CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

UNIT 6: PRESCRIPTION DRUG PROGRAMS

IN THIS UNIT

What's My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The **PA ONLY** symbol indicates the information in this section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in this section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

4.6 PHARMACEUTICAL OVERVIEW

Pharmacy networks

The prescription drug program offers pharmacy networks that include national chains and many local independent pharmacies. Drug benefits may vary slightly depending on the member's group program. Pharmacies have point-of-sale technology that confirms a member's eligibility, benefit design, and copayment information at the time of dispensing.

Under most prescription drug programs, members must use one of the participating pharmacies in Highmark's pharmacy network associated with their benefit plan. To find a network pharmacy that is conveniently located to them, members may consult the pharmacy directory by visiting **highmark.com** or calling Highmark Member Service at the phone number shown on their identification cards.

Highmark also offers a home delivery mail service option to most members. Under this option, members can get a 90-day supply of medication through the mail.* For most prescriptions, the member can save on the cost of the medication when it is obtained via the mail service pharmacy.

** Under the Children's Health Insurance Program (CHIP) in Pennsylvania, members receive a 34-day day supply at the pharmacy and also through home delivery mail service.*

What Is My Service Area?

How to use Highmark's formularies

Highmark's drug formularies include a list of FDA-approved prescription drug medications reviewed by our Pharmacy and Therapeutics (P&T) Committee. The formularies are designed to assist in maintaining the quality of patient care and containing cost for the patient's drug benefit plan. Our P&T Committee approves revisions to the drug formularies on a quarterly basis; updates will be provided to reflect such additions.

After a minimum of thirty (30) days notification is given to providers, products are removed from the formularies at least twice per year -- on January 1 and July 1 and after brand medications become generically available. Practitioners are requested to prescribe medications included in the formulary whenever possible. Our Clinical Pharmacy Strategies department will monitor provider-specific formulary prescribing and communicate with providers to encourage use of formulary products.

The drug formularies are divided into major therapeutic categories for easy use. Products that are approved for more than one therapeutic indication may be included in more than one category. Drugs are listed by brand and generic names.

Providers can access Highmark's formularies on the Provider Resource Center. Select **PHARMACY PROGRAM/FORMULARIES** from the main menu.

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4.6 PHARMACEUTICAL OVERVIEW, Continued

Provider appeal rights	If you are a participating provider with Highmark and you disagree with the decision to deny authorization or payment of a prescription drug, you have a right to appeal that decision. Please see **Chapter 5.5: Denials, Grievances, and Appeals** for additional information.
Telephone contact	For pharmacy benefit questions, the Highmark Prescription Drug Department can be contacted at **1-800-600-2227** between 8:30 a.m. and 4:30 p.m., Monday through Friday.
FOR MORE INFORMATION	This unit provides a brief overview of Highmark pharmacy benefit programs. To access all policies and updates, select **PHARMACY PROGRAM/FORMULARIES** from the main menu on the Provider Resource Center.

4.6 PHARMACEUTICAL HOME DELIVERY

Mail delivery

Home delivery service is a standard component of our prescription drug benefit. Members may call the Member Service telephone number on their identification card to obtain a mail order form.

Advantages of home delivery

Members may prefer to use the home delivery prescription service. This service enables most members to obtain up to a 90-day supply* at a discounted copayment compared to retail prescriptions.

** 34-day supply for CHIP members in Pennsylvania.*

What Is My Service Area?

How to assist members with home delivery

If a member must begin taking a new maintenance drug immediately, you may need to write two prescriptions. The member can have one of the prescriptions filled at a local pharmacy to begin taking the medication immediately. The member can send the other prescription to the home delivery service.

How members can enroll in home delivery

Members can obtain mail order forms for maintenance drugs by calling the Member Service telephone number on their identification card or by visiting their Highmark member website. They can reach their member website through our corporate website at highmark.com. They would click on the orange **CONSUMERS/MEMBERS/PROVIDERS** box, and then the appropriate link for their Highmark service area under **FOR MEMBERS**.

Once a member places an order, the member's information remains on file. Any subsequent refills do not require an order form. For refills, the member can call the toll-free number, send in the refill form with the applicable copayment, or visit their Highmark member website.

As a convenience to patients, practitioners may fax prescriptions directly to Express Scripts. For details regarding how to fax a prescription to the mail order pharmacy, please call Express Scripts at **1-800-903-6228**.

