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Overview

Our pharmacy benefits manager, FutureScripts®, handles the administration and claims processing of pharmacy benefits under 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 oversees our pharmacy policies and procedures and promotes 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; it meets on no less than a quarterly basis to review and update the formularies. Providers are notified of these changes through *Partners in Health Update*℠.

Before you prescribe drugs 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 for commercial Members

Members with an AmeriHealth New Jersey prescription drug benefit may have coverage through one of the programs listed in this section. Coverage for drugs is based on the Member's benefits program. Commercial formularies are reviewed over the course of the year for value, quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the marketplace. Some drugs may be subject to utilization management programs to ensure appropriate clinical use and cost efficiency.

Select Drug Program®

The Select Drug Program formulary provides the broadest access to cost-effective covered prescription drugs including generics, authorized generics, brands, and specialty drugs on multiple tiers. Generally, all FDA-approved medications are covered except for routinely excluded categories (e.g., drugs used for cosmetic purposes) and other specific drug exclusions.

Value Formulary

The Value Formulary is a restricted formulary. It provides a comprehensive list of medications including generics, authorized generics, brands, and specialty drugs. Drugs are included based on medical effectiveness and value.

The Value Formulary includes at least two agents to treat each covered disease state when available. New drugs are not included on the Value Formulary until reviewed by the Pharmacy and Therapeutics Committee. Drugs not covered on the Value Formulary are considered non-formulary; for these drugs, formulary alternatives can be found on the Plan's website. Non-formulary drugs are covered when a formulary exception approval is obtained through the prior authorization process.

Standard Drug Program

The Standard Drug Program is similar to the Select Drug Program except that it consists of a two-tier cost-share structure with the generic cost-share being lower than the brand cost-share.

Formulary Links

Commercial formulary	Online search tool link
3-Tier Select Drug Formulary	*https://client.formularynavigator.com/Search.aspx?siteCode=9622035051*
3-Tier Value Formulary	*https://client.formularynavigator.com/Search.aspx?siteCode=5929400044*

Participating pharmacy networks for commercial Members

Members should take their Member ID card to a pharmacy that participates in the FutureScripts 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.

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Mail-order program for commercial Members

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 processes mail-order prescriptions for our commercial Members.

For a Member to use this benefit, the Provider should write two separate prescriptions for the Member: (1) a prescription for the initial supply, which the Member may fill immediately at a retail pharmacy, and (2) a prescription for the mail-order program, which 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.

Drug formulary information for commercial Members

The prescription drug programs mentioned earlier in this section use formularies to give Members cost-effective access to covered medications. When prescribing medications, Providers should consider the particular formulary through which Members have prescription drug coverage.

Before prescribing a medication for Members, keep in mind the following:

- Non-preferred tier on the formulary is generally associated with higher cost-sharing than the preferred brand tier or generic tier (i.e., at the higher cost to the Member).
- Generally, when a brand name drug has a generic equivalent, the brand name drug is covered at the non-preferred level of cost-sharing on the Select Drug Program while the generic equivalent is covered at the generic level of cost-sharing.
- Some brand name drugs without generic equivalents, authorized generic drugs, and generic drugs are also covered at the non-preferred level of cost-sharing or may be non-formulary because there are other more cost-effective alternatives covered on the formulary to treat the same condition.

Below is a summary of tiers in the general order from lowest to highest level of cost-share on the Select Drug Program formulary and Value Formulary. Benefits vary by groups and all cost-share levels may not be available on all plans. *Note:* Non-formulary drugs are covered when a formulary exception approval has been obtained for which the Member will pay the highest, non-specialty level of cost-sharing.

- Generic
- Preferred Brand
- Non-Preferred Drug

Authorized Generic Drugs. These are brand name drugs that are marketed without the brand name on its label. An authorized generic may be marketed by the brand name drug company, or another company with the brand company's permission. Unlike a standard generic drug, the authorized generic is not approved by the FDA's abbreviated new drug application process (ANDA). For cost-sharing purposes, authorized generics are treated as brand name drugs and are not eligible for coverage on the generic tier(s).

