claims Submission- Contracted Pharmacies should use the following billing information to submit claims online via the PBM:
1. IEHP MEDICARE DUALCHOICE (HMO SNP) (For all Part D covered drugs)
PCN: 04110000
BIN: 012353
 2. IEHP MEDI-CAL, HEALTHY FAMILIES, & HEALTHY KIDS
PCN: 02550000
BIN: 600428
- L. National Provider Identifier (NPI)- Pharmacies must submit Pharmacy’s NPI number and Prescriber’s NPI number on each pharmacy claim.
- M. Prior Authorization submission Timeliness Guidance for Retroactive Pharmacy Exception Request- A retroactive PER may be considered for review only under the following conditions:
1. If the request is received within 90 days of the date the drug was dispensed (retail pharmacy)
 2. If the request is received within 10 days of the date from the date of service for SNF or outpatient non-retail pharmacy settings (i.e. dialysis center, outpatient infusion center)

Retroactive PER requests must include all medical justifications and cannot be submitted as urgent.

11. PHARMACY

T. Pharmacy Provider Policies and Procedures Summary

- N. Compounded Prescription for Non-Injectable Use - Compounded prescription (non-injectable) request must be submitted to IEHP using the PER form and the Compounded Drug Information Sheet. The reimbursement will be determined using the information provided on the Compounded Drug information sheet. Pharmacist should provide the active ingredients used in the Compounded Prescription for authorization review.
- O. Home Infusion Pharmacy
1. IEHP Members (IPA)
 - a. Drugs and drug-related per diem codes (i.e. TPN, antibiotics)- submit to IEHP
 - b. Home Infusion Supplies and administration- prior authorization and claims must be submitted to IPA
 2. IEHP Members (IEHP Direct)
 - a. Drugs and drug-related per diem codes (i.e. TPN, antibiotics)- submit to IEHP
 - b. Home Infusion Supplies and administration- submit to IEHP
 3. IEHP Medicare DualChoice (HMO SNP) Members
 - a. Home infusion drugs are covered under Part D. Part B covered drugs are covered by IEHP
 - b. Home Infusion Supplies and administration- prior authorization and claims must be submitted to IPA (or IEHP Direct)
- P. Lost or Stolen Medication/ Vacation Override
1. Lost or stolen medication may be approved for no more than a 30-day supply. Only one replacement will be approved per member per calendar year. Pharmacy should inform the Prescriber if the lost/stolen medication is a narcotic medication.
 2. Pharmacy may submit vacation override on behalf of a Member by submitting PER to IEHP. Only one vacation override will be approved per member per calendar year.
- Q. Pharmacy Audit- IEHP conducts Pharmacy Audits on a monthly basis (desktop and onsite) to ensure compliance with IEHP Pharmaceutical Services Policies and Procedures. IEHP may request Pharmacies to submit Corrective Action Plan (CAP) based on the results of the Audit. Pharmacies that are found to be consistently non-compliant may be terminated from the network.
- R. Pharmacy Complaints and Grievance- Pharmacy must respond to IEHP's complaints and/or grievance requests in writing within 5 business days. Late responses will not be submitted to the IEHP Grievance Department for consideration. Pharmacies that are

11. PHARMACY

T. Pharmacy Provider Policies and Procedures Summary

found to have a high unresolved grievance and complaint rates may be terminated from the network.

S. Return to stock /Auto-fill/ Claim Reversal Policy

1. Pharmacies should reverse all prescriptions filled and submitted for payment, but not picked up by the Member within 14 calendar days of date of service. Claims that are not reversed according to this policy are subject to recoupment via onsite and desktop audit.
2. All refill requests must be requested by the Member. Pharmacies are not allowed to auto-fill and submit claims to IEHP without Member's consent. Pharmacies will be subject to audit for compliance purposes.

T. Signature Log Requirement

1. The Pharmacy must maintain a signature log at all time. The Pharmacy must obtain signature from the Member during pick up (Members' ID must be verified). The log must contain the prescription number or a description of the drugs dispensed, the signature, and the date the medication was picked-up. The Pharmacy must make the signature log record available for a minimum of five years for audit purposes.
2. Delivery log- For drugs that are delivered to the Member's home, a signature must be obtained.

