- If approved, the prescribing physician will be notified of approval via fax or telephone, and the claims system will be coded with the approval.
- The participant may call the Customer Service phone number on his or her identification card to determine if the prescription is approved.
- If denied, the prescribing physician will be notified via letter, fax, or telephone.
- The participant is also notified of all denied requests via letter.The appeals process will be detailed on the denial letters sent to the participants and physicians.

Coverage for medications not on the formulary (specific to Select Drug Program® participants only)

Providers may request formulary coverage of a covered non-formulary medication when all formulary alternatives have been exhausted or there are contraindications to using the formulary alternatives. The provider should complete the covered non-formulary appeal form providing detail to support use of the covered non-formulary medication and should fax the request to 215-241-3073 or 1-888-671-5285. If the non-formulary request is approved, the drug will be paid at the appropriate formulary benefit level. If the request is denied, the participant and provider will receive a denial letter with the appropriate appeals language. Whether or not an appeal is filed, the participant may always obtain benefits for the covered non-formulary drug at the appropriate non-formulary benefit level. Out-of-pocket expenses for non-formulary drugs are higher than for formulary drugs.

Appealing a decision

If a request for prior authorization/preapproval or override results in a denial, the participant or physician, on the participant's behalf, may file an appeal. Both the participant and his or her provider will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. In all cases, the physician needs to be involved in the appeals process to provide the required medical information for the basis of the appeal.

Prescription Drug Program provider payment information

A Pharmacy Benefits Management company (PBM), administers our prescription drug benefits, and is responsible for providing a network of participating pharmacies and for processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. AmeriHealth anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a participant copayment.

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AmeriHealth utilizes an independent Pharmacy Benefits Management (PBM) company, FutureScripts®, to manage the administration of its commercial prescription drug programs. As our PBM, FutureScripts is responsible for providing a network of participating pharmacies, administering pharmacy benefits, and providing customer service to our participants and providers.

Prior Authorization

Prior authorization is a requirement that your physician obtain approval from your health plan for coverage of, or payment for, your medication. AmeriHealth requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing area physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by the participant's prescribing physician, and the participant's available prescription drug therapy history. Their review includes a determination that there are no drug interactions or contraindications, that dosing and length of therapy are appropriate, and that other drug therapies, if necessary, were utilized.

Without prior authorization, the participant's prescription will not be covered at the retail or mail order pharmacy (see 96-Hour Temporary Supply Program on following page). The prior authorization process may take up to two working days once complete information from the prescribing physician has been received. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a participant to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

Currently, the drugs listed below are a part of the prior authorization program. Prior authorization applies to all formulations of these specific drugs, including, but not limited to tablet, capsule, and oral suspension. Abstral® , AcipHex®, Actiq®, Adcirca™, Afinitor®, Alodox™, Altabax™, Ambien CR®, Amerge®, Ampyra™, AMRIX®, Amturnide™, Androderm®, Apidra®, SoloSTAR®, Aplenzin™, Atacand®/Atacand HCT®, Avapro®/Avalide®, Axiron®, Axert®, Banzel™, Beconase AQ®, BiDil®, Byetta®, Caduet®, Capresla®, Caverject®, Cayston™, Celebrex®, Cesamet®, Cialis®, Cimzia®, Cozaar®/Hyzaar®, Daytrana™, Dexilant®, Diabetic Test Strips (except Autodisc®, Breeze® 2, Contour®, FreeStyle Lite®, and Precision Xtra®), Edarbi™, Edex®, Edluar™, Effient™, Egrifta™, Enbrel®, Exforge®, EXFORGE HCT®, Exjade®, Fanapt™, Fentora®, Flector® Patch, Flonase®, Forteo™, Fortesta™, Frova®, Genotropin®, Gilenya™, Gleevec®, Glumetza™, Humalog®, Humatrope®, Humira®, Humulin®, HYCAMTIN® Capsules, Imitrex®, Intuniv™, Invega™, Iressa®, Keppra XR™, Kineret®, Lantus®, Levitra®, Livalo®, Lyrica®, Magnacet™, Maxalt®, Micardis®/Micardis HCT®, Mobic®, MUSE®, Nasacort® AQ, Nexavar®, Nexiclon™, Norditropin®, Noxafil®, Nucynta™, Nuedexta™, NutriDox™, Nutropin®, Nutropin AQ®, Nuvigil®, Oforta™, Omnaris®, Omnitrope®, Onglyza™, Onsolis™, Pennsaid®, Pradaxa®, PrandiMet™, Prevacid®, Prevacid/NapraPAC®, Prilosec® Suspension, Pristiq™, Protonix®, Provigil®, Pylera™, Qualaquin®, ReliOn®/Novalin®, Relpax®, Renvela®,Requip® XL™, Revatio™, Revlimid®, Rhinocort Aqua®, Rozerem™, Ryzolt™, Sabril®, Saizen®, Samsca™, Savella™, Serostim®, Silenor®, Simponi™, Sprycel®, Staxyn™, Striant®, Suboxone®, Subutex®, Sumavel™, Sutent®, Sylatron™, Symlin®, Taclonex®, Taclonex Scalp® Suspension, Tarceva®, Tasigna®, Tekamlo™, Tekturna®/Tekturna HCT®, Temodar® Oral, Testim®, Teveten®/Teveten HCT®, Tev-Tropin®, Thalomid®, Toviaz™, Treximet™, Twynsta®, Tykerb®, Uloric®, Ultram® ER, Valturna®, Veramyst®, Viagra®, Victoza®, Vimovo™, Vimpat™, Voltaren® Gel, Votrient™, Vytorin®, Vyvanse™, Xenazine™, Xyzal®, Zegerid®, Zipsor™, Zmax™, Zolinza®, Zolpimist™, Zomig®, Zorbtive®, Zortress®, Zytiga™, and Zyvox®.

