

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

PHARMACY PROCEDURE MANUAL



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INTRODUCTION

Partnership HealthPlan of California (PHC) is pleased to provide you with this Pharmacy Manual. This manual is intended for use by Pharmacy Providers who bill for PHC's prescription benefit through MedImpact. Although PHC is responsible for Pharmacy Management policy and overall program administration, PHC has contracted with a Pharmacy Benefit Manager (PBM), MEDIMPACT, to assist in the administration of its Pharmacy Management Program. PHC oversees MEDIMPACT'S role in assisting the pharmacy network with claims processing and day-to-day operations and has thus developed this manual for the following purpose:

1. Assist you in providing optimum pharmaceutical services to PHC members consistent with PHC policies and procedures.
2. Provide you with administrative guidelines and detail procedures to be followed to assure that your PHC customers receive pharmaceutical services consistent with their PHC scope of benefits.
3. Provide you with pertinent information which is necessary to achieve our mutual goal of providing quality pharmaceutical services to your PHC customers.

This manual is not intended to detail how pharmacy should be practiced nor how prescriptions should be filled.

The PHC Pharmacy Manual contains useful information on the following topics:

- Member Eligibility
- Covered Services
- Coordination of Benefits (COB)
- Claims Submission
- Drug Formulary
- Treatment Authorization Requests (TARs)
- Appeals Process

This information pertains to PHC members receiving pharmacy benefit under the Medi-Cal program. It does not pertain to members receiving Medicare benefits under the Partnership*Advantage* (PA) program.

The PHC Pharmacy Manual has been prepared to provide you with complete, easy to use information; therefore, reducing the need to contact PHC or MEDIMPACT for clarification, minimizing any delay with the prescription filling process. However, PHC realizes that improvements can always be made and that excellence can only be achieved through continuous quality improvement. PHC welcomes any suggestions related to this manual. Communication related to suggestions for improvement should be directed to the PHC Health Services Department at (800) 863-4144 or (707) 863-4133.



GENERAL INFORMATION

Participating Pharmacy Network

All participating pharmacies that provide pharmacy services for eligible members of PHC are contracted with PHC's Pharmacy Benefit Manager, MEDIMPACT. Pharmacy providers located in PHC's State contracted counties are referred to as "in-network" pharmacy providers and all other PHC pharmacy providers are referred to as "out-of-network" pharmacy providers. All PHC members are provided with an updated list of "in-network" pharmacy providers at the time of their enrollment.

Pharmacy Reimbursement

Participating pharmacies receive reimbursement from MedImpact for pharmacy services provided as specified for a covered medication and/or reimbursable service as identified in the MedImpact Pharmacy Network Agreement Plan Sheet. MedImpact reimbursement is based on the lower of: Average Wholesale Price (AWP) less the contracted discount plus the contracted dispensing fee; Maximum Allowable Cost (MAC) plus the contracted dispensing fee; or Usual & Customary (U&C); whichever is lowest. Reimbursements are paid on a bimonthly reimbursement cycle in a 30-day average time frame from MedImpact receipt of a reimbursable claim.

Pharmacy & Therapeutics (P&T) Committee

The Pharmacy & Therapeutics Committee meets four times per year and is responsible for making recommendations to the Physician Advisory Committee regarding the content of the PHC Drug Formulary, including new drug evaluations, therapeutic class reviews, development of Prior Authorization Criteria, Code 1 Restrictions and other matters regarding the PHC drug benefit. The committee's membership is comprised of the PHC Chief Medical Officer (CMO), the Associate Medical Director, the Health Services Director, the PHC Director of Pharmacy, the PHC Clinical Pharmacist and practicing physicians and pharmacists from the community. Community practitioners interested in becoming a P&T member may contact the PHC CMO or Pharmacy Director.

Scope of Drug Coverage

With very few exceptions, the scope of drug coverage for PHC members potentially includes all Food and Drug Administration (FDA) approved drugs as part of the drug benefit. Those FDA approved **drugs not on the PHC Drug Formulary are covered benefits with an approved Treatment Authorization Request (TAR)**. It is misrepresentation of the PHC drug benefit by pharmacy providers to attempt to collect cash payment from a PHC member and inform them that their prescriptions are "not covered". PHC is concerned that such responses misrepresent the scope of PHC drug coverage and result in members not receiving needed medications. Those pharmacies identified as misrepresenting the PHC scope of coverage will be subject to corrective action by PHC and MedImpact.



Care Coordination Programs

• **Growing Together Perinatal Program**

PHC offers clinical support services to pregnant individuals in collaboration with prenatal care providers and other case managers. Provider support and consultation services are available on difficult cases. The PHC staff is an excellent resource to community based services. Member Education is distributed assisting pregnant members to enter care within the first trimester with the use of incentives for attending prenatal visits. Additional assistance is given on an as needed basis for transportation to prenatal and postpartum visits, focused health education, access to childbirth education classes and assistance with breastfeeding.

• **Health Promotion and Prevention Services**

PHC offers clinical support services to all members in collaboration with physicians and other case managers that have been identified at risk due to high emergency room utilization, noncompliance issues and difficulty with access to care and or medication compliance. PHC will work with providers on strategies for managing challenging clients and is resourceful for community based services. Member Health Education is available in the form of referrals to health education classes and programs. These are published on a regular basis and mailed to the member's home address. To assist the provider with education a PHC Member Newsletter is also published on a regular basis.

• **Medical Case Management**

PHC offers individual case management in collaboration with physicians and other case managers for members that have been identified with moderate to severe asthma, high risk diabetes and chronic kidney disease.

PHC is the liaison to California Children's Services (CCS), a medical program for treating California residents under age 21 with physically handicapping conditions who meet medical and financial eligibility. Conditions such as, but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer and traumatic injuries are covered by CCS.

PHC administers EPSDT Supplemental Services for our members. These are medical, dental and or mental health services needed for a person under age 21 that exceeds the scope of benefits available to the general Medi-Cal population.

The PHC Care Coordination Program Department may be contacted at (707) 863-4276 or (800) 809-1350.



TELEPHONE SUPPORT NUMBERS

Contact	Subject	Telephone Number
MedImpact Customer Service Hours: Open 24/7, 365 days per year	Support / Help Desk On-Line Claims Assistance	(800) 788-2949
Partnership HealthPlan of California (PHC) Hours: M-F 8:00AM-5:00PM Sat./Sun.: Closed	General HealthPlan Information	(800) 863-4144 (707) 863-4100
PHC Pharmacy Dept.	Pharmacy / Drug Formulary / TAR Inquiries	(707) 863-4414 (707) 863-4330-FAX
PHC Member Services	Member Related Assistance / Eligibility Inquiries	(800) 863-4155 (707) 863-4120 (707) 863-4415-FAX
PHC Claims Dept.	Claims / Billing Inquiries (for claims billed directly to PHC)	(707) 863-4130 (707) 863-4119-FAX
PHC Provider Relations	General Provider Inquiries	(800) 863-4144 (707) 863-4100 (707) 207-0436-FAX
PHC Care Coordination	Individual Case Management Service for Members	(800) 809-1350 (707) 863-4276
AEVS (Automated Eligibility Verification System)	Eligibility Verification Share of Cost Transactions	(800) 456-2387
PHC Automated Eligibility System	Eligibility Verification	(800) 557-5471 (707) 863-4140
State Medi-Cal: EDS (Electronic Data Systems)	State Medi-Cal Help Desk / Order TAR Forms	(800) 786-4346
CCS (California Children Services)-Napa County	CCS Assistance	(707) 253-4391 (707) 253-4880-FAX
CCS – Solano County	CCS Assistance	(707) 784-8650 (707) 421-7484
CCS – Yolo County	CCS Assistance	(530) 402-2800 (530) 402-2809-FAX
Medicare-Cigna Region D	Medicare Part B Billing	(866) 243-7272
Kaiser	Member Services for Kaiser Capitated Members	(800) 464-4000
Molina Healthcare – West Sacramento	Member Services for Molina Capitated Members	(916) 373-1495
Molina Healthcare- Woodland	Member Services for Molina Capitated Members	(530) 668-9293
Rx America	Support / Help Desk for Molina Pharmacy Claims	(800) 770-8014

MEMBER ELIGIBILITY

The local County Social Services Agency determines member eligibility for Medi-Cal benefits. PHC's role is to administer the Medi-Cal benefits for those persons deemed eligible in Napa, Solano, Yolo and Sonoma Counties. PHC **DOES NOT** determine a person's eligibility for Medi-Cal benefits. PHC electronically receives Medi-Cal eligibility from the State Department of Health Services on a daily basis. After PHC receives the daily eligibility file it is then forwarded to MedImpact for inclusion into their on-line eligibility system.

Eligibility Verification

Each PHC member should present a PHC Identification Card at the time they have a prescription filled. The Identification Card contains the member's name, birth date and identification number. Currently the identification number (ID) is the member's nine digit Social Security Number (SSN). At the time of this printing PHC is in the process of changing the identification number to the Beneficiary Identification Card (BIC) number issued by the State. Once this change occurs the MedImpact system will accept either the BIC number or the SSN number that is to be used when submitting claims to MedImpact. If a prescription claim is rejected by MedImpact for "Non-Matched Cardholder ID", eligibility may be verified by the following procedure:

- 1) Call the State Automated Eligibility Verification System (AEVS) at (800) 456-2387. The AEVS eligibility file is updated throughout the day with the file being sent to PHC each evening. Thus a member may be eligible as verified through AEVS, but the updated file may not have been transferred yet to PHC and MedImpact.
- 2) If AEVS confirms that the member is eligible through PHC, then the pharmacy should complete an eligibility form (Attachment A) and fax it to PHC Member Services at (707) 207-0436 requesting the member be added to the MedImpact eligibility file. The claim may then be resubmitted on-line to MedImpact within 24 hours. If a member's eligibility needs to be updated on an urgent basis, the pharmacy may call PHC Member Services at (707) 863-4120 or (800) 863-4155 and request the eligibility file to be updated as soon as possible.
- 3) Pharmacy providers may also contact the PHC Automated Eligibility System at (707) 863-4140 or (800) 557-5471 to inquire about member eligibility.

During the interim while the member's eligibility status is being researched, pharmacies should exercise appropriate clinical judgment when determining whether to dispense medications pending eligibility verification.

