

Provider Manual

Section 14.0

Outpatient Pharmacy Services

Table of Contents

- 14.1 Prescribing Outpatient Medications for Passport Health Plan Members**
- 14.2 Drugs Covered by the Outpatient Pharmacy Benefit**
- 14.3 Drug Prior-Authorization Procedure**
- 14.4 Lock-In Pharmacy Program**



14.0 Outpatient Pharmacy Services

14.1 Prescribing Outpatient Medications for Passport Health Plan Members

Any health care provider licensed to prescribe medications in the Commonwealth of Kentucky may write a prescription for a Passport Health Plan member provided it is within the scope of the provider's medical licensure and the prescriber has a valid, current Kentucky Medicaid license number. The provider's National Provider Identifier (NPI) and Medicaid number must appear on the prescription presented to the member. Pharmacies must include the prescriber's NPI when submitting all prescriptions for coverage.

14.2 Drugs Covered by the Outpatient Pharmacy Benefit

Passport Health Plan must have available to its members all medications appearing on the Department for Medicaid Services (DMS) Drug List; however, the Plan may impose additional requirements for medical necessity through the use of prior authorizations. The Plan may also impose quantity limits or day supply limits, and other appropriate edits to drive both practice and evidence-based therapy. The Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists, and consumer representatives, meets regularly to update the preferred drug list. Working with Passport Health Plan's pharmacy benefits manager (PBM), the Pharmacy and Therapeutics Committee annually reviews each category of drugs to identify preferred drugs based upon clinical and pharmacoeconomic data.

Providers must use the Plan's Preferred Drug List. An updated Preferred Drug List is distributed via the Plan's *Pharmacy News* and is also available through your Provider Relations representative or the Plan's web site, www.passporthealthplan.com/providercenter. Providers may also view the Plan's Preferred Drug List selections via ePocrates[®]. However, please note ePocrates[®] is not inclusive of all indications.

14.2.1 Categories of Covered Drugs

Three categories of drugs (available on the Plan's web site, www.passporthealthplan.com/providercenter) are covered for Passport Health Plan members:

- **Preferred medications:** Drugs available without restriction that have been evaluated by Passport Health Plan's Pharmacy and Therapeutics Committee and found to provide pharmacoeconomic value, therapeutic benefits, and a history of safe use.
- **Prior-authorized drugs (PA):** These drugs may require the use of a non-prior-authorized drug (step therapy) and/or meet additional medical necessity criteria for approval. Medical necessity criteria may include peer-reviewed criteria, relevant and statistically-appropriate studies, and relevant FDA approvals for drug use as contained in drug approval processes.

- **Selected categories of over-the-counter (OTC) drugs:** Covered OTC drugs should be used in the course of current or ongoing therapy for a member and for episodes of care that the practitioner thinks is appropriate within that member's course of therapy and care. A valid prescription for these medications is required for dispensing.

Drugs in all three of the above categories may have limits for quantity dispensed, days' supply, and requirements for use as appropriate to medical necessity.

14.3 Drug Prior-Authorization Procedure

14.3.1 Drugs Requiring Prior Authorization

Drugs requiring prior authorization are outlined on the Plan's regularly updated Preferred Drug List. A current list may be found at www.passporthealthplan.com. Following are the general categories of drugs that require prior authorization. Please refer to the most recent Preferred Drug List for specific drugs.

- The use of any drug in excess of the usual prescribing limits as described in official compendia; regulatory filings; nationally published references, such as drug points; the United States Pharmacopoeia Dispensing Information (USPDI); or American Hospital Formulary System (AHFS).
- Brand name drugs for which generic products are available or have a therapeutic generic alternative. Generic substitution is mandatory unless prior authorized.

14.3.2 Drug Prior-Authorization Request Procedure

Prior authorizations (PAs) should be submitted directly to the Plan's pharmacy benefits manager (PBM) via fax using the fax numbers on the PA form. Pharmacies are not permitted to dispense prescriptions for cash payment in lieu of following the PA process.

It is imperative that the PA form be completed in its entirety for the PBM to apply Passport Health Plan's clinical criteria. The practitioner, pharmacist, or prescriber's representative may complete the form. The practitioner's signature is optional. PA forms are available by calling your Provider Relations representative or the Provider Relations department at (502) 585-7943. The form may also be downloaded from the Plan's web site, www.passporthealthplan.com.

Determine if the fax is urgent or standard, based upon the medicine's classification. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The use of urgent fax lines for non-urgent requests is not appropriate.

When the PA is received via fax, the PBM stamps the time it is electronically imaged. The information is processed by the PBM using clinical criteria provided by Passport Health Plan.

Authorization decisions are communicated to both the prescriber and the pharmacy via fax if both fax numbers are included on the PA request form.

To check the status of a PA, you may contact the PBM's help desk at (800) 578-0898.

14.3.3 Drug Prior-Authorization Decisions

The following are the possible decision outcomes of a drug PA request:

- **APPROVAL:** If the information is complete and meets criteria, the PA is approved. The approval is faxed to both the prescriber and pharmacy (if the pharmacy fax number is included on the PA request) within 24 hours for a non-urgent request and within four hours for an urgent request, during normal business hours. Based on the medication and if requested by the prescriber, approvals may be granted for six (6) to twelve (12) months.
- **DENIAL:** If a PA request does not meet clinical criteria, the request is reviewed by the Passport Health Plan physician advisor and may be denied. The denial is communicated via fax to the prescriber and via letter to the member. **All PA denials are issued by a licensed physician.** These decisions may be appealed to the Plan.