To help commercial Members understand their specific drug program and formulary, they have access to educational materials, including searchable look-up tools and formulary guides. To view the searchable drug tools or formulary guides, visit *www.amerihealthnj.com/rx* and select the appropriate option under Drug programs.

Requesting an exception for commercial Members

Non-formulary exceptions for Value Formulary Members

Providers may request consideration for coverage of a non-formulary medication when there has been a trial of, contraindication to, or documented inability to tolerate at least three formulary alternatives when applicable.

Tier exceptions

Providers may request consideration for preferred coverage of a non-preferred drug when there has been a trial of, or contraindication to, at least three formulary alternatives when applicable.

- Requests for a generic medication on the non-preferred drug tier will be lowered to the generic tier if the exception criteria are met.
- Requests for a brand medication or an authorized generic on the non-preferred drug tier can be lowered to the preferred brand tier if the exception criteria are met.

Restrictions apply to formulary exception requests. Drugs on the generic tier, the preferred brand tier and the specialty tier are not eligible for tier exceptions. If the Member's prescription drug benefit contains the full mandatory generic provision and the formulary exception is approved for a brand-name drug that has a generic equivalent, the Member will continue to be responsible for paying the dispensing pharmacy the difference between the negotiated discount prices for the generic drug and the brand drug plus the appropriate Member cost-sharing for a brand drug. Drugs on the preferred brand tier are not eligible for tier exception.

When requesting an exception, the Provider should complete the formulary exception request form, providing details supporting Medical Necessity for the request, and fax the request to 1-888-671-5285. If the formulary exception request is approved for a non-preferred drug, the drug will pay at the appropriate preferred brand or generic level of cost-sharing. If the request is denied, the Member and Provider will receive a denial letter with the appropriate appeals language. The forms are available online at *www.futurescripts.com/prior-authorization1.html*. If

the non-formulary request is approved, the drug will be covered at the highest applicable level of cost-sharing. Safety edits like quantity limits will still apply.

Prescription drug guidelines for commercial Members

AmeriHealth continuously monitors the effectiveness and safety of drugs and drug-prescribing patterns. Several procedures are used to support safe prescribing patterns for our prescription drug programs, such as prior authorization and safety edits such as age limits, quantity limits, morphine milligram equivalent (MME) limits, and concurrent drug utilization review (cDUR).

Prior authorization requirements

We require prior authorization of certain covered, FDA-approved drugs to confirm that the drugs prescribed are Medically Necessary and are being prescribed according to FDA approved or medically accepted use. The clinical criteria used for prior authorization review were developed and approved by the Pharmacy and Therapeutics Committee based on the recommendations from the FDA, manufacturers, medical literature, and actively practicing consultant Physicians and pharmacists.

Using these approved criteria, the clinical pharmacists at FutureScripts evaluate prior authorization requests based on clinical data and information submitted by the Providers and available prescription drug history. Their evaluation may include indications, contraindications, dosing and length of therapy appropriateness, and evaluation of other clinical options previously used if applicable.

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 appropriate level of cost-sharing according to his or her benefit. For detailed information on the drugs that are subject to prior authorization and for specific approval criteria, visit *www.amerihealthnj.com/rx* and select *Pharmacy Policy*.

When submitting requests, it is important to thoroughly complete all prior authorization forms or provided all requested information for electronic payment authorization (ePA) and to promptly respond to outreach efforts when there is missing information. The prior authorization process may take up to two business days once complete information from the Provider has been received. Incomplete information may result in a delayed decision.

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

How to submit a Prior Authorization

The process for requesting a prior authorization is as follows:

- The Provider prescribing the drug can access ePA platforms such as CoverMyMeds® and SureScripts™ to submit a prior authorization request. Alternatively, the Provider can complete a prior authorization fax form or write a letter of medical necessity and submit it to FutureScripts by fax at 1-888-671-5285. The forms are available online at *www.futurescripts.com/prior-authorization1.html*.
- FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist is not able to approve the request based on established criteria, it will be reviewed by a medical director.