U. All prescription records and documentation including signature logs must be retained for ten years per CMS requirements.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2010
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

11. PHARMACY

U. Member Request for Pharmacy Reimbursement

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP Members may submit Pharmacy Reimbursement Requests to get reimbursement for drugs or services covered by IEHP. All Member Reimbursement Requests are subject to IEHP Pharmacy Exception Request process.

PROCEDURE:

- A. Members must submit the Pharmacy Reimbursement Request form (see Attachment 11-14 in Section 11, "Attachments"), a copy of the cash register receipt, and a copy of the pharmacy print out to IEHP for review.
- B. The Pharmacy print out must contain pharmacy name, address, phone, medication name, strength and form, the national drug code (NDC), date of service, Prescriber's full name, quantity, and the total amount paid.
- C. The Request form must be submitted within 1 year from the date of service.
- D. The Request form must be signed by the Member.
- E. All Requests will be evaluated based on the medical necessity and the justification of the request within 30 days upon the receipt of the request.
- F. If IEHP denies the Member Reimbursement Request, the Member will receive a denial notification from IEHP.
- G. If a Member has shown a pattern of by passing Pharmacy Exception Request process, IEHP may notify the Member of the denials of all future reimbursement requests.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective Date:	January 1, 2011
Chief Title: Chief Medical Officer	Revised Date:	

11. PHARMACY

Attachments

<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
11-1	Request for Addition or Deletion of a Drug to the Formulary	2E, 11A
11-2	Pharmacy Exception Request (PER) Form	11B, 11Q
11-3	Part D Coverage Determination	11B, 11G
11-4	Coverage Determination – IEHP Member	11B
11-5	Model Transition Notice	11O
11-6	Coverage Denial Notice Approved	
11-7	Notice of Case Status	11B
11-8	Pharmacy Notice Approved	
11-9	Request for Additional Information	
11-10	Notice of Redetermination	
11-11	Notice of Right to an Expedited Grievance	
11-12	CMS1696 – Appointment of Representative	
11-13	Notice of Formulary Change	11B, 11G
11-14	Member Reimbursement Form	11U



INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP

**REQUEST FOR ADDITION OR DELETION
OF A DRUG TO THE FORMULARY**

GENERIC NAME: _____ BRAND NAME: _____

MANUFACTURER(S): _____

DOSAGE FORM: _____

Pharmacological Classification: _____

Indications: _____

What similar drugs are currently available? _____

What therapeutic advantage(s) does this drug have over the standard drug therapy? _____

In how many patients do you expect this drug to be used during the next six months? _____

What drug(s) currently used for this/these indications(s) may be deleted if this product is added to the formulary?

Should use of this drug be restricted to certain physicians or institutions because of the potential for misuse, high cost, or toxicity? _____

REQUESTER'S NAME: _____

ADDRESS & TELEPHONE: _____

SIGNATURE OF REQUESTER: _____ DATE: _____



Please Print

PER #: _____
(For IEHP Use Only)

PHARMACY EXCEPTION REQUEST (PER) FORM

FAX TO: IEHP

FAX #: (909) 890-2058

IEHP MEMBER

Member Name: _____ ID#: _____ DOB: _____ M F
Other ID: _____ Phone#: _____

PHYSICIAN

Prescribing Physician: _____ MD State License #: _____ MD Specialty: _____
Contact Name: _____ Phone #: _____ Fax #: _____

PHARMACY

Pharmacy Name: _____ Pharmacy NABP #: _____
Contact Name: _____ Phone #: _____ Fax #: _____

FORM

Form Completed By: _____ Today's Date: _____

PRESCRIPTION

Rx #: _____ Date of Original Rx: _____
Medication: _____
Strength: _____ Quantity: _____ Refills Remaining: _____
NDC #: _____ Directions: _____
Diagnosis: _____
Previous Therapy: _____
Medical justification for non-formulary drug: _____

Your request is: Approved Modified Request for More Information Misdirected Denied

Valid from: _____ Expires on: _____ Decision by: _____ Date: _____

Request for Expedited Review (For IEHP Medicare DualChoice (HMO SNP) Members Only)

REQUEST FOR EXPEDITED REVIEW (24 HOURS)
▶ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Please submit Request promptly to avoid any delays in patient care. IEHP will respond to the request within one working day. Providers should exercise appropriate clinical judgment in dispensing medication pending PER approval.