This list is subject to change.

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Age and gender limits

The FDA has established specific procedures that govern prescription prescribing practices. These rules are designed to prevent potential harm to patients and to ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals 14 and older, such as ciprofloxacin, or prescribed only for females, such as prenatal vitamins. The pharmacist's computer provides up-to-date information about FDA rules. If the participant's prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request preapproval of restricted medications when medically necessary. The approval criteria for this review were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing area physicians and pharmacists. The participant should contact the prescribing physician to request that he or she initiate the preapproval process. To determine if a covered prescription drug prescribed for you has an age or gender limit, call FutureScripts® at 1-888-678-7012.

Quantity level limits

Quantity level limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses and length of therapy of a particular drug. We have several different types of quantity level limits that are explained in detail below.

Rolling 30-day period

This quantity limit is based on dosing guidelines over a rolling 30-day period. Examples of quantity level limits per rolling 30-day period are Emend® (four 125mg capsules + eight 80mg capsules or four trifold packs [one 125mg capsule + two 80mg capsules]); Boniva® (two 150mg tablets); Avonex® (one kit, four injections); Betaseron® (15 vials); Copaxone® (32 vials); Fosamax Plus D™ (five tablets); and Rebif® (12 injections); migraine drugs such as: Amerge® (nine 2.5mg tablets), Imitrex® (36 50mg tablets), Maxalt® (12 10mg tablets), Migranal® (eight 4mg nasal spray units), Stadol NS® (four 10mg units), and Zomig® (nine 5mg tablets); sedative hypnotic drugs, such as Sonata® (14 capsules) and Ambien® (14 tablets); and oral narcotic drugs such as OxyContin® (90 units), Percocet® (180 units), and Percodan® (180 units). For example, if a participant went to the pharmacy on October 1, 2009, for one of these medications, the computer system would have looked back 30 days to September 1, 2009, to see how much medication was dispensed. The purpose of these limits is to make certain that these drugs are being used appropriately and to guard against overuse or stockpiling.

- **Refill too soon.** With this quantity level limit, if a participant used less than 75 percent of the total day supply dispensed, the claim will be rejected at the pharmacy. This will ensure that the medication is being taken in accordance with the prescribed dose and frequency of administration.

- **Therapeutic drug class**. This quantity level limit applies to some classes of drugs, such as narcotics (i.e. short and long acting). If a participant uses more than one drug within the same class, he or she may be unsafely duplicating medications and would be affected by the total quantity limits for a therapeutic drug class. Participants will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic drug class each month.

If a physician requires that a participant needs a medication therapy that exceeds any of the quantity level limits described above, the physician must request a quantity limit override. The participant is required to contact the prescribing physician to initiate a preapproval request for an override.

Some drugs may have a time period for quantity limit exceptions of 6 to 12 months. If the exception for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a participant to continue the drug therapy that exceeds a quantity limit after the expiration date, a new request for a quantity limit exception will need to be submitted and approved in order for coverage to continue.

To determine if a covered prescription drug prescribed for you has a quantity level limit, call FutureScripts at 1-888-678-7012.

PROCEDURES THAT SUPPORT SAFE PRESCRIBING

96-hour Temporary Supply Program

The 96-hour Temporary Supply Program applies to the following covered medications:

- Most medications that require prior authorization
- Medications that are subject to age limits (preapproval required for ages outside of recommended ranges)
- Migraine medications with quantity level limits, such as Amerge®, Imitrex®, Maxalt®, Migranal®, Stadol NS®, and Zomig® (preapproval of quantity override required for amounts over the quantity level limits)

Under the 96-hour Temporary Supply Program, if a participant's doctor writes a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity level limit for a medication, and prior authorization/preapproval has not been obtained by the doctor, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to the member with no out-of-pocket cost-sharing[1] at that time.
2. By the next business day, our PBM will contact the member's doctor to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by our PBM, the review will be completed and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled and the appropriate prescription drug out-of-pocket cost-sharing will be applied[1].
5. If denied, notification will be sent to the doctor and the member.

[1] Participants with an integrated drug benefit (e.g., CMM) will pay the discounted cost of the 96-hour supply as well as the remainder of the prescription order (if approved) at the time of purchase, and the medical claim for reimbursement will be processed through standard procedures.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/ preapproval request will be approved. Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations such as Retin-A® (tube), Enbrel® (2-week injection kit), medroxyprogesterone acetate (monthly injectable), and erectile dysfunction drugs. Additionally, certain drugs to treat hemophilia (antihemophilic factors) are not usually purchased at the pharmacy and must be special-ordered; therefore, they are not eligible for the 96-hour temporary supply.

The process for requesting a prior authorization/preapproval or override is as follows:

- The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and submits it to our PBM by fax at 215-241-3073 or 1-888-671-5285. A participant's physician may request the form by calling 1-888-678-7012. Participants may request the form through Customer Service on behalf of their physician, but it must be completed and submitted by the doctor
- The PBM will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.