- A decision is made regarding the request.
  - If approved, the Provider will be notified of the approval via fax and/or telephone, and the pharmacy claim adjudication system will be coded with the approval. *Note:* ePA approval can occur in real time, this means the Member can be approved for the drug prior to leaving the Provider's office with a prescription. The Member may call Customer Service at the number on his or her ID card to determine if the request is approved.
  - If denied, the Provider will be notified via letter, fax, or telephone. The Member is also notified via letter. The appeals process is detailed within the denial letters sent to the Member and Provider.

Some drugs are approved for a limited time, such as opioids and growth hormones. Prior authorizations will include an expiration date at the time of the approval when applicable. If your patient needs to continue the drug therapy after the expiration date, you will need to submit a new request.

ePRO

FutureScripts sends notifications to Providers of upcoming expirations of pharmacy prior authorizations through an electronic proactive prior authorization (ePRO) fax. Providers can respond to the notice via fax or through an electronic prior authorization system (ePA) platform. The ePRO fax includes the drug name and details about the prescription, including a suggestion for formulary alternatives (if applicable). It will also include a drug-specific prior authorization request form for each Member. Providers should consider if the prior authorization is still required or if the drug still fits the Member's needs. Every seven days, up to 28 days total, a reminder ePRO fax from FutureScripts will be sent to Providers who have not completed the request form.

PreCheck MyScript

PreCheck MyScript is an online tool powered by FutureScripts and embedded directly in electronic medical record (EMR) platforms. The tool gives Providers a real-time, seamless view of a Member's prescription cost-share amount based on the Member's specific health plan benefits.

These real-time details help improve Members' experience and health by:

- enabling Providers to have more constructive conversations with their patients;
- providing the information, comfort, and insight the Provider needs to make more informed prescribing decisions related to the pharmacy benefit;
- giving Providers more time to spend with their patients by auto-sorting through prescription drug lists and prior authorization processes;
- minimizing prescription delays, dispensing of unnecessary higher-cost medications, and other barriers that could lead to medication non-compliance.

PreCheck MyScript also gives the Provider insight into whether their patients medication requires a prior authorization. If prior authorization is required, Providers can request approval immediately through the tool.

96-Hour Temporary Supply Program

The 96-Hour Temporary Supply Program is available for certain drugs that require prior authorization. Under the 96-Hour Temporary Supply Program, if a Provider writes a prescription for a drug that requires prior authorization, and the prior authorization has not been obtained by the Provider, 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 either no out-of-pocket Copayment or the appropriate percentage cost-sharing as defined by the Member's benefit.
- The next business day, FutureScripts will contact the Member's Provider to request that he or she submit documentation of medical necessity or medical appropriateness for review.
- Once the completed medical documentation is received by FutureScripts, the review will be completed, and the request will either be approved or denied.
- If approved, the remainder of the prescription may be filled, and the appropriate prescription drug out-of-pocket cost-sharing will be applied.
- If denied, notification will be sent to both the Provider and the Member.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization request will be approved. This program limits a one-time release of 96-hour supply per drug. Some drugs are not eligible for the 96-Hour Temporary Supply Program due to packaging or other limitations.

Safety edits

Safety edits are applied to prescription medications to ensure safe and appropriate use of drugs. They are designed to align with the clinical practice guideline and FDA-approved use outlined in the manufacturer package insert.. These guidelines are designed to prevent potential harm to patients. There are safety edits that are based on the maximum daily dose approved by the FDA, the drug formulation, and the availability of multiple strengths of the drug where a dose can be achieved with another available strength and/or standard dosing. Some of these safety edits will prompt Member counseling at the point of sale (POS), while some will require prior authorization review. Examples of safety edits are age limits, quantity limits, morphine MME limits, and cDUR. *Note:* If applicable, safety edits will apply if a formulary exception is approved allowing coverage of a non-formulary drug.

Age limits

Some drugs are approved by the FDA only for individuals of a certain age. If the Member's prescription falls outside of the FDA guidelines, it may not be covered until prior authorization is obtained. 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 Provider may request coverage for drugs outside of the age limit when Medically Necessary. Approval criteria are reviewed by the Pharmacy and Therapeutics Committee.