Retroactive Eligibility

Some PHC members become retroactively eligible for PHC after the month in which services were rendered. To verify retroactive eligibility, pharmacy providers may access AEVS at (800) 456-2387 or the PHC Automated Eligibility System at (707) 863-4140 or (800) 557-5471. For further additional information pharmacy providers may call PHC Member Services at (707) 863-4120 or (800) 863-4155. Refer to the Claims Submission section of this manual for timeliness billing of retroactive claims.

Capitated Members – Kaiser and Molina

“Capitated Members” are those members who are eligible through PHC and have chosen a Primary Care Physician (PCP) who is affiliated with a contracted Medical Group provider that is responsible for all of the member’s medical care, including outpatient prescriptions. In Solano and Napa County, members who are assigned to Kaiser Medical Group for their PCP are “Kaiser Capitated Members” and must receive their prescriptions through a Kaiser facility. In Yolo County, members who are assigned to Molina Medical Group for their PCP are “Molina Capitated Members” and must receive their prescriptions through a Molina contracted pharmacy. Prescription claims for these “Capitated Members” will be denied on-line by MedImpact with a message informing the pharmacy that that the claim must be billed according to the member’s capitated arrangement. Pharmacy providers may verify “Capitated Member” status by calling the PHC Automated Eligibility System at (707) 863-4140 or (800) 557-5471. For further additional information pharmacy providers may call PHC Member Services at (707) 863-4120 or (800) 863-4155.

Newborns

Newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother’s eligibility. Refer to the Claims Submission section of this manual for billing instructions.

Share of Cost (SOC)

Some PHC members must meet a specified Share of Cost (SOC) for medical expenses, including prescriptions, before they can be eligible to receive Medi-Cal benefits within a given month. SOC dollar amounts can be verified through the Medi-Cal Automated Eligibility Verification System (AEVS). All health services including medical services, devices and prescription drugs, whether Medi-Cal covered or not, can be used to meet SOC. Pharmacies must clear SOC transactions through AEVS at the time services are rendered. Once the member has met his/her SOC obligation for a given month, all future prescriptions for that month may be billed to MedImpact.

Restricted Status

A PHC member may be placed on a restricted status for receiving prescription medications prescribed in an outpatient setting based on determination by the PHC CMO that such services may have been used inappropriately by the member. Members found to be possibly misappropriately using prescription medications may be subjected to the following types of restricted status:

- Prior Authorization (TAR) required for specific medications
- Prior Authorization (TAR) required for all controlled medications
- Allowed to use only one pharmacy, chosen by the member

Providers may request a PHC member to be reviewed for potential restricted status by contacting the PHC Health Services Department at (800) 863-4144 or (707) 863-4133.

California Children Services (CCS)

California Children Services (CCS) is a program of physical habilitation or rehabilitation for children 21 years of age and under with specific handicapping conditions. These children need specialist care, but their families are unable, wholly or partially, to pay for these services on a private basis. The program goal is to obtain for handicapped children the medical and allied services necessary to achieve maximum physical and social function.

Services for PHC members with CCS eligibility are paid by PHC. The CCS program will continue to approve members for eligibility for CCS services and for diagnosis and notify the Primary Care Provider and member. All prescription claims for CCS members with eligibility in Napa, Solano and Yolo Counties should be submitted to MedImpact for payment. Refer to the Claims Submission section of this manual for CCS billing procedures.

Services for Sonoma County PHC members with CCS eligibility are carved out. Pharmacies should bill CCS directly for those drugs associated with the CCS eligible condition.

Genetically Handicapped Persons Program (GHPP)

The Genetically Handicapped Persons Program (GHPP) is a State funded program which coordinates care of persons over age 21 years with certain medical conditions. All prescription claims for PHC members with GHPP eligibility are paid for by PHC and should be submitted to MedImpact. Providers with questions regarding GHPP may contact the Department of Health Services at (916) 654-0503.

Services for Sonoma County PHC members with GHPP eligibility are carved out. Pharmacies should bill GHPP directly.

Other Health Coverage (OHC)

Other Health Coverage (OHC) is any private health insurance plan or policy under which the recipient is entitled to receive health care services. OHC includes benefits through commercial insurance companies, prepaid health plans (PHPs), Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups, employer-employee benefit plans, including self-insured and self-funded plans.

Eligibility under Medicare is not considered OHC; however, Medicare supplement policies are considered OHC. Refer to the Coordination of Benefits (COB) section of this manual for instructions on billing for members with OHC and Medicare covered drugs and supplies.

Medi-Cal insurance coverage under PHC is always the payer of last resort. All pharmacy providers are required to bill OHC, and Medicare, before billing PHC. Effective 4/1/09 pharmacy providers may bill on line for Coordination of Benefits (COB)

Currently because the Point of Service (POS) network is not equipped to accept or adjudicate claims when there is a denial or partial payment from the OHC, providers must continue to hardcopy bill for these services. Under the authority of Title 22 of the California Code of Regulations providers may not refuse treatment of PHC members because either a member may also have insurance coverage in addition to PHC or the provider may be required to hardcopy bill.

Claims submitted electronically to MedImpact for members who have OHC with pharmacy benefits will reject with the message: "Bill Primary Carrier First". Refer to the Coordination of Benefits (COB) section of this manual under Commercial COB for billing instructions of secondary coverage.

Medicare

Medicare's outpatient prescription coverage is currently limited to selected drugs for cancer and organ transplant. **When a member is eligible for both Medicare Part B and PHC Medi-Cal, the pharmacy provider must bill Medicare as the primary insurer and PHC as the secondary insurer.** Refer to the Coordination of Benefits (COB) section in this manual under Medicare COB for billing instructions and a list of covered Medicare drugs and supplies.

Presumptive Eligibility (PE)

Presumptive Eligibility (PE) recipients are issued a paper Medi-Cal Presumptive Eligibility Identification Card (PREMEDCARD) to use until their Medi-Cal eligibility is determined or their PE period ends. Recipients are eligible for all Medi-Cal approved drugs prescribed for pregnancy-related services that are dispensed within the recipient's PE period time. Questions about the PE card should be directed to the provider who issued it.

PE information is unavailable through the Automated Eligibility Verification System (AEVS) and until further notice a PE card (PREMEDCARD) is considered acceptable proof of eligibility for PE services. The PREMEDCARD indicates an initial eligibility date with eligibility expiring on the last day of the month following the month in which PE is determined.

Pharmacy claims for these recipients ARE NOT a benefit of Partnership HealthPlan of California (PHC) and must be billed on the pharmacy claim form 30-1 and mailed to EDS. For more information regarding Presumptive Eligibility (PE) please refer to the EDS Pharmacy Instruction Manual pages 100-24-12 and 300-33-5 or call EDS at 800-257-6900.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Pharmacy Eligibility Update Form

Fax to (707) 863-4415

Instructions:

Complete this form to report PHC eligibility or to report a status change to primary coverage. A printout from the primary carrier reflecting the change, i.e. termination of coverage, no pharmacy coverage, must be submitted with this form.

___ Add Eligibility Information

___ Remove Pharmacy Coverage from Primary Carrier

1) Last Name _____ First Name _____

SSN: _____ DOB _____ Aid Code _____ Sex _____

State Eligibility Confirmation #(not required for removal of pharmacy coverage correction) _____

Date(s) of Service: _____

Comments: _____

*****Internal Use Only*****

Eligibility Confirmed: ___ Amisys ___ AEVS Confirmation #: _____ MR Initial: _____

2) Last Name _____ First Name _____

SSN: _____ DOB _____ Aid Code _____ Sex _____

State Eligibility Confirmation #(not required for removal of primary coverage) _____

Date(s) of Service: _____

Comments: _____

*****Internal Use Only*****

Eligibility Confirmed: ___ Amisys: ___ AEVS Confirmation #: _____ MR Initial: _____

**

Pharmacy Name: _____ Phone #: _____

Contact Name: _____ Date: _____

COVERED SERVICES

This section of the PHC Pharmacy Manual contains an overview of prescription benefits provided to PHC members, as well as specific guidelines for the pharmacy provider when providing prescription services to PHC members. Information regarding claim submission through MedImpact's on-line prescription claims processing system or for claims billed directly to PHC is provided in the Claims Submission section of this manual.

PHC's formulary requires mandatory generic substitution when an equivalent generic product is available.

Prescription Drugs

PHC's prescription drug formulary contains selected Federal Legend Drugs from all the major therapeutic drug classes. The drugs are listed in the drug formulary by the brand name. Refer to the Formulary section of this manual for further information regarding covered prescription drugs.

Injectable Drugs

Non-compounded injectable drugs are covered and billed on-line to MedImpact when dispensed in the original container. Covered injectable drugs are listed in the formulary under a separate "Injectable Drug" section. This section does not list all covered injectable drugs "for physician office, clinic or outpatient facility use." Non-pharmacy providers may contact the PHC Claims Department for information regarding other covered injectable drugs.

Compound Drugs For IV Infusion

Home Infusion Therapy is a covered benefit for PHC members. Claims for compounded IV infusion drugs do not require a TAR if the drug is listed in the formulary under "Injectable Drugs Formulary (Medi-Cal Only)". All drugs compounded for IV infusion and related administration supplies must be billed directly to the PHC Claims Department. Pharmacy claims for drug dispensed in the original container should be billed on-line to PHC's Pharmacy Benefit Manager.

Compound Drugs For Non-Parenteral Use

Extemporaneously compounded prescriptions for non-parenteral use are covered without a TAR if one of the ingredients is on the PHC Formulary, and the total billed cost is less than \$50.00. See the Claims Submission section for billing instructions.

Over-the-Counter (OTC) Drug

Over-the-counter (OTC) drugs, as with all drugs prescribed for PHC members, require a prescription from the prescribing physician to be covered. OTC drugs are listed in the formulary under a separate "Over-The-Counter" section.

Medical Supplies / Durable Medical Equipment (DME)

Medical Supplies and Durable Medical Equipment (DME), including diabetic supplies, ostomy supplies, incontinence supplies and disposable gloves are covered benefits for PHC members. Covered items are listed in the formulary under “Medical Supplies / Durable Medical Equipment”. See Billing Limitations under this section for billing limits.