Notice: This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify IEHP Pharmaceutical Services Department by telephone at (888) 860-1297.

P.O. Box 19026, San Bernardino, CA 92423-9026
Tel (888) 860-1297 Fax (909) 890-2058
Visit our web site at: www.iehp.org



INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP

Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- > Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- > Biotech or other specialty drugs for which drug-specific forms are required. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID#:			NPI# (if available):		
Address:			Address:		
City:	State:		City:	State:	
Home Phone:	Zip:		Office Phone #:	Office Fax #:	Zip:
Sex (circle):	M	F	DOB:	Contact Person:	

Diagnosis and Medical Information					
Medication:		Strength and Route of Administration:		Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:		Qty:	
Height/Weight:	Drug Allergies:		Diagnosis:		
Prescriber's Signature:				Date:	

**Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION**

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)
 → Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
 → Specify below: Anticipated significant adverse clinical outcome

Medical need for different dosage form and/or higher dosage
 → Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

Request for formulary tier exception
 → Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Other: _____ → Explain below

REQUIRED EXPLANATION: _____

Request for Expedited Review

REQUEST FOR EXPEDITED REVIEW [24 HOURS]
 → BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Notice: This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify IEHP Pharmaceutical Services Department by telephone at (909) 890-2049.



IEHP Medicare DualChoice HMO SNP

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations)

Enrollee's/Requestor's Information

Enrollee's Name _____ Enrollee's Date of Birth _____

Enrollee's Medicare Number _____ Enrollee's Part D Plan ID Number _____

Requestor's Name (if not enrollee) _____

Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

Enrollee/Requestor's Address _____ City _____ State _____ Zip Code _____

() _____
Phone

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

Prescribing Physician's Information

Name _____ Medical Specialty _____

Address _____ City _____ State _____ Zip Code _____

() _____ () _____
Work Phone Fax Office Contact Person

Type of Coverage Determination Request

- I need a drug that is not on the plan's list of covered drugs (formulary exception).*
- I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

- I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*
- I request prior authorization for the drug my doctor has prescribed.
- I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*
- My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.**

Additional information we should consider (*attach any supporting documents*):

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

- I need an expedited coverage determination (attach physician's supporting statement, if applicable)

Beneficiary/Requestor's Signature

Date

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Notice: This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify IEHP Pharmaceutical Services Department by telephone at (909) 890-2049.



INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP

Dear <Beneficiary Full Name>,

Please keep this letter for your records. You are getting this letter because you recently filled a prescription <for *insert prescription if known*> <that was not on our list of covered drugs (called a *formulary*)> /<that was subject to a prior authorization requirement that you did not meet>. This last fill of that prescription was a temporary solution. You now need to work with us or your doctor to change your prescription to one that we cover. If that isn't possible, you must request an exception from us for this prescription.

How do I change my prescription?

You can ask us if we cover another drug used to treat your medical condition. If we cover another drug for your condition, you can ask your doctor if this drug is an option for you. If your doctor tells you that another drug we cover isn't medically appropriate for treating your condition, you have the right to request an exception from us < *to cover your current prescription or insert prescription if known*>.

How do I request an exception?

The first step in requesting an exception is for you or your prescribing doctor to contact us. <*Provide the necessary address, fax number, and phone number*>.

Your doctor must submit a statement supporting your request. The doctor's statement must demonstrate that the requested drug is medically necessary for treating your condition. Once the physician's statement is submitted, we must notify you of our decision no later than 24 or 72 hours, depending on whether the request is an expedited request or a standard request. Your request will be expedited if we determine, or your doctor tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

What if my request is denied?

If your request is denied, you have the right to appeal and ask us to review our decision. You must request this appeal within 60 calendar days from the date of our first decision. <*You must file a standard request in writing or we accept standard requests by telephone and in writing. We accept expedited requests by telephone and in writing. Provide the necessary address, fax number, and phone number*>.

What if I have questions about this letter?

