

Passport Advantage
Provider Manual
Section 9.0
Outpatient Pharmacy Services

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9.0 Outpatient Pharmacy Services

The Passport Advantage outpatient prescription drug program is administered through PerformRx, the Plan's Pharmacy Benefit Manager (PBM).

The PBM Help Desk provides eligibility and technical adjudication assistance to dispensing pharmacists. These services are available 24 hours a day, 7 days a week.

- PerformRx HelpDesk: (866) 533-5490

9.1 Prescribing Outpatient Medications

Any health care provider licensed to prescribe medicines may write a prescription for a Passport Advantage member, provided it is within the scope of the provider's medical licensure and within the terms of Passport Advantage benefits.

9.2 Drugs Covered by the Outpatient Pharmacy Benefit

Passport Advantage covers outpatient medications under two separate benefits: the Medicare Part B benefit and the Medicare Part D benefit.

Medicare Part B

Passport Advantage covers outpatient medications under the Medicare Part B benefit according to the same coverage policies and limitations as the Medicare program.

Medicare Part D

Passport Advantage also covers outpatient medications under the Medicare Part D benefit. The Medicare Part D benefit varies from one Part D sponsor to another. The Passport Advantage Part D benefit is described below in Sections 9.2.1 through 9.6.

9.2.1 Formulary

As required by the Medicare program, Passport Advantage has a formulary for outpatient medications covered under the Plan's Part D benefit. In general, Passport Advantage will only cover drugs on our formulary. The Pharmacy and Therapeutics Committee comprised of physicians, pharmacists, and other qualified health professionals, meets regularly to update the formulary. Working with the Passport Advantage Pharmacy Benefit Manager (PerformRx), the Pharmacy and Therapeutics Committee reviews at least annually, each category of drugs to identify preferred drugs based upon clinical and pharmacoeconomic data.

If the Plan removes drugs from the formulary, adds prior authorizations, quantity limits and/or step therapy restrictions on a drug, or moves a drug to a higher cost-sharing tier, providers will be

notified via the Plan's web site at least 60 days prior to the effective date of the change. To view the Passport Advantage formulary, visit our web site at www.passportadvantage.org. To request a copy of the formulary, please contact PerformRx at (866) 533-5490.

9.2.2 Utilization Management

For certain prescription drugs, the Plan has additional requirements for coverage or limits on coverage. These include:

- Prior Authorization: Requires authorization from the Plan in order for these drugs to be covered as a benefit.
- Quantity Limits: Specifies the amount of a drug the Plan will cover per prescription or for a defined period of time.
- Step Therapy: Requires the trial of another medication prior to the Plan covering the requested medication.
- Generic Substitution: Generic drugs are available to Passport Advantage members at a lower cost share. Members are required to use the generic version of drugs on the Plan's formulary, except in cases where the generic version is medically inappropriate, unavailable or otherwise noted on the formulary.

9.3 Categories of Covered Drugs

Drugs on the Passport Advantage formulary are organized into different tiers. Copayments for members are determined according to which tier a drug is assigned. Generic drugs are placed in the lowest tier and will have the lowest copay. Brand name drugs are in a different tier and may have a higher copay amount. Brand name drugs may be categorized as preferred or non-preferred.

- Preferred Medications: Drugs available without prior authorization that have been evaluated by the Plan's Pharmacy and Therapeutics Committee and found to provide pharmacoeconomic value, therapeutic benefits, and a history of safe use based on evidence from the licensure, experience and clinical outcomes. Most generic drugs are preferred.
- Non-Preferred Medications: Drugs which may require prior authorization, step therapy or fulfillment of medical necessity criteria for approval. Medical necessity criteria include FDA-approved uses, peer reviewed medical literature, well-established clinical practice guidelines and pharmacoeconomic studies. These drugs may not offer a superior therapeutic, safety and pharmacoeconomic profile compared to preferred alternatives or they may have a generic equivalent.

Drugs in both categories may have additional limits and/or restrictions as described in Section 9.2.2 above.

9.4 Coverage Determination Requests

For Medicare, a prior authorization is a type of coverage determination. A coverage determination is any decision (i.e., an approval or denial) made by Passport Advantage regarding payment or benefits. The following actions are "coverage determinations":

- A decision to, or not to, provide or pay for a Part D drug that a member believes may be covered by the plan (including a decision not to pay because the drug is not on the plan's formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because the plan determines the drug is otherwise excluded under section 1862(a) of the Social Security Act);
- A decision concerning an exceptions request for non-formulary drugs;
- A decision on the amount of cost sharing for a drug; or
- A decision whether a member has, or has not, satisfied a prior authorization or other utilization management requirement.

