

## HEADER INFORMATION

<b>Owner</b>	Health Alliance Medical Plans contracts H1417, H1463, S4219
<b>Department:</b>	
<b>Subject:</b>	<b>Transitioning Process for Medicare Part D Members, including members in Long Term Care Facilities</b>
<b>Owner:</b>	Pharmacy
<b>Affected Departments:</b>	
<b>Effective Date:</b>	01/01/2012
<b>Revision Date:</b>	
<b>Review Date:</b>	01/01/2013
<b>Policy #:</b>	1232
<b>Policy Applies To:</b>	Medicare members with Part D

## PURPOSE OF THE POLICY

To define the transition process for members joining a Health Alliance Medicare Advantage Part D Benefit Plan that are currently utilizing medications covered by Part D, but which may not be coded on the Part D formulary or which may have restrictions such as Prior Authorizations or Step Edits.

## STATEMENT OF THE POLICY

Health Alliance will follow this policy for members joining the Medicare Advantage Part D Benefit who are currently on medications which may not be coded on the Medicare D Formulary or have restrictions. This transition process will allow members to continue their current maintenance medication therapy without interruption.

**Implementation Statement:** Health Alliance Medical Plans in conjunction with our Pharmacy Benefits Manager(PBM), MedImpact, use electronic systems to allow appropriate claims adjudication for transitioning Medicare Part D Beneficiaries, so that they are allowed to obtain their medications without interruption, whether the medication is Non-formulary, has utilization management (UM) edits, or the members are in a Long Term Care (LTC) Facility. Health Alliance's formulary is considered an "Open Formulary". There are few drugs that would not automatically go thru at point of sale (POS) for these beneficiaries. Any prescription which goes thru the PBM's electronic adjudication process and is noted to be a transition prescription will automatically be given a 30 day override or 31 day override in the case of LTC members. The pharmacy will see a message that the drug is not on formulary, but the claim will continue to adjudicate. The PBM generates a daily transition report for the health plan, and those transition claims are manually given an override for the rest of the plan year. The only exceptions are prescriptions for drugs which require Prior Authorization criteria to be met. These claims would be picked up on the daily transition report, a letter would be sent to the member, and a review for continuation of that drug with the appropriate criteria submitted by the member or physician would be initiated. This implementation

statement is in accordance with the PBM's implementation statement, attached below in Bullet 5 of this policy and Section 1.3 of the PBM, Medimpact policy.

## PROCEDURES

### 1. Transition Process for medications not currently coded on the Medicare Part D Formulary for 2010 for Retail and Long Term Care Prescriptions

- 1.1 Health Alliance will have an Open Formulary for our Medicare Advantage Part D Members. This means that drugs, which are not otherwise coded, currently listed on the most recent printed formulary document, or posted on the Health Alliance Medicare website will adjudicate at Tier 3, whether generic or brand, in accordance with any Prior Authorization or Step Edits that are in place. This does not include drugs deemed excluded by the Centers for Medicare and Medicaid or by Health Alliance.
- 1.2 In the event that a Medicare Advantage Part D member gets a rejection denial for "drug not on formulary" when at point of sale at the pharmacy, the following process needs to be followed, so Health Alliance Pharmacy Dept., can make a systems update and get the drug coded appropriately thru the Pharmacy Benefit Manager (PBM), Medimpact.
  - At point of sale, if a rejection code appears for "drug not on formulary", the pharmacist should call into Health Alliance Pharmacy Dept. and request an override so the member's prescription will adjudicate.
  - A pharmacy co-ordinator will put in an override, which will allow the prescription to adjudicate at Tier 3 for whatever supply is written.
  - Timeframe for the override should be within 24hrs
  - In the event, that the pharmacy does not call into the health plan for an override, the claim will still go thru at point of sale due to the electronic system edits put in place by our PBM. The system allows for the one-time, temporary 30-day fill or 31-day fill for LTC members.
  - Prior Authorization or Exceptions request forms can be obtained thru Health Alliance Pharmacy Department at 1-800-851-8078. The department will mail, fax, or email the form.
  - The Prior Authorization Form is attached at the end of this document for print
  - The Transition Policy link is also viewable thru the Medicare Plan Finder Website .
  - The Transition Policy extends across contract years in accordance with the PBM attached policy section 1.2
- 1.3 Long Term Care pharmacies who come across the same rejection code, should follow the same process

