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Overview

Our pharmacy benefits managers, FutureScripts® and FutureScripts® Secure, handle the administration and claims processing of the AmeriHealth prescription drug programs. As part of our commitment to comprehensive coverage, we offer a wide range of plans covering prescription drugs approved by the U.S. Food and Drug Administration (FDA).

The Pharmacy and Therapeutics Committee was formed to oversee our pharmacy policies and procedures and to promote the selection of clinically safe, clinically effective, and economically advantageous medications for our Members. The Committee is comprised of internal and external clinical pharmacists and Physicians in a variety of specialties.

The Pharmacy and Therapeutics Committee periodically reviews and evaluates our drug formularies to ensure their continued effectiveness, safety, and value. The Committee meets on no less than a quarterly basis to review and update the formularies. Physicians are notified of these changes through Partners in Health Update™.

Before you prescribe to Members, we recommend that you become familiar with this section. In it, you will find information about our prescription drug programs, formularies, and prior authorization process.

Prescription drug programs

Select Drug Program®

The Select Drug Program is an incentive-based formulary that includes generic drugs and a defined list of brand drugs. The program is set up with a three-tiered cost-sharing structure: generic formulary, brand formulary, and non-formulary brand. Generic formulary drugs are covered at the lowest formulary level of cost-sharing, brand formulary drugs are covered at a higher formulary level of cost-sharing, and non-formulary brand drugs are covered at the highest non-formulary level of cost-sharing. Coverage for drugs is based on the Member’s Benefits Program.

Standard Drug Program

The Standard Drug Program is an open formulary drug program. It consists of a two-tiered Copayment structure, with the generic Copayment being lower than the brand Copayment. However, flat Copayment and Coinsurance options are also offered. Coverage for drugs is based on the Member’s Benefits Program, which includes exclusions and other pharmacy edits.

Deductible/Coinsurance Drug Program

The Deductible/Coinsurance Drug Program is an open formulary program with increased Member cost-sharing. The program includes an up-front Deductible (per person, per calendar year) and Coinsurance, combined with an annual out-of-pocket maximum. Coverage for drugs is based on the Member’s Benefits Program, which includes exclusions and other pharmacy edits.

Medicare Part D

Medicare Part D, a Medicare prescription drug benefit is designed to help Medicare Beneficiaries gain access to insurance coverage for prescription drugs. It also provides Medicare Beneficiaries who have limited income with extra help paying for prescription drugs.

Medicare Advantage HMO Members who qualify have access to comprehensive coverage with low cost-sharing, which allows them to pay only a small amount for their prescriptions.
**Part D vaccine administration**

The Centers for Medicare & Medicaid Services (CMS) requires that vaccine administration for Medicare Advantage HMO Members be covered under their Medicare Part D benefits. Part D Members have four options for receiving a vaccination. The available options and how you can collect payment from the Member are as follows:

<table>
<thead>
<tr>
<th>Where Member receives vaccine</th>
<th>Who administers vaccine</th>
<th>Member payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>Pharmacist</td>
<td>Member pays his or her pharmacy Copayment/Coinsurance to the pharmacy.</td>
</tr>
</tbody>
</table>
| Pharmacy                      | Physician               | Member pays his or her Copayment/Coinsurance to the pharmacy for the vaccine.  
Physician may request the standard fee for the administration up front. |
| Physician's office            | Physician               | Physician may request the standard fee for the vaccine and its administration up front. |
| FutureScripts Secure Direct Ship Specialty Pharmacy Program* | Physician               | Member pays his or her pharmacy Copayment/Coinsurance to the direct ship Provider for the vaccine.  
Physician may request the standard fee for the administration up front. |

*FutureScripts Secure Direct Ship Specialty Pharmacy Program is available under the Member’s pharmacy coverage.

It is important that you routinely ask your Medicare Advantage HMO Members to show their Medicare ID cards. This will ensure the appropriate collection of the Member’s responsibility.

When you collect payment directly from the Member for either a Part D vaccine or administration, be sure to provide the Member with a receipt. The Member should then submit the receipt, along with a Direct Member Reimbursement Form, to AmeriHealth for reimbursement consideration and to ensure that all out-of-pocket expenses are accurately accumulated toward his or her other pharmacy benefits. Members can request this form by contacting Customer Service.

