

Prescription drug guidelines



Our prescription drug plans are designed to provide you with safe and affordable access to covered medications. It's important to know how to find out what's covered by your plan and what guidelines may apply to those drugs.

Our prescription drug plans are administered by a pharmacy benefits management (PBM) company that is responsible for maintaining a network of participating pharmacies, administering benefits, conducting prior authorization reviews, and providing customer service. This document explains the prior authorization process, age and quantity limits, and a number of other ways we support the safe prescribing of covered medications.

This document applies to the Standard Formulary, Select Drug Program[®] Formulary, and Value Formulary.



What you need to know

- Learn how to find out what prescription drugs are covered by your plan.
- You may need additional approval from your health plan before you receive prescription drugs.
- Safety edits, such as age and quantity limits, apply to some prescription drugs.
- Your doctor may request coverage for non-formulary medications on your plan, also known as a formulary exception.
- You have a right to appeal a coverage decision you disagree with.
- Understand how we work with the PBM.

Formulary

The formulary is a list of drugs covered by your prescription drug plan. If you're not yet a member, you can visit [amerihealth.com/rx](https://www.amihealth.com/rx) to view the formulary guides or searchable tools. You can also call **1-888-678-7012** to find out if a drug is included in your plan's formulary. As a member, you can log in at [amerihealth.com](https://www.amihealth.com) to find drugs on the formulary and view and manage your prescription drug plan. The pharmacy tools and services available will help you better understand your prescription drug coverage so you can take full advantage of the cost-saving options available to you.

Log in at [amerihealth.com](https://www.amihealth.com) to:

- Review your prescription records — what you spent and when and where your prescriptions were filled
- Locate a network retail pharmacy near you
- Review your coverage and cost-sharing information
- Price a specific drug and compare savings with a generic equivalent
- Access formulary information
- Check on drug-drug interactions

To see the formulary status of a drug or to find out if the drug requires prior authorization, please refer to the formulary guide or searchable tool at [amerihealth.com/rx](https://www.amihealth.com/rx). You can also call the Pharmacy Benefits number on the back of your member ID card to find out whether a drug is included in your formulary.

Prior authorization

Prior authorization means that your doctor must obtain approval from your health plan for coverage of, or payment for, your medication. AmeriHealth requires prior authorization of certain covered drugs to confirm that the drug prescribed is medically necessary, clinically appropriate, and is being prescribed according to the FDA-approved labeled or medically accepted use. Some examples of drugs that require prior authorization are drugs to treat conditions like hemophilia, cancer, and hepatitis C. The approval criteria were developed and approved by the Pharmacy and Therapeutics Committee, a group of doctors and pharmacists from the area.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by your prescribing doctor, and your available prescription drug therapy history. Their evaluation may include a review of potential drug-drug interactions or contraindications, appropriate dosing and length of therapy, and utilization of other drug therapies, if necessary.

Once prior authorization has been obtained, your prescription will be covered at the retail or mail-order pharmacy.

Important: The prior authorization process may take up to two business days once complete information from the prescribing doctor has been received. Incomplete information will result in a delayed decision.

Safety edits

Safety edits are applied to prescription medications to ensure the safe and appropriate use of drugs. They are designed to align with the latest clinical practice guidelines and FDA-approved use outlined in the manufacturer package insert. There are different types of safety edits, some of which will prompt member counseling at the point of sale or require prior authorization review.

Age limits. If your prescription falls outside of the FDA guidelines, it may not be covered until prior authorization is obtained. Some drugs are approved by the FDA only for individuals ages five and older, such as Zafirlukast (generic for Accolate). In addition, an age limit may be applied when certain drugs are more likely to be used in certain age groups. For example, drugs to treat Alzheimer's disease may require prior authorization for use in young adults. The prescriber may request consideration for an age limit override when medically necessary. The approval criteria for this review were developed and approved by the Pharmacy and Therapeutics Committee. Contact your doctor to initiate the prior authorization process. To determine if a covered prescription drug prescribed for you has an age limit, visit [amerihealth.com/rx](https://www.amihealth.com/rx) or call the Pharmacy Benefits number on the back of your member ID card.

Quantity limits. Quantity limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses, standard dosing, and/or length of therapy. We have several different types of quantity limits that are explained in detail below. The purpose of these limits is to ensure safe and appropriate utilization. If you require more than the limit, your doctor will need to submit a prior authorization request.

