

# **Provider Manual**

## **Section 12.0**

### **Outpatient Pharmacy Services**

#### *Table of Contents*

- 12.1 Prescribing Outpatient Medications for Passport Health Plan Members**
- 12.2 Covered Outpatient Pharmacy Benefits**
- 12.3 Drug Prior-Authorization Procedure**
- 12.4 Lock-In Program**



# 12.0 Outpatient Pharmacy Services

## 12.1 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 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 for the prescription to be filled. Pharmacies must include the prescriber's NPI when submitting all prescriptions for coverage.

## 12.2 Covered Outpatient Pharmacy Benefits

Passport must have available to its members all medications appearing on DMS Drug List; however, Passport may impose additional requirements for medical necessity through the use of prior authorizations. In addition, Passport covers certain diabetic supplies. Passport may also impose quantity limits or day supply limits, and other appropriate edits to promote both safety and evidence-based therapy. The Pharmacy and Therapeutics Committee, comprised of practitioners, pharmacists, and consumer representatives, meets regularly to update the preferred drug list. Working with Passport'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 to promote cost-effective, evidence-based practices.

Providers are encouraged to use Passport's Preferred Drug List. Providers may view the preferred drug list via Passport's online searchable formulary. Updates to the Preferred Drug List are also distributed via Passport's *Pharmacy News* Bulletin which is also available through your Provider Network Account Manager or Passport's website

[www.passporthealthplan.com/pharmacy/communication/news/index.aspx](http://www.passporthealthplan.com/pharmacy/communication/news/index.aspx)

### 12.2.1 Categories of Covered Drugs

Three categories of drugs (available on Passport's web site, <http://www.passporthealthplan.com/pharmacy/formulary/index.aspx>) are covered for Passport members:

- **Preferred medications:** Drugs that have been evaluated by Passport's Pharmacy and Therapeutics Committee and found to provide pharmacoeconomic value, therapeutic benefits, and a history of safe use. Some preferred drugs may have age edits and require step therapy.
- **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 FDA approvals for drug use.
- **Selected categories of over-the-counter (OTC) drugs:** Covered OTC drugs should be

used in the course of current or ongoing therapy. 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 to ensure medical necessity.

### **12.2.2 Categories of Covered Diabetic Supplies**

The following diabetic supplies are only covered through the pharmacy with a valid prescription:

- Blood glucose meter
- Blood glucose test strips
- Calibrator solutions
- Insulin syringes
- Blood ketone test or reagent strips
- Urine test or reagent strips
- Lancets
- Lancing devices
- Pen needles

Quantity limits may apply.

## **12.3 Drug Prior-Authorization Procedure**

### **12.3.1 Prescription Medications and Prior Authorization**

#### **12.3.1.1 When is a Prior Authorization (PA) Required?**

PA is necessary for some medications to establish medical necessity and to ensure eligibility for coverage per State and/or Federal regulations. This may be due to specific Food and Drug Administration (FDA) indications, the potential for misuse or overuse, safety limitations, or cost-benefit justifications.

PA is required for medications that are:

- Outside the recommended age, dose or gender limits;
- Non-preferred (potential for “step therapy<sup>1</sup>” before approval);
- Non-formulary;
- Duplication in therapy (i.e. another drug currently used within the same class);
- New to the market and not yet reviewed by Passport’s Pharmacy & Therapeutics (P&T) Committee;
- Prescribed for off-label use or outside of certain diseases or specialties; or,
- An incorrect ICD-9 before 10/01/15 date of service and ICD-10 after 10/01 code when required.

### 12.3.1.2 How to Submit and Receive Notification on a PA

STEP 1: Determine if the drug requires PA.\*

- For the PA status of specific covered medications, please refer to our online searchable formulary by visiting [www.passporthealthplan.com/pharmacy](http://www.passporthealthplan.com/pharmacy).

STEP 2: Complete the PA form in its entirety.

- The Passport Prior Authorization Form is available on [www.passporthealthplan.com/pharmacy](http://www.passporthealthplan.com/pharmacy).
- A physician, nurse practitioner, or pharmacist may complete this form.

STEP 3: Submit the completed form for review to (844)-380-8831 or complete the online submission form at <http://passporthealthplan.com/pharmacy/pharmacy-portal-2/> and click on “Online Prior Authorization.” If the request is for a hospital discharge, check that box on the form.

STEP 4: Receive the response.

You may expect a response within 24 hours after submission.

Your office must have the area code programmed into your fax machine with a Called Subscriber Identification (CSID) number in order to receive fax confirmation of PA receipt.

<sup>1</sup> *Step therapy is defined as a trial of the safest and most cost effective therapy prior to progressing to other, more costly or recently-approved therapies (i.e. “step protocol”).*

*\*Timeframes are developed in accordance with requirements established by the Kentucky Department for Medicaid Services (DMS) and are subject to change. Incomplete or unclear information on the form may delay processing of a PA.*

### 12.3.1.3 What Happens During the PA Review Process:

1st review: A pharmacy technician compares all information on the request to Passport’s clinical authorization criteria. Passport utilizes medical criteria developed in collaboration with our Pharmacy Benefits Manager (PBM) and the P&T Committee. Criteria are derived from one or more of the following:

- Published American Federal Food and Drug approval indications for Therapy;
- Federal and/or State regulatory requirements;
- Drug compendia such as the American Hospital Formulary Service-Drug Information (AHFS-DI), the Gold Standard Clinical Pharmacology, the DrugDex or “Facts and Comparisons;”
- Evidence-based guidelines provided by non-biased resources from government agencies, such as the Agency for Healthcare Review and Quality(AHRQ), the American Society of

Clinical Oncologists (ASCO), or the American Academy of Pediatrics (AAP); and/or,

- Current medical literature and peer-reviewed, non-biased publications based on appropriate scientifically designed study protocol with validated outcome endpoints.

