PRIME THERAPEUTICS®

Prime Perspective

Pharmacy Newsletter from Prime Therapeutics LLC

Prime Perspective provides information and updates about Prime services

June 2022: Issue 87

INSIDE

From the auditor's desk

Assisting network Pharmacies in doing the right thing

Prior Authorization submissions

Step Therapy, also referred to as Contingent Therapy, requires a Covered Person to try one or more preferred medications before a non-preferred medication is considered for payment. Claims for drugs subject to Step Therapy will reject with Reject Code 75 "Prior Authorization Required" or 608 "Step Therapy Alternate Drug Therapy Required Prior to Use of Submitted Product Service ID." It is not permissible to submit claims for the preferred medications without obtaining a valid prescription order.

A Clinical Prior Authorization Request is used for medications that require a clinical review of specific criteria before the medication is covered by the Benefit Sponsor. This request often includes clinical documentation from the Prescribing Provider. In no event may the Pharmacy complete/submit a Clinical Prior Authorization Request; the Pharmacy must follow Point of Sale (POS) messaging and notify the Covered Person and/or Prescribing Provider of the need for a Prior Authorization Request.

Unacceptable claim submission practices

Pharmacies must review and adhere to federal, state, and local laws, rules and regulations set forth within their contract and, as an extension, Prime's Provider Manual. These documents explicitly call out claim submission practices that are both acceptable and unacceptable and need to be reviewed regularly to remain in compliance. For example, it is not permitted practice to submit claims utilizing any pharmacy credentials (NABP, NPI, etc.) other than your own, unless permitted by applicable law. Likewise, it is not permitted to allow another entity to submit claims utilizing your pharmacy's credentials on your behalf, unless permitted by applicable law. If a Covered Person, pharmacy representative, or Prescribing Provider has any questions regarding a Covered Person's pharmacy benefit, it is best practice to contact the Covered Person's Benefit Sponsor with any questions.

Benefit limit

Plans are often set up with benefit limits that restrict the amount of a drug and/or billing. These are often 30- or 90-day duration limits and may differ for specialty drugs. The Pharmacy is responsible for and expected to accurately bill medications. If a rejection is presented indicating a benefit limit, the Pharmacy must alter their billing. If the Pharmacy can dispense a lesser amount to remain within the benefit limit, the Pharmacy should do that. For example, Skyrizi is dosed at week 0, week 4, and then every 12 weeks. If dispensing two doses for 112 days, a rejection may indicate a dosing limit and the Pharmacy should then dispense one dose for a 28-day supply. For future fills, if the benefit limit is 30 days, the Pharmacy will bill one dose for 30 days rather than the 84 days that the medication would last.

continued

When the Pharmacy is unable to bill a medication for the correct days' supply per the directions on the prescription, the Pharmacy is responsible for adhering to dispensing in accordance with the directions of the prescription. The frequency of dispensing the order is expected to follow the cadence of when the medication is needed, although messaging, such as refill too soon, will be based on the benefit limit.

Drug Utilization Review (DUR)

Prime uses various messages through Drug Utilization Review (DUR) to ensure patient safety and appropriate dispensing. DUR messaging may include notification of duplicate therapy, safety edits such as opioids or drug interactions, early refill notification and more. The pharmacist is responsible for reviewing DUR edits and making an appropriate clinical decision based on the messaging. The pharmacist shall assess the information and make an appropriate clinical judgement which may include collaboration with the Prescribing Provider. The pharmacist should document conversations with Prescribing Providers and/or additional information as appropriate (reason medication is needed early, interaction verification, dosage/drug change, etc.).

Failure to comply with Prime's terms and conditions, including, but not limited to, those described above, may result in placement on a corrective action plan, full or partial financial recoupment, termination of participation in one or more Networks, termination of the Agreement, and other remediation actions, as determined by Prime and permitted by applicable law.