Quantity limits

Quantity limits are designed to allow a sufficient supply of medication based on FDA-approved maximum daily doses, standard dosing, and/or length of therapy of a particular drug. The purpose of these limits is to ensure safe and appropriate utilization. If a Member requires more than the limit, the

Member's Provider will need to submit a prior authorization request. Similar to other prior authorization requests, quantity limit override requests for certain drugs may have a limited approval timeframe. The various types of quantity limits are described below:

- **Quantity Over Time:** This quantity limit is based on dosing guidelines over a rolling time period. For example, sumatriptan 50mg tablets are limited to a quantity of 18 tablets per 30 days.
- **Maximum daily dose:** This quantity limit is based on maximum number of units of the drug allowed per day. For example, zolpidem is limited to 1 tablet per day.
- **Refill too soon:** This limit is in place to encourage appropriate utilization and minimize stockpiling of prescription medications. Based on this edit, a Member can receive a refill of a prescription after 75 percent utilization. Additional refills will pay once 75 percent of the supply has been consumed. For example, a 30 days' supply of atorvastatin tablets filled on 1/1/2020, will be refillable again on or after 1/24/2020.
- **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. Low dose opioids such as Percocet® and its generic are limited to two 5-day supplies within 60 days.

Cumulative limits

AmeriHealth applies additional safety measures to opioid products by limiting the total daily dose. This limit accounts for all the different opioid products through a measurement called the morphine milligram equivalent (MME) dose. The MME is a number that is used to determine and compare the potency of opioid medications. It helps to identify when additional caution is needed. The daily limit is calculated based on the number of opioid drugs, their potencies, and the total daily usage. Prior authorization is required for an opioid dose that exceeds 90 MME per day. MME limits apply to the opioid products containing the active ingredients listed below:

- codeine
- dihydrocodeine
- fentanyl
- hydrocodone
- hydromorphone
- levorphanol
- meperidine
- methadone
- morphine
- opium
- oxycodone
- oxymorphone
- tapentadol
- tramadol
- benhydrocone

Prescription stimulants are an integral part of treatment for attention deficit hyperactivity disorder (ADHD) but they are also one of the most frequently abused prescription drugs in the United States. To encourage safe prescribing, AmeriHealth New Jersey has implemented a cumulative dose limit for prescription stimulants **effective January 1, 2020**.The cumulative dose limit is based on the cumulative daily dose of drugs with the same active ingredient. Prior authorization is required when the request exceeds the recommended dose for medications with that active ingredient outlined below:

Active ingredient	Common Brand Name(s)	Cumulative Daily Dose Limit
Amphetamine	Adzenys® [XR ODT/ER]; Dyanavel®; Evekeo® [ODT]	60mg/day
Amphetamine/Dextroamphetamine	Adderall® [IR/XR]; Mydayis®	60mg/day
Dextroamphetamine	Dexedrine®; Zenzedi®; ProCentra®	60mg/day

Active ingredient	Common Brand Name(s)	Cumulative Daily Dose Limit
Lisdexamfetamine	Vyvanse®	70mg/day
Methamphetamine	Desoxyn®	60 mg/day
Dexmethylphenidate	Focalin® [IR/XR]	40mg/day
Methylphenidate	Ritalin® [IR/LA]; Daytrana®; Cotempla®; Metadate® [ER/CD]; Methylin®; Quillivant® XR; Concerta®; Aptensio® XR; QuilliChew® ER; Adhansia® XR; Jornay PM™	72mg/day

Please see the Stimulant Policy for more information *www.amerihealth.com/pdfs/providers/pharmacy_information/pharmacy_policies/stimulants.pdf*.

Pediatric Opioid limits

AmeriHealth remains committed to fighting the opioid epidemic in our region. Since implementing the five-day supply limit for members, based on claims data, AmeriHealth has seen a 45 percent reduction in opioid prescriptions, as well as a 36 percent reduction in opioid users.

In an ongoing effort to reduce the risk of substance use disorder in members under 18 years of age, while helping to ensure access to acute pain treatment, AmeriHealth has implemented the following limits **January 1, 2020:**

Opioid product	Days' supply limit
Short-acting opioids and opioid-containing cough and cold products	Two 3-day fills within 60 days
Opioid-containing headache products	One 3-day fill within 30 days

cDUR

cDURs are built into the pharmacy claim adjudication system to review a Member's prescription history for possible drug-related problems including drug-drug interactions and drug therapy duplications. Drugs may reject at the POS and/or generate a message to the dispensing pharmacist when there is a safety concern. The dispensing pharmacist can review the issue with the Provider and override the rejection, if appropriate, for most edits.

