TheHealthPlan

Chapter 10

Pharmacy

Introduction

The Health Plan (THP) promotes optimal therapeutic use of pharmaceuticals by encouraging the use of cost-effective generic and/or brand drugs in certain therapeutic classes.

THP has processes in place that explain how members, pharmacists, and practitioners determine which medications are covered under members' benefit, any utilization management requirements and where members can fill medications.

THP publishes a prescription formulary at least annually for Commercial (including Exchange plans), Medicare Advantage and Self-Funded/Administrative Services Only (ASO) lines of business on the corporate website at **healthplan.org**. The formulary indicates a drug's copay tier and utilization management requirements including prior authorization, step therapy, or quantity limit requirements.

THP has drug policy coverage criteria to encourage the use of preferred drugs in the therapeutic class for the treatment of certain diseases. THP publishes the drug policy coverage criteria for Commercial, (including Exchange plans), Mountain Health Trust (WV Medicaid), and Self-Funded/ASO lines of business on the provider portal at myplan.healthplan.org →"Policies." Drug policy coverage criteria for Medicare Advantage is published under Additional Resources on the Medicare portion of the corporate website at healthplan.org → "Medicare" "Quality Assurance and Utilization Management." Select drugs require prior authorization based on specific plan requirements.

Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the Food and Drug Administration (FDA) "orange book" as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug. This is also known as "AB" rated.
THP pharmaceutical management program allows consideration of medical necessity exceptions for members in obtaining coverage for non-preferred drugs and brand drugs when a generic is available.

Prescriptions can be filled at any participating THP pharmacy within the member's pharmacy network. Where allowed by **Freedom of consumer choice for pharmacy** (WV House Bill 4112), THP reserves the right to redirect medications to a specific pharmacy such as a specialty pharmacy for certain medications. Any medication redirection will be communicated to practitioners via the prior authorization notification letter.

Clinical Criteria for Pharmaceutical Management Program

THP utilizes both external clinical vendor and internal utilization management policies to perform medical necessity reviews for pharmaceuticals. Drug policy coverage criteria is developed based on reasonable medical evidence and guidelines using one (1) or more of the following:

- FDA label literature, national accepted treatment guidelines, and/or standard medical reference compendia adopted by the United States Department of Health and Human Services.

Additional factors take into consideration include:

- Individual member circumstances and medical history, West Virginia Bureau for Medical Services (BMS) Preferred Drug List, Coverage Details and Criteria/Policy Manual (for WV Medicaid policies only), preferred covered drugs for the condition, preferred formulary agents in the drug class and cost analysis.

Policies are reviewed at least annually by the clinical vendor or THP using the above development criteria and additional factors. Recommendations are reviewed by Pharmacy and Therapeutics Committees.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee serves as an advisory committee responsible for providing multi-disciplinary oversight and review of new and evolving pharmaceuticals for possible inclusion in the benefit structure for THP's pharmaceutical management program. The P&T Committee also works to ensure compliance with FDA label literature, national accepted treatment guidelines, standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

Specialty Pharmacy Program

Specialty drugs are used to treat complex, chronic conditions and/or rare diseases. Extensive management for safety and effectiveness is often needed along with dosage monitoring and adjustment for optimal treatment of the member's condition.

Specialty drugs require prior authorization to ensure appropriate utilization of the drug. Dispensing may be limited to pharmacies with specific services and distribution programs to ensure proper management and delivery of these medications. Diseases targeted to receive therapy include, but are not limited to, rheumatoid arthritis, severe chronic psoriasis, multiple sclerosis, hepatitis C, hemophilia, certain cancers, growth deficiency, cystic fibrosis, Crohn's disease, and organ transplant.

To verify if a medication is considered a specialty drug, please refer to the **formulary** (list of covered drugs). Specialty drug names will be followed by "SP" for specialty drug and listed as tier 4, 5, or 6 in the formulary.

Pain Management Program and Opiate/Opioid Management

THP limits the acute use of opioid medications for moderate to severe pain from acute injury, medical treatment, or surgical procedure for fully insured and employer funded members. The first fill of an opioid medication will be limited to a 7-day supply. This limit is for the first fill of an opioid medication for a member who has no history of opioid usage in the past 130 days.

For THP members that need further pain management, a prior authorization will be required if the opioid:

- Exceeds 80 morphine milligram equivalents
- Is taken for greater than 90 consecutive days
- Is long acting
- Use of more than one immediate release and one extended-release opioid

A clinical pharmacist will review the coverage review to evaluate that the opioid is being utilized in accordance with the utilization management policy. Additionally, if necessary, the member can be limited to one (1) prescriber and one (1) pharmacy.

Formulary medications will be preferred over non-formulary medications. Step therapy rules may be applied when reviewing a request for non-formulary medications. Also, dosing and quantities may be limited. If the prescribing practitioner does not bill THP for services, no coverage of opioids will be provided through the pharmacy benefit.

Prescribers issuing controlled substances to MHT members must review the WV PDMP in accordance with Section 5042 of the SUPPORT Act prior to issuance. In the case that a prescriber cannot check the PDMP despite a good faith effort by the prescriber, the prescriber must document such good faith effort, including the reason(s) why the prescriber was not able to check the PDMP. Prescribers may be required to submit, upon request, such documentation to BMS.

THP's Pharmacy Network

THP members may obtain prescriptions at any participating THP pharmacy. For the location of a participating pharmacy, contact Express Scripts, THP's prescription benefit manager at 1.800.988.2262 or express-scripts.com. The member's THP ID card must be presented to the pharmacy. The member may be required to pay a copayment based on their prescription drug plan.

Formulary

THP formularies are a listing of prescription medications that are preferred for use. Formulary drugs will be a covered benefit when dispensed at participating pharmacies. Non-formulary drugs are not covered without an approved coverage determination from THP. Coverage requests may be requested.