Nutritional Supplements (Oral / Enteral)

Nutritional supplements for oral and enteral administration are a covered benefit for PHC members with an approved TAR. See the Claims Submission section for billing instructions.

Carve-Out Drugs

Certain HIV/AIDS drugs and certain psychotherapeutic drugs have been eliminated from PHC’s scope of service and are referred to as “carve-out drugs”. For Sonoma County members with California Children Services (CCS) eligible conditions, the drugs for the eligible conditions are carved out. These drugs continue to be a benefit for eligible PHC members but PHC is not financially responsible and the pharmacy provider must bill claims for these drugs to State Medi-Cal. These drugs are listed in the formulary and have a “carve-out” footnote (♠ or ♡) stating that the pharmacy provider must bill State Medi-Cal. PHC will notify providers of new drugs added to the Carve-out lists in the Quarterly Pharmacy Update.

CARVE-OUT HIV/AIDS DRUGS

GENERIC NAME	TRADE NAME
Abacavir sulfate	Ziagen
Abacavir, lamivudine, Zidovudine	Trizivir
Abacavir/Tenofovir Disoproxil Fumarate	Epizicom
Atazanavir sulfate	Reyataz
Darunavir Ethanolate	Prezista
Delavirdine mesylate	Rescriptor
Didanosine	Videx, Videx-EC, Videx PED
Didanosine/Ca Carb/Mg	Videx Chewable
Efavirenz Sustiva	
Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate	Atripla
Emtricitabine E	mtriva
Emtricitabine/Tenofovir Disoproxil Fumarate	Truvada
Enfuvirtide Fuzeon	
Fosamprenavir Lexiva	
Indinavir sulfate	Crixivan
Lamivudine	Epivir
Lopinavir/Ritonavir Kaletra	



Nelfinavir Viracept	
Nevirapine Viram	une
Ritonavir Norvir	
Saquinavir mesylate	Invirase
Stavudine Zerit	
Tenofovir disoproxil fumarate	Viread
Zidovudine/Lamivudine Co	mbivir

CARVE-OUT PSYCHOTHERAPEUTIC DRUGS

GENERIC NAME	TRADE NAME
Amantadine HCL	Symmetrel
Aripiprazole Abilif	y
Benzotropine mesylate	Cogentin
Biperiden HCL	Akineton
Biperiden Lactate	Akineton injection
Buprenorphine HCL	Buprenex
Buprenorphine/Naloxone Suboxone	
Chlorpromazine HCL	Thorazine
Chlorprothixene Taractan	
Clozapine Clozaril	
Fluphenazine Decanoate	Prolixin
Fluphenazine Enanthate	Prolixin
Fluphenazine HCL	Prolixin
Haloperidol Haldol	
Haloperidol Decanoate	Haldol
Haloperidol Lactate	Haldol
Isocarboxazid Marplan	
Lithium Carbonate	Various
Lithium Citrate	Various
Loxapine HCL	Loxitane
Loxapine succinate	Loxitane
Mesoridazine besylate	Serentil
Molindone HCL	Moban
Olanzapine Zyprexa	
Olanzapine/Fluoxetine Sym	byax
Paliperidone Invega	
Perphenazine Trilafon	
Phenelzine sulfate	Nardil
Pimozide Orap	
Procyclidine HCL	Kemadrin
Promazine HCL	Sparine
Quetiapine fumarate	Seroquel
Risperidone Risperdal	
Risperidone depot	Risperdal Consta
Thioridazine Mellaril	

Thiothixene Navane	
Thiothixene HCL	Navane
Thioridazine HCL	Mellaril
Tranlycypromine sulfate	Parnate
Trifluoperazine Stelazine	
Triflupromazine HCL	Vesprin
Trihexyphenidyl HCL	Artane
Ziprasidone HCL	Geodon
Ziprasidone mesylate	Geodon

Billing Limitations

- **Mandatory Generic Substitution**

PHC requires generic substitution when an equivalent generic product is available. However, clinicians may prescribe a brand name drug with a “do not substitute” order when there is clinical justification for doing so, but submission of a Treatment Authorization Request (TAR) is necessary. If a formulary drug is a single-source product (i.e., no generic has been FDA approved), then the brand is covered without a TAR.

- **Code 1 Restricted Drugs**

Code 1 Restricted Drugs are drugs covered with a restriction that limit the use of a drug based on diagnosis, failure or intolerant to 1st line therapy, specific use of the drug, member’s place of residence (i.e. Skilled Nursing Facility), or specialty of the prescriber. A list of Code 1 Restricted Drugs is contained in the Formulary section of this manual. Code 1 Restricted Drugs are also designated in the formulary with a symbol © and the Code 1 restriction is listed next to the drug. Any other use of the drug is considered non-formulary and requires a TAR. See the Claims Submission section for billing instructions of Code 1 Restricted Drugs.

Although Code 1 Restricted Drugs do not require a TAR, the dispensing pharmacist is expected to contact the prescriber’s office to document the Code 1 restriction when necessary. It is NOT sufficient for the prescription simply to have a “Code 1” on its face, even if it is apparently designated by the prescriber. Information as to the name of the person verifying compliance of the restriction with the prescriber, the date and time of the call and the full signature of the pharmacist receiving such information should be kept with the prescription.

- **Step Therapy Edit**

A Step Therapy Edit (STE) allows a drug to be filled without a TAR if the member has had a 1st line drug filled within the last 120-180 days depending on the drug and/or if the member meets other specified criteria. A list of drugs with a Step Therapy Edit is contained in the Formulary section of this manual. Drugs requiring a STE are designated in the formulary with **STE** with a 1st line or drug or specific criteria listed.

- **Formulary Dispensing Limits**
Selected formulary drugs have a dispensing limit that limits the drug to a specified quantity, duration of use or member age. A list of drugs that have dispensing limits is contained in the Formulary section of this manual. Drugs with a dispensing limit are also designated in the formulary by the symbol Ψ with the dispensing limit listed next to the drug.
- **Days Supply**
PHC allows prescribed drugs to be dispensed in quantities up to a maximum of a ninety (90) day supply for generic drugs and 30 days for Brand Name (Single Source) drugs. For patients stable on maintenance Brand Name drugs, a TAR may be submitted for up to a 100 day supply.
- **\$500 Limit**
Any single prescription that exceeds \$500, and not designated with a #500 exempt footnote, requires a TAR, even if it is a formulary item.
- **Medical Supplies**
Incontinence Supplies: A TAR is required if the monthly accumulative cost for all related supplies exceeds \$50.00. Washes and creams will only be authorized if the prescriber indicates medical necessity such as skin breakdown.
Disposable Gloves: Maximum dispensing is 100 gloves per month.
Ostomy Supplies: A TAR is required if the monthly cumulative cost for all related supplies exceeds \$150.00.
Diabetic Supplies: Blood Glucose Strips and lancets are limited to a maximum of 100 per 25 days for members on insulin, and 50 per 25 days for members not on insulin. Supplies are limited to those for the TrueTrack System, all others require a TAR.

All other prescriptions for members exceeding these limits require a submitted TAR with medical justification.

CLAIMS SUBMISSION

MedImpact Healthcare Systems, Inc. is the Pharmacy Benefit Manager (PBM) contracted with PHC to process pharmacy claims for all of PHC's eligible members. **All prescription claims for PHC members must be submitted through MedImpact. ALL PRESCRIPTION CLAIMS SUBMITTED DIRECTLY TO PHC WILL BE RETURNED TO THE PROVIDER FOR SUBMISSION TO MEDIMPACT. All inquiries regarding claims submission, rejected claims, plan limitations, or PHC's pharmacy benefit should be directed to MedImpact Pharmacy Help Desk at (800) 788-2949.** Customer Service Open 24/7, 365 days of year.

Electronic Claims Submission (ECS)

MedImpact's prescription claims processing is accomplished in a real-time point-of-sale mode through the MedImpact on-line claims adjudication system. Pharmacies must use the NCPDP (National Council of Prescription Drug Programs) Telecommunication Standard Version 3.2A or higher to comply with MedImpact's standard for on-line claims submission. The BIN Number or "Electronic Address" for MedImpact is **003585**.

Member information required for submitting on-line claims:

- First and last name
- Date of birth
- ID number
- Relationship to cardholder "1"

On-Line Drug Utilization Review (DUR)

The On-Line Drug Utilization Review (DUR) process assists pharmacists in providing quality care by identifying potential therapeutic conflicts. As claims are sent to MedImpact, the DUR process assesses the prescription against the claims history of the member. An on-line message is sent to the pharmacy when a potential problem exists. **If assistance is required regarding a DUR message contact MedImpact Pharmacy Help Desk at (800) 788-2949.**

Universal Claim Form (UCF) Billing

Electronic Claims Submission (ECS) is the preferred method to submit claims to MedImpact. All claims not submitted by ECS **MUST** be submitted on a Universal Claims Form (UCF). Other forms cannot be accepted. MedImpact reserves the right to assess a processing fee for claims submitted on UCFs. Refer to the Coordination of Benefits section, under Commercial COB, for instructions on completion of the UCF.

Timeliness of Submitted Claims

Pharmacies have up to 30 days from the date of service to submit claims on-line or 120 days by UCF to MedImpact. The exceptions to this policy are:

- If a member was not eligible with PHC at the time service was rendered and was subsequently granted retroactive eligibility; a 120-day billing limit is calculated from the date retroactive eligibility was established.
- If a member has other primary insurance and claims are processed by the primary insurance carrier, a 120-day billing limit is calculated from the time the other insurance carrier rendered a payment determination.

DAW (Dispense as Written)

MedImpact's on-line adjudication system **ONLY ACCEPTS DAW = 0** for all claims submitted by Electronic Claims Submission. PHC requires generic substitution when an equivalent generic product is available.

However, prescribers may order other brand name drugs with a "do not substitute" when there is clinical justification for doing so. In this case, submission of a Treatment Authorization Request (TAR) by the pharmacy is necessary, with medical justification for brand included on the TAR. Those pharmacy providers who have difficulty submitting on-line claims with a DAW = 0 due to software limitations should contact the MedImpact Pharmacy Help Desk at (800) 788-2949 for claims submission assistance.