Note: If applicable, quantity limits will apply if a formulary exception is approved, allowing coverage of a non-formulary drug.

Quantity over time. This quantity limit is based on dosing guidelines over a rolling time period. For example, if a drug has a quantity limit over a 30-day time period and you went to the pharmacy on January 1 for one of these medications, the plan would have looked back 30 days to December 2 to see how much medication was dispensed. The purpose of these limits is to prevent the dispensing of excessive quantities. Examples of quantity limits over time are:

- Ibandronate (generic for Boniva[®]) 150 mg = 1 tablet per 30 days
- Sumatriptan (generic for Imitrex[®]) 50 mg = 18 tablets per 30 days
- Diabetic supplies such as blood glucose test strips = 200 strips per 30 days
- Oral erectile dysfunction agents such as sildenafil (generic for Viagra[®]) = 8 tablets per 30 days

Note: This limit applies to all oral erectile dysfunction agents, and it is cumulative.

Maximum daily dose. This quantity limit defines the maximum number of units of the drug allowed per day. This limit is based on the maximum daily dose approved by the FDA, the formulation, and/or availability of multiple strengths of the drug where a dose can be achieved with another available strength. Examples of maximum daily dose quantity limits are:

- Sedative hypnotic drugs, such as zolpidem (generic for Ambien®) = 1 tablet per day
- Oral opioid drugs, such as oxycodone/acetaminophen (generic for Percocet®) 5/325 mg = 12 tablets per day
- Guanfacine ER 24 hour = 1 tablet per day

Refill too soon. This limit is in place to encourage appropriate utilization and minimize stockpiling of prescription medications. For example, based on this edit, a member can receive a refill of a prescription after 75 percent utilization. However, if the same prescription is refilled every month at the 75 percent utilization point, an excess supply will be accumulated. The claims system looks at the member's refill history over the past 365 days to calculate the supply on hand before dispensing a refill. If there is more than an 18-day supply on hand for a 30-day fill (or 36-day supply for a 90-day fill), the claim will reject and the next available refill date will be provided.

Day supply limit. This limit is based on the day supply and not the quantity. However, quantity limits may apply as well. Day supply limits apply to some classes of drugs, such as opioids. If a quantity limit applies, you will be limited to the maximum daily dose for that drug. The following are examples of drugs that have a day supply and a quantity limit:

- Butalbital-containing headache agents, such as butalbital/aspirin/caffeine or opioids, such as oxycodone tablets
 - Day supply limit = 5-day supply per 30 days for adults (18 or older); 3-day supply per 30 days for younger than 18
 - Quantity limit = 6 tablets per 1 day
 - Maximum quantity allowed without prior authorization = 30 tablets (6 tablets per day for 5 days)
- Opioid-containing cough and cold products, such as hydrocodone/homatropine
 - Day supply limit = Two 5-day supplies per 60 days for adults (18 and older); two 3-day supplies per 60 days for younger than 18
 - Quantity limit = 30 ml per 1 day
 - Maximum quantity allowed without prior authorization = 150 ml (30 ml per day for 5 days)

If your doctor wants to prescribe you a medication therapy that exceeds any of the utilization limits described above, your doctor must request a quantity limit override. You are required to contact the prescribing doctor to initiate the request.

If the prior authorization and formulary exception are approved for up to two years, the expiration date will be given at the time the approval is made. If your doctor wants you to continue the drug therapy as requested after the expiration date, a new request for a prior authorization needs to be submitted and approved for coverage to continue.

To determine if a covered medication prescribed for you has a quantity limit or requires prior authorization, call the Pharmacy Benefits number on the back of your member ID card or visit amerihealth.com/rx.

Morphine Milligram Equivalent (MME) limit. The cumulative daily limit of 90 Morphine Milligram Equivalent (MME) per day will be applied across all opioids. This limit is calculated based on the total daily dose of the opioid drug, by itself or in combination with other opioids. For members whose opioid dose exceeds 90 MME/day, prior authorization is required.