Choosing a Preferred Drug Formulary

Formulary Tier Definitions

- Prescription – Drugs that can only be dispensed upon order (prescription) by a qualified practitioner of care. Additionally, only drugs which are labeled "Caution: Federal law prohibits dispensing without a prescription" will be considered eligible
- Generic – A drug available as a chemically and therapeutically equivalent copy of a brand name drug. It is usually available from several manufacturers. Generics must meet federal standards for potency and bioavailability
- Brand Drug – A prescription item only available from a single source supplier
- Multi-Source Brand Drugs – Brand name drugs which are manufactured by more than one producer. These agents are usually available as generic equivalents
- Over-the-Counter Drugs (OTC) – Drugs which are not restricted to prescription-only status. These agents are available for purchase without practitioner approval and are not covered by THP
- Home Delivery Service – Certain group benefit designs allow members to receive medications at home via the mail. (See your specific benefits for details)

Pharmaceutical Substitution and Interchange Program

Only generic drugs that are listed in the FDA "orange book" as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug. Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Failure to dispense the generic will subject the member to a higher copayment consisting of the brand copayment plus the cost difference between the brand and generic drug.

Generic Difference Policy

If a prescription order specifies that a brand name drug must be dispensed when the generic equivalent is available, or the prescription order allows for generic substitution and the member elects to have the prescription filled with a brand name drug instead, the member must pay the brand copayment plus the difference between THP cost of a brand name and its generic equivalent i.e., THP only pays for the generic cost. Non-formulary brand versions of generic drugs require coverage review.

Non-Formulary Requests (Exception Policy)

Certain non-formulary medications are eligible for coverage only after a member-specific approval has been prior authorized. Member-specific criteria may include age, gender, and clinical conditions determined by the practitioner for authorization to be granted for a specific drug. A non-formulary exception request can be made by the member, member's representative, or practitioner. A Formulary Exception Request Form may be accessed at myplan.healthplan.org or by contacting Pharmacy Services.

THP Pharmacy Service Department is available Monday through Friday 8 a.m. to 5 p.m. and after hours via telephonic auto attendant's emergency option seven days a week, including holidays at 1.800.624.6961, ext. 7914.

Requests will be reviewed according to the following criteria:

- The request for the non-formulary drug is for a condition or medical need not met by existing drugs on THP formulary
- In the practitioner's medical judgment, the formulary alternatives have been ineffective in the treatment of the member's disease or condition (documentation in the member's clinical record is required)
- The formulary alternative causes, or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the member (documentation in the member's clinical record is required)

Prior Authorization for Coverage

Prior authorization for coverage consists of criteria-based programs for determining whether members qualify for coverage of a requested drug based upon the plan's drug policy coverage criteria. Drug policy coverage criteria are based on recommendations of the Pharmacy and Therapeutics Committee. These criteria are periodically reviewed for alignment with FDA label literature, national accepted treatment guidelines, Standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

Mandatory Generic Policy and Formulary Override Procedure

Pharmacy benefits with a mandatory generic component require that if the prescription item ordered is available from a generic supplier, THP will cover the maximum allowable cost of the generic. Additional costs of brand name medication will be the responsibility of the member. This is regardless of any dispense as written indicators (DAW).

Exemption Review Request Procedure

At the time of dispensing, the pharmacy will transmit a claim to THP. If the item submitted is available as a generic, THP returns the cost of the prescription in the following manner:

Brand submitted	Generic submitted
The brand copay is assessed + the difference in the cost of the generic and brand product to arrive at a brand penalty copayment. Copay = brand copayment + penalty	The generic copayment is assessed, and it is the member's responsibility to pay at the time of dispensing

Exemptions

The following agents are exempt from mandatory criteria:

Generic drugs not listed in the FDA "orange book" of generic equivalents with an "AB" rating. "AB" rating is defined as therapeutic and generic equivalent.

In cases of defined medical necessity, an exemption to the mandatory generic policy may be authorized. Exemption requests can be called to pharmacy services at 1.800.624.6961, ext. 7914.

The requests must include:

- Supporting medical literature describing treatment failures of the generic
- Defined allergic potential to a specific component in a generic not found in the brand product. i.e., fillers, dyes, preservatives
  - Documented treatment failure of a specific member with supporting clinical assessment and appropriate lab readings
  - Member refusal to take the generic is not acceptable

Pharmacy Prior Authorizations

THP's Pharmacy Services Department assists with member coverage, eligibility and prior authorization requirements. THP's medical pharmacy prior authorization requirements can be found on THP's secure provider portal at myplan.healthplan.org and corporate website at healthplan.org.

Traditional Prior Authorization (TPA)

THP Pharmacy Services Department adjudicates coverage review determinations and prior authorization updates. Traditional prior authorization criteria are developed and conform to plan coverage conditions for client review and selection and in administering prior authorization policies. Traditional prior authorization rules require coverage review for all claims presented for a given drug to determine if the member meets drug policy coverage criteria.

Smart Rules – Automated Prior Authorization Processes at the Point of Sale

Smart rules in pharmacy benefit manager's system use sophisticated logic in conjunction with available drug history, member reported health information, and medical claims information to automatically determine whether a member qualifies for coverage of a drug based on the plan's drug policy coverage criteria. As a result, smart rules limit coverage reviews to only those claims where the member's information is least likely to meet drug policy coverage criteria.

Quantity Per Dispensing Event

Quantity per dispensing event rules set dispensing quantity thresholds that reduce client exposure to unnecessary cost, without creating obstacles to access for most members. Drugs that are subject to quantity per dispensing event rules usually have specific quantity limitations approved by the FDA. Through traditional prior authorization, members can be approved for an additional quantity limit exception.