Procedures That Support Safe Prescribing

AmeriHealth NEW JERSEY

Prior Authorization

AmeriHealth (AH) 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 was developed and endorsed by the Pharmacy and Therapeutics Committee which is an established group of Medical Directors and independent area physicians and pharmacists.

Using this approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by the member's prescribing physician, and the member'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 were utilized, if necessary.

Without prior authorization, the member'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.

Currently, the medications that are part of the prior authorization program include Aciphex®, Ambien CR, Amevive, Atacand®/Atacand HCT®, Avapro®/Avalide®, Benicar®/Benicar HCT®, Botox®, Byetta®, Caverject®, Celebrex®, Cialis®, Cozaar®/Hyzaar®, Cymbalta®, Diovan®/Diovan HCT®, Edex®, Enbrel®, Forteo®, Gleevec®, Humira®, Iressa®, Kineret®, Levitra®, Lipitor®, Lunesta®, Lyrica®, Micardis®/Micardis HCT®, Mobic®, Muse®, Myobloc®, Neosol®, Nexavar®, Nexium®, NuLev®, Paxil CR®, Prevacid®, Prevacid/NapraPAC®, Protonix®, Provigil®, Raptiva®, Revatio®, Revlimid®, Rozerem®, Singulair®, Sutent®, Symlin®, Synagis®, Tarceva®, Teveten®/Teveten HCT®, Thalomid®, Ultram ER®, Viagra®, Xolair®, Zavesca®, Zmax®, and Zyvox® . This list is subject to change.

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 ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals over age 14 such as ciprofloxacin, or if prescribed only for females, such as prenatal vitamins. The pharmacist's computer provides up-to-date information about FDA rules. If the member's prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request pre-approval of restricted medications when medically necessary. The approval criteria for this review were developed and endorsed by the Pharmacy and Therapeutics Committee which is an established group of Medical Directors and independent area

physicians and pharmacists. The member should contact the prescribing physician to request that he/she initiate the pre-approval 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. The first type of quantity limit is based on a maximum 90-day supply of a medication per fill. Examples of quantity level limits when a prescription is written by the member's physician for a 90-day supply per fill include Avonex® 3 kits (12 injections), Betaseron® 45 vials, Copaxone® 96 vials, Fosamax Plus D® 15 tablets, and Rebif® 36 injections. Examples of quantity limits where the prescription would typically be written for a 30-day supply include 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. If the member's prescription exceeds the quantity limit, the pharmacist will fill for the appropriate day supply and then the member must follow up with his or her physician regarding future prescriptions. The member's physician may request a quantity limit override if the member's therapy requires him or her to receive a larger daily dose of medication. The member should request that the prescribing physician initiate the pre-approval request for an override.

Another type of quantity limit is based on FDA dosing guidelines over a rolling day period. Examples of quantity level limits per rolling 90-day period are Emend® (125mg 12 capsules + 80mg 24 capsules or 12 tri-fold packs [125mg 3 capsules + 80mg 6 capsules]), Boniva® (150 mg 6 tablets), and also migraine drugs such as: Amerge® 2.5mg 27 tablets, Imitrex® 50mg 108 tablets, Maxalt® 10mg 36 tablets, Migranal® 4mg nasal spray 24 units and Zomig® 5mg 27 tablets. In addition some infertility agents which are typically prescribed for a 30-day supply (if covered under the group contract) such as Fertinex® 60 ampules, Follistim® 60 ampules, Gonal-F® 60 ampules, Humegon® 60 ampules, Pergonal® 60 ampules, and Repronex® 60 ampules are included in these quantity limits per rolling 30-day period.

An example of a rolling 90-day quantity limit is, if a member went to the pharmacy for a prescription drug that has a 90-day quantity level limit on October 1, 2005, the computer system would have looked back 90 days to July 1, 2005 to see how much medication was dispensed. If the quantity exceeded the FDA recommendations, the member's physician would have been required to submit information to the Pharmacy Services Department to explain why the increased quantity was needed. The member would have been required to contact the prescribing physician to initiate the pre-approval request for an override. The purpose of these limits is to make certain that these drugs are being used appropriately and to guard against overuse or stockpiling.

Another type of quantity level limit is "Refill too Soon". If a member has used less than 75% 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.

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

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 (pre-approval required for ages outside of recommended ranges).
- Migraine medications with quantity level limits such as Amerge®, Imitrex®, Maxalt®, Migranal®, Stadol NS® and Zomig® (pre-approval of quantity override required for amounts over the quantity level limits).

Under the 96-Hour Temporary Supply Program, if a member'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/pre-approval 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, the Pharmacy Services Department 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 Pharmacy Services, 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] Members 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/pre-approval 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/Pre-Approval 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 the Pharmacy Services Department by fax at 215-241-3073 or 1-888-671-5285. A member's physician can request the form by calling 1-888-678-7012. Members can request the form through Member Services on behalf of their physician, but it must be completed and submitted by the doctor.
- AmeriHealth Pharmacy Services Department 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.
- **If approved,** the prescribing physician will be notified of approval via fax, or telephone and the FutureScripts™ Rx Claim System will be coded with the approval.
- The member can call the member service phone number on his/her identification card to determine if the prescription is approved.
- **If denied,** the prescribing physician will be notified via letter, fax, or telephone.
- The member is also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to the members and physicians.

Coverage for medications not on the Formulary (specific to Select Drug Program® members 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 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 member and provider will receive a denial letter with the appropriate appeal language. Whether or not an appeal is filed, the member 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/pre-approval or override results in a denial, the member or physician, on the member's behalf, may file an appeal. Both the member and their 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 appeal 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), which is affiliated with AmeriHealth, administers our prescription drug benefits, and is responsible for providing a network of participating pharmacies and 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. AmeriHeatlh 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 member copayment.