4.6 PRESCRIPTIVE PRESCRIBER AUTHORITY APPLIED TO MEDICARE PART D PRESCRIPTION DRUG CLAIMS

What Is My Service Area?

Background

The Centers for Medicare & Medicaid Services (CMS) recently released guidance to the industry that indicates that taxonomy will have a critical role in defining how Medicare claims process. The taxonomy or taxonomies associated to a prescriber's National Provider Identifier (NPI) will tell claims' systems all over the country whether a prescription drug claim should process or reject.

Prescriptive authority logic applied effective September 11, 2018

Effective September 11, 2018, Express Scripts®, the pharmacy benefit management company that processes Highmark prescription drug claims, implemented state prescriptive authority logic within their pharmacy claims processing system for Medicare Part D claims.

If the Medicare Advantage prescribing practitioner does not meet the criteria determined by state law regarding assignment of correct taxonomy code(s) to their National Provider Identifier (NPI), Express Scripts will leverage the National Council for Prescription Drug Programs state-level prescriptive authority rejection reason code, 876.

This may mean that your patient's prescription will not be filled at the pharmacy if your NPI is not within compliant taxonomy code requirements. Highmark recommends that providers review taxonomy codes assigned to their NPIs and update taxonomy codes, if necessary. It is also recommended that you review this information annually and make updates as frequently as required.

Express Scripts Prescriber Taxonomy FAQ

To ensure continued member access and data accuracy, it is crucial that you be familiar with what taxonomy is, how it works, and that your NPI is associated with a valid taxonomy code that correctly reflects what you do.

Express Scripts' **Prescriber Taxonomy FAQ** provides the information you need to know about taxonomy codes, including instructions for updating your taxonomy code(s), if necessary. This document is also available on the Provider Resource Center – select **PHARMACY PROGRAM/FORMULARIES** from the main menu on the left, and then **Pharmacy Information**.

4.6 DRUG MANAGEMENT

Prescription drug management

The Pharmaceutical Management Programs (Clinical Management Programs) are designed to safeguard patients from potentially harmful drug interactions and side effects, optimize clinically appropriate therapy, promote appropriate prescription drug utilization, and promote compliance with recommended drug quantity, dosage, and intended use of product.

These programs bring together every individual or entity involved in the management and delivery of pharmaceutical care: plan sponsor, practitioners, members, and pharmacists. The programs are administered across all lines of business and are seamless across both retail and home delivery prescription drug benefit programs. These programs achieve this by:

- Identifying specific prescribing situations that may represent inappropriate utilization based on nationally-recognized clinical practice guidelines or manufacturer's recommended dosage
- Providing the appropriate clinical interventions and follow-up necessary with physicians and patients to foster more appropriate and effective use of prescription therapy.

Pharmaceutical Management Programs

Highmark's Pharmaceutical Management Programs include the following:

- Drug Utilization Review
- Quantity Level Limit Program
- Prior Authorization Program
- Managed Prescription Drug Coverage (MRxC) Program
- Formulary Management

Highmark's Pharmacy and Therapeutics Committee has approved all of these program policies. This committee is composed of network physicians and pharmacists who consider the safety, efficacy, and appropriate use of medications when reviewing these policies. Changes and updates to these criteria are distributed quarterly to all network providers via a formulary update.

Please select **PHARMACY PROGRAM/FORMULARIES** from the main menu on the Provider Resource Center to access all policies and updates.

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4.6 DRUG MANAGEMENT, Continued

Medical necessity criteria for drug management

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, CMS as to the Medicare Advantage program, etc.), Highmark has adopted a universal definition of medical necessity. The term "Medically Necessary," "Medical Necessity," or such other comparable term in any provider contract shall mean health care services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

a. in accordance with generally accepted standards of medical practice;
b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
c. not primarily for the convenience of the patient or the provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

4.6 MEDICAL INJECTABLES DRUG PROGRAM

Introduction

Highmark has a streamlined program through which network physicians must obtain certain medical injectable drugs exclusively through Walgreens Specialty Pharmacy. In addition, Highmark has also delegated Walgreens Specialty Pharmacy to manage Highmark's authorization process required for certain drugs in the program.

Drugs included in the program

Highmark provides a **list of drugs included in the program** that is reviewed regularly and updated as needed.