**Note:** These procedures do not apply to hepatitis B (for intermediate and high-risk individuals), influenza, and pneumococcal vaccines, which are covered through the Member’s Part B (medical) benefits. These three vaccines may continue to be administered and billed as usual. All other vaccines, including childhood vaccines, are covered under Part D and must be billed through the Member’s Part D benefits.

**Part D vaccine ordering instructions**

If a Part D vaccine is needed, there are two ways the Member can get it:

1. **Write a prescription.** The Physician should write a prescription for the Part D vaccine that a Member can take to a retail pharmacy. The Member will be charged the appropriate Part D Copayment/Coinsurance, and the vaccine will count toward his or her true out-of-pocket (TrOOP) expense. The Member should then bring the vaccine back to the Physician’s office for administration. He or she should pay the Physician the full fee for the administration of the vaccine. If the Physician also charges for the office visit, the Member is responsible for the applicable office visit Copayment. The Physician should provide the Member with a receipt for payment of the vaccine administration, and the Member can submit that receipt to his or her Part D carrier for reimbursement consideration.
2. **Use the FutureScripts Direct Ship Specialty Pharmacy Program.** Through this program, the vaccine can be shipped to the Physician’s office for administration. See page 13.7 for more information.

**Participating pharmacy network**

Members should take their Member ID cards to a pharmacy that participates in the FutureScripts or FutureScripts Secure network. Many retail pharmacies in the U.S. are part of this network, including large chains and independently owned pharmacies. When Members are traveling in the U.S., participating pharmacies will accept Member ID cards and dispense medications based on the Member’s pharmacy benefits.

**Mail order program**

Most of our prescription drug programs include a mail order option that offers a convenient, cost-effective way for Members to receive their medications. FutureScripts and FutureScripts Secure process mail order prescriptions for our Members. For a Member to use this benefit, write two separate prescriptions for the Member: One prescription is for the initial supply, which the Member may fill immediately at a retail pharmacy, and the second prescription is for the mail order program and should be written for a 90-day supply of medication. Members receive information on how to fill mail order prescriptions upon enrollment. Shipments through the mail order program are available to all areas in the U.S.

**Preventive drugs covered at $0 Copayment**

Under the Patient Protection and Affordable Care Act, health insurers are required to cover preventive services for commercial Members at no cost-sharing. Three classes of drugs are considered preventive for certain ages and genders and are covered at a $0 Copayment as listed in the following table:

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Gender</th>
<th>Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Folic acid (prescriptions with 0.4 – 0.8 mg)</td>
<td>Women only</td>
<td>All ages</td>
</tr>
<tr>
<td>Iron supplements</td>
<td>All</td>
<td>Children ages 6 months through 1 year</td>
</tr>
<tr>
<td>Oral fluoride</td>
<td>All</td>
<td>Children ages 6 months through 6 years</td>
</tr>
</tbody>
</table>

*Note: The $0 Copayment does not apply to Medicare Advantage HMO Members.*

**Drug formulary information**

The Select Drug Program and Medicare Part D use formularies to give Members cost-effective access to covered medications.

**Select Drug Program® Formulary**

The Select Drug Program Formulary is maintained by the Pharmacy and Therapeutics Committee and is an incentive-based formulary. It includes all generic drugs as well as a defined list of brand drugs that have been selected for formulary coverage based on their medical effectiveness and value. The formulary includes at least two agents to treat each covered disease state. The entire formulary is reviewed over the course of the year for quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the marketplace. As a result, formulary additions and deletions occur throughout the year.
Before prescribing a medication for Select Drug Program Members, keep in mind the following:

- Members in the Select Drug Program typically pay a fixed Copayment for up to a 30-day supply of drugs listed on the formulary.
- Generic formulary medications are covered at the lowest formulary level of cost-sharing.
- Brand formulary medications are covered at a higher formulary level of cost-sharing.
- Non-formulary brand medications are covered at the highest non-formulary level of cost-sharing.

To help Members understand the Select Drug Program, they have access to educational materials, including the Select Drug Program Formulary Guide. To obtain a copy of the Select Drug Program Formulary Guide, go to [www.amerihealth.com/rx](http://www.amerihealth.com/rx).