Pharmacy audit information

For more information regarding pharmacy audits, including common billing errors, pharmacy audit appeals and pharmacy audit guidelines, please visit Prime's website at **https://www.primetherapeutics.com/resources/.**

Medicare news/Medicaid news

Medicare E1 Eligibility Query

An E1 Eligibility Query is a real-time transaction submitted by a Pharmacy to RelayHealth, the Transaction Facilitator contracted by CMS to house Medicare eligibility information and respond to transaction requests. 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.

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 **https://medifacd.mckesson.com/e1/**.

Pharmacies should not submit an E1 Query 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 reject code:

- NCPDP Reject Code 569

Pharmacies are required to provide a Covered Person with 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 to Covered Persons are posted on Prime's website at **https://www.primetherapeutics.com/resources/additional-resources/.**

Home Infusion 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) 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 needed medication or an appropriate substitute. If the 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 claim rejection.

A copy of the CMS Notice of Medicare Prescription Drug Coverage and Your Rights to Covered Persons has been included on Page 4 of this publication.

National Plan/Provider Enumeration System – updates

To ensure pharmacy directory accuracy, the National Plan/Provider Enumeration System (NPPES) now allows Pharmacies to certify their National Provider Identifier (NPI) data. Please submit any changes to your Pharmacy's demographic information, including Pharmacy name, address, specialty and telephone number, as soon as you are aware of these changes.

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.

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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: 02/28/2025)

Florida news

Florida Blue utilization management program

Utilization management (UM) program updates for the upcoming quarter, when available, will be posted on Prime's website at **https://www.primetherapeutics.com/resources/.**

HCSC news

HCSC Medicare Part B

Continuous blood glucose monitor prior authorization with quantity limit criteria for 2022

Continuous Glucose Monitoring (CGM) has the potential to improve glycemic control while decreasing the incidence of hypoglycemia. Patients with type 1 diabetes and selected patients with type 2 diabetes treated with multiple daily insulin injections, particularly patients with frequent hypoglycemia or hypoglycemic unawareness, are most likely to benefit from CGM. The below Prior Authorization criteria was developed to ensure approval for patients who will benefit the most.

Prior Authorization criteria for approval

- The patient has diabetes mellitus.
- The patient is insulin dependent with multiple (three or more) daily injections of insulin or a Medicare-covered continuous subcutaneous insulin infusion (CSII) pump.
- The patient's insulin treatment regimen requires frequent adjustments based on BGM or CGM readings.
- Six months prior to ordering CGM, the practitioner has an in-person consultation with the patient to evaluate their diabetes control and determines that criteria are satisfied.

Covered CGM products and quantity limits

Agent	Quantity Limit
Dexcom G4 Platinum Sensor	4 sensors/28 days
Dexcom G4 Platinum Transmitter	1 transmitter/90 days
Dexcom G4 Platinum Receiver	1 receiver/365 days
Dexcom G5/G4 Sensor®	4 sensors/28 days
Dexcom G5 Transmitter®	1 transmitter/90 days
Dexcom G5 Receiver®	1 receiver/365 days
Dexcom G6 Sensor®	4 sensors/28 days
Dexcom G6 Transmitter®	1 transmitter/90 days
Dexcom G6 Receiver®	1 receiver/365 days
Freestyle Libre Sensor – 10 day®	3 sensors/30 days
Freestyle Libre Reader – 10 day®	1 reader/365 days
Freestyle Libre Sensor – 14 day®	2 sensors/28 days
Freestyle Libre Reader – 14 day®	1 reader/365 days
Freestyle Libre 2 Sensor®	2 sensors/28 days
Freestyle Libre 2 Reader®	1 reader/365 days

*Approval Length: 1 year

Restasis Brand-for-Generic (B4G)

First generic for Restasis launched in February 2022

Mylan/Viatris launched the first generic for Restasis on February 3, 2022. Apotex and KVK followed with their own Authorized Generics (AGs) but are categorized as MSC Y versus the true generic from Mylan/Viatris. All three products have a similar Actual Wholesale Price (AWP) with negligible variation in price. The timeline for additional entries is unclear due to the complexities of the FDA's bioequivalence recommendations, and Prime is anticipating at least 6–9 months at the current pricing. No generic is currently available for multi-dose formulation.