### 2. Transition Process for new members and Long Term Care residents on maintenance medications which have restrictions such as Step Edits

- 2.1 If a member is transitioning to Health Alliance and has been maintained on a medication, which has restrictions such as Step Edits, they will be allowed to continue on their medication without fulfilling the Step Edit.

- 2.2 If the prescription is for a brand new medication that the member has not been maintained on, then the member will be required to fulfill the requirements before being able to obtain the new medication.
- 2.3 Health Alliance’s P&T Committee will not be involved in overseeing the transition process other than approving policies, because the process allows transitioning beneficiaries to continue their medications without limits.

**3. Transition Process for medications which are listed as “Specialty Medications” or need Prior Authorization on the Medicare Part D Formulary for Retail and Long Term Care Prescriptions**

- 3.1 Members which require a medication listed as a Specialty Medication or need a Prior Authorization on the Medicare Part D Formulary will be able to have their Specialty medication continue for one month, at which time patient and patient’s physician are required to send in the requested prior authorization material to Health Alliance to meet Health Alliance’s coverage criteria for continuation of therapy, which is supplied by Health Alliance’s Specialty Pharmacy provider, when appropriate.
- 3.2 Current Specialty Medications listed on the Medicare Part D Formulary are at a Tier 5 level
- 3.3 Health Alliance Pharmacy Department will ensure the member receives appropriate written notice within three business days of a temporary fill.

**4. Health Alliance Medical Plans Transition Policy Webaddress:**

5. [https://healthalliance.org/HA20/Policies/Med% 20D% 20Transition% 20Policy.pdf](https://healthalliance.org/HA20/Policies/Med%20D%20Transition%20Policy.pdf)

6.

**5. Medimpact’s Supporting Transition Policy:**



<b>Document Title</b>	Transition Process Requirements for Medicare Part D				
<b>Document #</b>	900-PL-103	<b>Versio n</b>	4.0	<b>Supersedes</b>	None
<b>Process owner (title)</b>	Product Manager I, GPS			<b>Effective Date:</b>	01-01-2011

<b>Approver Name</b>	<b>Title</b>	<b>Signature</b>	<b>Date Approved</b>
Carine Scherlippens	Director, Medicare Programs		
Lisa Byerley	VP, Corporate Compliance		
Elinor Colby	VP, Enterprise Effectiveness		

<b>Purpose</b>	The purpose of this policy is to describe MedImpact’s process for transitions and ensure that continued drug coverage is provided to new and current Part D members. The transition process allows for
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	a temporary supply of drugs and sufficient time for members to work with their health care providers to select a therapeutically appropriate formulary alternative, or to request a formulary exception based on medical necessity. Transition processes will be administered by MedImpact in a manner that is timely, accurate and compliant with all relevant CMS guidance and requirements as per 42 CFR §423.120(b)(3)
<b>Quality Records</b>	Transition of Care Notification File Implementation Questionnaire (IQ)
<b>Related Documents</b>	42 CFR §423.120 Chapter 6 Medicare Part D Manual Medicare Marketing Guidelines 400-PD-011 Medicare Part D Coverage Determinations

