APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

POLICY:

A. The IEHP formulary is a continually updated list of medications immediately available to practitioners and Members. It contains information on co-payment requirements and the procedures for obtaining Code 1 and non-formulary medications.

B. The IEHP Pharmacy and Therapeutics (P&T) Subcommittee makes decisions regarding which medications are included on the formulary.

C. The IEHP P&T Subcommittee evaluates the clinical use of drugs, develops policies for managing drug use and drug administration, and manages the formulary system. The Quality Management (QM) Committee has final approval of P&T Subcommittee decisions.

D. The P&T Subcommittee objectively appraises, evaluates, and selects pharmaceutical products for formulary inclusion and exclusion. This is an ongoing process to ensure the optimal use of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use, and cost.

E. IEHP does not accept any incentives to use a specific drug on a preferred status; therefore, the IEHP formulary does not contain any drugs with preferred status.

F. Due to the multiplicity of drugs on the market and the continuous introduction of new drugs into the market, IEHP P&T Subcommittee meets on a quarterly basis to update the formulary.

G. In cases where generics (multi-source) drugs become available and the cost is comparable to similar formulary drugs within the same class (plus or minus 10%). The Senior Director of Pharmaceutical Services and Chief Medical Officer may approve the drug to be added on the IEHP Formulary immediately.

H. The Subcommittee provides recommendations regarding protocols and procedures for the use of non-formulary medications.

I. The Subcommittee provides recommendations regarding educational materials and programs about drug products and their usage to all IEHP practitioners and Providers.

J. The P&T Subcommittee develops and monitors quality issues in regards to correct drug use for IEHP and its Members. This includes drug utilization review (DUR) and drug use evaluation (DUE) programs.
11. PHARMACY

A. Formulary Management

K. The P&T Subcommittee recommends disease state management or treatment guidelines for specific diseases or conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions.

L. The treatment guidelines are evidence based guidelines from recognized sources or developed by board-certified practitioners from appropriate specialties.

M. The current treatment guidelines include Depression, Attention Deficit/Hyperactivity Disorder (ADHD), Diabetes, Asthma, Hyperlipidemia, Allergic Conjunctivitis, Anti-Infective Guide, Respiratory Syncytial Virus (RSV), Multiple Sclerosis, Migraine, Pulmonary Arterial Hypertension, Hepatitis C, and Hypertension.

N. All treatment guidelines are reviewed annually. IEHP sends written notification to IEHP Providers regarding the availability of new guidelines. All current guidelines are available through our website at www.iehp.org.

O. IEHP provides an online formulary search tool on the IEHP website at www.iehp.org. A printed version is available upon request.

P. On an annual basis, IEHP notifies the Members regarding the formulary update schedule through the Member Newsletter. Members may also access the IEHP Website to obtain the latest formulary changes.

PROCEDURES:

A. IEHP P&T Subcommittee’s membership consists of the IEHP Senior Director of Pharmaceutical Services or designee as Chairperson, Chief Medical Officer, Senior Medical Director, seven (7) clinical pharmacists (representative of the overall IEHP network) and seven (7) practicing physicians (representative of the overall IEHP network) as voting members. The IEHP staff includes the Director of Quality Management, Senior Director of HealthCare Informatics, Clinical Pharmacist, and Director of Health Administration. The Pharmaceutical Services Administrative Assistant acts as secretary to the Subcommittee. The Subcommittee meets on a quarterly basis at IEHP offices.

