Section 16
Pharmacy Services

The Alliance has subcontracted with MedImpact to provide pharmacy services to all members. Members must go to a MedImpact-participating pharmacy for prescriptions. For more information regarding the Alliance Pharmaceutical Services Access, please see Policy 403-1126 – Pharmaceutical Services Access.

Drug Formulary

The Alliance has its own drug formulary, developed with input from local providers. Our formulary, which is not the same as the state formulary, is reviewed and updated annually. Please refer to the Alliance Formulary to find out if a particular medication is listed. You may download a copy of the formulary directly from the pharmacy page on the Alliance provider website.

Carved-Out Drugs

The Alliance formulary contains drugs from all therapeutic classes except for those that are carved out of the Alliance pharmacy benefit. The Alliance does not cover drugs in the following classes: antipsychotics, AIDS drugs, Blood Factors, Coagulation factors, Alcohol detoxification drugs, Heroin Detoxification drugs, and Dependency Treatment drugs (Buprenorphine, etc.). These carved-out drugs should be billed to state Fee-for-Service Medi-Cal.

Authorizations for Non-Formulary Drugs

Prior authorization is necessary for a prescription drug that is not on the Alliance Drug Formulary or exceeds the limit of days, age, quantity, or cost allowed per formulary. Beginning January 1, 2015, prior authorization requests must be submitted on the Prescription Drug Prior Authorization Request Form for Alliance Care IHSS members. This form can be found on the pharmacy page on the Alliance provider website or Form Library. Submissions on other forms will not be accepted. Use of this form for Medi-Cal members is encouraged, but optional, at this time.

Submission of prior authorization requests is preferred through the Alliance Provider Portal. Alternatively, providers may submit requests by fax to (831) 430-5851 or by mail to:

Central California Alliance for Health
Health Services Department – Pharmacy
PO Box 660012
Scotts Valley, CA 95067-0012

Questions regarding urgent prior authorization requests may be directed to the Alliance Pharmacy department by calling (831) 430-5507 or (800) 700-3874 ext. 5507.

To complete a prior authorization request, *all* of the following information must be provided:

- Member name, ID number and DOB.
- Requesting provider name and contact information.
- Description of requested drug or item (must include Healthcare Common Procedure Coding System (HCPCS) code if physician or facility administered drug is requested).
- All of the following are also required for an authorization request to be considered complete:
- Prescriber name, address, phone number and fax number.
- Pharmacy name, address, phone number and fax number (if authorization submitted by pharmacy).
- Diagnosis (or ICD code) that most accurately describes the indication for the medication. Please include all medically relevant diagnoses for review purposes.
- Quantity requested per fill or per date of service (DOS).
- Number of fills or DOS requested.
- Directions for use.
- Expected duration of therapy.
- Documentation of appropriate clinical information that supports the medical necessity of the requested drug or item, including:
    - Other drugs or therapies for this indication that have already been tried and failed. Please include what the outcomes were.
    - Why alternatives on the Alliance formulary cannot be used.
    - Any additional information to support diagnosis and medical justification such as lab results and specialist consults.

Incomplete and/or illegible forms may be denied or voided.

Approval of a non-formulary drug will be given if the patient has failed treatment with formulary alternatives or has intolerable side effects or contraindications to formulary alternatives. Trials conducted through the use of samples will be redirected to formulary equivalent medications.

The Alliance will prefer the use of a biosimilar if the member has not tried its branded counterpart. For more information, please see Policy 403-1142 - Biosimilars.

For providers who wish to administer Synagis in their office, the Statement of Medical Necessity form is required to be submitted along with the prior authorization request. The Alliance will cover Synagis for members who meet Conditions of Usage listed in Policy 403-1120 – Synagis.

Providers can contact the Alliance Pharmacy department at (800) 700-3874 ext. 5507.

For more information on the authorization review process, please see Policy 403-1103 - Pharmacy Authorization Request Review Process.

Authorizations for Physician-Administered Drugs

Physician-administered drugs that require prior authorization will have criteria consistent with pharmacy benefit criteria based on the recommendations of the Pharmacy and Therapeutics Committee. Prior authorization for the pharmacy benefit will be applicable to pharmaceutical physician administered drugs. If a physician/facility administered drug requiring prior authorization has no prior authorization criteria, it will be reviewed for medical necessity.

For more information on the authorization review process for physician/facility administered drugs, please see Policy 403-1141 – Physician/Facility-Administered Drugs Requiring Prior Authorization.

Alliance Opioid Policy

The Alliance has developed policies in collaboration with internal and external stakeholders to help ensure the safe and appropriate use of opioid medications.

The Alliance has established 50 mg MED (morphine equivalent dose) as the opioid ceiling for the treatment of chronic non-cancer pain. Quantity limits have been established for formulary opioid medications not to exceed a maximum daily dose of 50mg MED and not to exceed a maximum of 7 day supply. Requests for quantities greater than the quantity limits will require a prior authorization submission and will be reviewed for medical necessity. For members stable on high-dose regimens, providers will have to submit chart notes, a CURES attestation, and medical justification for plans for tapering (or why the member cannot be safely tapered) for continuation of care. The Alliance will allow refills for opioid prescriptions when greater-than or equal-to 90% of the days' supply of the prescription is met. The next refill request, for when less than 90% of the days' supply of an opioid prescription has elapsed, will require a prior authorization with medical justification for early refill.For more information on the Opioid Utilization Review process, please see Policy 403-1139 - Opioid Utilization Review.