<b>Doc Type</b>	<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Work Instruction
<b>Usage and Scope</b>	<input type="checkbox"/> Used within Dept only <input type="checkbox"/> Used inter-department or all Business Unit <input type="checkbox"/> Used Enterprise-Wide <input checked="" type="checkbox"/> Cross-functional - used by 2 or more Business Units Scope: This policy is necessary with respect to: (1) new enrollees into prescription drug plans at the beginning of a contract year; (2) the transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year; (3) the transition of individuals who switch from one plan to another after the beginning of a contract year; (4) enrollees residing in long-term care (LTC) facilities; and (5) in some cases, current enrollees affected by formulary changes from one contract year to the next. Applicable personnel in Government Programs, Health Services and Operations follow this policy. This document is intended to describe processes necessary to meet regulatory requirements as of the effective date above.
<b>External Sharing</b>	<input type="checkbox"/> <b>No, do not share externally</b> <b>Yes, may share with:</b> <input checked="" type="checkbox"/> <b>Client</b> <input checked="" type="checkbox"/> <b>Regulatory agencies</b> <b>Other:</b>
<b>Document Protection</b>	<b>Is password required for viewing?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Is printing allowed?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

**Change Control**

<b>Versio n</b>	<b>Review date</b>	<b>Status</b>	<b>Author/Reviewer</b>	<b>Approval Review Date</b>
3.0	03/01/2010	Approved	Carine Scherlippens	06/18/2010
4.0	03/28/2011	Approved	Carine Scherlippens	03/28/2011

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## 1. Policy

### 1.1 Overview

MedImpact supports Plans in administering a transition process that is in compliance with the established CMS transition requirements.

MedImpact will ensure that its transition policy will apply to non-formulary drugs, meaning both (1) Part D drugs that are not on a plan's formulary; and (2) Part D Drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules. MedImpact will ensure that its policy addresses procedures for medical review of non-formulary drug requests, and when appropriate, a process for switching new Part D plan enrollees to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

Also in accordance with CMS requirements, MedImpact ensures that drugs excluded from Part D coverage due to Medicare statute are not eligible to be filled through the transition process. However, to the extent that a Plan covers certain Part D excluded drugs under an Enhanced benefit, those drugs should be treated the same as Part D drugs for the purposes of the transition process.

### 1.2. Transition Population

MedImpact will maintain an appropriate transition process consistent with 42 CFR §423.120(b)(3) that includes a written description of how, for enrollees whose current drug therapies may not be included in their new Part D plan's formulary, it will effectuate a meaningful transition for: (1) new enrollees into prescription drug plans at the beginning of a contract year; (2) the transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year; (3) the transition of individuals who switch from one plan to another after the beginning of a contract year; (4) enrollees residing in long-term care (LTC) facilities; and (5) in some cases, current enrollees affected by formulary changes from one year to the next.

### 1.3. Transition Period

MedImpact allows Plans to choose the number of transition days offered under their transition policy. CMS requires a minimum of 90 days from the start of coverage under a new plan. The 90 days are calculated from the member's Part D plan start date. MedImpact will extend its transition policy across contract years should a beneficiary enroll in a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply. This 90 day timeframe applies to retail, home infusion, LTC and mail-order pharmacies. Plans may choose to enhance their transition policy to provide coverage beyond the CMS minimum requirements.

With the exception of MedImpact's Transition Across Calendar Years processes described later in this policy, it is ultimately the responsibility of the Plan to indicate which of their members should be in a transition period. Plans

must place their members into a transition period by populating the appropriate Member Plan Part D Start Date in Segment Code 5 of the Type 24 File (Member Attribute Load File). The transition period (90-day minimum) is then calculated from the Member Plan Part D Start Date with the Plan. MedImpact will ensure that it will apply all transition processes to a brand new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.

#### 1.4. Implementation Statement

**a) Claims Adjudication System:** MedImpact has systems capabilities that allow MedImpact to provide a temporary supply of non-formulary Part D drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

**b) Pharmacy Notification at Point-Of-Sale:** Until such time as alternative transactional coding is implemented in a new version of the HIPAA standard, MedImpact will promptly implement either: (1) appropriate systems changes to achieve the goals of any additional new messaging approved by the industry through NCPDP to address clarifying information needed to adjudicate a Part D claim (see the 5.1 Editorial Document), or (2) alternative approaches that achieve the goals intended in the messaging guidance.