B. Factors related to optimal pharmacotherapy and considered in formulary deliberations include:

1. Pharmacologic considerations (e.g., drug class, similarity to existing drugs, side effect profile, mechanism of action, therapeutic indication, drug-drug interaction potential, clinical advantages over other products in the specific drug class);

2. Unlabeled uses and their appropriateness;

3. Bioavailability data;

4. Pharmacokinetic data;

5. Dosage ranges by route and age;
11. **PHARMACY**

A. **Formulary Management**

6. Risks versus benefits regarding clinical efficacy and safety of a particular drug relative to other drugs with the same indication;

7. Patient risk factors relative to contraindications, warnings and precautions;

8. Special monitoring or medication administration requirements;

9. Cost comparisons against other drugs available to treat the same medical condition(s); and

10. Pharmacoeconomic data.

C. IEHP is a generic mandatory plan. Brand name products, when generics exist, may be requested by submitting the Prescription Drug Prior Authorization Request Form along with justification of use and proven failure of the generic version. Please refer to Policy 11B, “Prior Authorization for Non-Formulary Medications,” for more information.

D. Selected medications have FDA-approved generic equivalents or biosimilar products available. IEHP mandates generic dispensation for all quality generic products. Quality generic medications are those medications that have received an “AB” rating by the FDA. IEHP only allows payment for “AB” rated generic medications. Biosimilar products approved by the FDA are also covered by the IEHP formulary. Lower quality generics are not covered by the IEHP formulary. This mandate is enforced by the use of an NDC block at the point of sale.

E. Exceptions to the mandatory generic formulary are as follows:
   1. Carbamazepine (Tegretol, Digoxin (Lanoxin));
   2. Levothyroxine (Levothroid, Levoxyl, Synthroid);
   3. Phenytoin (Dilantin);
   4. Valproic Acid/Divalproex Sodium (Depakene/Depakote); and
   5. Warfarin (Coumadin).

F. Selected medications have step-therapy protocols. Step-therapy protocols are built under clinical evidence based review and is approved by the IEHP P&T Subcommittee. Such medications are non-formulary, and if the prerequisite criteria are met, the claims are allowed without prior authorization. Angiotensin Receptor Blockers, and COX-2 Inhibitors are examples of medications that have built-in step-therapy protocols.

G. IEHP P&T Subcommittee meets quarterly or as needed to update the formulary by reviewing:
   1. Medical literature including clinical trials (i.e., MEDLINE search, and Cumulated Index Medicus database search);
   2. Relevant findings of government agencies, medical and pharmaceutical associations, national institutes of health, and regulatory body publications;
11. PHARMACY

A. Formulary Management

3. Relevant patient utilization and experience;
4. Current therapeutic guidelines and the need for revised new guidelines; and
5. IEHP Provider and practitioner recommendations for addition or deletion of drugs to the formulary.

H. The IEHP Formulary and Treatment Guide is available on the IEHP website at www.iehp.org. A printed version is available upon request by contacting the following:
   1. For Members – IEHP Member Services Department at 1-800-440-IEHP (4347); or
   2. For Providers and Practitioners – IEHP Pharmaceutical Services Department at (909) 890-2049.

I. The Formulary is also available to Providers and Members through the IEHP website (https://ww3.iehp.org/en/providers/pharmaceutical-services/).

J. When necessary, between annual publications, IEHP notifies its practitioners and Providers in writing about the formulary additions, deletions, Code-1 restriction changes, and policies and procedures modifications.

K. Requests for formulary additions should be submitted to the P&T Subcommittee on the IEHP Request for Addition/Deletion of a Drug to the Formulary (See Attachment, “Request for Addition or Deletion of a Drug to the Formulary” in Section 11). The request is reviewed by the IEHP Chief Medical Officer and placed on the next P&T agenda unless a similar request has been recently reviewed by the Subcommittee.

L. All new IEHP practitioners and pharmacists receive a copy of the formulary in their orientation materials.

INLAND EMPIRE HEALTH PLAN

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11. PHARMACY

B. Prior Authorization For Non-Formulary Medications

**APPLIES TO:**

A. This policy applies to all IEHP Healthy Kids Members.

**POLICY:**

A. All non-formulary medications require prior authorization utilizing the Prescription Drug Prior Authorization Request Form (See Attachment, “Prescription Drug Prior Authorization Request Form” in Section 11).