Return to Stock / Claim Reversal

Prescriptions filled and submitted for payment, but not picked up by the member within a reasonable time frame must be reversed on-line. The requirement applies to unused reusable stock in all types of pharmacies, including Long Term Care pharmacies. Pharmacies are advised to maintain documentation of all reversals to demonstrate compliance with this requirement.

Refill Too Soon

Prescriptions refilled at a "too frequent" interval, based on day's supply reported with the claim will be rejected with a "Refill Too Soon" edit. A prescription is considered to be filled "too frequent" if less than 75% of the days supply submitted with the last fill has not elapsed.

To avoid a "Refill Too Soon" claim denial when the prescriber has increased the amount of drug to be taken by a member, the pharmacy should enter a therapy change code of "05" in the Denial Override field and the claim will be approved. If the claim does not approve, MedImpact Pharmacy Help desk at (800) 788-2949 should be contacted for

assistance. The therapy change code will not allow early refills for those medications that exceed the monthly dispensing limit as indicated in the formulary.

Refill Too Soon: Nursing Home/ Board and Care Home

MedImpact Pharmacy Help desk at (800) 788-2949 may approve a one-time override per medication within a one-year time frame for claims that reject for “refill to soon” if the member is being placed in a Nursing Home or Board and Care Home and is not allowed to take their medications into the Home with them. If a second request is made within the one year, a TAR must be submitted to PHC for authorization review.

Lost, Stolen, Spilled Medications

MedImpact may approve a one-time override per medication (non-controlled) within a one-year time frame for lost, stolen, or spilled medications. If a second request is made within the one year, a TAR must be submitted to PHC for authorization review.

Controlled medications are not applicable for this benefit.

Vacation Supply

Pharmacies may call MedImpact to request a one-time override per medication (Formulary Drugs only) within a one-year time frame for a vacation supply of up to 60 days. Subsequent requests for a second vacation supply within a one-year time frame on the same medication must be requested to PHC through the TAR process. Please inform members that PHC will not authorize vacation supplies beyond a 60 day supply as eligibility for Med-Cal is questionable when the member is absent from the area for more than 2 months.

Newborns

Newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother’s eligibility. Claims submissions for newborns should be under the mother’s nine-digit I.D. number (social security number) using the newborn’s name and date of birth and a cardholder relationship of “1”. Claims submission after this time frame will require the newborn to be eligible under their own I.D. number.

Compounded Prescriptions

Claims for extemporaneously compounded prescriptions for non-parenteral use should be submitted as follows:

- Submit the National Drug Code (NDC) number of highest cost legend ingredient in the compounded prescription
- Submit the total quantity of the amount dispensed
- Enter a “2” in the compound field that the drug is a compound

- Calculate the ingredient cost of all the ingredients in the compound based on your pharmacies reimbursement rate as indicated on the Pharmacy Network Agreement Plan Sheet from MedImpact

If none of the ingredients used in the compound are on the PHC Formulary, or the total billed amount exceeds \$50.00 a Treatment Authorization Request (TAR) is required. A completed compound worksheet must be submitted with the TAR.

National Provider Identifier (NPI) Number

All prescription transactions submitted to MedImpact must include the NPI. MedImpact will reject claims submitted without a valid identification number. PHC has asked MedImpact to minimize member disruption and temporarily allow both the NPI “01” qualifier and the DEA “12” qualifier to be used on a claim as a valid physician identifier. Prescriptions written by a Physician Assistant (PA), Nurse Midwife (NM), and Nurse Practitioner (NP) must meet state law and be submitted utilizing the supervising physician’s DEA number.

MedImpact continually evaluates pharmacies’ compliance with providing accurate prescriber identification numbers. The accuracy of these numbers impacts the effectiveness of PHC’s Drug Utilization Reports (DURs) and member drug profiling reports that are furnished to the member’s prescribing physician.

Code 1 Restricted Drugs

If a drug meets the “Code 1” restriction listed in the PHC Formulary the drug may be billed on-line to MedImpact by placing a “07” in your computer software’s prescription Denial Override Field. This is the same designated override field used when submitting claims to EDS for State Medi-Cal. Please verify current Code 1 requirement in PHC formulary, as Code 1 requirements may change. PHC Code 1 requirements will be different from the State’s Fee-for Service Medi-Cal Code 1 requirements.

Nutritional Supplements (Oral / Enteral)

A TAR is required for all nutritional supplements to be used on an out-patient basis. All requests must be accompanied by a completed Nutritional Supplement Form (Attachment B) documenting medical necessity. Claims submission to MedImpact for nutritional supplements require the quantity submitted to be in **milliliters (mls) or grams (gms)**, not **number of boxes, cans or bottles**. Claims for administration supplies for enteral feedings are to be submitted to the PHC Claims Department. Supplements for members residing in an acute care hospital or Long Term Care (LTC) facility are included in the per diem rate or capitation paid to the facility.

Medical Supplies / Durable Medical Equipment (DME)

Claims submissions for medical supply and DME items not listed in the PHC Formulary require an approved TAR for payment. Claims for formulary medical supplies, DME items and non-formulary items approved by a TAR (excluding incontinence supplies, disposable gloves, and ostomy supplies) with a National Drug Code (NDC) number must be submitted to MedImpact. **Items without an NDC number, all incontinence supplies, disposable gloves, and ostomy supplies must be submitted directly to the PHC Claims Department.**

PHC Claims Department will accept HCFA 1500 Forms and the State Medi-Cal Pharmacy Claim Form 30-1C. Providers with questions regarding claims submitted to the PHC Claims Department may contact that department directly at (707) 863-4130.

CCS Claims Submission Procedure

For Sonoma County members with a CCS eligible condition, CCS is carved out. Bill CCS directly for medications and supplies for the CCS eligible condition and PHC for medications not related to the CCS eligible condition.

Services for PHC members in Solano, Napa and Yolo Counties with CCS eligibility are paid by PHC. The CCS program approves members for eligibility for CCS services and issues Service Authorization Request (SAR). *Prescription claims from retail pharmacies for CCS members should be billed on-line to MedImpact for payment.*

If a Healthy Kids member has an approved CCS covered condition, pharmacy should bill CCS directly.

The following claims submission procedure is for PHC members who also have California Children Services (CCS) eligibility. All pharmacy claims for these members should be billed on-line to MedImpact using the following procedure:

- **PHC Formulary Medications:** No TAR required. Pharmacy submits claim on-line to MedImpact.
- **PHC Non-Formulary Medications:** TAR required.
 - 1) **With CCS/GHPP Authorization:**
 - a) Pharmacy faxes TAR to PHC with CCS Authorization attached. In lieu of completing the Diagnosis and Medical Justification pharmacy writes “CCS Authorization Attached”. Remainder of TAR is completed as usual.
 - b) PHC enters TAR into the MedImpact System and faxes back to pharmacy.

c) Pharmacy submits claim on-line to MedImpact.

2) **With CCS Denial:**

- a) Pharmacy faxes completed TAR to PHC with CCS Denial attached
- b) Remainder of TAR is completed as usual

3) **Without CCS Authorization or Denial:**

- a) Pharmacy faxes completed TAR to PHC, inclusive of diagnosis and medical justification
- b) If medication is potentially related to the CCS condition PHC faxes TAR to CCS for review
- c) CCS reviews TAR and faxes back to PHC
- d) If CCS Approves TAR: PHC will enter into the MedImpact System as authorized by CCS and fax back to pharmacy for on-line submission
- e) If CCS denies TAR: PHC will review to determine approval, deferral or denial and fax back to pharmacy
- f) If medication is not related to the CCS condition PHC will review to determine approval, deferral or denial and fax back to pharmacy



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
360 Campus Lane, Suite 100
Fairfield, CA 94534
(707) 863-4100
FAX (707) 863-4330

NUTRITIONAL SUPPLEMENT
MEDICAL JUSTIFICATION

Member Name: _____ Date: _____
Member ID #: _____ TAR# _____

★ Required Patient Information:

- 1. Does this patient reside in a Skilled Nursing Facility (SNF)? YES ___ NO ___
2. How many cans/bottles/packets will this patient require per day/week/month? ___ Per ___
3. Please explain why this patient is UNABLE to maintain adequate nutrition with ordinary foodstuffs and describe alternative nutrition programs that have been tried or considered (e.g.: changed food consistency such as pureed, assistance with menu alternatives and feeding etc.
4. What is the patient's current height and weight with date of last weight?
Height: ___ Weight: ___ Date: ___
5. Describe the patient's pertinent medical and weight history, such as how much weight loss over what period of time, medical risk factors for malnutrition, etc.
6. Why did you select this particular formula and what are the nutritional goals for this patient (weight goal, intake goal)?
7. How will you evaluate the patient's progress towards goal (monthly weights, albumin levels, etc.)?
8. Is this requested item to be used as a ___ temporary or a ___ long-term supplement to a regular diet, or as a ___ complete dietary replacement program? (check one). If the supplement is temporary, how long do you estimate the patient will require it? ___(Months)
9. If there is a question about this TAR request, who should be contacted? _____

If this patient would benefit from an appointment with a Registered Dietitian, please FAX a RAF to the SCHSS Clinical Nutrition Program @ FAX # (707) 435-2217, or send an E-RAF. Questions? Call(707) 435-2216



COORDINATION OF BENEFITS (COB)

Some PHC members have prescription coverage through other payment sources. Examples of other coverage include Medicare Part B, Medicare HMO, or private health insurance, under which a member is entitled to receive prescription benefits. All PHC pharmacy providers are required to bill other health coverage before billing PHC Medi-Cal. This is referred to as Coordination of Benefits (COB).

MedImpact's Point of Sale (POS) network is equipped to accept and adjudicate electronic claims when there is a denial or partial payment from the other health coverage. This is called electronic Coordination of Benefits (eCOB). MedImpact provides pharmacies with specific instructions to accept and process eCOB claims for PHC members. The process and instructions are compliant with NCPDP standards. If the pharmacy is unable to process eCOB claims due to software limitations, a Universal Claim Form (UCF) may be submitted to MedImpact.

Providers may not refuse service to PHC members who have other insurance coverage in addition to PHC Medi-Cal. PHC also prohibits pharmacy providers from billing members for the copay amount or for a prescription that is a primary insurance plan exclusion.