**c) Edits During Transition:** During an enrollee's transition period, the only edits that are enforced by MedImpact's claims adjudication system are: (1) edits to help determine Part B vs. Part D coverage, (2) edits to help prevent coverage of non-Part D drugs (i.e., excluded drugs); and (3) edits to help promote safe utilization of a Part D drug (i.e., quantity limits based on FDA maximum recommended daily dose, early refill edits).

MedImpact will ensure that the transition policy provides refills for transition prescriptions dispensed for less than the written amount due to quantity limits for safety purposes or drug utilization edits that are based on approved product labeling.

**d) Pharmacy Overrides at Point-Of-Sale:** During the member's transition period, all edits (with the exception of those outlined in part c above) associated with non-formulary drugs are automatically overridden by MedImpact's claims adjudication system at the point-of-sale.

MedImpact will ensure that pharmacies can override step therapy and prior authorization edits - other than those that are in place to determine Part B versus Part D coverage, prevent coverage of non-Part D drugs, and promote safe utilization of a Part D drug (e.g., quantity limits based on FDA maximum recommended dose, early refill edits) - during transition at point-of-sale.

Pharmacies can also contact MedImpact's Pharmacy Help Desk directly for immediate assistance with point-of-sale overrides. MedImpact can also accommodate overrides at point-of-sale for emergency fills as described in section 1.6.

**1.5. Transition Fills for New Members in the Outpatient (Retail) Setting**

MedImpact will ensure that in the retail setting, the transition policy provides for at least a one-time, temporary 30-day fill (unless the enrollee presents with a prescription written for less than 30 days in which case the Part D sponsor must allow multiple fills to provide up to a total of 30 days of medication.) anytime during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage.

**1.6. Transition Fills for New Members in the LTC Setting**

MedImpact will ensure that in the long-term care setting: (1) the transition policy provides for a 31-day fill (unless the enrollee presents with a prescription written for less than 31 days), with multiple refills as necessary, up to a 93 days supply during the first 90 days of a beneficiary's enrollment in a plan, beginning on the enrollee's effective date of coverage; (2) in the long-term care setting, after the 90 day transition period has expired, the transition policy provides for a 31-day emergency supply of non-formulary Part D drugs (unless the enrollee presents with a prescription written for less than 31 days) while an exception or prior authorization is requested; and (3) for enrollees being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such enrollees are allowed to access a refill upon admission or discharge.

**1.7. Emergency Supplies and Level of Care Changes for Current Members**

An Emergency Supply is defined by CMS as a one-time fill of a non-formulary drug that is necessary with respect to current members in the LTC setting. Current members that are in need of a one-time Emergency Fill or that are prescribed a non-formulary drug as a result of a level of care change can be placed in transition by the Plan via Segment Code 5 of the Type 24 File. MedImpact can also accommodate a one-time fill in these scenarios via a manual override at point-of-sale, if authorized by the Plan to do so.

**1.8. Optional Medicare Part D LTC Notification Report**

The MedImpact Medicare Part D LTC Notification Report is designed to assist Plans by notifying them when a member who is not Low Income Cost-Sharing (LICS) Level 3 has a prescription filled while in a Nursing Home, LTC Facility or a Rest Home. Plans may use this report to identify members that may be in need of a one-time emergency fill or that qualify for transition due to a level of care change.

**1.9. Transition Across Contract Years**

For current enrollees whose drugs are no longer on the Sponsor's formulary, Sponsor will effectuate a meaningful transition by either: (1) providing a transition process consistent with the transition process required for new

enrollees beginning in the new contract year; or (2) effectuating a transition prior to the beginning of the new contract year.

MedImpact POS logic is able to accommodate option 1 by allowing current members to access transition supplies at the point-of-sale when their claims history from the previous calendar year contains an approved claim for the same drug that the member is attempting to fill through transition. This process only applies to current members that are not otherwise placed in transition by the Plan via Segment Code 5 of the Type 24 File. To accomplish this, POS looks for Part D claims in the member's claim history that were approved prior to January 1 of the new plan year and that have the same HICL, Dosage Form, Product flag and Indicator flag values as the transition claim.

