PRIME THERAPEUTICS®

Prime Perspective

Quarterly Pharmacy Newsletter from Prime Therapeutics LLC

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INSIDE

From the auditor's desk

Preparing for an onsite audit

When your pharmacy receives notice of an upcoming onsite audit, follow the next steps to prepare for the audit:

- Plan pharmacy staffing for the day of the audit. In addition to regular staffing, someone must be assigned to assist the auditor.
- Use the masked prescription list to assemble bundled hardcopies and their associated pickup signature logs. Participating Pharmacy will receive the masked prescription list from Prime seven days prior to the audit. Prime will review the bundled hardcopies and signature logs on the day of the audit. Please note Prime may review electronic or printed documentation from the Participating Pharmacy's computer system.
- Make sure the following documents are on hand for the auditor to review:
  - Pharmacy liability insurance certificate
  - Professional liability certificate
  - Board of Pharmacy license
  - DEA license
  - Pharmacist and pharmacy technician licenses
  - Fraud Waste and Abuse training materials, including evidence of training completion
  - Copy of the Medicare Prescription Drug Coverage and Your Rights form
- Prepare a dedicated space for the auditor to work. The auditor will set up a laptop computer and will need enough space to review specific documents, which will be requested on the day of the audit. An electrical outlet near the work space may be helpful.
- Assign a staff member to be ready when the auditor arrives. Their role will be to pull the specific prescriptions that are requested on the day of the audit, show the auditor requested pharmacy inventory, and participate in the audit interview.

Upon completion of the onsite audit, the auditor will complete an exit interview with the assigned staff member. During this time, the auditor will review with the assigned staff member the following:

- Preliminary audit findings
- Missing documentation still required to complete the audit
- Next steps for the audit
- Contact information for the auditor

The assigned staff member will be asked to sign the exit interview and will receive a copy of the review form.

If you have any questions following an onsite audit, you may contact the Pharmacy Audit Department at **pharmacyaudit@primetherapeutics.com** or contact the auditor listed on the onsite audit notification.

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: **primetherapeutics.com › Resources › Pharmacy + provider › Pharmacy audit.**

Medicare news/Medicaid news

Medicare E1 Eligibility Query

The E1 Eligibility Query is a real-time transaction submitted by a Participating 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 Benefit Plan Sponsor.

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**

Participating Pharmacies should not submit an E1 for pharmaceutical manufacturer co-pay assistance coupon programs.

CMS standardized pharmacy notice

CMS requires all Medicare Part D Benefit Plan 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 Plan at Point-of-Sale (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: **primetherapeutics.com › Resources › Pharmacy + provider › Medicare › More Resources › Medicare Prescription Drug Coverage and Your Rights form.**

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.

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 a 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.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0975. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

Form CMS -10147 OMB Approval No. 0938-0975 (Expires: 02/28/2020)

HCSC news

Utilization Management Frequently Asked Questions for Blue Cross® and Blue Shield® of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas*

Participating Pharmacies may receive questions from Medicare Part D Covered Person's regarding their drug coverage. The Q&A below is being provided to serve as a tool to provide context to Covered Person's who experience a Point-of-Service (POS) reject due to utilization management criteria. Below are some common questions you may encounter:

Q: What is a Prior Authorization?

A: Prior authorization (sometimes called pre-approval) means that your medicine needs to be approved by your health plan before it will be covered. You or your Prescribing Provider will need to request that approval so that your health plan can review and determine if coverage can be provided. Your Prescribing Provider will explain why you need this particular medicine and why it is the best option for you. The health plan may request that your Prescribing Provider provide additional information in to order to make a decision.

Q: Why does a drug need a Prior Authorization?

A: A drug may be used for only certain health conditions. The information your Prescribing Provider provides for a prior authorization allows the health plan to determine if the medicine is being used to treat the appropriate condition and that it also meets other health plan or Medicare requirements. Sometimes medicines/treatments may be covered under Medicare Part B. A Prior Authorization request can help determine whether a medicine is covered under Medicare Part B or Part D.

Q: What do I need to do if my prescription requires a Prior Authorization?

A: You or your Prescribing Provider will need to request an approval of the prescription from your health plan.

Pharmacist – I have already contacted your Prescribing Provider to start the prior authorization process for you. I recommend that you also contact your Prescribing Provider to ensure that they have started the prior authorization process.

Q: What is Step Therapy?

A: Step Therapy means you must try a different medicine(s) before you can "step up" to the one that your Prescribing Provider prescribed. If you don't follow the process for step therapy when it's required, then the medicine may not be covered by your health plan. You or your Prescribing Provider can request an exception to the step therapy if you have already tried the other drugs or if they are not appropriate for you.

Q: Why does this drug have a Step Therapy?

A: Step therapy programs help manage the rising cost of prescription drugs, and the overall cost of health care. A "step" approach encourages the safe, cost-effective use of medication by first trying lower-cost medications whenever appropriate.

Q: What is a Quantity Limit?

A: Your prescription benefit limits the quantity that you can get filled at once or how often this drug can be dispensed. In order to obtain quantities above this amount, you or your Prescribing Provider will need to request a quantity limit exception from your health plan.

Q: Why do they have a Quantity Limit on this drug?

A: Quantity Limit programs promote safe and cost-effective drug use. They also help reduce waste and overuse.

Q: What if my medicine is not covered?