2022 Restasis/cyclosporine ophthalmic emulsion 0.05% – Brand before Generic

HCSC is continuing to cover Restasis at the preferred brand tier through 2022, while keeping it as a generic non-formulary drug. As such, the **Prior Authorization on Restasis was removed effective 3/15/22 for HCSC plans.** Once the generic option is on par with the after-rebate price of Restasis, the generic will be added to the Formulary and Pharmacies can begin converting patients to the generic drug. Generic tiering placement is dependent on final drug cost and formulary type. Network Pharmacies will be notified via fax blast and POS messaging. Call Center support will also be available. This strategy aligns with HCSC's goal of reducing drug costs for the benefit of patients.

Prime news

New Brand-for-Generic strategies for 2022

Brand-for-Generic (B4G) strategies help ensure the lowest overall cost for plans when a brand drug loses its patent. As patents for brand drugs expire, the first generic to market may be exclusive to one manufacturer or limited to a few generic manufacturers that cannot supply the entire market. The limited number of manufacturers results in generic costs remaining high and only slightly lower than the brand cost.

B4G strategies limit generic use through generic exclusion or utilization management while encouraging a member to temporarily remain on the brand drug. Members remain on brand drugs but pay the generic cost share until more affordable generics are available.

Beginning in 2022, select Prime clients will prefer brand Vascepa 1 gram and brand Restasis single use vials over the generic equivalent products. Once a client implements this strategy, POS messaging will direct Pharmacies to submit claims for the brand product.

Biosimilars

Biosimilar products, both interchangeable and noninterchangeable, have the potential to drive significant savings into the health care system. Prime supports biosimilars, and select Prime clients prefer the Semglee and unbranded insulin glargine products over the originator brand, Lantus. Most members should be able to receive the interchangeable product from the Pharmacy without notifying a Prescribing Provider in advance, in accordance with state law.

Prime appreciates your support in helping our members switch to the preferred interchangeable products. We encourage our pharmacy partners to evaluate ways to link originator products and biosimilars where appropriate in pharmacy filling systems as the area of pharmacy biosimilars expands over the next few years.

Pharmacy licensure

Pharmacies with independent contracts must provide Prime with the following on an annual basis:

- Certificate of Insurance with proof of general and professional liability insurance

To update our records, please visit our website at **https://pharmacy.primetherapeutics.com/en/resources/pharmacists/ac.html.**

Choose **Renewal of Pharmacy Certificate of Insurance** from the options and follow the instructions to upload and submit a PDF of your current or renewed Certificate of Insurance.

Provider Manual update

A new version of Prime's Provider Manual with an effective date of July 1, 2022, is available for review on Prime's website at **https://www.primetherapeutics.com/resources/provider-manual/.** Please continue to use the January 2022 Provider Manual until July 1, 2022.

MAC list updates

If a 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 Pharmacy will receive a secure username and password via email.

How to reach Prime Therapeutics

As a service to Pharmacies, Prime publishes the *Prime Perspective* 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:

- By phone: Prime's Pharmacy Contact Center **800.821.4795** (24 hours a day, 7 days a week)
- By email: **pharmacyops@primetherapeutics.com**
- By mail: 2900 Ames Crossing Road, Eagan, MN 55121

Where do I find formularies?

For commercial formularies, access either the Blue Cross Blue Shield plan website or **https://www.primetherapeutics.com/resources/commercial-formularies/.**

For Medicare Part D formularies, access **https://www.primetherapeutics.com/resources/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** (Pharmacy Login located at top right).

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, Pharmacy or anyone else, notify Prime:

- Phone: **800.731.3269**
- Email: **fraudtiphotline@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**

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