Commercial COB

PHC can indicate if a member has other primary insurance coverage by submitting a COB indicator of 2 on MedImpact's member eligibility file. The COB indicator of 2 indicates a member has other primary insurance coverage and will reject online prescription claims with a POS message, "**Bill Primary Carrier First**". The pharmacy should use the following procedure when this message is received:

- **Confirmation of other insurance coverage:** Confirm other primary insurance coverage status by requesting the insurance information from the member, or by calling the Automated Eligibility Verification System (AEVS) at (800) 456-2387. AEVS will indicate if the member has other coverage, and the letter "P" under the scope of coverage to indicate pharmacy benefits under a commercial health plan, The letter "R" indicates that member has pharmacy benefits under a Part D plan. If you are still unable to determine primary pharmacy coverage status from either of these sources, the pharmacy may call PHC Member Services at (707) 863-4120 or (800) 863-4155 for additional assistance.
- **Claims submission when other insurance confirmed:** If the pharmacy determines that the member *does* have other pharmacy insurance coverage, the pharmacy bills the prescription claim online to the primary insurance carrier. The copay or deductible amount is then billed to MedImpact, the secondary insurance carrier, by populating the required COB fields.



- If the pharmacy is unable to bill the secondary insurance carrier online, then a UCF may be submitted to MedImpact for processing. The UCF must be accompanied by documentation of the amount paid by the primary insurance carrier.
- Documentation may be either the primary insurance Explanation of Benefits (EOB), or a copy of the pharmacy's adjudication screen.
- **MedImpact will accept both online and hardcopy UCF copay billings for all prescriptions approved for payment by the primary insurance carrier. Online processing of all COB claims is recommended by PHC. On line copay amounts exceeding \$50 limits/claim will require an approved TAR from PHC.**
- **Claims submission for prescriptions not covered by primary insurance:** If the prescription is not on the primary insurance formulary, then the pharmacy must pursue normal procedures to obtain a prior authorization from the primary insurance carrier. If the prior authorization is denied and an alternative primary insurance formulary drug cannot be used, and the drug is on PHC's formulary, the pharmacy may then bill the prescription claim to MedImpact through the online COB process. If the prescription is denied by the primary insurance carrier and not on PHC's formulary, then the pharmacy must submit a TAR to PHC. An approved TAR is required for eCOB processing.
- **Claims submission for other insurance plan exclusions:** If the primary insurance carrier does not cover the prescription as a plan exclusion, and the drug is on PHC's formulary, the pharmacy may then bill the prescription claim to MedImpact using the online COB process. For example, many insurance carriers do not cover OTC or medical supply items, whereas PHC does cover these items. If the prescription is a primary insurance plan exclusion and not on PHC's formulary, then an approved TAR from PHC is required for processing.
- **Member does not have other primary insurance:** If the pharmacy determines that the member does not have other pharmacy insurance coverage or other pharmacy insurance benefits have been exhausted, then a completed Eligibility Update Form (Attachment A in the Member Eligibility section) attached by a copy of the adjudication screen showing a rejected claim due to "No coverage" should be faxed to PHC Member Services at (707) 863-4415. If the pharmacy is unable to produce a copy of the adjudication screen, they should have the member call PHC Member Services for assistance. Member Services will then research the primary insurance prescription coverage status and add the member to the MedImpact eligibility file if the member is found not to have primary pharmacy insurance coverage.
- **Billing Notes:**
Completion of the UCF Form: Next to the Group No. field, indicate if the claim is for a copay only or a plan exclusion. If submitting for copay or deductible amounts, enter the copay/deductible amount only, not the ingredient cost and dispensing fee.



Complete ingredient cost, dispensing fee, and billed amount for plan exclusion claims only. Documentation from the primary insurance carrier must be attached to the UCF.

Mailing Address for COB Claims:

MedImpact Healthcare Systems, Inc.
Operations Dept. Attn: COB Claims
10680 Treena St., 5th floor
San Diego, CA 92131

Medicare COB

Some PHC members have primary coverage for prescriptions through Medicare Part B. If the member has Medicare Part B coverage, the pharmacy must submit claims for Medicare-covered drugs/supplies to the Medicare carrier as the primary insurance. PHC requires that participating pharmacy providers accept assignment on all Medicare/PHC Medi-Cal claims billed on the member's behalf. The assignment acceptance is an agreement with Medicare that **the provider will not charge the member, including coinsurance and deductible amounts**, and will accept Medicare's determination of approved charges.

- **Drugs and supplies covered under Medicare Part B:** This partial list contains drugs and supplies which are currently covered under Medicare Part B. However, some coverage limitations may apply in accordance with specific Medicare regulations. Pharmacy providers are encouraged to verify coverage through other reference sources and/or by contacting the Medicare fiscal intermediary. Other drugs, medical supplies, biologicals, blood modifiers and nutritional therapies covered by Medicare are PHC non-formulary items and will be monitored for Medicare coverage through the TAR process. Please refer to your Medicare Supplier Manual for a detailed listing of these items.

CATEGORY	MEDICARE COVERED DRUGS / SUPPLIES
Diabetic Equipment and Supplies (1)	Blood Glucose Monitors Blood Glucose Testing Strips Lancets Lancet Auto Injectors Reagent Strips
Oral Anti-Cancer Drugs	Busulfan (Myleran) Capecitabine (Xeloda) Cyclophosphamide (Cytosan) Etoposide (Vepesid) Melphalan (Alkeran) Temozolomide (Temodar)
Immunosuppressive Drugs (2) (Covered after an organ transplant)	Cyclosporin (Neoral, Sandimmune, Gengraf) Mycophenolate Mofetil (Cellcept) Sirolimus (Rapamune) Tacrolimus (Prograf)

- (1) Not covered by Medicare if member is residing in a SNF
- (2) Member must have enrolled in Medicare at the time of transplant

- **Medicare Provider Number:** Pharmacy providers must have a Medicare Provider Number to bill Medicare for covered drugs and supplies. To obtain a Medicare Provider Number, providers must contact the National Supplier Clearing House, P.O. Box 100142, Columbus, SC 29292-3142 or by phone at (866) 238-9652
- **Cigna Medicare Region D:** Provider may contact Medicare at (866) 243-7272 or access the web at www.cignamedicare.com for all questions pertaining to billing and coverage parameters. To order a Medicare Supplier Manual provider may call (202) 512-1629.
- **Claims submission procedure for Medicare covered drugs/supplies:**
 - 1) MedImpact’s eligibility file will indicate when a member has Medicare Part B coverage and will reject on-line prescription claims for Medicare covered drugs and supplies with the edit message “**Must Bill Medicare**”.
 - 2) The pharmacy bills Medicare according to the billing instructions as provided by Medicare.
 - 3) The Medicare carrier may transfer any crossover claims to PHC for processing for Medi-Cal reimbursement for coinsurance and deductibles. However, if the pharmacy has not received crossover adjudication from PHC within six (6) weeks of receiving Medicare payment, the pharmacy should “hard-copy bill” MedImpact directly on a UCF form. Pharmacy providers can bill MedImpact directly at:



MedImpact Healthcare Systems, Inc.
Operations Dept. Attn: COB Claims
10680 Treena St., 5th floor
San Diego, CA 92131

- **Medicare Part D**

PHC Medi-Cal is not responsible for Medicare Part D or the copays/deductibles for Medicare Part D drugs. PHC is only responsible as the payor for excluded Medicare Part D drugs.

Partnership*Advantage* is a MAPD plan to members that have Medicare and Medi-Cal. Enrollment into the Partnership*Advantage* plan is optional.

FORMULARY OVERVIEW

The PHC Formulary is updated and distributed to all PHC providers on a yearly basis. The Pharmacy & Therapeutics Committee, contingent upon approval from the Physician Advisory Committee, continually updates and revises the formulary based on sound clinical evidence, efficacy, safety and pharmacoeconomic considerations. Suggested formulary modifications may be requested by PHC prescribers, pharmacists or PHC staff. All suggested formulary modifications should be directed to the PHC Pharmacy Director or CMO. Please refer to the Provider Formulary Addition Request Form at the end of this section. **PHC would like to emphasize to all providers that with very few exceptions, all FDA approved drugs potentially are a covered benefit, and those drugs not listed in the formulary are covered with an approved Treatment Authorization Request (TAR).** Providers may request a current copy of the Formulary by contacting the PHC Pharmacy Department at (707) 863-4414. The Formulary is also available on PHC's website at www.partnershiphp.org.



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
FORMULARY DISPENSING LIMITS

7-01-09

Brand Name Drugs are Limited to 30 day supply; for additional supply please submit a TAR.

DRUG	DISPENSING LIMIT
ACCOLATE (Zafirlukast)	STEP EDIT: Requires previous use of an oral inhaled corticosteroid in the last 120 days
ACCUTANE (Isotretinoin)	Maximum of 20 weeks of treatment per year
ACTOPLUS MET (Pioglitazone/Metformin)	STEP EDIT: Requires previous use of metformin, thiazolidinedione or insulin in the past 120 days.
ACTOS (Pioglitazone)	STEP EDIT: Requires previous use of metformin, thiazolidinedione or insulin in the past 120 days. Maximum of 1 tablet per day dosing.
ADDERALL (Amphetamine Mixtures), ADDERALL-XR	For use in members aged 3- 16 years old.
ADVAIR (Salmeterol/Fluticasone) DISKUS	STEP EDIT: Requires previous use of an oral inhaled corticosteroid in the last 120 days Maximum of 1 unit per month
ALAVERT (Loratidine oral tablets)	Maximum 1 tablet per day dosing.
ALLEGRA (Fexofenadine 60, 180mg)	STEP EDIT: Requires previous use of loratidine or cetirizine in the last 120 days.
ALOMIDE (Lodoxamide)	STEP EDIT: Requires previous use of Naphcon A, Vasocon A or ketotifen-OTC in the last 120 days
AMBIEN (zolpidem)	Maximum of 120 tablets per year & limited to 1 tablet per day dosing
ATIVAN (Lorazepam) Tablets	Maximum of 90 tablets in 23 days
ATROVENT (Ipratropium) INHALER	Maximum of 2 units per month
AVANDAMET (Rosiglitazone/Metformin)	STEP EDIT: Requires previous use of metformin, thiazolidinedione or insulin in the last 120 days
AVANDARYL (Rosiglitazone/glimepiride)	STEP EDIT: Requires previous use of metformin, thiazolidinedione or insulin in the last 120 days
AVAPRO (Irbesartan)	CODE 1: For members with diabetic nephropathy; other Dx with T/F ACE inhibitor. Limited to ½ tablet dosing.
AZMACORT (Triamcinolone)	Maximum of 3 units per month
AZOPT (Brinzolamide)	Maximum of 10mls per month
BENICAR (Olmesartan), Benicar-HCT	CODE 1: For members who have tried & failed ACE inhibitors. Formulary strengths are 5 & 40mg only. For 20 mg, use 40mg ½ tablets.
BETAGAN (Levobunolol)	Maximum of 10mls per month
BETOPIC (Betaxolol)	Maximum of 10mls per month
BIAXIN (Clarithromycin)	CODE 1: For the treatment of H. pylori, limited #500 BID, #28.
CEFTIN (Cefuroxime) Tablets	Maximum of 20 tablets per month
CELEXA (Citalopram)	Limited to ½ tablet substitution
CHANTIX (Varenicline Tartrate)	Limited to 12 week treatment duration. Submit TAR for treatment extension.