#### **1.10. Transition Extension**

Sponsor will make arrangements to continue to provide necessary Part D drugs to enrollees via an extension of the transition period, on a case-by-case basis, to the extent that their exception requests or appeals have not been processed by the end of the minimum transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request). The Plan can extend the member's transition period by populating a new Member Plan Part D Start Date in Segment Code 5 of the Type 24 File. On a case-by-case basis, point-of-sale overrides can also be entered by the Plan or by MedImpact (if authorized by the Plan to do so) in order to provide continued coverage of the transition drug(s).

#### **1.11. Cost-sharing for Transition Supplies**

MedImpact will ensure that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts for low-income subsidy (LIS) eligible enrollees. For non-LIS eligible enrollees, MedImpact will ensure that cost-sharing for a temporary supply of drugs provided under its transition process is based on one of the sponsor's approved cost-sharing tiers (if the sponsor has a tiered benefit design) and is consistent with cost-sharing the sponsor would charge for non-formulary drugs approved under a coverage exception.

#### **1.12. Six Classes of Clinical Concern**

Per CMS guidance, members transitioning to a Plan while taking a drug within the six classes of clinical concern must be granted continued coverage of therapy for the duration of treatment, up to the full duration of active enrollment in the Plan. Utilization management restrictions and/or non-formulary status, which may apply to new members naïve to therapy, are not applied to those members transitioning to the Medicare Part D plan on agents within these key categories. The six classes include:

- 1) Antidepressant;
- 2) Antipsychotic;
- 3) Anticonvulsant;

- 4) Antineoplastic;
- 5) Antiretroviral; and
- 6) Immunosuppressant (for prophylaxis of organ transplant rejection).

### **1.13. Member Notification**

MedImpact provides Plans (via FTP) with a daily file called the Transition Notification File. The Transition Notification File, which contains claims data and other member information, provides Plans with all of the information needed to contact members and providers regarding transition fills. Sponsor will send written notice via U.S. first class mail to enrollee within three business days of adjudication of a temporary fill. The notice must include (1) an explanation of the temporary nature of the transition supply an enrollee has received; (2) instructions for working with the plan sponsor and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary; (3) an explanation of the enrollee's right to request a formulary exception; and (4) a description of the procedures for requesting a formulary exception. Sponsor will use the CMS model Transition Notice via the file-and-use process or submit a non-model Transition Notice to CMS for marketing review subject to a 45-day review. Providing written notification to the member and/or provider in accordance with CMS requirements is ultimately the responsibility of the Plan. Plans also have the option to contract with MedImpact's print vendor to receive the Transition of Care Notification File and facilitate the fulfillment process of member notification on Plan's behalf.

MedImpact and MedImpact's print vendor adhere to all CMS Marketing Guidelines as set forth in Chapter 3 of the Medicare Managed Care manual. Sponsor will make their transition policy available to enrollees via link from Medicare Prescription Drug Plan Finder to Sponsor web site and include in pre-and post-enrollment marketing materials as directed by CMS.

### **1.14. Prescriber Notification**

As provided in 42 CFR section 423.120(b)(3)(v), CMS mandated that reasonable efforts are made to notify prescribers of affected enrollees who receive a transition notice under paragraph (b)(3)(iv). To support plans with this requirement, MedImpact developed a Prescriber Transition Notification template and a File Specification document for plans to utilize. All of the member, prescriber and claim details required to populate the Prescriber Transition Notification template are included in the Transition Notification Files that are sent to plans daily, as described in section 1.13 above.

Plans are given the option to contract with MedImpact's preferred print vendor to mail the Prescriber Transition Notifications, to mail them on their own, or to use an alternate method of their own choosing to notify prescribers of affected enrollees who receive transition fills. For plans that contract with MedImpact's preferred print vendor, Prescriber Transition Notifications are mailed to the prescriber at the same time the transition notice is mailed to the member.