If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours listed below:

November 15 to March 1: 8:00 am to 8:00 pm, PST, 7 days a week, including holidays

March 2 to November 14: 8:00 am to 6:00 pm, PST, Monday through Friday

Sincerely,

IEHP Pharmaceutical Services Department



INLAND EMPIRE HEALTH PLAN

Approved OMB #0938-0976

Notice of Denial of IEHP Medicare DualChoice HMO SNP Prescription Drug Coverage

Date: _____

Enrollee's name: _____ Member ID number: _____

We have denied coverage of the following prescription drug(s) that you or your physician requested: _____

We denied this request because: _____

What If I Don't Agree With This Decision?

You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have **the right to ask us for an exception** if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower cost-sharing amount. You can also ask for an exception to utilization management tools, such as a dose restriction or step therapy requirement. Your physician must provide a statement to support your exception request.

Who May Request an Appeal?

You or someone you name to act for you (your **appointed representative**) may request an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others may already be authorized under State law to act for you.

You can call us at: 1-(877) 273-IEHP (4347) to learn how to name your appointed representative. If you have a hearing or speech impairment, please call us at TTY 1-800-718-4347.

Form No. CMS-10146

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS
For more information about your appeal rights, call us or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours) - You can request an expedited (fast) appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**
- If you ask for an expedited appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days) - You can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?

You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How Do I Request an Appeal?

For an Expedited Appeal: You or your appointed representative should contact us by telephone or fax at the numbers below:

Phone: 1-(877) 273-IEHP (4347)
Fax: (909) 890-2168

For a Standard Appeal: You or your appointed representative should mail or deliver your written appeal request to the address(es) below:
P.O. Box 19026, San Bernardino,
CA 92423-9026

What Happens Next? If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact Information:

If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours listed below:

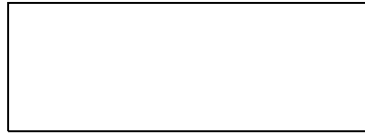
November 15 to March 1: 8:00 am to 8:00 pm, PST, 7 days a week, including holidays
March 2 to November 14: 8:00 am to 6:00 pm, PST, Monday through Friday

Other Resources To Help You:

Medicare Rights Center
Toll Free: 1-888-HMO-9050

Elder Care Locator
Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048



IEHP Medicare DualChoice HMO SNP

NOTICE OF CASE STATUS

<Date>

Member Name
Street Address
City, State Zip Code

Member ID Number: <111-111111A>
Case Number: <insert number>

Dear <insert name>:

This letter is to inform you that your request for a [“standard initial decision”] [“fast initial decision”] [“standard” appeal] [“fast” appeal] was forwarded to an independent organization for review on <insert date>.

[For a “standard initial decision” request: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 72 hours after receiving your request.]

[For a “fast initial decision” request: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 24 hours after receiving your request.]

[For a “standard” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 7 calendar days after receiving your appeal.]

[For a “fast” appeal: Your case file was forwarded to an independent review organization because we did not provide you with an answer within 72 hours after receiving your appeal.]

The law requires us to forward your case file to an independent review organization within 24 hours if we do not provide you with an answer within the required time frame.

The independent review organization has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. *[Plans must indicate if there is a charge for the copy.]*

You have the right to submit additional evidence about your case. If you choose to submit additional evidence, you should send it promptly to the independent review organization at <address><fax>

If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours listed below:

November 15 to March 1: 8:00 am to 8:00 pm, PST, 7 days a week, including holidays
March 2 to November 14: 8:00 am to 6:00 pm, PST, Monday through Friday

Thank You.

Inland Empire Health Plan

IEHP MEDICARE DUALCHOICE HMO SNP PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

You **have the right to get a written explanation** from your Medicare drug plan if:

- Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed by your doctor.
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

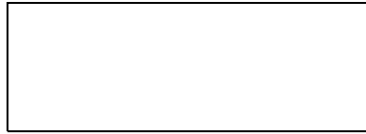
You **also have the right to ask** your Medicare drug plan **for an exception** if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;" or
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception if you believe you need a drug that is not on your drug plan's formulary or believe you should get a drug you need at a lower cost-sharing amount.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:
 1. The prescription drug(s) that you believe you need.
 2. The name of the pharmacy or physician who told you that the prescription drug(s) is not covered.
 3. The date you were told that the prescription drug(s) is not covered.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to distribute this information collection once it has been completed is one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



IEHP Medicare DualChoice HMO SNP

Request for Additional Information

<Date>

Member Name
Street Address
City, State Zip Code

Member ID Number: <111-11-1111A>

Case Number: <insert number>

This letter is in response to your request for a *<indicate type of request, e.g., formulary or tiering exception, expedited redetermination>* that *<you OR your physician>* filed with us on *<insert date>*. *<A*

“formulary exception” request is when you ask for a drug that is not on *<Plan name>*’s list of covered drugs (called a "formulary"), or ask us not to apply a prior authorization or other requirement to a drug on our formulary *>*. **OR** *<A* “tiering exception” request is when you ask for a non-preferred drug at the preferred cost level*>*.