DRUG	DISPENSING LIMIT
CIPRO (Ciprofloxacin)	Maximum of 60 tablets per month
CLARITIN (Loratadine) Tablets	Maximum of 1 tablet per day dosing
COMBIVENT (Albuterol/Ipratropium)	Maximum of 2 units per month
COSOPT (Timolol/Dorzolamide)	Maximum of 10mls per month
CYTOTEC (Misoprostol)	Limited to use up to 90 days per year
DALMANE	Maximum of 1 capsule per day dosing
DARVOCET N (Propoxyphene Napsylate/APAP) 100mg Tablets	Restricted for use in mbrs less than 65 years old & Maximum of 120 tablets per month
DIABETIC SUPPLIES (Test Strips & Lancets)	Maximum of 100 per 25 days for members on insulin, and 50 per 25 days for members not on insulin.
DEXEDRINE (Dextroamphetamine)	For use in members between 4 and 16 years old.
DDAVP (Desmopressin)	Limited to use in members aged 15 yrs and older. TAR required for ages less than 15.
DETROL LA (Tolterodine Tartrate LA)	Limited to members aged 65 or greater.
DIFLUCAN (Fluconazole) Tablets, 150mg single dose only	Maximum of 2 tablets per 30 days
DITROPAN XL (Oxybutynin XL)	Limited to members aged 65 or greater.
DUETACT (Pioglitazone/Glimepiride)	STEP EDIT: Must have had a previous claim for metformin, thiazolidinediones or insulin in last 120 days.
EFFEXOR (Venlafaxine) Tablets	STEP EDIT: Must have had a previous trial of fluoxetine in the last 120 days Maximum of 3 tablets per day dosing
EFFEXOR (Venlafaxine) XR	STEP EDIT: Must have had a previous trial of fluoxetine in the last 120 days Maximum of 1 capsule per day for the 37.5mg and 75mg capsules & 2 capsules per day for the 150mg capsule
ELIDEL (Pimecrolimus 1% cream)	Limited to ages 5 and younger and maximum of 30g per fill.
EMPIRIN W/ CODEINE (Aspirin/Codeine) ¼ gr, ½ gr	Maximum of 240 tablets per month
ESTRACE (Estradiol, Micronized)	Maximum of 1 tablet per day dosing
ESTRA TEST (Estrogens, esterified/MT)	Maximum of 1 tablet per day dosing
FIORICET (Butalbital/Caffeine/APAP)	Maximum of 50 tablets per month
FIORINAL (Butalbital/Caffeine/Aspirin)	Maximum of 50 tablets per month
FLEXERIL (cyclobenzaprine)	Maximum of 120 tablets per month
FLOXIN (Ofloxacin)	Maximum of 28 tablets per month
FLOVENT (fluticasone) INHALER	Maximum of 1 unit per month
FLOVENT-HFA (fluticasone) INHALER	Maximum of 2 units per month
FLOVENT (fluticasone) DISKUS	Maximum of 1 unit of 60 per month
FLOXIN (Ofloxacin)	Maximum of 28 tablets per month



DRUG	DISPENSING LIMIT
FORADIL (Formoterol)	Maximum of 1 unit per month
FOSAMAX (Alendronate) Tablets - 35mg, 70mg	35mg & 70 mg Only – Limit of 4 tablets in 28 days.
IMITREX NASAL SPRAY	Maximum of 1 unit per month, limited to 6mg strength
IMITREX 6mg INJECTION	Maximum of 4 syringes per month
IMITREX Tablets	Maximum of 9 tablets per month of 1 strength
INSULIN-All Forms	Maximum of 4 vials(10ml) per month or 1 box of cartridges (15ml)
INTAL	Maximum of 2 units per month
IOPIDINE	Maximum of 10mls per month
LAMICTAL (Lamotrigine)	Non-Formulary Item, 1/2 tablet dosing required on TARS. Submit 1/2 of 100mg for 50mg dose, 1/2 of 150mg for 75mg dose, 1/2 of 200mg for 100mg dose.
LESCOL (Fluvastatin)	Maximum of 1 capsule / tablet per day dosing
LEVAQUIN (Levofloxacin)	Maximum of 10 tablets per Rx.
LIBRIUM (Chlordiazepoxide)	Maximum of 90 tablets per month.
LIPITOR (Atorvastatin)	Non-Formulary Item, 1/2tablet substitution required on TARS.
LOTREL (amlodipine/benazepril)	Maximum of 1 capsule per day dosing
LOVENOX (Enoxaparin)	Maximum of 20 syringes per fill and maximum of 2 fills per year
MAXAIR (Pirbuterol Acetate) INHALER	Maximum of 2 units per month
METADATE (Methylphenidate), METADATE-ER	For use in members between 6 and 16 years old. CD forms are non-formulary.
MEVACOR (Lovastatin)	Maximum of 1 tablet per day dosing
MIACALCIN (Calcitonin-Salmon) SPRAY	Maximum of 2 units per month
MIRALAX, MIRALAX-OTC	Maximum 2 week supply (255g Rx, 238g OTC)
NEURONTIN (Gabapentin)	Maximum of 3600mg per day. Capsules are formulary. Formulary tablet strengths are limited to 600 & 800mg only.
NICOTINE TRANSDERMAL PATCHES	Maximum of up to 90 patches within a 1 year period
NICOTINE GUM	Maximum of up to 180 tablets within a 1 year period
NIX (Permethrin)	Maximum of 60mls every 90 days
NORCO (Hydrocodone 10mg/APAP 325mg)	Maximum of 120 tablets per month
NORVASC (amlodipine)	Maximum of 1 tablet per day dosing
OCUFLOX O/S (Ofloxacin o/s)	Maximum of 5ml.
OPTIPRANOLOL (Metipranolol)	Maximum of 10mls per month
OVIDE (Malathion)	Maximum of 60mls every 90 days



DRUG	DISPENSING LIMIT
OXY IR (Oxycodone Immediate Release)	<i>Maximum of 100 per month.</i>
PEPCID (Famotidine)	<i>Maximum of 60 tablets per month</i>
PILL CUTTER	<i>Maximum of 1 cutter every 180 days</i>
PLAN B (Levonorgestrel)	<i>Maximum of 3 fills of 1 (2) pack per 90 days</i>
POLY VI FLOR (Multi Vitamins/ Sodium Fluoride)	<i>For use in children less than 8 years old</i>
POLY VI SOL (MULTI-VITE)	<i>Limited to use in children under 8 years</i>
PRENATAL VITAMINS (Generic Rx & OTC)	CODE 1: <i>Limited to women who are pregnant or breastfeeding.</i>
PREVEN (Levonorgestrel/Ethinyl Estradiol + Pregnancy Test Kit)	<i>Maximum of 3 kits in 90 days</i>



DRUG	DISPENSING LIMIT
PRILOSEC (Omeprazole) OTC 20mg Tablets	<i>Maximum of 2 tablets per day dosing</i>
PROPINE (Dipivefrin)	<i>Maximum of 10mls per month</i>
PROVENTIL (Albuterol) NEBULIZER SOLN 5mg/ml (20ml bottle)	<i>Limited to 40ml (2 bottles) per month.</i>
PROVENTIL (Albuterol) NEBULIZER UNIT DOSE 83mg/ml, 3ml	<i>Limited to 225ml (75 doses) per month.</i>
PROZAC (fluoxetine) CAPSULES/TABLETS	<i>Maximum of 80mg per day dosing. Limited to use of 10mg & 20mg strengths; 40mg is non-formulary.</i>
PULMICORT (budesonide) RESPULES	<i>Restricted for use in members less than 9 years old Maximum of 60 respules per month. Limited to 0.25 & 0.5mg/2ml. 1.0mg/2ml is non-formulary.</i>
PULMICORT (budesonide) INHALER	<i>Maximum to a maximum of 1 unit per month</i>
QVAR (Beclomethasone) INHALER	<i>Maximum of 1 unit per month</i>
RELENZA (Zanamivir) INHALER	CODE 1: <i>Restricted to members over age 65 or with HIV, transplant, cancer, or chronic respiratory disease. Limit of 1 fill during the months of September thru March</i>
REMERON (Mirtazapine)	<i>Maximum of 1 tablet per day dosing</i>
RESTORIL (Temazepam) 15mg, 30mg	<i>Maximum of 1 capsule per day dosing (7.5mg is excluded from formulary).</i>
RITALIN (Methylphenidate), short acting & SR/ER forms only	<i>For use in members between 6 and 16 years old.(Ritalin LA is excluded from formulary).</i>
ROBAXIN (Methocarbamol)	<i>Maximum of 120 tablets per month</i>
ROXICODONE (Oxycodone) IR tablets	<i>Maximum of 100 tablets per month</i>
SERAX (Oxazepam)	<i>Maximum of 90 in 23 days.</i>
SEREVENT (salmeterol) DISKUS	<i>Maximum of 1 unit of 60 per month</i>
SINGULAIR (Montelukast)	STEP EDIT: <i>Requires previous use of either a nasal corticosteroid or an oral inhaled corticosteroid in the last 180 days</i>
SUNSCREEN/SUNBLOCK	CODE 1: <i>Restricted to use by members on maintenance photo sensitive drugs. Limit 1 Rx per month & maximum allowable cost of \$8 per container.</i>
SUPRAX (Cefixime) tablets 400mg	CODE 1: <i>Restricted to the treatment of gonorrhea. Limited to 2 tablets per fill.</i>
TAMIFLU (Oseltamivir)	CODE 1: <i>Restricted to members over age 65 or with HIV, transplant, cancer, or chronic respiratory disease. Limit of 1 fill of 10 tablets during the month of September thru March.</i>
TILADE (Nedocromil)	<i>Maximum of 2 units per month</i>
TIMOPTIC (Timolol Maleate) OPHTHALMIC DROPS, TIMOPTIC XE	<i>Maximum of 10mls per month</i>
TRANXENE (Chlorazepate) tablets	<i>Maximum of 90 tablets per month.</i>
TRI VI FLOR (Vitamins A,D,C/ Sodium Fluoride)	<i>For use in children less than 8 years old</i>