**Non-formulary exceptions for Select Drug Program Members**

Physicians, on behalf of Members, may request coverage of a non-formulary medication at the formulary level of cost-sharing when all formulary alternatives have been exhausted or when there are contraindications to using the formulary alternatives. The Physician should complete the Non-Formulary Exception Request form, providing detail to support the use of the non-formulary medication, and fax it to 1-888-671-5285. The form can be found at [www.futurescripts.com/priorauthorization](http://www.futurescripts.com/priorauthorization).

If the non-formulary exception request is approved, the Physician will receive written notification, and the drug will be processed at the appropriate formulary level of cost-sharing. If the request is denied, the Member and Physician will receive a denial letter that explains the appeals process, and the Member can receive benefits for the covered non-formulary brand drug at the highest non-formulary level of cost-sharing.

**Medicare Part D Drug Formulary**

The Medicare Part D Drug Formulary is designed to provide quality pharmaceutical coverage at an affordable cost for Medicare Beneficiaries. With the Medicare Part D Drug Formulary, Members pay a Copayment or Coinsurance at retail pharmacies for up to a 90-day supply of drugs listed on the formulary. Since nonpreferred prescription medications may result in a higher level of cost-sharing for Members, we suggest you review the Medicare Part D Drug Formulary for preferred formulary alternatives, which have a lower level of cost-sharing.

**Procedures for Safe Prescribing**

AmeriHealth monitors the effectiveness and safety of drugs and drug-prescribing patterns. Several procedures, such as prior authorization, have been established to support safe prescribing patterns.

**Prior authorization requirements**

We require prior authorization of certain covered, FDA-approved drugs for specific medical conditions. The approval criteria were developed and endorsed by the Pharmacy and Therapeutics Committee and are based on information from the FDA, manufacturers, medical literature, actively practicing consultant Physicians and pharmacists, and appropriate external organizations.

FutureScripts and FutureScripts Secure evaluate requests for these drugs based on clinical data and information submitted by the prescribing Physician and available prescription drug history. Clinical pharmacists determine whether there are any drug interactions or contraindications, whether dosing and length of therapy are appropriate, and whether clinical options have been evaluated.

If the request cannot be approved by applying established review criteria, a FutureScripts medical director reviews the request. If the request is not approved, the drug will not be a covered pharmacy benefit for...
your patient, and he or she will be responsible for the entire cost of the drug. If the request is approved, your patient will be charged the highest level of cost-sharing.

**Commercial Members**

For pharmacy-related services, Participating Providers are required to use the appropriate form from www.futurescripts.com/priorauthorization to request prior authorization for Members. You can also call FutureScripts at 1-888-678-7012 to have prior authorization forms faxed directly to your office.

For detailed information on the drugs that are subject to prior authorization and for specific approval criteria, visit www.amerihealth.com/rx. The prior authorization process may take up to two business days once information is received from the prescribing Physician. It is important to completely fill out the appropriate form for the drug being requested.

**Medicare Advantage HMO Members**

For Medicare Advantage HMO Members, the prior authorization process may take up to 72 hours to review and make a determination. An expedited request takes 24 hours. Visit www.amerihealthmedicare.com/find_a_drug/ah_prior_authorization.html for a complete list of drugs requiring prior authorization and the appropriate request forms.

*Note:* The list of drugs requiring prior authorization is subject to change. As the list changes, notification is given through Partners in Health Update.

**Expiration of prior authorization for narcotic drugs**

There is a time limit of 6 to 12 months on prior authorization approvals for narcotic drugs. Prior authorizations will include an expiration date at the time of the approval. If you want your patient to continue the drug therapy after the expiration date, you will need to submit a new request.

**Age and gender limits**

Age and gender limits are designed to prevent potential harm to Members and promote appropriate use. The approval criteria are based on information from the FDA, medical literature, actively practicing consultant Physicians and pharmacists, and appropriate external organizations. Approval criteria are endorsed by the Pharmacy and Therapeutics Committee.

If the Member’s prescription does not meet the FDA age and gender guidelines, it will not be covered unless an exception is requested and approved. To request an age or gender limit exception, complete the General Pharmacy form and fax it to 1-888-671-5285 for review. The form can be found at www.futurescripts.com/priorauthorization.