A: First talk with your Prescribing Provider. There may be another medicine that is on your plan's drug list (formulary) that your Prescribing Provider can prescribe. If there is no other medicine or if you would like your Prescribing Provider to request a formulary exception for this medicine, you or your Prescribing Provider will need to contact your health plan to process the request.

Q: What is a Formulary Exception request?

A: This request would be used to get coverage for a medicine not listed on the drug list (formulary), such as when your Prescribing Provider believes a non-formulary drug is best for you.

Q: How do I request a Formulary Exception for drug?

A: If your Prescribing Provider feels that the original medicine (non-formulary medicine) is best for you, your Prescribing Provider can submit a request for a formulary exception. The first step is to ask your Prescribing Provider to call the number on the back of your insurance card. Your Prescribing Provider will then need to submit a statement supporting your request. The Prescribing Provider statement must explain how:

- This drug is medically necessary to treat your condition
- None of the drugs on your plan would be as effective, or they have unwanted effects.

Q: How will I know if my request has been approved?

A: Once a decision is made, your health plan will send a letter to you and your Prescribing Provider. If you have questions regarding the decision contact your health plan or your Prescribing Provider for information.

*Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Florida news

Florida Blue utilization management programs

Utilization management program updates for the upcoming quarter, when available, will be posted at **primetherapeutics.com › Resources › Pharmacy + provider › Pharmacy providers › UM program updates.**

Prime news

Electronic prior authorization can save you time

Obtaining a prior authorization (PA) for prescription medications can be a time-consuming and frustrating process for Participating Pharmacies and Prescribing Providers. The process has traditionally required paper forms, faxes and follow-up phone calls, having the potential to take time away from a Covered Person's care.

Electronic prior authorization (ePA) is an online method for Prescribing Providers and Participating Pharmacies to submit utilization management (UM) requests to Prime in a streamlined, structured manner. PAs are a critical part of the medication delivery process. PAs help to manage medicines that have a significant potential for misuse, overuse or inappropriate use.

Prime has contracted with CoverMyMeds® to provide an ePA solution that will allow Participating Pharmacies and Prescribing Providers the ability to submit PA requests online. This online solution also allows Participating Pharmacies and Prescribing Providers to submit and track PA results.

Pharmacy licensure

In order to ensure that all license documents are current, Participating Pharmacies must provide Prime with copies of the following documents on an annual basis:

- Pharmacy License
- DEA Certificate
- Certificate of Insurance with proof of General and Professional Liability Insurance

Please include your **NCPDP number** on each of the documents when sending them to Prime. Submit the documents via fax to **877.823.6373** or email to **primecredentialing@primetherapeutics.com.**

Provider Manual update

Prime is in the process of updating its Provider Manual. The new Provider Manual will be effective September 1, 2018 and will be posted in August on Prime's website: **primetherapeutics.com › Resources › Pharmacy providers › Provider manual.**

MAC list updates

If a Participating Pharmacy would like access to Prime's Maximum Allowable Cost (MAC) lists, weekly MAC changes, the sources used to determine MAC pricing and the appeals process, please refer to Prime's website for registration instructions. After network participation is verified, the Participating Pharmacy will receive a secure user name and password via email.

How to reach Prime Therapeutics

As a service to Participating Pharmacies, Prime publishes *Prime Perspective* quarterly to provide important information regarding claims processing. Prime values your opinion and participation in our network. If you have comments or questions, please contact us:

- Phone: Prime Pharmacy Contact Center **800.821.4795** (24 hours a day, seven days a week)
- Email: **pharmacyops@primetherapeutics.com**

Looking for formularies?

For Commercial formularies access either the Blue Cross Blue Shield plan website or **primetherapeutics.com › Resources › Pharmacists + providers › Pharmacy providers › Formularies – Commercial.**

For Medicare Part D formularies access **primetherapeutics.com › Resources › Pharmacists + providers › Pharmacy providers › Formularies – Medicare Part D.**

Keep your pharmacy information current

Prime uses the National Council for Prescription Drug Programs (NCPDP) database to obtain key pharmacy demographic information. To update your pharmacy information go to **www.ncpdp.org › NCPDP Provider ID** (on the left side).

Report Compliance, Privacy, or Fraud, Waste and Abuse concerns

Prime offers the following hotlines to report compliance, privacy, and Fraud, Waste and Abuse (FWA) concerns:

Compliance

Report suspected compliance concerns:

- Phone: **612.777.5523**
- Email: **compliance@primetherapeutics.com**

Privacy

Report privacy concerns or potential protected health information (PHI) disclosures to Prime:

- Privacy Hotline: **888.849.7840**
- Email: **privacy@primetherapeutics.com**

Fraud, Waste and Abuse

If you suspect Fraud, Waste or Abuse (FWA) by a Covered Person, Prescribing Provider, Participating Pharmacy or anyone else, notify Prime:

- Phone: **800.731.3269**
- Email: **reportfraud@primetherapeutics.com**

Anonymous Reporting

Report a compliance concern or suspected Fraud, Waste or Abuse anonymously by contacting Prime's 24-hour anonymous compliance hotline:

- Phone: **800.474.8651**
- Email: **reports@lighthouse-services.com**
- Third-party vendor's website: **www.lighthouse-services.com/prime**

Notes

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Time Sensitive

Information from Prime Therapeutics

- Claims processing instructions
- Utilization management updates from Blue Cross and Blue Shield plans
- Prime audit requirements
- Medicare Part D and Medicaid requirements