Appealing a decision

If a request for prior authorization or exception results in a denial, the Member, or the Provider on the Member's behalf (with the Member's consent), may file an appeal. Both the Member 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. To assist in the appeals process, it is recommended that the Provider be involved to provide any additional information based on the appeal.

Preventive drugs covered at $0 Copayment for commercial Members

As described in the Affordable Care Act (ACA), certain preventive medications, without cost-sharing with a prescription when provided by a participating retail or mail-order pharmacy. Drugs that are considered preventive for certain ages and drug criteria are covered at a $0 Copayment as listed in the following table:

Drug class	Drug criteria	Age criteria
Folic acid	Applies to prescriptions for 0.4 – 0.8 mg.	Younger than 51
Oral fluoride	Limited to strength less than 0.5 mg.	Children ages 6 months to 16 years
Aspirin	Applies to prescriptions for 81 mg.	Adults ages 50 through 59 to prevent cardiovascular disease; women after 12 weeks' gestation who are at high risk for preeclampsia
Breast cancer chemotherapy prevention	Applies to prescriptions for tamoxifen 20 mg only.	Ages 35 and older
Tobacco interventions and nicotine replacements	Tobacco interventions include Chantix®, bupropion HCL (generic Zyban), nicotine replacements include nicotine gums, nicotine inhalers, and nicotine patches.	Adults who use tobacco products
Statins for prevention of cardiovascular disease	Applies to prescriptions for lovastatin 40 mg or less.	Ages 45 through 75 years
Bowel Preparations for preventive colon cancer screening	Generic bowel preparation products	Adults age 50-75
HIV Preexposure prophylaxis (PrEP)	Applies to emtricitabine/tenofovir disoproxil fumarate 200mg-300mg and tenofovir 300mg	Persons who are at high risk of HIV acquisition.

Mandated by the Women's Prevention Services provision of the ACA, many contraceptives are covered at 100 percent when provided by a participating Provider. For drugs not available as the POS at 100 percent coverage, an exception would be considered when the drug is described as either a preventative medication identified by the US Preventive Services Task Force (USPSTF) or the Women's Preventive Services provision of the Patient Protection and Affordable Care Act (PPACA).*Note:* The $0 Copayment does not apply to Medicare Advantage Members of one of our Affiliates.

Blood Glucose Meter Program for commercial Members

Prior authorization requirements for test strips

AmeriHealth New Jersey requires prior authorization for any test strips that we consider non-preferred. In other words, if a Member chooses to use a test strip, you will need to complete a prior authorization form on your patient's behalf. If the prior authorization is not approved, the non-preferred 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 non-preferred test strips is approved, your patient will be charged the highest level of cost-sharing. You can access a prior authorization form for diabetic test strips online at *www.futurescripts.com/prior-authorization31.html#D*. Be sure to include supporting documentation for medical necessity.

Free meters for preferred test strips

Free Blood Glucose Meter Program

Preferred Test Strips

LifeScan® products are the preferred brands of test strips for the prescription drug programs. It offers your patients simple and accurate test strips and monitoring systems. The preferred test strips include OneTouch Verio® and OneTouch Ultra®.

Free Blood Glucose Meters

LifeScan® blood glucose meters, including OneTouch Verio Flex® and OneTouch Verio®are available at no cost to our members. Below is a comparison chart of important features of the blood glucose meters and corresponding test strip.

	OneTouch	
Blood Glucose Meter	OneTouch Verio Flex® meter	OneTouch Verio® meter
Sample size (uL)	0.4	0.4
Test time	5 seconds	5 seconds
Approved test sites	Fingertip	Fingertip
Sample fill technique	End or Tip	Right or Left side fill
Calibration type	No coding	No coding
Height of read-out (mm)	15	12
Downloadable Software	OneTouch Reveal®	OneTouch Reveal®
Corresponding test strips	OneTouch Verio® Test Strips	OneTouch Verio® Test Strips

To order a free meter from LifeScan®, you or your patient should contact the manufacturer directly by either calling LifeScan® Service Center at 1-866-355-9962 with Order Code: 594PRX100.

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

Prescription drug programs for Medicare Advantage Members of one of our Affiliates

Coverage for drugs with a Medicare Advantage plan is based on the Member's benefits program. Medicare formularies are reviewed over the course of the year for value, quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the marketplace. Medicare formularies are also compliant with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS). As a result, they are updated throughout the year. Some drugs may be subject to utilization management programs to ensure appropriate clinical use and cost efficiency.

Medicare Part D

Medicare Part D, a Medicare prescription drug benefit, is designed to provide quality pharmaceutical coverage at an affordable cost for Medicare Beneficiaries. It also provides Medicare Beneficiaries who have limited income with extra help paying for prescription drugs.

Medicare Advantage Members of one of our Affiliates who qualify have access to comprehensive coverage with lost cost-sharing, which allows them to pay only a small amount for their prescriptions.

Prescribing requirements

Supported by the ACA and as required by CMS, prescribing Providers must include their individual (Type 1) National Provider Identifier (NPI) on all prescriptions for Medicare Advantage Members of one of our Affiliates who are covered under Medicare Part D.

Prescriber identifiers are valuable Part D program safeguards. These identifiers are the only data on Part D drug claims to indicate that legitimate practitioners have prescribed drugs for Medicare enrollees. Without valid prescriber identifiers, efforts made by CMS to determine the validity, medical necessity, or appropriateness of Part D prescriptions and drug claims may be limited.

Part D vaccine administration (e.g., Zostavax®, Shingrix™)

CMS requires that Medicare Part D vaccine administration for Medicare Advantage Members of one of our Affiliates 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:

Where the Member receives vaccine	Who administers the vaccine	Member payment
Pharmacy	Pharmacist	Member pays their pharmacy. Copayment/Coinsurance to the pharmacy.
Pharmacy	Physician	Member pays their pharmacy 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 Specialty Pharmacy	Physician	Member pays their pharmacy Copayment/ Coinsurance to the Specialty Pharmacy for the vaccine. Physician may request the standard fee for the administration up front.

It is important that you routinely ask your Medicare Advantage Members of one of our Affiliates to show their Medicare ID cards. This will ensure 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 their other pharmacy benefits. Members can request this form by contacting Customer Service.

Note: These procedures do not apply to Medicare Part B immunizations, which include hepatitis B (for intermediate and high-risk individuals), influenza, or pneumococcal vaccines, which are covered through the Member's Part B (medical) benefits. Members must receive Part B vaccines from a Provider who can bill it as a medical claim, which may also include clinics inside certain pharmacies that are contracted with AmeriHealth as Participating Providers, such as CVS, Rite Aid, and Walgreens. 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. **For office administration:** 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 their true out-of-pocket (TrOOP) expense. The Member should then bring the vaccine back to the Physician's office for administration. They 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 their Part D carrier for reimbursement consideration.
2. **For administration at the pharmacy:** The Member may obtain a covered Part D vaccine, and have it administered at a local retail pharmacy where they will be charged the applicable cost-share.

Participating pharmacy networks for Medicare Advantage Members of one of our Affiliates

Medicare Advantage Members of one of our Affiliates should take their Member ID card to a pharmacy that participates in the 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.

FutureScripts Secure pharmacy network for Medicare Advantage Members of one of our Affiliates

We contract with FutureScripts Secure to provide Medicare Part D prescription benefit management services for Medicare Advantage Members of one of our Affiliates.

The network includes:

- national chain and independent retail pharmacies
- long-term care and home-infusion pharmacies
- Indian Health Service/Tribal/Urban Indian Health (I/T/U) Program pharmacies
- a network mail-order pharmacy service

In order to receive benefits through the plan, prescriptions generally must be filled at a network pharmacy.

Standard and Preferred Pharmacies

Some pharmacies contract with our plan to offer lower cost-sharing to plan Members. This is known as preferred pharmacy cost-sharing. Members may fill prescriptions at either a preferred or standard pharmacy. They can save money on certain prescriptions by using a preferred pharmacy. For Medicare Advantage Members of one of our Affiliates with a 5-tier formulary:

- Tier 1 and 2 prescriptions (which include most generic drugs) will have lower Copayments when filled at preferred pharmacies.
- Tier 1 and Tier 2 has two-time copay when a 90 supply is filled at a Preferred Retail Pharmacy.
- Tier 3, 4, and 5 prescriptions (which include brand-name, specialty, and high-cost generic drugs) will have the same Copayments at both preferred and standard pharmacy locations.

Mail-order program for Medicare Advantage Members of one of our Affiliates

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 Secure processes mail-order prescriptions for Medicare Advantage Members of one of our Affiliates.

For a Member to use this benefit, the Physician should write two separate prescriptions for the Member: (1) a prescription for the initial supply, which the Member may fill immediately at a retail pharmacy, and (2) a prescription for the mail-order program, which 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.

Drug formulary information for Medicare Advantage Members of one of our Affiliates

The prescription drug programs mentioned earlier in this section use formularies to give Members cost-effective access to covered medications. When prescribing medications, Providers should be sure to consider what formulary through which Members have prescription drug coverage.

Before prescribing a medication for Medicare Advantage Members of one of our Affiliates, keep in mind the following:

- Most generic medications are covered at the lowest formulary level of cost-sharing.
- Preferred brand formulary medications are covered at a higher formulary level of cost-sharing.
- **For Medicare Part D:** Non-preferred prescription medications may result in a higher level of cost-sharing for Members. Be sure to review the Medicare Part D Drug Formulary for preferred formulary alternatives, which have a lower level of cost-sharing.

Prescription drug guidelines for Medicare Advantage Members of one of our Affiliates

AmeriHealth continuously monitors the effectiveness and safety of drugs and drug-prescribing patterns. Several procedures support safe prescribing patterns for our prescription drug programs, such as prior authorization, quantity limits, and MME limits.

Prior authorization requirements

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

Using criteria approved by the Pharmacy and Therapeutics Committee, FutureScripts Secure evaluates requests for these drugs based on clinical data and information submitted by the prescribing Physician and available prescription drug history. Clinical pharmacist reviews will include contraindications, dosing, and length of therapy appropriateness, and evaluation of other clinical options previously used.

If the request cannot be approved by applying established review criteria, a FutureScripts Secure 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 appropriate level of cost-sharing according to his or her benefit.

When submitting requests, it is important to thoroughly complete all prior authorization forms and to promptly respond to outreach efforts when there is missing information.

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

How to submit a prior authorization

Participating Providers are required to use the appropriate form at *www.futurescripts.com/prior-authorization2.html* to request prior authorization for Medicare Advantage Members of one of our Affiliates. Per CMS requirements, a standard Coverage Determination Request form must be completed within 72 hours for Medicare Advantage Members of one of our Affiliates. All expedited/urgent reviews must be completed within 24 hours.

Expiration of prior authorization

Some drugs are approved for a limited time, such as narcotics and growth hormones. Prior authorizations will include an expiration date at the time of the approval when applicable. If your patient needs to continue the drug therapy after the expiration date, you will need to submit a new request.

ePRO

FutureScripts sends notifications to Providers of upcoming expirations of pharmacy prior authorizations through an electronic proactive prior authorization (ePRO) fax. Providers can respond to the notice via fax or through an electronic prior authorization system (ePA) platform. The ePRO fax includes the drug name and details about the prescription, including a suggestion for formulary alternatives (if applicable). It will also include a drug-specific prior authorization request form for each Member. Providers should consider if the prior authorization is still required or if the drug still fits the Member's needs. Every seven days, up to 28 days total, a

reminder ePRO fax from FutureScripts will be sent to Providers who have not completed the request form.

PreCheck MyScript

PreCheck MyScript is an online tool powered by FutureScripts and embedded directly in electronic medical record (EMR) platforms. The tool gives Providers a real-time, seamless view of a Member's prescription cost-share amount based on the Member's specific health plan benefits.