**Quantity limits**

Quantity limits are designed to allow a sufficient supply of medication based on FDA-approved maximum daily doses and length of therapy of a particular drug. The various types are described below:

- **Refill too soon.** With this quantity limit, if a Member 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 limit applies to some classes of drugs, such as narcotics (e.g., short-acting and long-acting). If a Member 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. Members will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic drug class each month.
To determine if a covered drug for a patient has a quantity limit, call FutureScripts at 1-888-678-7012. For detailed examples of quantity limits and procedures that support safe prescribing, visit our website at www.amerihealth.com/safeprescribing-pa-de.

To request a quantity limit exception, complete the General Pharmacy form found at www.futurescripts.com/priorauthorization and fax it to 1-888-671-5285 for review.

96-Hour Temporary Supply Program

We are aware that there may be times when an urgent supply is necessary for a medication requiring prior authorization. A one-time, 96-hour supply may be obtained for these medications. **Obtaining a 96-hour temporary supply does not guarantee that the prior authorization request will be approved.**

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

- most medications that require prior authorization;
- migraine medications with quantity limits, such as Amerge®, Imitrex®, Maxalt®, Migranal®, Stadol NS®, and Zomig® (Preapproval of quantity exception required for amounts over the quantity limits);
- medications that are subject to age limits (Preapproval required for ages outside of recommended ranges).

Under the 96-Hour Temporary Supply Program, if you write a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity limit for a medication and prior authorization has not been obtained, the following steps will occur:

- 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 at that time.
- By the next business day, FutureScripts or FutureScripts Secure will contact you to request that you submit the necessary documentation of Medical Necessity for review.
- Once the completed medical documentation is received by FutureScripts or FutureScripts Secure, the review will be completed and the medication will be approved or denied.
  - **If approved:** The remainder of the prescription order will be filled, and the appropriate level of cost-sharing will be applied.
  - **If denied:** Notification will be sent to you and the Member.

- Members with an integrated drug benefit (e.g., Comprehensive Major Medical) 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.

**Note:** Some medications are not eligible for the 96-Hour Temporary Supply Program due to packaging or other limitations. Examples of ineligible medications are Retin-A® (tube), Enbrel® (2-week injection kit), medroxyprogesterone acetate (monthly injectable), and erectile dysfunction drugs.

30-day transition supply (Medicare Part D only)

A new Member who is currently taking medications that are not on the formulary or require prior authorization can receive a one-time, 30-day supply during the first 90 days of enrollment. These medications may require prior authorization or another exception listed in this section.

The retail pharmacy will receive an online message to process the claim, and the Member will be charged the applicable level of cost-sharing for this supply. The Member will receive a letter notifying him or her to contact the prescribing Physician, and the Physician will need to complete a prior authorization or
exception request. The prescribing Physician will receive a copy of the letter. Processing of a transition supply request is not a guarantee of approval of the prior authorization or exception request.

**Appealing a decision**

If a request for prior authorization or an exception results in a denial, the Member, or the prescribing Physician on behalf of the Member, may file an appeal. Both the Physician and the Member will receive written notification of the denial, which will include the reason for denial and how to initiate 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.

**Pharmacy programs**

**FutureScripts® Direct Ship Specialty Pharmacy Program**

We coordinate with FutureScripts to offer the Direct Ship Specialty Pharmacy Program to Members who have pharmacy coverage through AmeriHealth. Through this program, you can obtain specialty injectables and specialty oral medications that are covered under the pharmacy benefit for your patients.

When using in the FutureScripts Direct Ship Specialty Pharmacy Program, keep in mind the following:

- Quantities for specialty injectables and specialty oral medications will be evaluated to promote appropriate prescribing. In addition, medications obtained through this program may be subject to the Member’s benefits exclusions and review of Medical Necessity.
- Refills will be coordinated without additional paperwork.

ICORE Healthcare (ICORE), a leader in specialty pharmacy services, is the exclusive specialty pharmacy Provider within the FutureScripts specialty network. All prescription drug requests for commercial Members submitted through the FutureScripts Direct Ship Specialty Pharmacy Program will be routed to ICORE for fulfillment.