This list is also available on the Provider Resource Center by selecting **PHARMACY PROGRAM/FORMULARIES** from the main menu, and then **Pharmacy Information.** On the program page, you will also find additional information, including referral forms by therapy/drug and the necessary information that you will need to provide to Walgreens Specialty Pharmacy when ordering.

Certain drugs require authorization

Certain drugs on the Medical Injectable Drugs Program list require authorization.

To determine if a drug from the program's list of drugs requires authorization, please refer to Highmark's **List of Procedures/DME Requiring Authorization**.

This list is also available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**. It can also be accessed quickly from the **Quicklinks Bar** by selecting **REQUIRING AUTHORIZATION**.

Ordering drugs

Walgreens Specialty Pharmacy can be reached by calling **1-888-347-3416** to place an order. Walgreens Specialty Pharmacy bills Highmark and ships to the medical provider. Highmark does not reimburse network physicians for products included in the Medical Injectable Drugs Program. **Note:** Financial assistance resources are available to patients who qualify; delivery of the drug may be delayed if a patient seeks financial assistance.

Walgreens Specialty Pharmacy is open seven days a week and offers several delivery options, monitoring of your refill needs, patient education and support, and has clinical pharmacists available 24 hours a day, seven days a week to answer patient questions.

BlueCard® patients

When treating out-of-area BlueCard® patients, providers can order certain injectable drugs for office administration for these patients. You may also choose to purchase and bill Highmark directly for injectable drugs for BlueCard patients, in which case you will receive reimbursement based on your contracted rate.

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4.6 MEDICAL INJECTABLES DRUG PROGRAM, Continued

Obtaining authorization

Authorizations must be obtained by the prescribing physician. Walgreens Specialty Pharmacy will only accept authorizations by fax.

To obtain information and the authorization request form, physicians can call Walgreens Specialty Pharmacy's authorization department at **1-888-347-4894**.

Hospital guidelines

In circumstances where the ordering physician directs the member to the hospital for the drug and/or its administration, the following must be considered by the facility:

- Some drugs on the Medical Injectable Drug Program list require authorization. Only the ordering physicians, who have access to the member's clinical information, can obtain this authorization through Walgreens Specialty Pharmacy, regardless of where the drug is administered.

  Physicians are instructed to notify Walgreens Specialty pharmacy if the drug is to be administered at a facility in the outpatient setting so that the facility name can be added to the authorization record.
- If the facility receives an order/request to administer a drug to a Highmark member that is included in the Medical Injectable Drugs Program and requires authorization, the facility should verify that an authorization exists for the facility to provide the drug and/or the administration. Please check the **Referral/Auth Inquiry** in NaviNet® to determine if the physician has obtained authorization.
- If an authorization is not present, please contact the ordering physician who must contact Walgreens Specialty Pharmacy to obtain an authorization.
- The facility is not expected to obtain authorization for either the drug or its administration. However, if the facility administers and/or provides a procedure that requires authorization and an authorization does not exist, the facility claim will reject. If the facility claim is denied, a retrospective authorization request must be initiated by the ordering physician.
- Highmark will reimburse the facility for the drug and/or the administration when the authorization has been granted.

FOR MORE INFORMATION

Please refer to the **Medical Injectable Drugs Program** page on the Provider Resource Center for additional information specific to your service area. From the main menu, select **PHARMACY PROGRAM/FORMULARIES**, and then click on **Medical Injectable Drugs Program**.

4.6 PRESCRIPTION DRUGS FOR MEDICARE ADVANTAGE HOSPICE PATIENTS

What Is My Service Area?

Background

On March 10, 2014, the Centers for Medicare & Medicaid (CMS) issued guidance on payment for drugs under the Medicare Part A Hospice Benefit and Part D Prescription Drug Benefit for beneficiaries enrolled in hospice.

The goal of this guidance was to ensure that the hospice and Part D programs correctly pay for prescription drugs covered under each respective Medicare benefit while ensuring timely access to needed prescription medications.

Why blue italics?

Drugs and/or biologicals covered under Medicare Part A Hospice Benefit

The hospice plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. Drugs and/or biologicals that are necessary for the palliation and management of the terminal illness and related conditions are the responsibility of the hospice provider. They are appropriately covered under the Medicare Part A Hospice Benefit rather than the Part D Prescription Drug Benefit.