In order to process your request, we need additional information from your physician.

<Plans must specifically describe the type of written documentation they require from the physician.>

For formulary exceptions: Plans may require a statement that the drug is medically necessary to treat the enrollee’s condition because: (1) all of the covered drugs on the Plan’s formulary for the same condition would not be as effective for the enrollee as the non-formulary drug, would have adverse effects for the enrollee, or both; (2) step therapy has been or is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance, or has caused or is likely to cause an adverse reaction to the enrollee; or (3) the number of doses that is available under a dose restriction for the drug has been or is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance.

For tiering exceptions: Plans may require a statement that the preferred drug for the treatment of the enrollee’s condition would not be as effective as the requested drug and/or that the preferred drug would have adverse effects for the enrollee.

If applicable, for either type of exception request, Plans must also indicate if this letter is a request for additional supporting medical documentation>.

If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours listed below:

8:00 am to 8:00 pm (PST), 7 days a week, including holidays

Thank you.

Inland Empire Health Plan



IEHP Medicare DualChoice HMO SNP

Redetermination Notice

Denial of IEHP Medicare DualChoice Prescription Drug Coverage

Date:

Enrollee's name:

Member ID number:

We have affirmed our initial coverage determination denying the following prescription drug(s) that you or your physician requested: _____

We denied this request because: _____

What If I Don't Agree With This Decision?

You have the right to ask for an independent review (appeal) of our decision. You have **the right to ask for an exception** if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower cost-sharing amount. You can also ask for an exception to utilization management tools, such as a dose restriction or step therapy requirement. Your physician must provide a statement to support your exception request. If you want to appeal our decision, you must request your appeal in writing within 60 calendar days after the date of this notice. You must send your written request to the independent reviewer at the following address:

[Insert Part D QIC
information]

Who May Request an Appeal?

You or someone you name to act for you (your **appointed representative**) may request an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others may already be authorized under State law to act for you.

You can call us at: (877)-273-4347 to learn how to name your appointed representative. If you have a hearing or speech impairment, please call us at TTY (800) 718-4347_____

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours) - You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, the independent reviewer must give you a decision no later than 72 hours after receiving your appeal.

- If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, **the independent reviewer will automatically expedite the appeal.**
- If you ask for an expedited appeal without support from a doctor, the independent reviewer will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days) - You can request a standard appeal for a case that involves coverage or payment. The independent reviewer must give you a decision no later than 7 days after receiving your appeal.

What Do I Include with My Appeal?

You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary), your prescribing physician must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How Do I Request an Appeal?

You or your appointed representative should mail your written appeal request to the address below:

IEHP Grievances and Appeals Department

P.O. Box 19026, San Bernardino,

CA 92423-9026

What Happens Next? If you appeal, the independent reviewer will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least \$110. If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact Information:

If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours listed below:

November 15 to March 1: 8:00 am to 8:00 pm, PST, 7 days a week, including holidays

March 2 to November 14: 8:00 am to 6:00 pm, PST, Monday through Friday

Other Resources To Help You:

Medicare Rights Center
Toll Free: 1-888-HMO-9050
TTY:

Elder Care Locator
Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048



IEHP Medicare DualChoice HMO SNP

Notice of Right to an Expedited Grievance

Date:

Patient Name:

Patient ID Number:

Notice of Right to an Expedited Grievance

_____ You are receiving this notice because we are denying your request to expedite (put on a fast track) your initial request for a Part D drug.

_____ You are receiving this notice because we are denying your request to expedite (put on a fast track) your appeal for a Part D drug.

Your request has been transferred to our regular processing time frame.

Initial requests will be processed no later than **72 hours** and appeal requests will be will be processed no later than **7 calendar days** from the day we received your request.