DRUG	DISPENSING LIMIT
TRI VI SOL WITH IRON (A,D,C)	Limited to use in children under 8 years old
TYLENOL W/ CODEINE (APAP/Codeine) ¼ gr, ½ gr, liquid	Tablets-Maximum of 120 tablets per month Liquid-Maximum of 480 mls per month
ULTRAM (Tramadol)	Maximum of 120 tablets per month
VALIUM (Diazepam) Tablets	Maximum of 90 tablets per month
VANTIN (Cefpodoxime Proxetil) Tablets	Maximum of 2 tablets per fill
VENTOLIN HFA (Albuterol) Inhaler	Maximum of 2 units per month; limited to GSK brand only.
VICODIN (Hydrocodone/APAP) 5mg/500mg Tablets	Maximum of 240 tablets per month
VITAMIN D (Ergocalciferol) 50,000 unit caps	Maximum of 4 capsules per month dosing (1 per week)
VITAMIN E CAPSULES	CODE 1: For treatment of tardive dyskinesia
VITAMINS-PRENATAL (Generic Rx or OTC)	CODE 1: For women who are pregnant or lactating
WELLBUTRIN (Bupropion) Tablets	Maximum of 3 tablets per day dosing
WELLBUTRIN (Bupropion Sustained Release) SR Tablets	Maximum of 2 tablets per day dosing
XANAX (Alprazolam) Tablets	Maximum of 90 tablets per month
ZETIA (Ezetimibe) Tablets	STEP EDIT: Requires prior use of formulary statin, atorvastatin, Zetia or Vytorin in the last 120 days.
ZITHROMAX (Azithromycin) tablets	Maximum of 6 tablets per fill for 250mg; 3 per fill for 500mg; 8 per fill for 600mg.
ZOFRAN (Ondansetron) Tablets	CODE 1: For prophylaxis of nausea and vomiting associated with cancer chemotherapy and radiation therapy. Limit of 9 tablets per fill and 2 fills per month for 6 months
ZOLOFT (Sertraline) Tablets	Limited to ½ tablet substitution
ZYBAN (Bupropion-SR)	Maximum of 180 tablets within a 1 year period
ZYRTEC OTC (Cetirizine) Syrup	Restricted for use in members less than 6 years old Maximum of 300mls per month



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
 360 Campus Lane, Suite 100
 Fairfield, CA 94534
 (707) 863-4100
 FAX (707) 863-4330

ATTACHMENT C

PROVIDER FORMULARY ADDITION/CHANGE REQUEST FORM

Drug Name	
Dosage Forms and Strengths	
FDA Approved Indications	
Rationale for Request (superior efficacy/safety profile, unique indications, comparative cost-effectiveness): *Please also attach any relevant articles supporting this request*	
Requested By (print)	
Phone Fax Email	
Please include or attach any supporting documents and send to: <div style="text-align: center;"> PHC Pharmacy Director 360 Campus Lane, Suite 100 Fairfield, CA 94534 (707) 863-4234 FAX: (707) 863-4330 Email: glouie@partnershiphp.org </div>	
Signature X	Date

To be considered for review all sections of form must be completed & form must be received by PHC 30 days prior to the quarterly Pharmacy & Therapeutics (P&T) Committee meeting.



FORMULARY UPDATES

The PHC Pharmacy & Therapeutics (P&T) Committee meets on a quarterly basis and is responsible for reviewing additions, changes and deletions to the drug formulary. Providers are then notified with a Formulary Update listing all changes that have been approved by the P&T Committee. These changes are then incorporated into the Drug Formulary which is printed and distributed in January of each year. The Formulary and Formulary Updates are also available on the PHC website at www.partnershiphp.org.

Please insert the quarterly Formulary Updates in this section



MAXIMUM ALLOWABLE COST (MAC) LIST

PHC requires generic substitution when an equivalent generic product is available. Maximum Allowable Cost (MAC) pricing is a reimbursement schedule developed by MedImpact that determines the ingredient cost used to calculate reimbursement for generic pharmaceutical products. If a formulary drug is not listed on the Maximum Allowable Cost (MAC) list, then the brand name of that drug is covered without a TAR.

The Pharmacy and Therapeutics Committee recognizes that this medication possess narrow therapeutic dose response characteristics. Therefore, although this drug is listed on the MAC list, for when the drug is dispensed generically, the brand name of this drug is also available and payable at the brand reimbursement rate without a TAR.

MedImpact distributes an updated MAC List to pharmacy providers on every two weeks with the EOB and the enclosed MAC List is the most current version available.

Please replace this list with future updated lists that you will receive from MedImpact.



TREATMENT AUTHORIZATION REQUEST (TAR)

Although PHC has contracted MedImpact to assist in the administration of the Pharmacy Management Program, all prior authorization requests are submitted directly to PHC through the Treatment Authorization Request (TAR) process. Every effort is made to approve or deny each TAR upon the initial submission. Pharmacists should make reasonable efforts to obtain Diagnosis and medical justification information, including conferring with the prescriber to facilitate the evaluation of a TAR. Prescriptions for the following require a TAR:

- All non-formulary medications
- Brand name drugs when an equivalent generic is available
- Drugs not meeting the Code 1 restriction criteria
- Drugs not meeting the Step Therapy Edit (STE) criteria
- Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits
- Any prescription that costs \$500 or more and not designated with a #500 exempt footnote
- Compounded prescriptions if none of the ingredients used in the compound are on the PHC Formulary, or the total billed amount exceeds \$50.00
- Selected Electronic COB claims that are rejected. (see Coordination of Benefits Section 5 for specifics)

Each submitted TAR is reviewed by a clinical pharmacist or PHC authorized Pharmacy Technician who will approve or defer the request for more information. All TARs that lack medical justification for the intended use of the drug will be denied by the PHC CMO.

TAR Forms

PHC utilizes the TAR Form 50-2 which is the same form used by State Medi-Cal. PHC does not supply TAR forms to providers. Providers may obtain TAR forms by contacting the EDS Provider Support Center at (800) 541-5555. **A new TAR form with an assigned TAR Control Sequence Number is required for each submitted request.** Copies of TAR forms with a TAR Control Sequence Number that have been previously submitted will not be accepted.

TAR Submission

Prior authorization requests must be requested by the provider of service by submitting a completed TAR by FAX to PHC at (707) 863-4330. PHC does not accept verbal prior authorization requests by telephone.



Timeliness Submission of TARs

All TAR's must be received by PHC no more than fifteen (15) business days after the requested start date of service. TARs received by PHC that do not adhere to the timeframes defined for timely submissions are denied as an administrative denial. Administrative denials are NOT subject to provider appeals process.

Retroactive TARs

Retroactive TARs received after fifteen (15) business days of requested date of service may be considered for review only under the following conditions:

- When certification of the Medi-Cal beneficiary's eligibility by the county welfare department was delayed.
- When a member does not identify himself/herself to the provider as a Medi-Cal member by deliberate concealment or because of physical or mental incapacity to so identify himself/herself. TAR must be received by PHC within 60 calendar days from the requested date of service.
- When other coverage (e.g., Medicare or other health insurance) denied payment of a claim for services. TAR must be received by PHC within 60 calendar days from the date of denial from other health insurance.
- When a member has obtained retroactive eligibility. The TAR must be received by PHC within 60 calendar days of the date retroactive Medi-Cal eligibility was established.

Provider Notification of TAR Action

Notification of action on a TAR (Approved, Modified, Deferred, Denied) will be made to the submitting provider by PHC within one (1) business day of receiving a completed TAR. Inquiries regarding status of a TAR may be directed to the PHC Pharmacy Department @ (707) 863-4414.

- **Approved TARs**

PHC enters the approved TAR into the MedImpact system and faxes the TAR back to the requesting provider. The approved TAR is entered directly into the member's prescription file and the billing provider is not required to enter the TAR Control Sequence Number when submitting the claim to MedImpact.

- **Modified TARs**

A modified TAR is a TAR that is approved with a quantity that differs from the requested quantity submitted by the provider. The modified TAR is entered into the MedImpact system and faxed back to the requesting provider. Members are provided written notification of modified TARs. Deferred TARs, Incomplete TARs or TARs that require additional information will be deferred back to the provider by PHC. If the provider does not respond to the request for additional information within 14 business days (Mon-Fri) days, the TAR will be denied.



- **Denied TARs**

Written notification of a denied TAR that lacks medical justification for the intended use of the drug or a deferred TAR past 30 days will be sent to the member, the requesting pharmacy provider and the prescribing physician. The denied TAR will include the reason for the denial and information about the appeals process.

Emergency After Hour Authorizations

Emergency authorizations for TAR's outside of PHC's normal business hours (M-F 8am to 5pm), including weekends and holidays may be requested from MedImpact at (800) 788-2949. MedImpact may authorize up to a 5 day supply of medication, pending further authorization by PHC. In an emergency situation, when both PHC and MedImpact are unavailable, PHC will authorize a retroactive TAR allowing the pharmacy to dispense up to a 5 days supply of a non-formulary drug.

TAR Form Completion

The TAR completion procedure is the same as it is for State Medi-Cal, except that PHC allows only one drug per TAR form to be submitted.