Drugs that were used prior to a Medicare Advantage member's hospice election will be covered under the Medicare Part A Hospice Benefit only if those drugs will continue as part of the hospice plan of care and are necessary for the palliation and management of the terminal illness or related conditions.

If any of a member's existing medications are determined unreasonable or unnecessary for the palliation of pain and/or symptom management by the hospice interdisciplinary team, these medications would not be covered under the Medicare Part A Hospice Benefit. If the member still chooses to have these medications filled at the pharmacy, the medications are not covered by Part D and payment for these medications becomes the member's responsibility.

Maintenance drugs

After hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, there are maintenance drugs that are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal prognosis. These maintenance drugs would be the responsibility of the hospice provider and covered under the Part A Hospice Benefit.

Drugs eligible under Part D

For prescription drugs to be eligible under the Part D Prescription Benefit when a member elects hospice, the drug(s) must be for the treatment of a condition that is completely unrelated to their terminal illness and/or related conditions. These drugs continue to be subject to standard Part D formulary management practices, including quantity limitations, step therapy, and prior authorization.

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4.6 PRESCRIPTION DRUGS FOR MEDICARE ADVANTAGE HOSPICE PATIENTS, continued

What Is My Service Area?

Authorization requirements for select Part D drugs

When a Medicare Advantage member is in a hospice election period, Highmark requires prior authorization for six categories of drugs to determine coverage eligibility under the Part D Prescription Benefit:

- *Analgesics*
- *Anticonvulsants*
- *Antiemetics (antinauseants)*
- *Antieoplastics*
- *Anxiolytics (antianxiety)*
- *Laxatives*

The prescription medications must be for the treatment of a condition that is completely unrelated to the member's terminal prognosis or related condition. Hospice providers are expected to maintain a record of the clinical basis for the statement that the drug is unrelated and provide it upon request. In documenting Part D coverage of the drugs designated to require authorization, a statement indicating that the drug is unrelated to the terminal illness and related conditions is sufficient.

*Highmark's **Medicare Part D Hospice Authorization Information Form** can be completed by a member's representative or the prescribing physician to initiate the prior authorization process. Per CMS guidelines, a hospice provider cannot request a coverage determination on behalf of the member.*

*This form can be accessed on the Provider Resource Center by selecting **PHARMACY PROGRAM/FORMULARIES**, and then **Pharmacy Information**. Once completed, the form can be faxed or mailed to Highmark.*

Why blue italics?

Highmark Pharmacy Policy J-30

*Please see **Pharmacy Policy J-30**: **Administrative Prior Authorizations for Medicare Part D Plans – Medicare** for Highmark's policy on Part A vs. Part D coverage determinations for members in hospice.*

*To access Highmark Pharmacy Policy on the Provider Resource Center, select **PHARMACY PROGRAM/FORMULARIES** from the main menu, and then **Pharmacy Policies - SEARCH**.*

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4.6 PRESCRIPTION DRUGS FOR MEDICARE ADVANTAGE HOSPICE PATIENTS, continued

What Is My Service Area?

Hospice termination or revocation

In the event of hospice termination or revocation, documentation is to be submitted to Highmark by the hospice facility, member, or prescriber to confirm that the member is no longer receiving the hospice benefit. Highmark will accept any of the following documentation:

- *Written statement of revocation*
- *Notice of Medicare Non-Coverage*
- *Copy of the Hospice Discharge Summary*

Upon receipt of this documentation, Highmark will remove the Part D prior authorization requirement for the member (unless a new hospice period start date is reported).

Auto-shipment under Part D

If a member is receiving Part D prescriptions through auto-shipment prior to electing hospice, auto-shipment is required to be promptly discontinued after the member has elected hospice.

Why blue italics?

Coordination between hospice and Part D plan

Coordination of benefits between hospice providers and the Part D plan is required to further ensure appropriate payment for drugs under either the Medicare Part A Hospice Benefit or the Part D Prescription Drug Benefit.

Due to delays in notification of a member's hospice election, Part D plans may pay for a hospice drug claim prior to knowing that hospice coverage was in effect for the date of service. Hospice providers are expected to cooperate with the Part D plan when seeking recovery for claims paid incorrectly under Part D.

FOR MORE INFORMATION

To learn more about hospice benefit election, please see the Highmark Provider Manual's **Chapter 2.2: Medicare Advantage Products and Programs**.