You may resubmit your request.

You may **resubmit your request** to expedite (put on a fast track) your initial request or appeal. If your prescribing physician tells us that applying the standard time frame could put your life or health at risk, we will automatically expedite your request.

You may file an expedited grievance.

If you disagree with our decision not to give you a fast decision, you may file an **expedited grievance** with us. We must decide within **24 hours** if our decision to deny making a fast decision puts your life or health at risk.

If we determine that we should have expedited your request, we will do so immediately and notify you of our decision.

If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours listed below if you want to file an expedited grievance, or want more information:

November 15 to March 1: 8:00 am to 8:00 pm, PST, 7 days a week, including holidays
March 2 to November 14: 8:00 am to 6:00 pm, PST, Monday through Friday

You can also call 1-800-MEDICARE for more information about the expedited grievance process.

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER
---------------------	-----------------

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation.

(Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
-----------	------

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE
-----------	------

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



IEHP Medicare DualChoice HMO SNP

Notice of Formulary Change

<Date>

Member Name
Street Address
City, State Zip Code

Member ID Number: <111-11-1111A>

Dear <insert name>:

This letter is to inform you of a change to our formulary.

Effective on <insert date>, <insert name of drug> *<Plan must state if the drug is being removed from the formulary or if there has been a change to the drug's preferred or tiered cost-sharing status. >*

We are <removing or changing the tiering structure of> <insert name of drug> because <Plan must explain the reason for removal of the drug from the formulary or why there is a change to the drug's preferred or tiered cost-sharing status. >

You may be able to use another drug to treat your medical condition that <is on our formulary or is in the same drug tier as <insert drug name. > These drugs include *<Plan must indicate alternative drugs that are in the same therapeutic category/class or in the same cost-sharing tier. >* You should ask your doctor if one of these drugs is right for you. If your doctor prescribes one of these drugs for you, your expected cost will be *<Plans must indicate the expected cost of the alternative drug(s). >*

If your doctor believes that none of the drugs listed above is right for you due to your medical condition, you may request <an exception to our formulary or a tiering exception. > To file a request, *<Plan must describe the process for filing an exception, including the need for the prescribing physician's supporting statement, and refer the enrollee to the appropriate section(s) in the EOC for more information. >*

Or, you can call us at phone number listed below for help in asking for this type of decision.

Attachment 11-13
Notice of Formulary Change

If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours listed below:

November 15 to March 1: 8:00 am to 8:00 pm, PST, 7 days a week, including holidays

March 2 to November 14: 8:00 am to 6:00 pm, PST, Monday through Friday

Thank you.

Inland Empire Health Plan

Inland Empire Health Plan Pharmacy Reimbursement Request



Section 1: Member Information		
Member Last Name	First Name	Contact Number
Member ID	Date of Birth	
Street address		
Section 2: Type of claim		
<input type="radio"/> Medical	<input type="radio"/> Vaccine only	<input type="radio"/> Injection
<input type="radio"/> Prescription	<input type="radio"/> Vaccine and injection	
Section 3: Instructions		
Submit this claim form, a copy of the receipt and Pharmacy print out to IEHP		
Section 4: Required information for claim process		
Your claim receipt/Pharmacy print out must contain the following information in order to be processed for payment. If below the information is not received, your claim cannot be processed and will be denied for missing information.		
<input type="radio"/> Pharmacy name, address, phone	<input type="radio"/> Medication quantity	
<input type="radio"/> Medication name, strength and form	<input type="radio"/> Total amount paid for medication	
<input type="radio"/> Date of service (must be within 1 year)	<input type="radio"/> National Drug Code (NDC)	
<input type="radio"/> Prescriber full name		
Section 5: Reason for request		
Section 6: Signature		
The above statements and attachments are true and complete to the best of my knowledge		
X _____	_____	
Signature	Date	

Claim submission is not a guarantee of payment. Non-Formulary medications are subject to prior authorization. Claim must be submitted within 1 year from the Date of Service.

Claim Mailing Address:
IEHP Member Services Department
P.O. Box 19026
San Bernardino
CA 92423

Questions?
Call IEHP Member Services:
1-877-273-IEHP (4347)
8:00a.m.-8:00p.m. (PST)
TTY/TDD users should call 1-800-718-4347

Legal Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties.