PRIME THERAPEUTICS®

Prime Perspective

Quarterly Pharmacy Newsletter from Prime Therapeutics LLC

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INSIDE

From the auditor's desk

Claims adjudication and following point of sale messaging

Prime Therapeutics (Prime) administers pharmacy benefits on behalf of many different Benefit Sponsors. Each individual Benefit Sponsor determines benefit plan designs, such as:

- specific drugs covered (formulary)
- specific ingredients covered
- other benefit design attributes
- cost-sharing
- days' supply limitations

Each formulary and benefit set-up determines claim coverage and may vary by Covered Person. As the claim is processed, the Participating Pharmacy receives system messaging on the status of the submission. Participating Pharmacies are required to follow all system messaging.

Following point of sale messaging

Claim submissions, including resubmissions, must be entered according to the written prescription and point-of-sale (POS) messaging for a Participating Pharmacy to be in compliance with Prime's terms and conditions of pharmacy network participation.

If you receive a POS message such as, but not limited to, those listed below, please obtain a prior authorization (PA) or call the phone number listed before dispensing the prescription to the Covered Person:

- Drug requires prior authorization.
- This compound may require review. Please call customer service at 1-800-216-9920.
- Compounds dollar amount exceeds max, call pharmacy help desk at 1-866-590-3012. Maximum amount due of $XXX.
- REQ REVIEW. CALL PHARMACY HELP DESK.
- Maximum amount due of $XXX.

This article is not intended to be an exhaustive list of requirements. Please see your Pharmacy Participation Agreement and the Prime Provider Manual for a full listing of requirements. The Prime Provider Manual is available online at: **PrimeTherapeutics.com › Resources › Pharmacists and providers › Provider manual.**

Pharmacy Audit information

For more information regarding Pharmacy Audit, including common billing errors, pharmacy audit appeals and pharmacy audit guidelines please visit Prime's website at: **PrimeTherapeutics.com › Resources › Pharmacists and providers › Pharmacy audit.**

Medicare news/Medicaid news

Medicare E1 Eligibility Query

The E1 Eligibility Query is a real-time transaction submitted by the Pharmacy to RelayHealth, the Transaction Facilitator. It helps determine a Covered Person's Medicare Part D coverage and payer order if the Covered Person has insurance through more than one provider.

Participating Pharmacies generally submit E1 Queries when Covered Persons do not have their Medicare Part D Identification Card.

Additional information on E1 Transactions can be found at **http://medifacd.relayhealth.com/e1**.

Pursuant to anti-kickback statute Section 1128B(b) of the Social Security Act, Participating Pharmacies should not submit an E1 for pharmaceutical manufacturer copay assistance coupon programs as they are not considered Prescription Drug Services.

CMS standardized pharmacy notice

CMS requires all Medicare Part D Benefit Sponsors to use a single uniform exceptions and appeals process with respect to the determination of prescription drug coverage for a Covered Person under the plan. Medicare Part D claims will be rejected when a claim cannot be covered under the Medicare Part D benefit at POS.

Pharmacy claims will be rejected with the following POS rejection message:

- NCPDP Reject Code 569

Participating Pharmacies are required to provide the CMS Notice of Medicare Prescription Drug Coverage and Your Rights to Covered Persons when they receive National Council for Prescription Drug Programs (NCPDP) reject code 569. The CMS Notice of Medicare Prescription Drug Coverage and Your Rights is posted on Prime's website at: **PrimeTherapeutics.com › Resources › Pharmacists and providers › Medicare › More Resources › Medicare Prescription Drug Coverage & Your Rights**.

Home Infusion Participating Pharmacies receiving the NCPDP reject code 569, must distribute the CMS notice to the Covered Person either electronically, by fax, in person or by first class mail within 72 hours of receiving the claim rejection.

Long Term Care (LTC) Participating Pharmacies receiving the NCPDP reject code 569, must contact the Prescribing Provider or LTC facility to resolve the rejected claim to ensure the Covered Person receives their medication. If the Participating Pharmacy must distribute the CMS notice, they must fax or deliver the notice to the Covered Person, the Covered Person's representative, Prescribing Provider or LTC facility within 72 hours of receiving the rejection.

In addition, a copy of the CMS Notice of *Medicare Prescription Drug Coverage and Your Rights* has been included on page three of this publication.

Florida news

Florida Blue implements reject code for non-approved FDA drugs

Effective July 1, 2016, Florida Blue implemented changes to its reject messaging for all drugs that are already currently excluded from the pharmacy benefit due to lacking FDA approval.

Pharmacy claims will reject with the following POS rejection message:

- NCPDP Reject Code 70: "PLAN EXCLUSION. DRUG NOT FDA APPROVED"

Florida Blue utilization management programs

Utilization management program updates for the upcoming quarter, when available, will be posted at: **PrimeTherapeutics.com › Resources › Pharmacists and providers › Pharmacy providers › UM program updates**.

OMB Approval No. 0938-0975

Enrollee's Name: _____ (Optional)

Drug and Prescription Number: _____ (Optional)

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

Form CMS -10147