These real-time details help improve Members' experience and health by:

- enabling Providers to have more constructive conversations with their patients;
- providing the information, comfort, and insight the Provider needs to make more informed prescribing decisions related to the pharmacy benefit;
- giving Providers more time to spend with their patients by auto-sorting through prescription drug lists and prior authorization processes;
- minimizing prescription delays, dispensing of unnecessary higher-cost medications, and other barriers that could lead to medication non-compliance.

PreCheck MyScript also gives the Provider insight into whether their patients medication requires a prior authorization. If prior authorization is required, Providers can request approval immediately through the tool.

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:

- **Quantity Over Time.** This quantity limit is based on dosing guidelines over a rolling time period. For example, sumatriptan 50mg tablets are limited to a quantity of 8 tablets per 30 days
- **Maximum daily dose.** This quantity limit is based on maximum number of units of the drug allowed per day. For example, zolpidem is limited to 1 tablet per day.
- **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.

MME limits

AmeriHealth New Jersey complies with the Centers for Medicare and Medicaid Services (CMS) requirement to apply additional safety measures to opioid products.

Members new to an opioid medication will be limited to a 7-day supply for their first fill. All other prescription fills for opioid medications will be limited to a 30-day supply.

AmeriHealth New Jersey limits the total daily dose of opioids through a measurement called the MME dose. MME is a number that is calculated from the number of opioid drugs, their potencies and the duration of therapy. It is used to determine and compare the potency of opioid medications and helps to identify when additional caution is needed.

There are two safety interventions at the pharmacy based upon the MME dose:

- The first intervention produces a claim rejection at 90 MME that does not require a prior authorization but may require intervention from your pharmacist.
- The second intervention produces a claim rejection at 200 MME or greater and requires a prior authorization.

Medicare Part D 30-day transition supply

A new Member who is currently taking medications that are not on the formulary or require a prior authorization can receive a one-time, 30-day supply during the first 90 days of enrollment into the Plan. 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 exception results in a denial, the Member, or the Physician on the Member's behalf (with the Member's consent), may file an appeal. Both the Member and his or her Physician 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 the Physician be involved to provide any additional information on the basis of the appeal.

Blood Glucose Meter Program for Medicare Advantage Members of one of our Affiliates

Medicare Advantage Members of one of our Affiliates must use diabetic test strips and a glucose monitor from the preferred manufacturer brands, Accu-Chek® and OneTouch® in order to have their test strips and glucose meters covered at $0 Copayment.

If their current glucose monitor does not work with either of these preferred brands of test strips, Medicare Advantage Members can obtain a new glucose monitor at no cost with a prescription from a Provider.

Test strips can be obtained from either a network pharmacy or durable medical equipment supplier.

Medication Therapy Management Program for Medicare Advantage Members of one of our Affiliates

We offer a Medication Therapy Management (MTM) program to Members enrolled in a Medicare Advantage plan of one of our Affiliates.

MTM includes services that seek to facilitate communication between health care professionals and Members to help improve health outcomes. Pharmacists who are part of the MTM program review medications to identify potential adverse interactions, while also educating Members on

medication side effects and interactions. They can even identify ways to save money on out-of-pocket medication costs.

Medicare Advantage Members of one of our Affiliates who qualify, based on their disease state and number of medications they are taking, will be automatically enrolled in the MTM program and will receive the following:

- **Comprehensive medication review.** Participants in the program will receive an outreach phone call from a clinical pharmacist for a brief medication consultation, to be arranged around Members' schedules. There is no limit to how much time Members can spend talking with the pharmacist during the consultation.

  During the call, the pharmacist will review the medications Members are taking to:

  – address goals for medication therapy;

  – raise awareness of cost-effective alternatives, such as generics;

  – answer any questions Members may have about their medication.

- **Personal Medication List and Action Plan**. After the consultation, the pharmacist will summarize the medications discussed and their respective directions into a Personal Medication List and an Action Plan. These will be mailed to the member and can be brought to the Member's next doctor visit for discussion.

- **Continuous review.** Members will have their prescription claims data continuously reviewed and analyzed to determine if there are any areas for therapeutic intervention. Their doctor will receive a fax containing potential intervention opportunities.

If you have any questions regarding the MTM program, please contact PerformRx at 1-888-349-0501.