# 6. PHARMACY

## A. Pharmacy Benefits and Services

***SAPPLIES TO:***

A. This policy applies to all IEHP Covered Members.

***POLICY:***

A. IEHP's contracted Pharmacy Benefit Manager (PBM) provides administrative services and support for the IEHP Covered pharmacy benefit. Administrative services include claims management, formulary administration, prior authorization and utilization management, pharmacy drug rebate administration, Provider support services, and other ancillary and reporting services to support the administration of IEHP Covered.

***PURPOSE:***

A. To ensure that IEHP members have access to necessary medications and pharmaceutical care and to assure that pharmacy benefits are administered in compliance with all applicable laws, regulations, and regulatory guidance. The PBM works in conjunction with the overall healthcare services provided by IEHP to promote the health and well-being of its members.

***PROCEDURES:***

**Pharmacy Benefit**

A. Pharmacy Benefit Administered by MedImpact Healthcare Systems

1. IEHP contracts with MedImpact Healthcare Systems, a pharmacy benefit management company to administer its prescription drug benefit under IEHP's direction and oversight.

B. IEHP Pharmacy Network

1. In accordance with IEHP's out-of-network liability practices, only pharmacies identified as Network Pharmacies may provide the Prescription Drug benefit under this plan. The current list of pharmacies in the IEHP Covered Pharmacy Network are listed on the IEHP website.[1] Pharmacies that are not in the IEHP Covered Pharmacy Network are considered non-contracted Pharmacies.[2]

C. Formulary

1. IEHP delegates Pharmacy and Therapeutic Committee activities and formulary administration to the PBM. IEHP uses the PBM's formulary to administer the Covered California pharmacy benefit. The IEHP Pharmaceutical Services department provides oversight and monitoring over the PBM formulary activities.

[1] https://www.iehp.org/en/browse-plans/covered-california
[2] IEHP Evidence of Coverage (EOC)

2. The updated Formulary is posted monthly on the IEHP website.[3]
3. Certain covered drugs have restrictions such as the following:[4]
    a. Step Therapy (ST): Step therapy is the process of beginning therapy for a medical condition with drugs considered first-line treatment. A member must first try another drug on the formulary before the prescribed drug is covered. The prescribing physician can request an exception to the step therapy rule.
    b. Quantity Limits (QL): IEHP may limit the amount of some drugs a member can get per prescription or limit the number of times it can be refilled. An The prescribing physician can request an exception to the quantity limits rule.
    c. Prior Authorization (PA): Refers to a request for coverage of pharmacy benefit or services, which includes documentation establishing that the requested pharmacy benefit or service is medically necessary or a medical necessity for the member based upon an individualized assessment by their treating health care practitioner of applicable evidence-based criteria or guidelines.
4. FDA-approved generic drugs will be preferred in most situations, even when a brand-name drug is available. The request can be approved if there is a documented medical need. Pharmaceutical management procedures and restrictions can be found on the IEHP website.[5]

D. IEHP is responsible for the following benefits, when billed by a pharmacy on a pharmacy claim:
1. Covered outpatient drugs, including physician administered drugs;
    a. FDA-approved medications that require a prescription either by California or Federal law.
    b. Insulin.
    c. Pen delivery systems for the administration of insulin, as Medically Necessary.
    d. Diabetic testing supplies, including these:
        1. Lancets.
        2. Lancet puncture devices.
        3. Blood and urine testing strips.
        4. Test tablets.
    e. Drugs with a United States Preventive Services Task Force ("USPSTF") rating of A or B.

[3] https://www.iehp.org/content/dam/iehp-org/en/documents/coveredcalifornia/Formulary.pdf
[4] IEHP EOC
[5] https://www.iehp.org/content/dam/iehp-org/en/documents/coveredcalifornia/Formulary.pdf

f. Contraceptive drugs and devices, including these:

1. Diaphragms.
2. Cervical caps.
3. Contraceptive rings.
4. Contraceptive patches.
5. Oral contraceptives.
6. Emergency contraceptives.
7. Over-the-counter contraceptive products

g. Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug, such as syringes and inhaler spacers.

2. Medical supplies;
3. Enteral nutritional products; and
4. Prescription drugs related to major organ transplant, unless a Member has other primary health insurance or Medicare.

E. Prior Authorization (PA)

1. IEHP delegates the pharmacy benefit prior authorization function to the PBM. The IEHP Pharmaceutical Services department provides oversight and monitoring over the PBM's prior authorization activities.
2. The prior authorization process is used to ensure that drug benefits are applied as intended and that Plan Members receive the most appropriate, safe, and cost-effective medication therapy. Prescribers are required to get pre-approval before prescribing a specific drug in order for that medication to qualify for coverage under the terms of a pharmacy benefit plan.
3. Form 61-211 will need to be completed to request prior authorization.