B. The Prescription Drug Prior Authorization Request Form must be used for all Prior Authorization (PA) requests. All information necessary to make a medical necessity determination must be submitted by the Providers. In the event the information required for PA review is missing from the PA form the request will be denied.

C. Submission of the Prescription Drug Prior Authorization Request Form is not required when medications are used in emergent or urgent circumstances.

D. All Prescription Drug Prior Authorization Request Forms must contain information that supports the medical necessity of a non-formulary drug or a Code 1 drug that does not meet criteria. In addition, all PA Forms must include previous successful or failed therapies, any allergies, or any other clinical condition when applicable.

E. All requests are reviewed and acted on within twenty-four (24) hours Monday - Friday 8am to 5pm. Pharmacists and other practitioners are encouraged to exercise appropriate professional and clinical judgment when determining whether to dispense medications pending PA approval. IEHP reimburses pharmacies that dispense a sufficient supply of medication to last until the PA has been reviewed.

F. Request for cash reimbursements are considered as PA Requests. The request may be considered up to one (1) year from the date of service.

G. Unless specifically noted differently on the PA form, all approvals expire after one (1) year.

**PROCEDURES:**

A. IEHP supplies all practitioners with the Prescription Drug Prior Authorization Request Form and instructions for its use (See Attachment, “Prescription Drug Prior Authorization Request Form” in Section 11).

B. PA forms are used for the following:
   1. Drugs or dosage forms not included in the IEHP formulary.
   2. Code 1 drugs used for treatment of conditions or criteria other than those specified by their restrictions.
11. PHARMACY

B. Prior Authorization For Non-Formulary Medications

3. Branded drugs, when generic are available. Exceptions are:
   a. Carbamazepine (Tegretol);
   b. Digoxin (Lanoxin);
   c. Levothyroxine (Levothroid, Synthroid);
   d. Phenytoin (Dilantin);
   e. Valproic Acid/Divalproex Sodium (Depakene/Depakote); and
   f. Warfarin (Coumadin).

4. Prescriptions for formulary drugs that do not comply with missed
   Dose/Duration/or Quantity guidelines (as outlined in the IEHP formulary).

C. Prescription Drug Prior Authorization Request Forms are submitted via the IEHP website
   (www.iehp.org), or fax at 909-890-2058, or by calling IEHP Pharmaceutical Services
   Department at 909-890-2049 or 1-888-860-1297.

D. Members on medications that are deleted from the formulary, by the Pharmacy and
   Therapeutics Subcommittee, may continue to receive the medications if the prescribing
   physicians continue to prescribe the medications for the Members.

E. IEHP staff reviews individual medication requests; thoroughly surveys the Member’s
   existing medication regimen, previous successful or failed therapies, any allergies, or any
   other clinical condition when applicable; and either approves or denies the request.

   1. **Request Approved:** An approval code is entered into the claims processing
      system to allow the claim to adjudicate on-line for the span of the approval period
      (maximum 1 year).

   2. **Request Dismissed or Cancelled:** PA request was submitted to IEHP by mistake
      or if requested by Provider.

   3. **Request Denied:** Documentation provided did not meet approval guidelines.

   4. **Request Denied Administratively:** PA request was denied based on reasons
      other than medical necessity reason (i.e. lack of information, Member not eligible,
      or using a wrong PA form).

F. The IEHP Clinical Pharmacist consults with the appropriate specialists as part of the
   decision-making process for requests involving unusual or clinically complicated
   conditions.

G. Prior to denying a request, the IEHP Clinical Pharmacy staff consults with the prescribing
   physician to offer an alternative pharmacotherapeutic regimen, and to discuss the specific
   reason for the denial.
11. PHARMACY

B. Prior Authorization For Non-Formulary Medications

H. The IEHP Clinical Pharmacy staff discusses the requests that are found to be medically unjustifiable with the Clinical Pharmacist prior to denying them. The IEHP Clinical Pharmacist signs all denied PA Forms.