Through ICORE, members will receive convenient access to the following specialty services:

- **Comprehensive coordination of care.** This coordination of care includes benefits investigation, prior authorization coordination, and ongoing refill reminders.
- **Direct access to pharmacists and nurses.** The ICORE support staff is available toll-free to answer any questions that your AmeriHealth patients may have.
- **Clinical programs.** ICORE monitors patient progress to achieve optimal treatment outcomes.
- **Educational materials.** Patients have access to helpful materials, such as instruction guides to assist with self-administering medication.
- **Free delivery.** Medications are delivered at no cost to the patient’s home or another address in the U.S. in two to five business days from the date the order is received.
- **Ancillary supplies.** Items such as syringes and needles are available with the medication at no additional cost.

To get a member started in the FutureScripts Direct Ship Specialty Pharmacy Program, please call FutureScripts at 1-888-678-7012 or visit [www.futurescripts.com/priorauthorization](http://www.futurescripts.com/priorauthorization) and download the *Direct Ship Injectables Form.* If any of your AmeriHealth patients have questions about this transition, please have them call the telephone number listed on their ID card under pharmacy benefits.
Self-injectable drugs
Most self-injectable drugs are covered under the pharmacy benefit. However, injectables that cannot be administered without medical supervision, that are mandated by law, or that are required for Emergency treatment will continue to be covered under the medical benefit at the appropriate level of cost-sharing.

Note: The AmeriHealth Direct Ship Injectables Program facilitates the shipment and precertification (as required) of injectable medications and other injectable drugs that are covered under the medical benefit and are not commonly stocked in a Physician’s office. For more information about drugs covered under the medical benefit and the AmeriHealth Direct Ship Injectables Program, go to www.amerihealth.com/directship.

Blood Glucose Meter Program
Bayer HealthCare LLC and Abbott Laboratories are the preferred brands of test strips for our prescription drug programs. In addition, they are the only test strips on the Select Drug Program Formulary.

- For Abbott monitors. Preferred test strips include FreeStyle®, FreeStyle Lite®, and Precision Xtra®.
- For Bayer monitors. Preferred test strips include Contour®, Breeze2®, Elite®, and Autodisc®.

Prior authorization requirements for test strips
We require prior authorization for any test strips that we consider nonpreferred. In other words, if a Member chooses to use a test strip that is not listed above, you will need to complete a prior authorization form on your patient’s behalf. If the prior authorization is not approved, the nonpreferred test strips will not be a covered pharmacy benefit for your patient, and he or she will be responsible for the entire cost of the test strips. If the request for the nonpreferred test strips is approved, your patient will be charged the highest level of cost-sharing.

You can download the Diabetic Test Strips prior authorization form online at www.futurescripts.com/priorauthorization. Be sure to include supporting documentation for Medical Necessity. If your request contains insufficient information, it may be returned to you or the request may be denied.

Free meters for preferred test strips
Both Abbott and Bayer glucose meters are available at no cost to our Members who are using to one of the preferred test strips. Free meters can be obtained directly from either manufacturer, as detailed in the following information:

- Abbott Diabetes Care products. The Abbott Diabetes Care products include the following blood glucose meters:
  - FreeStyle Lite® Blood Glucose Monitoring System
  - FreeStyle Freedom® Lite Blood Glucose Monitoring System
  - Precision Xtra® Blood Glucose and Ketone Monitoring System

More information about these products is available at www.abbottdiabetescare.com/products. To obtain an Abbott meter at no cost, you or your patient should call Abbott Diabetes Care at 1-866-224-8892 or visit their website at www.meters.abbottdiabetescare.com.
- **Bayer Diabetes Care products.** The Bayer family of products offers the following blood glucose meters: Contour® Meter; Breeze®2 Meter.

  Learn more about these products at [www.bayerdiabetes.com/sections/ourproducts.aspx](http://www.bayerdiabetes.com/sections/ourproducts.aspx). To obtain a Bayer meter at no cost, you or your patient should call Bayer Diabetes Care at 1-877-229-3777.

If you have questions about the preferred test strips or the Blood Glucose Meter Program, contact FutureScripts at 1-888-678-7012.