2nd review: If the request does not meet Passport's clinical authorization criteria, it is forwarded to a registered pharmacist. Additional information may be requested via fax or telephone from the prescribing provider.

3rd review: If the pharmacist cannot approve the request, the request is forwarded electronically to a Passport Medical Director for a decision.

#### **12.3.1.4 How Providers Are Notified of PA Decisions**

A fax will be sent to the requesting provider's submitted fax number with one of the following PA decisions.

**Approved** The PA request has been approved for pharmacy reimbursement. Based on the medication and if requested by the prescriber, approvals may be granted for up to twelve (12) months.

**Partial Denial** Reimbursement has been approved for a therapeutic alternative or for a different dose than requested.

**Deferral** The final PA action was not decided due to the need for additional information. Providers must fax the requested information back to the PBM in order to obtain a final PA decision.

**Denial** The PA request was denied. All PA denials are issued by a licensed physician. These decisions may be appealed.

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

#### **12.3.1.5 Emergency Supply**

Pharmacies may dispense a 72-hour emergency supply of medication if they are unable to contact the prescriber for prior authorization. This does not apply to drugs excluded from coverage by state and federal regulations.

#### **12.3.1.6 Prescription Cost Sharing**

Beginning January 1, 2014, some Passport members will have a copay for prescriptions. Copay requirements are as follows:

**2014 Cost Sharing Requirements**

\$0	Generic Drugs
\$2	Preferred Drugs
\$4	Non-preferred Drugs

Total cost sharing cannot exceed an aggregate of 5% of a family's income per calendar quarter. The pharmacy will be made aware of any copayment responsibility and will collect it from the member when the claim is adjudicated.

A pharmacist may refuse to dispense a prescription to a member who does not pay the cost sharing amount at the time of picking up the prescription; however, the pharmacist must dispense a 72-hour supply of the prescribed drug if the member has an emergency condition which requires an emergency supply of the drug.

The following members do not have a copayment requirement unless they receive a non-preferred medication.

- Members 18 years of age and under;
- Pregnant members;
- Institutionalized members;
- Members receiving family planning services and supplies;
- American Indians receiving services directly by an American Indian health care provider or through referral under contract health services;
- Members in hospice care; and,
- Members receiving preventive services.

### **12.3.2 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 Passport 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 following the same procedure as pre-service appeals (see Section 2.11 for additional information).

### **12.4 Lock-In Program**

The Passport Lock-In Program is designed to ensure medical and pharmacy benefits are received at an appropriate frequency and are medically necessary. The Lock-In Program is a requirement of the Kentucky DMS.

Inappropriate use or abuse of Medicaid benefits may include:

- Excessive emergency room or practitioner office visits;
- Multiple prescriptions from different prescribers and/or pharmacies; and/or
- Reports of fraud, abuse, or misuse from law enforcement agencies, practitioners, Office of the Inspector General, pharmacies, and Passport staff.

Under the Lock-In Program, a member's medical and pharmacy claim history and diagnoses are reviewed for possible overutilization. Members who meet the criteria will either be locked-in to a designated hospital for non-emergency services; and/or one prescriber, who may not necessarily be the member's PCP, and one pharmacy for controlled substances.

- Members who receive services from a non-designated or non-referred provider (i.e. via PCP) and are informed of the financial responsibility before the service is provided will be responsible for payment.
- Members who receive services provided in the emergency department of a hospital for a condition that is not determined to be an emergency will also be responsible for payment.
- Lock-in members must be provided the Acknowledgement of Responsibility for Payment form located at <http://www.chfs.ky.gov/dms/provider.htm>.

All designated providers (i.e. PCPs, controlled substance prescribers, hospitals and pharmacies) will receive written notice of the member's Lock-In status. All members have the right to appeal within the first 30-days of the Lock-In effective date.

Initially, a member will be locked-in for a minimum of 24 months. At least annually, members will be reviewed to determine whether to maintain their lock-in status for another 12-month period.

The Lock-In Program is not intended to penalize or punish the member. The program is intended to:

- Connect members with case managers who can identify reasons for over use of medical services and provide education on their health care needs;
- Reduce inappropriate use of health care services;
- Facilitate effective utilization of health care services; and
- Enhance quality of care by developing a stable patient-physician and patient-pharmacist relationship.

#### **12.4.1 How to Refer a Member**

To refer a member, to determine if a member is part of the Lock-In program, or for general questions regarding the program, please contact the Pharmacy Coordinator for pharmacy or controlled substance prescriber inquiries or the ER Coordinator at 502-588-8564 for hospital inquiries.

#### **12.4.2 How to Report Fraud and Abuse**

If you suspect fraud and/or abuse by a Passport member or provider, it is your responsibility to report this immediately by calling one of the telephone numbers listed below:

Corporate Compliance Hotline: (855) 512-8500

KyHealth Choices Medicaid Fraud Hotline: (800) 372-2970