I. A copy of the response is faxed back to the requesting practitioner.

J. The IEHP compensation plan for Clinical Pharmacy staff who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

K. In the event that timely completion of the Prescription Drug Prior Authorization Request Form by the practitioner is not possible, IEHP Clinical Pharmacy staff authorizes the request over the telephone and document the information for logging into the database.

L. After business hours, on weekends, and holidays, pharmacy Providers should dispense up to a three (3) day supply of formulary and non-formulary medication to IEHP Members in emergent circumstances.

M. In a case where the review is retrospective, the notification can be sent to the Member within thirty (30) days of the receipt of information that is reasonably sufficient to make a decision.

N. The pharmacy receives guaranteed reimbursement for all emergency fills by completing the Prescription Drug Prior Authorization Request Form (See Attachment, “Prescription Drug Prior Authorization Request Form” in Section 11). Emergency claims require documentation of the nature of the emergency situation. This can be in the form of an Emergency Certification Statement. The Emergency Certification Statement must be attached to the claim and include:

1. The nature of the emergency, including relevant clinical information about the patient’s condition;

2. Why the emergency services rendered were considered to be immediately necessary; and

3. The signature of the physician, podiatrist, dentist, or pharmacist who had direct knowledge of the emergency.

The statement must be comprehensive enough to support a finding that an emergency situation existed. Justification can consist of statement such as: medication is necessary to prevent a break in ongoing treatment, patient has been stabilized and is being discharged from an acute care facility, medication is necessary to prevent patient from being danger to self or other, etc.

O. Pharmacies can submit an emergency seventy-two (72) hours supply claim without a prompt by the doctor. However, it is helpful if the prescriber requests the seventy-two (72) hours medication in addition to submitting the Prescription Drug Prior
11. PHARMACY

B. Prior Authorization For Non-Formulary Medications

Authorization Request Form (See Attachment, “Prescription Drug Prior Authorization Request Form” in Section 11) – as a reminder to the pharmacy.

P. The final authority for obtaining medications not included in the IEHP formulary rests with the IEHP Chief Medical Officer. All documents and written materials are forwarded to the Chief Medical Officer for review if an appeal is filed by the prescribing physician, IPA, pharmacist, Member, or Member’s responsible party.

Q. The Member, Member’s representative, IPA, pharmacist or Provider/practitioner appealing a denial or modification on behalf of a Member, forwards all documents and written materials to the Grievance Department for processing of the appeal. Refer to Section 16, “Grievance Resolution System” for more information.

R. Urgent requests that meet criteria will be reviewed and decided upon. Urgency is defined as an imminent threat to the Member’s health, including loss of life, limb, or other major bodily function, or when a delay would be detrimental to the Member’s ability to regain maximum function. A notification will be sent out to the Provider and the Member as to the outcome will be given in a timely fashion, which is not to exceed two (2) business days after receipt of the request. IEHP’s Chief Medical Officer expedites the review and decides with the prescribing practitioner, if applicable, what course of action is necessary, based on the medical circumstances. Please refer to Section 16 “Grievance Resolution System” for more information.
C. Medication Handling Requirements at PCP Sites

APPLIES TO:
A. This policy applies to all Primary Care Physicians (PCPs) who treat IEHP Healthy Kids Members.

POLICY:
A. IEHP requires that the staff at any PCP site dispensing medication follow all applicable policies and procedures. The PCP is responsible for monitoring and tracking all dispensing of medications performed on-site.
B. To ensure proper handling and storage of pharmaceuticals at PCP offices.
C. To ensure that all applicable statutory or regulatory standards regarding medication handling and storage are followed and maintained at the PCP offices.