### **1.15. PDE Reporting**

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Since this is a CMS required process, any drugs dispensed that qualify under the transition period are reported as covered Part D drugs with appropriate Plan and member cost sharing amounts on the Prescription Drug Event (PDE).

#### **1.16. CMS Submission**

Sponsor will submit a copy of its transition process policy to CMS.

#### **1.17. Pharmacy and Therapeutics Committee Role**

For MedImpact's standard formulary Plans only, the MedImpact Pharmacy and Therapeutics Committee (P&T) maintains a role in the transition process in the following areas:

- 1) The MedImpact P&T committee reviews and recommends all MedImpact formulary step therapy and prior authorization guidelines for clinical considerations; and
- 2) The MedImpact P&T committee reviews and recommends procedures for medical review of non-formulary drug requests, including the MedImpact exception process.

#### **1.18. Exception Process**

MedImpact follows an overall transition plan for Medicare Part D members; a component of which includes the exception process. MedImpact's exception process integrates with the overall transition plan for these members in the following areas:

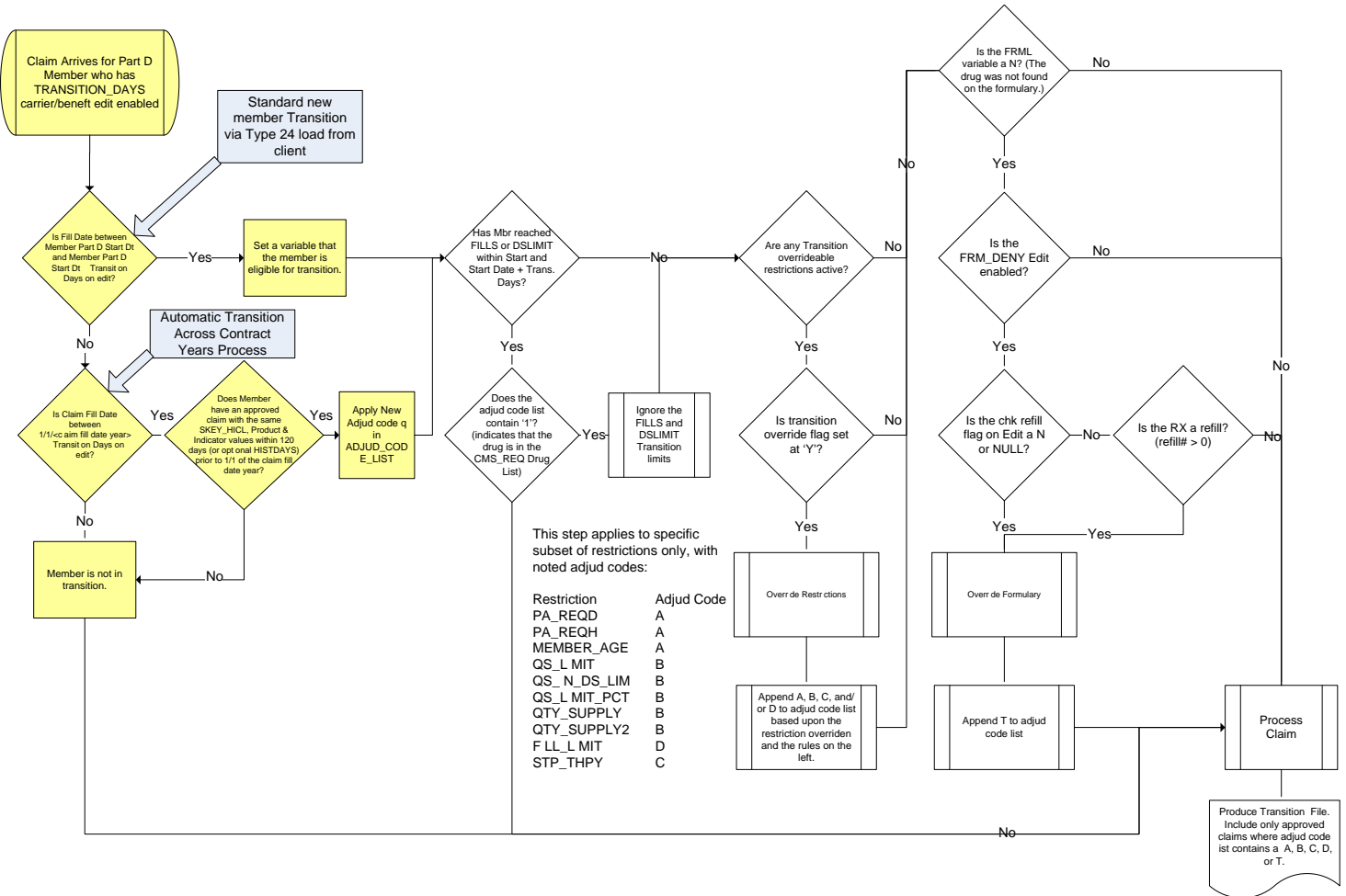
- 1) MedImpact's exception process complements other processes and strategies to support the overall transition plan. The exception process follows the guidelines set forth by the transition plan when applicable.
- 2) When evaluating an exception request for transitioning members, the Plan's exception evaluation process considers the clinical aspects of the drug, including any risks involved in switching, when evaluating an exception request for transitioning members.
- 3) The exception policy includes a process for switching new Medicare Part D plan members to therapeutically appropriate formulary alternatives failing an affirmative medical necessity determination.

Sponsor will make available prior authorization or exceptions request forms upon request to both enrollees and prescribing physicians via a variety of mechanisms, including mail, fax, email, and on plan web sites.

## Appendix A. Glossary

Term	Description
CMS	Centers for Medicare and Medicaid Services – The agency within the US Federal Government that is charged with the execution and maintenance of the law defining the prescription drug program for senior citizens, the disabled, and the infirm.
FTP	File Transfer Protocol – One of the methods used by MedImpact and its clients to transfer electronic files via the Internet. The first two bits of the file indicate the type of file.
HICL	An FDB data warehouse term that is an alpha-numeric code used to describe drugs ingredients. The HICL codes have been sequenced according to an ingredient sequence table. The HICL sequence table establishes relative importance to each ingredient, relative to other ingredients. The relative importance of an ingredient is based on its clinical and therapeutic use. The most important ingredients are sequenced first and the least significant are sequenced last.
Level of Care Changes	Level of care changes include the following changes from one treatment setting to another: <ul style="list-style-type: none"> <li>• Enter LTC facility from hospitals or other settings;</li> <li>• Leave LTC facility and return to the community;</li> <li>• Discharge from a hospital to a home;</li> <li>• End a skilled nursing facility stay covered under Medicare Part A (including pharmacy charges), and revert to coverage under Part D;</li> <li>• Revert from hospice status to standard Medicare Part A and B benefits; and</li> <li>• Discharge from a psychiatric hospital with medication regimens that are highly individualized.</li> </ul>
LTC	Long Term Care
MSB	Multi-source Brand – A branded drug that through cross-licensure is sold under more than one brand name.
NCPDP	A 7-digit number assigned to a pharmacy by the NCPDP, with the first 2 identifying the state and the last 5 identifying the pharmacy.
PA	Prior Authorization - The process undertaken to make a benefit determination that is made prior to the intended delivery of the healthcare service, treatment or supply under review (e.g., a Pre-Service Claim). Prior Authorization includes requests for coverage determination for medications that are designated on the client part D formulary as “Prior Authorization Required”, “Step Therapy”, “Quantity Restrictions” or for requests for exception for non-formulary medications or co-insurance amount.
PDE	Prescription Drug Event. File that reports all claims transactions to CMS for inclusion in the annual financial reconciliation between CMS and the plans.
Plan	Medicare Part D Plan Sponsors who are MedImpact clients.
POS	The acronym given to MedImpact’s point-of-sale prescription transaction processing computer system. Also indicates that the actual retail transaction occurs when the claim is submitted electronically by the pharmacy.
P&T Committee	Pharmacy & Therapeutics Committee – An independent group of external & internal health care practitioners that are responsible for evaluating the efficacy, safety and cost effectiveness of medications to determine potential additions, subtractions and other changes to a formulary.
SSB	Single Source Brand – This drug has a single source of manufacturing.
UM	Utilization Management – A set of guidelines that can be applied independently or jointly that otherwise restrict access to the dispensing or consumption of prescription drugs. The four basic restrictions are prior authorization (PA), quantity limits (QL), step therapy (ST) and tier placement. UM is a tool used by health plans to ensure safe, efficacious and cost-effective use of medication by beneficiaries.

## Appendix B. POS Transition Flow Diagram



### Health Alliance Prior Authorization Form:

### REQUEST FORM

Completion of all fields is required.

#### URGENT REQUEST

Per health care reform, urgent means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient's life/health, or the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.



# Health Alliance REQUEST FORM

**Medical Management Department**  
Fax (217) 337-8440  
 **Pharmacy Department**  
Fax (217) 255-4598

**MEDICAL RECORDS MUST ACCOMPANY ALL REQUESTS**

**SECTION 1**—To be completed for **ALL** requests. Please print clearly. Incomplete or illegible information will delay the review process.

Date _____	Reason for Request: <input type="checkbox"/> Not Available in Network <input type="checkbox"/> Unable to Schedule in Timely Manner <input type="checkbox"/> Other [please specify] _____
------------	--

_____	_____	_____
Patient Name	Patient Health Alliance ID Number	Patient
Birthdate		
_____	(_____) _____	
Requesting Physician's Name	Requesting Physician's Phone Number	Requesting
Physician's Fax Number		

Diagnosis Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Procedure Code: \_\_\_\_\_ Procedure: \_\_\_\_\_

_____	_____	_____
Facility	Practitioner	Provider Phone Number
Fax Number		Provider
Physician Signature _____		Date

### Tertiary/Out-of-Network Referrals

Referred to: \_\_\_\_\_

_____	_____
Physician	Facility
Physician Phone Number (_____) _____	Physician Fax Number
(_____) _____	

Service Reason:  
 Consult       Consult and Treatment

# Visits: \_\_\_\_\_ Length of Referral: \_\_\_\_\_

The patient has been encouraged to contact Health Alliance to verify coverage for visiting this provider.

Physician Signature \_\_\_\_\_

Date

**Pharmacy Medical Exception/Rx Preauthorization (Fax to (217) 255-4598)**

Drug Requested \_\_\_\_\_

Strength \_\_\_\_\_

Diagnosis \_\_\_\_\_

List [1] Therapy failure on formulary drugs in the same therapeutic/disease class, [2] Why failed, and [3] Medical rationale for request.

1)

\_\_\_\_\_

2)

\_\_\_\_\_

3)

\_\_\_\_\_

Physician Signature \_\_\_\_\_

Date

com-refmrv3-0910

Health Alliance • 301 S. Vine St. • Urbana, Illinois 61801  
(217) 337-8061 • Fax (217) 337-8440

## HISTORY

T.Howerton RPh revised for 2007 -1.1.07

Thowerton RPh-took out language stating LTC facility had to recv spec meds from a specialty pharmacy 1.1.08

SMadigan-clarify wording in section 3.3 -1.1.09

Thowerton RPh-1.1.2010 no chngs

Thowerton RPh- 4.12.2010 added Medimpact's Transition Policy under our policy

Thowerton RPh-1.1.2011 no chngs

Thowerton RPh-4.14.211-removed MI old policy and attached updated revised

## APPROVED BY

Signature(s): \_\_\_\_\_

*(Signature copies are kept in Compliance)*

Date: \_\_\_\_\_

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