The following item numbers and descriptions correspond to the sample TAR Form (50-2) included at the end of this section.

TAR FORM COMPLETION INSTRUCTIONS	
ITEM NUMBER	DESCRIPTION
1	Type of Service Requested: Enter an "X" in the appropriate box to indicate Retroactive request.
2	Provider Phone No.: Enter telephone number and area code.
3	Provider Name and Address: Enter provider name and address.
4	Fax Number: Enter provider Fax number.
5	Provider Number: No longer required for claims billed to MedImpact. NPI # for Paper Claims.
6	Patient Name, Address, Telephone Number: Enter member information in this space.
7	Medi-Cal Identification No.: Enter the member's identification number 10 digit CIN#.
8	Sex and Age: Use "M" for male, or "F" for female. Enter age of member.
9	Date of Birth: Enter the member's date of birth in a six-digit format.
10	Patient Status: Enter an "X" in the appropriate box.
11	Diagnosis Description: Enter the description of the diagnosis. Include all relevant diagnoses for review purposes.



12	Medical Justification: Provide sufficient documentation of appropriate clinical information that supports the medical necessity of the requested item. Documentation of other drugs tried previously and the clinical outcomes are also required.
13	Prescriber Name, Specialty, Telephone Number, Fax Number: Enter prescriber information in this space.
14	Authorized Yes/No: Leave blank. Consultant will indicate if the requested item is authorized.
15	Approved Units: Leave blank. Consultant will indicate the number of times the requested item has been authorized.
16	Specific Services Requested: Provide name, strength, directions for use and requested start date of authorization. PHC REQUIRES ONLY ONE REQUESTED ITEM PER TAR FORM.
17	Units of Service: Enter the total number of times authorization for the dispensed quantity is requested.
18 Procedure Code	Code: Enter the manufacturer 9-digit National Drug Code (NDC) Code.
19	Quantity: Enter the total number of tablets, capsules, volume of liquid (in mls) or quantity of ointments/creams (in grams).
20	Charges: Complete for compounded items only.
21	For PHC Use: Leave this space blank.
22	For PHC Use: Leave this space blank.
23 & 24	Authorization is Valid for Services Provided: Leave blank. Consultant will indicate valid dates of authorization for this TAR.
25	TAR Control Number: This number is for reference only to identify a submitted TAR. Providers are not required to enter this number when submitting a claim for an approved TAR.
26	Signature of Physician or Provider: Form must be signed by the physician, pharmacist or authorized representative.

CONFIDENTIAL PATIENT INFORMATION
FOR F.I. USE ONLY

F.I. USE ONLY

40 41
42 43

1 _____

CCN _____

SERVICE CATEGORY

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

(PLEASE TYPE) **FOR PROVIDER USE** (PLEASE TYPE)

VERBAL CONTROL NO. _____
TYPE OF SERVICE REQUESTED: DRUG OTHER
REQUEST IS RETROACTIVE? YES NO
IS PATIENT MED-CARE ELIGIBLE? YES NO
PROVIDER PHONE NO. (____) _____

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS:

PLEASE TYPE YOUR NAME AND ADDRESS HERE
PROVIDER NAME AND ADDRESS

3. PROVIDER NUMBER

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)
4 _____
STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER (AREA) _____

MEDICAL IDENTIFICATION NO. _____
SEX: _____ AGE: _____ DATE OF BIRTH: _____
7 _____ 8 _____

PATIENT STATUS: HOME BOARD & CARE
SNF / ICF ACUTE HOSPITAL

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:
 APPROVED AS REQUESTED DENIED DEFERRED
 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) JACKSON VS RANK PARAGRAPH CODE

BY: _____ MEDICAL CONSULTANT DATE _____ REVIEW INDICATOR
I.D. # _____ 34 _____ 35 _____ 36 _____ 37 _____ 38 _____ 39 _____ 40 _____ 41 _____ 42 _____ 43 _____ 44 _____

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

35 1 2 3 4 5 6

LINE NO.	AUTHORIZED		APPROVED UNITS	SPECIFIC SERVICE REQUESTED	UNITS OF SERVICE	REQUIREMENTS PROCEDURE CODE	QUANTITY	CHARGE
	YES	NO						
1	<input type="checkbox"/>	<input type="checkbox"/>	10			11	12	\$
2	<input type="checkbox"/>	<input type="checkbox"/>	14			15	16	\$
3	<input type="checkbox"/>	<input type="checkbox"/>	18			19	20	\$
4	<input type="checkbox"/>	<input type="checkbox"/>	22			23	24	\$
5	<input type="checkbox"/>	<input type="checkbox"/>	26			27	28	\$
6	<input type="checkbox"/>	<input type="checkbox"/>	30			31	32	\$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED
37 FROM DATE _____ 38 TO DATE _____
TAR CONTROL NUMBER
39 OFFICE _____ SEQUENCE NUMBER _____ PI _____

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE. SEND TO FIELD SERVICES (F.I. COPY) SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

APPEALS PROCESS (Medi-Cal)

The PHC Medi-Cal Appeals Process offers providers dissatisfied with the processing or payment of a claim, resubmission of a claim, a claim inquiry, or denial of a TAR, a method for resolving problems.

Provider Appeal Process for Claims Payment or a Denied Claim

1. Pharmacy providers dissatisfied with the processing or payment of a claim, including a denied claim, may seek an adjustment by submitting a Claim Inquiry Form (CIF) to the PHC Health Services Pharmacy Department. The CIF should contain additional information/corrections necessary to allow claim payment within the PHC/Medi-Cal benefits and claims processing guidelines. Providers have six (6) months to CIF a claim from the original date of the claim on the MedImpact Explanation of Benefits (EOB). CIFs received after six (6) months are subject to automatic denial. PHC will acknowledge receipt of the CIF within 15 working days and will respond with a Claims Inquiry Response (CIR) Letter indicating the outcome of the CIF review within 45 working days. If the claim submitted with the initial CIF does not appear on the EOB or a CIR Letter has not been received, the provider may file an appeal. Include all copies of the Claims Inquiry Acknowledgments with the Appeal.
2. Upon receipt of the outcome of the CIF, providers have a one time window of 90 days from the date of the CIF denial to re-CIF their claim with additional corrections.
3. If the CIF is not approved and the claim status is maintained, the provider may submit a “claim appeal” within 90 days of the CIF denial. Failure to submit an appeal within the 90-day time period will result in the appeal being denied. A claim which is submitted on appeal has already been reviewed and denied two separate times once on the original claim submission and once as the result of a CIF submission and/or a re-CIF. PHC will acknowledge receipt of the Appeal within 15 working days and will and will respond with an Appeal Response Letter indicating the outcome of the Appeal review 45 days.
4. Providers who are still not satisfied with the outcome of a Claim Appeal may file a Grievance with the PHC Provider Relations Department. Provider Grievances must be submitted in writing within 30 days of receipt of the Appeal Response Letter.

Provider Appeal Process for a Denied TAR

Pharmacy providers may request an appeal of a Utilization Management decision for a denied TAR on behalf of a member by calling or writing the Health Services Department

within 30 days of the denial. The CMO refers the appeal to Associate Medical Director to a member of the Quality / Utilization Advisory Peer Review Committee or a board certified specialist for further consideration. The Peer Review Committee member or certified specialist may then request further information from the provider if needed. PHC has 30 working days to make a decision after receiving the request or receiving the additional information requested. The decision is communicated to the provider and member within 5 working days. Providers who disagree with the decision of the appeal may then file an informal or formal Provider Grievance with PHC.

Prescribers wishing to discuss denials of medications for medical necessity may call the PHC CMO at (707) 863-4261.

Expedited Appeals

Expedited Appeals may be initiated by the member or by the provider acting on behalf of the member. Expedited appeals are performed by PHC only when, in the judgment of PHC, a delay in decision making might seriously jeopardize the life or health of the member.

Providers needing more information on the Claims Inquiry process, the Appeals process or the Provider Grievance process may contact the PHC Provider Relations Department at (800) 863-4144 or (707) 863-4100.

Administrative Denial Appeals

TARs received by PHC that do not adhere to the timeframes defined for timely submissions are denied as administrative denial. Administrative denials are **NOT** subject to the provider appeals process.



PHARMACY AUDITS

MedImpact maintains an ongoing Pharmacy Audit Program to assure pharmacy, member, and prescriber compliance with PHC's program policies and procedures. The Pharmacy Network Agreement with MedImpact contains a provision allowing MedImpact during regular business hours and upon reasonable notice to have access to all information maintained by the pharmacy related to pharmaceutical services. It is understood that such audits may be made at any time during the term of the Agreement and within one year after its expiration. Should such audit determine that a claim or claims resulted in overpayment to the pharmacy, MedImpact shall have the right to recover the amount overpaid.

Audit Triggers

The MedImpact Audit Program is supported by continuous in-house analysis of statistical dispensing triggers. These triggers include, but are not limited to:

- Average claim amount
- Quantity dispensed versus days supply
- Ratio of usual & customary billing to amount calculated payments
- Claim reversals
- Total number of rejects
- Use of physician identifiers
- Control drug percent
- Generic percent
- Refill percent
- Average number of prescriptions per member

Audit Programs

MedImpact utilizes the following type of audit programs:

- **Onsite Audits:** The MedImpact auditor visits the pharmacy to perform a comprehensive review which includes claims analysis, a general overview and examination of the pharmacy's practices, procedures, patient counseling program, and an overall facility requirements analysis.
- **In-Depth Electronic Audits:** On-line claims from preselected quarters are automatically flagged utilizing **predetermined** criteria and subjected to audit procedures.
- **Monthly Bench/Desk Audits:** Each month MedImpact's audit department scores and ranks pharmacies in targeted categories using a Statistical Provider Audit report and reviews those pharmacies that don't comply to established parameters.

PHARMACY UPDATES

This section is reserved for pharmacy providers to insert PHC Medi-Cal Pharmacy Updates that will be distributed periodically to all PHC in-network pharmacy providers. The updates will contain valuable information regarding formulary changes and additions, plan parameter changes, billing procedures, prior authorization criteria, the Treatment Authorization Request (TAR) process and other necessary information.

Insert Pharmacy Updates Here