Denial rationale is included on every PA denial fax, usually with a recommendation for an alternate preferred medication. However, denials for medications not indicated for clinical use may not include medication alternatives.

- **RECONSIDERATION** (via therapeutic substitution per 201 KAR 2:280): Per 201 KAR 2:280, a pharmacist may dispense a therapeutic equivalent drug product or may make adjustments in the quantity and direction to provide for an equivalent dose of the preferred formulary therapeutic alternative under the conditions of the regulation:
 1. A pharmacist may dispense a therapeutic equivalent drug product under the following conditions:
 - a. The ordering practitioner has indicated formulary compliance approval on the prescription in one of the following ways:
 - In the practitioner's own handwriting.
 - By checking a formulary compliance approval box on a preprinted form.
 - b. The pharmacist receives a formulary change as a consequence of the patient's third-party plan; and,
 - c. The product designated as preferred by the third-party formulary is in the same therapeutic class as the prescribed drug.
 - d. The pharmacist, within 24 hours of the formulary compliance substitution, shall notify the ordering practitioner in an original writing or by facsimile:
 - That the pharmacist engaged in formulary compliance; and,
 - The therapeutic equivalent drug product was dispensed.
 2. The pharmacist may make adjustments in the quantity and directions to provide for an equivalent dose of the preferred formulary therapeutic alternative.

14.3.4 Urgent Drug Prior-Authorization Requests

Urgent PA requests should be faxed to the PBM during regular business hours (Monday through Friday, 11 a.m. to 8 p.m. EST) using the urgent fax line as indicated in Section 14.3.4.1 below.

Remember, however, that inappropriate use of the urgent PA process will slow down the entire PA process for other providers.

As previously stated, determine if the fax is urgent or standard, based upon the medicine's classification. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The use of urgent fax lines for non-urgent requests is not appropriate.

14.3.4.1 Drug Prior Authorization Request Fax Numbers

Fax the completed PA form to one of the following fax numbers:

- Standard PA fax: **(877) 693-8280**.
- **Urgent** PA fax: **(877) 693-8476**.

14.3.4.2 Drug Prior Authorization Request Timeframes

Expect a response within the following timeframes, based on the type of request:

- Standard fax request: no sooner than **24 hours** after submission.
- **Urgent** fax request: no sooner than **4 hours** after submission.

You may call the PBM's Help Desk at (800) 578-0898 to alert them of the situation so they can closely monitor your urgent PA.

14.3.4.3 Emergency Supply

Since the PA department is not available at all times, the pharmacist may process an emergency supply if, in their clinical judgment, it is in the best interest of the member to do so. The maximum quantity that can be dispensed for Passport Health Plan is a **3-day supply**. This does not apply to narcotic agents.

14.3.5 Urgent Drug Prior-Authorization Requests After Hours

For medications that require a PA, the pharmacist may use his or her clinical judgment to dispense an emergency supply for up to three (3) days and a quantity that is appropriate for emergency needs. This policy is in effect only during the hours that the PBM Help Desk is closed (see hours below), and the use of this override is closely monitored for appropriateness.

The PBM Help Desk provides eligibility and technical adjudication assistance to dispensing pharmacists. The hours of operation are 7 days a week from 8 a.m. to 9 p.m.

14.3.6 Denial and Appeal Process

An authorization request for outpatient pharmacy services may be denied for lack of medical necessity, or it may be denied for failure to follow administrative procedures outlined in the Provider Contract or this *Provider Manual*. Denial letters are generated by the Plan to the member and the prescriber. The PBM faxes a denial notification to the prescriber and the pharmacy if fax numbers are available.

Your office must have the area code programmed into your fax machine with a CSID (Called Subscriber Identification) in order to receive fax confirmation of PA receipt with the seven (7) digit transaction number identifier. This 7-digit identifier is required if you call regarding a PA status.

Appeals for pharmacy services are handled by Passport Health Plan following the same procedure as pre-service appeals (see Section 6.11 for additional information).

14.4 Lock-In Pharmacy Program

Passport Health Plan has the right to assign (lock-in) a member to a specific pharmacy and/or practitioner when it has a reasonable belief that the member has abused the Plan's benefits and/or services.

The purpose of the lock-in program is to improve the quality of care for members and to decrease overutilization of certain pharmacy and medical services. This program works by focusing member access to services by limiting the number of providers and pharmacies. Members are assigned to one practitioner (PCP or other specialist) and to one pharmacy. Passport Health Plan will only pay for prescriptions, as listed above, filled at the lock-in pharmacy and written by the lock-in practitioner (exceptions may apply to Passport Health Plan members with Medicare or for emergency situations).

The following reasons may indicate the need to restrict a member to a specific provider:

- Simultaneous multiple drug (polypharmacy) use in the same therapeutic class inconsistent with the patient's medical diagnoses.
- Frequent use of medication beyond the usual expectation for the patient.
- Excessive amounts of drug(s) per day not compatible with diagnosed illness/condition.
- Use of drugs for illness/condition that usually could be managed by noncontrolled drugs.
- Use of multiple providers (PCPs, specialists, ERs) to obtain controlled substances without benefit of other provider's knowledge.
- Review of pertinent medical records from providers (PCPs, specialists, ERs) indicating illness/condition does not warrant use and/or frequency of controlled drugs.
- Refusal by member to follow the plan of treatment at a pain management clinic.
- Diversion of controlled drug(s) from one individual to others based on amounts and dosages obtained and expected clinical outcomes including review of pharmacy and/or physician records.
- Discharge of a member from a practice due to non-compliance or abuse of benefits.

A member may be referred to the Plan's Lock-In Committee by calling the program coordinator at (502) 585-7947.