After Hours Access

24-hour access is provided by any 24-hour pharmacy that contracts with the Alliance's PBM. Currently, access to 24-hour pharmacies is available in Santa Cruz (Watsonville) and Monterey (Salinas and Seaside) counties.

When there is an emergency after the Alliance's business hours (Monday-Friday 8:00 – 5:00 PM PST) or on holidays, the Alliance's PBM is authorized to enter a five-day override if the pharmacy states that it is for an emergency. The Alliance will receive and retrospectively review a report of all emergency overrides placed by the PBM. MedImpact is the Alliance's PBM and they can be reached at (800) 788-2949.

Alternatively, pharmacies can dispense a 72-hour supply of medically necessary non-formulary medication(s) if the pharmacist deems it is an emergency and the Alliance is closed. A retroactive prior authorization request can be submitted by the pharmacy for the 72 hour supply and will be approved by the Alliance on the next business day.

Continuity of Care for New Members

In the event that a new member is being treated with a non-formulary drug at the time of their enrollment with the plan, the Alliance will work with Alliance providers to ensure that they receive continuity of care with their pharmaceutical services.

For more information on continuity of care for new members, please see Policy 403-1114 - Continuing Pharmacy Care for New Members.

Drug Utilization Review (DUR)

The Alliance operates a DUR program to educate physicians and pharmacists to better identify patterns, and reduce the frequency of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care, both among physicians, pharmacists, and patients, and fraud or abuse associated with specific drugs or groups of drugs. For more information on the DUR program, please see Policy 403-1143 - Drug Utilization Review.

Billing and Reimbursement

Billing for "Carved Out" Medications

Procedures for Fee-for-Service reimbursement for "carved out" medications for psychiatric illnesses, substance abuse treatment, HIV/AIDS, erectile dysfunction and coagulation factors can be found on the Medi-Cal website in the Part 2 manual for Pharmacy. The complete list of "carved out" medications can be found on pages 6-8 of the MCP: County Organized Health System file.

For information on how to obtain reimbursement for compounding drugs, please see Policy 403-1135 – Compound Drugs Requiring Special Handling.

The Alliance 340B Pharmacy Program

For information on billing for drugs purchased under the 340B program, please see Policy - 403-1145-Pharmacy 340B Program.

For information on billing for drug waste, please see Policy – 403-1146-Drug Waste Reimbursement

Additional Pharmacy Benefits

Enteral Nutrition Product Benefit

Prior authorization is required for all Enteral Nutrition Products, including nutrition support (tube feed) formulas, oral nutrition supplements and specialty infant formulas. Prior authorization requests can be submitted by the prescribing or servicing provider, and may be submitted via the Provider Portal or fax. A copy of the prescription and recent chart notes detailing the member's diagnosis and medical necessity of the product being prescribed must be submitted. The criteria the Alliance uses to review authorization requests for medical necessity is outlined in the *Enteral Nutrition Products* section of the Medi-Cal Part 2 Pharmacy Provider Manual and further defined in Appendix A of Policy 403-1136 – Enteral Nutrition Products.

Medical Nutrition Therapy

Medical Nutrition Therapy (MNT) provided by a provider (MD, DO, PA, NP or an RD is a covered Benefit for all lines of business for members that meet qualifying conditions or deemed at nutritional risk. Treatment authorization request must be submitted for authorization.

Providers offering MNT to Alliance members should use the following codes for authorization and claims payment:

- CPT-4 Code 97802 - MNT, initial assessment and intervention, individual, face-to-face with patient, each 15 minutes.
- CPT- 4 Code 97803 - MNT, re-assessment and intervention, individual, face-to-face with patient, each 15 minutes.
- CPT – 4 Code 97804 - MNT, group (2 or more individual (s)), each 30 minutes.

Annual MNT coverage is a maximum of 3 hours for the first calendar year and 2 hours per calendar year in subsequent years.

Conditions include but are not limited to;

- Pediatric obesity with a BMI >95th percentile
- Cancer with significant weight loss
- Pre-Post bariatric surgery
- Conditions impairing digestion and absorption
- Underweight status or unintended weight loss

For more information on MNT, please see Policy 403-1149 - Medical Nutrition Therapy.

OTC Acetaminophen and Sharps Containers

Since 2011, over the counter (OTC) acetaminophen products have not been a covered benefit for state Medi-Cal. However, the Alliance continues to cover OTC acetaminophen products *with a prescription* for our Medi-Cal members. The Alliance also provides coverage of sharps containers for all members who receive diabetic supplies or self-injectable prescription drugs. A *prescription is required* for Medi-Cal Members to obtain OTC acetaminophen and sharps containers.