F. Non-formulary Drugs

1. IEHP delegates the pharmacy benefit-formulary drug review function to the PBM. The IEHP Pharmaceutical Services department provides oversight and monitoring over the PBM's prior authorization activities.
2. A drug that is not on the formulary will require authorization from before the member can fill the prescription. To decide if the non-formulary drug will be covered, the PBM may ask for a "supporting statement", which explains why the drug is Medically Necessary. The PBM will reply to the doctor and/or pharmacist within 24 hours for urgent requests or 72 hours for standard requests after getting the requested medical information. Urgent circumstances exist when a health condition may seriously jeopardize life, health, or the ability to regain maximum function or when undergoing a course of treatment using a non-

formulary drug.

**IEHP and Delegate Responsibilities**

A. IEHP and its Delegates remain responsible for activities including but not limited to the following:

1. Overseeing and maintaining all activities necessary for IEHP Covered Member care coordination, continuity of care, and related activities; and
2. Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing medication therapy management, medication reconciliation, and comprehensive medication management activities.

Please see Section 7, "Coordination of Care" and 9A,"Delegation and Monitoring" for more information.

**Provider Responsibilities and Resources**

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining continuity of care. Please see Policy 07A1 – "Care Management Requirements - PCP Role" for more information.

B. Providers may claim reimbursement for Physician Administered Drugs (PADs) or drugs administered by clinical staff in a physician's office, outpatient facility, or hospital outpatient facility as follows:

1. If billing on medical or institutional claim form such as CMS-1500, submit to IEHP per 13A, "Claims Processing;" or
2. If billing on pharmacy claim form, submit to:

Inland Empire Health Plan – Claims
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

All ancillary codes including, but not limited to, Per Diem S-Codes or nursing codes associated with administration of the drug, are billed on a CMS-1500 form, and are therefore IEHP's responsibility.

C. Providers that disagree with the written determination of the dispute by the Payor may appeal to IEHP in writing within six (6) months of the date of the written determination.

1. Appeals should be submitted to:

IEHP – Provider Claims Resolution and Recovery Unit
P.O. Box 4319
Rancho Cucamonga, CA 91729-4319

For more information about the appeal process, please 13E "Provider Dispute Resolution - Health Plan Claims Appeals"

D. Please see Section 10, "Grievance and Appeal Resolution System" for information on the Member grievance and appeal process.

| INLAND EMPIRE HEALTH PLAN | | |
|---|---|---|
| **Regulatory/ Accreditation Agencies:** | ☐ DHCS | ☐ CMS |
| | ☒ DMHC | ☐ NCQA |
| **Original Effective Date:** | January 1, 2024 | |
| **Revision Date:** | | |

# 6. PHARMACY

## B. Member Request for Pharmacy Reimbursement

***APPLIES TO:***

A. This policy applies to all IEHP Covered Members.

***POLICY:***

A. IEHP Members may submit Pharmacy Reimbursement Requests for consideration of reimbursement for drugs or services covered by IEHP for which the Member believes they were incorrectly charged. See Policy 6A, "Pharmacy Benefits and Services" for an overview of the types of drugs covered by the Plan.

***PROCEDURES:***

A. IEHP not accept verbal Payment Determination requests, including those that are payment requests.

B. Written Payment Requests

1. IEHP accepts written Payment Determination requests, including those that are payment requests.
2. Written requests for Payment Determination can be accepted on either a MedImpact Direct Member Reimbursement Form (DMR Form) or any written document as long as it contains the required information.
3. Members must provide the following items:
    a. Member number
    b. RX number
    c. Fill date
    d. NDC number of the medication (an 11 digit code that corresponds to a medication used and sold in the United States)
    e. DEA/NPI number of the physician (situational)
    f. NCPDP/NPI number of the pharmacy
    g. Quantity
    h. Day supply or date range
    i. Paid amount
    j. Proof of purchase of the prescription for which payment is requested (includes one of the following):
        1) A copy of the actual detailed pharmacy receipt (not the cash register receipt);
        2) Some other form, print out, or drug summary provided directly by the pharmacy and authorized as an original from the pharmacy; or

3) A completed DMR Form signed by the pharmacist and a copy of the cash register receipt.

C. The request must be submitted within one (1) year from the date of service.

D. If all required data elements cannot be obtained through outreach to the provider, a lack of information notification will be mailed to the member within thirty days from the receipt of the request for payment determination, informing the member that the required documentation is incomplete.

E. Reimbursement requests will be evaluated based on the medical necessity and the justification of the request. IEHP and/or assigned delegate will notify Members of the decision and make payment, when appropriate, no later than thirty (30) calendar days after receiving all the requested documentation for reimbursement.

F. If the Member Reimbursement Request and all documentation were received timely and the request is eventually denied, the Member will receive a mailed written Notification of Denial Letter within thirty days from the receipt of the request for coverage determination.

G. If the request is denied for lack of documentation or exceeds one year from date of service, the Member will receive the denial notification by phone.

H. If a Member has shown a pattern of bypassing IEHP's Pharmacy Prior Authorization Request process, IEHP may notify the Member of the denial of all future reimbursement requests.

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