

# Pharmacy



## **Medicaid**

CareSource provides pharmaceutical management procedures to practitioners annually. Changes are made in writing by mail, fax or email or via the web.

On April 1, 2010, The Michigan Department of Community Health (MDCH) made changes to coverage of certain medications for Medicaid members. The drug classes previously identified as the “MHP 60/40 Carve Outs” will no longer be covered as part of the Michigan Medicaid Health Plan benefit, including the CareSource Health Care plan benefit. These changes are pursuant to direction from the Centers for Medicare and Medicaid Services (CMS) to the Michigan Medicaid agency. Please refer to the Michigan Pharmaceutical Product List (MPPL) for the carve-out drug lists found on the Pharmacy Benefit Manager website at <https://michigan.fhsc.com/>.

Medications within the drug classes listed will be added to the existing 100% carve out and billed at point-of-sale directly to MDCH’s contracted Pharmacy Benefit Manager.

Effective April 1, 2010, beneficiaries age 21 years and older will incur a \$1.00 co-pay for generic medications or \$3.00 co-pay for brand name medications.

There will be no co-pays for beneficiaries under the age of 21 per Medicaid policy. These medications will be subject to current Fee-For-Service (FFS) pharmacy policies and coverage limitations, including prior authorization requirements. Please discuss these changes with your patients. We will provide notification on [www.caresource.com](http://www.caresource.com) to CareSource members.

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## **Preferred Drug List (Formulary Medication)**

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CareSource maintains its own Preferred Drug List (PDL). This is a list of the most commonly used drugs preferred by CareSource. It is not a complete drug listing. CareSource has a Pharmacy and Therapeutics Committee that meets quarterly to review and make recommendations for drug list status. As each edition of the PDL is printed, it is then distributed to CareSource providers in the CareSource network. Additional copies may be obtained by visiting [www.caresource.com](http://www.caresource.com). CareSource covers a one month supply of all medically necessary Medicaid covered drugs. Some medication may require prior authorization. CareSource provides pharmaceutical management procedures to practitioners annually and when changes are made in writing by mail, fax or email or via the web.

## Pharmacy Benefit Management

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CareSource utilizes a pharmacy benefit manager, CVS Caremark, for drugs not covered by the Michigan Department of Community Health (MDCH) carve-out. To find out the medications included in the MPPL list and their coverage rules, please visit <http://michigan.fhsc.com>.

## Generic Substitutions

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Medicaid requires that a generic drug must be dispensed if a generic is available. Participating CareSource providers are notified annually of the drugs included in the PDL. Drugs included in the drug list are covered. In general, this includes:

- Most generic medications
- Limited over-the-counter, medically necessary medications when prescribed in writing by a licensed medical practitioner
- Certain smoking cessation products — up to a three month supply per year

## 72-hour Emergency Supply Policy

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In an emergency, State and Federal law requires that a pharmacy dispense a 72-hour, three day supply of medication for any patient awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication, whether or not the PA request is ultimately approved or denied. The Pharmacy must call for authorization at **1-800-390-7102** and follow the prompts for pharmacy.

## Drug Prior Authorizations Process

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Prescriptions for medication requiring prior approval may be approved when medically necessary and when PDL alternatives have demonstrated ineffectiveness. Providers can access a Pharmacy Prior Authorization request online at [www.caresource.com](http://www.caresource.com) through our Provider Portal. In these circumstances, the provider may fax a completed Prior Authorization Request Form (sample form in the Supplements/Forms section of this manual) to CareSource at **1-866-930-0019**. Requesting providers will receive a response within 24 hours (or sooner, depending upon the urgency of the request.)

## Pharmacy Prior Authorizations

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CareSource uses CVS Caremark as our pharmacy benefit manager. All requests for pharmaceutical prior authorizations should be directed to CareSource by calling **1-800-390-7102** or faxing to 1-866-930-0019. Or you can visit [www.caresource.com](http://www.caresource.com).

### Fax Number

Medicaid Pharmacy Prior Authorization: 1-866-930-0019  
For technical requests, call at **1-866-668-0321**.