Drugs requiring prior authorization are outlined on the Plan's regularly updated formulary. A current formulary may be found at www.passportadvantage.org. Following are general reasons for prior authorization. Please refer to the most recent formulary for specific drug prior authorization requirements.

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

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 Agreement or the Provider Manual. Denial notices are generated by the Plan to the member. The member's denial notice will include information regarding the member's appeal rights.

9.4.1 Prior Authorization Request Procedure

Prior authorizations (PAs) should be submitted directly to the PBM via fax using the numbers on the form. Standard requests must be faxed to (866) 369-6038. A response will be provided within 72 hours. Please see Section 9.4.2 for information regarding expedited PA requests.

A copy of the Passport Advantage Coverage Determination Form is provided in Section 13 Forms and Documents. It is imperative that this form be completed in its entirety for the PBM to apply Passport Advantage clinical criteria. The prescriber, member or their appointed representative may

complete the form. Additional Coverage Determination 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.passportadvantage.org.

When the Coverage Determination Form is received via fax, the PBM auto-stamps the time it is received. To receive a fax confirmation of receipt, a provider office must have the area code programmed into the fax machine with your Called Subscriber Identification (CSID) number. The information is processed by the PBM using clinical criteria provided by Passport Advantage. Authorization decisions are communicated to the prescriber, member and/or appointed representative.

To check the status of a PA request, you may contact the PBM's help desk at (866) 533-5490. Prior authorization approvals are valid until the end of the contract year (i.e. calendar year for Passport Advantage).

9.4.2 Expedited Drug Prior Authorization Requests

Expedited PA requests including those related to a hospital discharge should be faxed to the PBM using the Expedited Fax Line at (866) 533-5491. A response will be provided within 24 hours if the Coverage Determination form is complete. Providers may call the PBM Help Desk at (866) 533-5490 for assistance 24 hours a day, 7 days a week.

Expedited requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the member's life, health or ability to regain maximum function. The use of expedited fax lines for non-expedited requests is not appropriate and will slow the entire process for other providers with actual expedited requests.

9.4.3 Drug Prior-Authorization Decisions

The decision outcomes of a drug PA request are as follows:

APPROVAL: If the information is complete and meets criteria, the PA is approved. The approval is faxed to the prescriber within 72 hours for a standard request and within 24 hours for an expedited request. The member is notified via an automated call system and via letter.

DENIAL: If a PA request does not meet clinical criteria, the request is reviewed by the Passport Advantage Medical Director and may be denied. The denial is communicated via fax and letter to the prescriber and via letter to the member.

9.5 Part D Transition Policy

To be eligible for a temporary supply, Passport Advantage members must meet the two requirements below:

1. The change to their drug coverage must be one of the following types of changes:

- The drug they have been taking is **no longer on the plan's Drug List**.

- -- or -- the drug they have been taking is **now restricted in some way**.

2. Members must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

Passport Advantage will cover a temporary supply of the member's drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of *30-day supply*, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

Passport Advantage will cover a temporary supply of the member's drug **one time only during the first 90 days of membership** in the plan. This temporary supply will be for a maximum of *30-day supply*, or less if the prescription is written for fewer days.

- **For those who are new members, and are residents in a long-term care facility:**

Passport Advantage will cover a temporary supply of the member's drug **during the first 90 days of membership** in the plan. The first supply will be for a maximum of 31-day supply, or less if the prescription is written for fewer days. If needed, we will cover additional refills during the member's first 90 days in the plan.

- **For those members who have been a member of the plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:**

Passport Advantage will cover one 31-day supply supply, or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- Members who have a change in level of care (setting) will be allowed up to a one-time 31-day transition supply per drug. For example, members who:

- Enter long-term care (LTC) facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary, with very short term planning taken into account (often under 8 hours).
- Are discharged from a hospital to a home.
- End their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary.
- End a long-term care facility stay and return to the community.

If a member has more than one change in level of care in a month, the pharmacy will have to call the plan to request an extension of the transition policy.

9.6 Member Copayments

Passport Advantage members are subject to low prescription drug copayments based on their level

of low income subsidy, which is determined by the Centers for Medicare & Medicaid Services (CMS).

Once a Passport Advantage member and the Medicare program have paid the “limit on true out-of-pocket costs” toward the member’s drug benefit in a calendar year, the member will not be required to pay additional copayments for the remainder of the calendar year.