

Section 13 – Pharmacy

Medicaid

Ohio's Medicaid Managed Care Plans (MCPs) are not responsible for prescription drug coverage for their members.

Effective February 1, 2010, prescription drug coverage for members of Medicaid MCPs transferred to the Medicaid Fee-For-Service (FFS) program. This change is only for retail prescription drugs and those that are administered in the patient's home, including drugs administered through a home health agency.

Prescribing CareSource providers for Medicaid members must contact the FFS vendor, ACS, for medication prior authorizations. All Medicaid consumers will have the same list of covered drugs and same prior authorization policy.

Details of this change include, but are not limited to the following:

- Co-Payment Requirements: Consumers may be required to pay a co-payment for prescription drugs. Prescribing providers may be asked by Medicaid consumers to prescribe medications that will not be subject to a co-payment.
- The federal requirement for tamper-resistant prescription pads will now include prescriptions for members of MCPs because they will be billed to the FFS program. Please see the ODJFS Website for more information.
- Some medical supplies are now covered under the pharmacy FFS program, including diabetes supplies, spacers, peak flow meters and condoms. As such, these supplies can no longer be billed under the Durable Medical benefit.
- To support member access and convenience, other medical supplies, such as wound care supplies and enteral feeds, can continue to be filled to the CareSource Pharmacy Benefit Manager through the retail pharmacy as previously done.
- Medications that are administered in a provider setting such as a physician office, hospital outpatient department, clinic, dialysis center, or infusion center will be billed to the MCP. Prior Auth requirements now exist for many injectables.
- A transition period for MCP members will be in effect from February 1 through April 20, 2010. For claims within these dates of service, MCP members will be able to continue to receive medications that were filled under the MCP within the previous six months.

A “quick list” of preferred drugs is available at <http://jfs.ohio.gov/ohp/bhpp/meddrug.stm>. This site also includes other information about the Ohio Medicaid pharmacy program, including the approved drug list, Pharmacy Provider Manual, prior authorization request fax form, and Pharmacy and Therapeutics Committee information. Providers may also request a pocket-sized copy of the preferred drug list and/or a visit from an educational outreach pharmacist by calling ACS at (614) 682-2034.

For questions pertaining to FFS prior authorization and prior authorization requests, please contact ASC by calling **1-877-518-1546** or faxing 1-800-396-4111.

For additional questions related to Ohio Medicaid or the Pharmacy Carve Out, visit the Ohio Department of Job and Family Services Website at <http://www.jfs.ohio.gov>.

NOTE: The information above only applies to CareSource's CFC and ABD plans.



Medicare

Preferred Drug List (Formulary Medication)

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 our Website at www.caresource.com.

Tiered Medications

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 specialty drugs.
- Cost-Sharing **Tier 4** includes non-preferred brand 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.

Tiered Cost Sharing Exceptions

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 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.

Part D Phone Numbers for Prior Authorization

CareSource uses a Pharmacy Benefit Manager to handle prior authorization requests. All requests for pharmaceutical prior authorizations should be directed to CareSource Medicare prior authorizations by calling toll-free **1-800-488-0134**:

- Part D coverage determination, press 1
- Part D grievances, press 2
- Part D appeals, press 3
- Mail order, press 4
- Fax on Demand press 5

Written request via fax: **1-866-950-9375** for oral medications and injectable/specialty medications by faxing to 1-866-950 9375. Or you can visit the Website at www.caresource.com.

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



Pharmacy Prior Authorization

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 CMS approved criteria. The Pharmacy Benefit Manager's 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.

Prescribers or their designated agents may request authorization by one of the following mechanisms:

Prior Authorization Procedures

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

Online — www.caresource.com, via our secure online Provider Portal

Email — Please contact CareSource at **1-800-488-0134** 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 Forms section of this manual

Mail — Send prior authorization requests to:

**CVS Caremark
P.O. Box 53993
Phoenix, AZ 85072-3993**

Phone — Call our toll-free number at **1-800-488-0134** and follow the appropriate menu prompts for pharmacy.

Formulary Exceptions

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 Formulary Exception Prior Authorization form in the 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 can appeal our decision.

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. The following are 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. ”
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- 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. ”
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- 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 copayment or co-insurance amount we require you 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."
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- If your drug is in Tier 4 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

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. Section 9 of this Manual explains how to make an appeal.

Appeal

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)

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 **1-800-488-0134** or refer to the Section 9 of this manual. We will work with you to try to find a satisfactory solution to your problem.

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 our Website at www.caresource.com for a complete list of network pharmacies.