*CareSource uses CVS Caremark as our pharmacy benefit manager. All requests for pharmaceutical prior authorizations should be directed to CareSource: Medicaid prior authorizations by calling **1-800-390-7102** or faxing to 1-866-930-0019.*

## Step Therapy/Quantity Limits

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Some formulary medications may require adherence to step therapy criteria or quantity limits. Step therapy requires that a first-line preferred medication, which is generally accepted as therapeutically equivalent, be tried before a second-line preferred or non-preferred medication. Quantity limits have been established on some drugs to align with recommended treatment courses and to help reduce over utilization and abuse. Exceptions to quantity limits may be granted with medical necessity as prescribed by a provider.

### Non-covered medications include:

- Infertility, cosmetic purposes or erectile dysfunction
- Any drug that may be obtained without charge under other local, state or federal programs
- Any drug labeled “Caution: Limited by federal law to investigational use”

If you feel it is medically necessary for a member to have a non-preferred drug, please request an exception by forwarding information about the non-preferred drug to CareSource. Please fax the information toll-free to **1-866-930-0019** using the Prior Authorization Request Form in the Supplements/Forms section of this manual. Your request will be reviewed and a decision made within 24 hours of receipt. If the request is not authorized, you will be notified of the reason. A pharmacist may request a 72-hour supply of medication on all non-preferred medications if clinically required after-hours or for emergency situations. Drugs such as fertility, cosmetic and erectile dysfunction medications are considered benefit exclusions and will not be considered.

## Prior Authorization Procedures

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Prior authorizations for Pharmacy services can be obtained by contacting CareSource online, by email, phone, fax or mail:

**Online:** [www.caresource.com](http://www.caresource.com)

**Email:** Please contact CareSource at **1-800-390-7102** for email address related to your request.

**Fax:** Send pharmacy requests to 1-866-930-0019. Copies of prior authorization forms can be found in the Supplements/Forms section.

**Mail:** Send prior authorization requests to:

**CareSource**  
**P.O. Box 1307**  
**Dayton, OH 45401-1307**

### Network Pharmacy

Our Pharmacy Directory gives you a complete list of our network pharmacies — that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit the website for a complete list of network pharmacies at [www.caresource.com](http://www.caresource.com).

## **Medicare**

### **Preferred Drug List (Formulary Medication)**

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The CareSource Preferred Drug List (Formulary) is the list of drugs that are covered as a pharmacy plan benefit for CareSource members. The CareSource Advantage formulary was selected in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. CareSource Advantage will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a CareSource Advantage network pharmacy, and other plan rules are followed.

For a complete listing of all prescription drugs covered by CareSource Advantage, please visit [www.caresource.com](http://www.caresource.com).

### **Tiered Medications**

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The plan has four cost-sharing tiers. Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing **Tier 1** includes generic drugs, this is the lowest tier
- Cost-Sharing **Tier 2** includes preferred brand drugs
- Cost-Sharing **Tier 3** includes non-preferred brand and generic drugs
- Cost-Sharing **Tier 4** includes specialty drugs, this is the highest tier

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

You can access the Preferred Drug List (PDL) online by visiting the CareSource Advantage website at [www.caresource.com](http://www.caresource.com).

### **Tiered Cost Sharing Exceptions**

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In certain circumstances, a member may request a reduction in the co-payment or co-insurance amount for a drug on the formulary.

A member must meet appropriate medical necessity criteria before the tiered cost sharing exceptions will be approved. To determine medical necessity, the CareSource Advantage Plan Pharmacy Benefit Manager will verify, through the provider's supporting statement(s) and/or standards documented in clinical guidelines adopted by the Plan, that all drugs in the lower preferred tiers:

1. Would not be as effective for the member as the requested drug
2. Would have adverse effects for the member, or both

Tiered cost sharing exception requests will be processed through CareSource's Pharmacy Benefit Manager's prior authorization review process.

## Medicare Part D Phone Numbers for Prior Authorization

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CareSource uses a Pharmacy Benefit Manager to handle Prior Authorization requests. All requests for pharmaceutical prior authorizations should be directed to CVS Caremark (Medicare Prior Authorizations) by calling toll-free **1-800-390-7102**.

- If you are a provider, press 3
- For questions or authorizations related to pharmacy, press 2
- For Medicaid authorizations or questions, press 1
- For Medicare Part D authorizations or questions, press 2

Written request via fax: **1-866-950-5359** for oral medications and injectable/specialty medications by faxing 1-866-950-5359. Or you can visit [www.caresource.com](http://www.caresource.com).

For technical support, call **1-866-668-0321**.