Medications containing an active ingredient in the table below are impacted by MME limits:

- Benzhydrocodone
- Codeine
- Dihydrocodeine
- Fentanyl
- Hydrocodone
- Hydromorphone
- Levorphanol
- Meperidine
- Methadone
- Morphine
- Opium
- Oxycodone
- Oxymorphone
- Tapentadol
- Tramadol

Cumulative stimulant limits. When used in high doses, CNS (central nervous system) stimulants (e.g., amphetamine, methylphenidate) are associated with increased risk for cardiac-related adverse events, such as hypertension and new or worsening psychosis, including manic behavior. Cumulative stimulant limits are a safety measure to ensure the provider has assessed the member for alternative medication and advised about the risks associated with stimulant use. Cumulative stimulant limits work by calculating the total daily stimulant dose by the drug's active ingredient. Claims for stimulants that exceed the limits outlined below require prior authorization.

Active ingredient	Medications impacted (brands and generics)	High cumulative daily dose
Amphetamine	Adzenys® [XR ODT/ER], Dyanavel® [XR], Evekeo® [ODT]	60 mg/day
Amphetamine/Dextroamphetamine	Adderall® [IR/XR], Mydayis®	60 mg/day
Dextroamphetamine	Dexedrine®, Zenzedi®, ProCentra®, Xelstrym™	60 mg/day
Lisdexamfetamine	Vyvanse®	70 mg/day
Methamphetamine	Desoxyn®	60 mg/day
Dexmethylphenidate	Focalin® [IR/XR]	40 mg/day
Methylphenidate	Ritalin® [IR/LA], Daytrana®, Cotempla®, Metadate® [ER/CD], Methylin®, Quillivant® XR, Concerta®, Aptensio® XR, QuilliChew® ER, Adhansia® XR, Jornay PM™, Methylphenidate (Relexxii®)	72 mg/day
Serdexmethylphenidate	Azstarys™	52.3 mg/day

Note: Prior authorization and other safety edits, including quantity limits and age limits, continue to apply.

Concurrent Drug Utilization Review. Concurrent Drug Utilization Reviews (cDUR) are built into the prescription claim adjudication system to review a member's prescription history for possible drug-related problems, including drug-drug interactions and duplicate therapies. Drugs may reject at the point of sale or generate a message to the dispensing pharmacist when there is a safety concern. The dispensing pharmacist can review the issue with the prescribing physician and override the rejection if appropriate.

Examples of cDUR messages are:

- Drug-drug interaction: Sildenafil (Viagra®/Revatio®) and nitroglycerin in combination may lead to potentially fatal hypotension.
- Drug therapy duplication: Simvastatin and atorvastatin in combination will trigger a message to alert the dispensing pharmacist that there is a duplication of statin therapy.

Prior authorization process

- Your doctor can access electronic prior authorization (ePA) platforms, such as CoverMyMeds and SureScripts, to submit a prior authorization request. Alternatively, your doctor may complete a prior authorization form or write a letter of medical necessity and submit it to the PBM by fax at **1-888-671-5285**.
- 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.
- If approved, the prescribing doctor will be notified of approval via fax or telephone and the claims system will be coded with the approval.
- You may call the Pharmacy Benefits number on the back of your member ID card to determine if the prescription is approved.
- If denied, the prescribing doctor will be notified via letter, fax, or telephone.
- You are also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to you and your doctor.

Coverage for medications not on the formulary (for Value Formulary members only)

Doctors may request formulary coverage of a non-formulary medication when there has been a trial of at least three formulary alternatives, when available, or there are contraindications to using the formulary alternatives. Your doctor should complete a non-formulary exception request form, providing details to support use of the non-formulary medication, and should fax the request to **1-888-671-5285**. If the non-formulary request is approved, the drug will be paid at the highest applicable cost-sharing. Edits like quantity limits and MME limits will still apply. If the request is denied, you and your doctor will receive a denial letter with the appropriate appeals language.

Appealing a decision

If a request for prior authorization/preapproval or exception results in a denial, you, or your doctor on your behalf (with your consent), may file an appeal. Both you and your doctor will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that you keep your doctor involved to provide any additional information on the basis of the appeal.

Prescription drug program information

The PBM administers our prescription drug benefits and is responsible for providing a network of participating pharmacies and processing prescription drug 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 may incorporate certain savings resulting from rebates into reductions in the overall cost of prescription drug benefits. Under most benefit plans, prescription drugs are subject to member cost-sharing.