## Pharmacy Prior Authorization

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CareSource will process coverage determinations and exception requests in accordance with Medicare Part D regulations. Requests will be handled through the Prior Authorization review process. Prior Authorization requires a drug to be “pre-approved” in order for it to be covered under a benefit plan.

The Prior Authorization staff will adhere to the CareSource Advantage Centers for Medicare and Medicaid Services (CMS) approved criteria. The Pharmacy Benefits Manager National Pharmacy and Therapeutics Committee establishes clinical guidelines, and other professionally recognized standards in reviewing each case, rendering a decision based on established protocols and guidelines.

Providers can submit prior authorization requests by phone or fax. Providers will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

Standard requests will be reviewed and determinations will be made within 72 hours.

Expedited or urgent requests will be reviewed and determinations will be made in 24 hours. A request is considered urgent if the requestor believes that applying the standard process may seriously jeopardize the member’s life, health, or ability to regain maximum function.

Providers will be notified by phone or fax of the determination.

## Prior Authorization Procedures

Prescribers or their designated agents may request authorization for Pharmacy services by contacting CareSource online, by email, phone, fax or mail:

**Online:** [www.caresource.com](http://www.caresource.com)

**Email:** Please contact CareSource at **1-800-390-7102** for the email address related to your request.

**Fax:** 1-866-950-5359. Copies of prior authorization forms can be found in the Supplements/Forms section of this manual

**Mail:** Send prior authorization requests to:

CVS Caremark

PO Box 22690

Salt Lake City, UT 84122-0690

**Phone:** Call our toll-free number at 1-800-390-7102 and follow the appropriate menu prompts for Pharmacy.

**A copy of the drugs requiring prior authorization, step therapy or quantity limits are available on our website.**

## Formulary Exceptions

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The Preferred Drug List (Formulary) contains many commonly prescribed drugs. During the course of a plan member's medical care, there may be instances when a member requires a non-formulary drug or a drug that has formulary limits or restrictions (e.g., step-therapy requirements, prior authorization or quantity limits).

CareSource Advantage may approve an exception request for a non-formulary drug or a drug that has formulary limits or restrictions when medically necessary. To determine medical necessity, CareSource Advantage will verify through the provider's supporting statement(s) and/or standards documented in clinical guidelines adopted by CareSource Advantage, that:

- The member has tried and failed and/or has documented contradictions or intolerance to the equivalent formulary medications, and
- No other formulary agent is appropriate to treat the member's condition.
- Exception requests will be processed through the prior authorization process

Please see the Medicare Part D Coverage Determination Form in the Supplements/Forms section of this manual.

An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception you have the right to appeal our decision.

*A copy of the drugs requiring prior authorization, step therapy or quantity limits are available on our website.*

When you ask for an exception, you will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you can ask us to make:

**1. Covering a Part D drug for you that is not on our plan's List of Covered Drugs (Formulary).** (We call it the "Drug List" for short.)

**Legal Terms** — Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a "**formulary exception.**"

- If we agree to make an exception and cover a drug that is not on the Drug List, your patient will need to pay the cost-sharing amount that applies
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover

**2. Removing a restriction on the plan's coverage for a covered drug.**

There are extra rules or restrictions that apply to certain drugs on the plan's List of Covered Drugs.

**Legal Terms** — Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception.**"

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand-name drug.
  - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the co-payment or co-insurance amount we require your patient to pay for the drug.

**3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your patient will pay as their share of the cost of the drug.

**Legal Terms** — Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a "**tiering exception.**"

- If your drug is in Tier 3 you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 1 or Tier 2. This would lower your patient's share of the cost for the drug.

## Tell Us The Medical Reasons

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You must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

### Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as you continue to prescribe the drug for your patient and that drug continues to be safe and effective for treating the condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal.

## Appeal

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An appeal is defined as a special kind of complaint a member may make if he/she disagrees with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs they already received. A member may also make a complaint if he/she disagrees with a decision to stop services that they are receiving. For example, a member may ask for an appeal if our Plan doesn't pay for a drug/item/service they think they should be able to receive.

### What To Do If You Have A Problem or Complaint

#### Coverage Decisions, Appeals, Complaints

Our member's health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please contact us for Grievances, Organization Determinations, Coverage Determinations and Appeals questions at **1-800-390-7102**. We will work with you to try to find a satisfactory solution to your problem.

## Network Pharmacy

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*You must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information when you ask for the exception.*