PROCEDURES:
A. All stock and sample drugs must be checked monthly for their expiration dates.
B. A physician who dispenses drugs must store all drugs to be dispensed in an area that is secure (B&P § 4172).
   1. A secure area must be a locked storage area within the physician’s office.
   2. The area must be secure at all times.
   3. The keys to the locked storage area must be available only to staff authorized by the physician.
C. All records for dispensing of medications must be open to inspection at all times during business hours by authorized individuals, and must be preserved for at least three (3) years.
D. Storage areas must meet the following requirements:
   1. Drug storage areas must be neat and clean.
   2. All medications must be properly labeled with expiration date and lot number.
   3. Oral and injectable medications must be stored separately from medications intended for external use.
   4. All medications must be stored in a locked cabinet with access only by authorized persons.
E. Physicians dispensing medications to Members in their offices must meet the following requirements (B&P § 4172, 4170 and Title 16, CCR § 1356.3):
11. PHARMACY

C. Medication Handling Requirements at PCP Sites

1. The medication is dispensed to the physician’s own patient and the drugs are not furnished by a nurse or attendant.

2. The medications are necessary in the treatment of the condition for which the physician is attending the patient.

3. Physicians must record the disposition of medications and keep them for at least three years.

F. Any medication stored in a refrigerator must be completely separate from food or other items in the refrigerator. This can be accomplished by having a separate refrigerator for medications, or by storing medications in a separate container within the refrigerator.

G. The temperature of a refrigerator should be maintained at 35° F to 46° F.

H. The temperature of a freezer must be maintained at -58° F to -57° F.

I. Physicians must follow the storage and handling guidance as described by the Centers for Disease Control and Prevention (CDC).

J. Daily temperature logs for freezer and refrigerator must be maintained.

K. Needles and syringes must be kept in locked secure cabinets.

L. All medication is considered good through manufacturer’s expiration date; however, physician offices must consider the integrity of the vial and its effect on the potency, and/or sterility of the medication before each use.

M. Compliance with IEHP medication handling requirements is monitored during Department of Health Care Services (DHCS) required facility reviews, as described in Policy 6A, “Site Review and Medical Records Review Survey Requirements and Monitoring.”

REFERENCES:

A. Business and Professions Code §§ 4170 and 4172

B. 16 California Code of Regulations § 1356.3
11. PHARMACY

D. Code 1 Medications

APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

POLICY:

A. Code 1 medications are restricted to specified medical conditions, age group, and/or other specific circumstances.

B. All Code 1 drugs and specific requirements for their use are printed in the IEHP formulary (See Attachment, “Code 1 Medications” in Section 11).

C. Physicians who write prescriptions for Code 1 drugs must document, on the prescription, the Member’s diagnostic or clinical condition that fulfills the Code 1 restriction.

D. The dispensing pharmacist is responsible for verifying that applicable Code 1 requirements have been met.

E. Approval for use of Code 1 medications not meeting the IEHP approved Code 1 requirements for use may be obtained by submitting the Prescription Drug Prior Authorization Request Form (See Attachment, “Prescription Drug Prior Authorization Request Form” in Section 11).

PROCEDURES:

A. The dispensing pharmacist must confirm through drug history or contact with the prescriber that all applicable Code 1 requirements have been met. (Refer to the IEHP website for a current list of Code 1 medication requirements). The pharmacist must document this information, and make available all such records for desktop or in-store audits.

B. Once verifications of requirements have been performed, the pharmacist should enter the appropriate override code indicating that the requirements have been met.

C. All Code 1 documentation is subject to desktop and in-store audits. Payment for prescriptions processed using the override code for which the appropriate documentation is not available, may be recovered from the dispensing pharmacy.

D. IEHP pharmacy staff produces monthly utilization reports for Code 1 medications. The Chief Medical Officer, Senior Director of Pharmaceutical Services, Pharmacy and Therapeutics Subcommittee, and other committees as necessary review these reports.

E. Authorization for dispensing Code 1 medications used for treatment of conditions or criteria other than those specified by their restriction may be obtained by submitting the Prescription Drug Prior Authorization Request Form. Refer to Policy 11B, “Prior Authorization for Non-Formulary Medications.”
11. PHARMACY

D. Code 1 Medications

F. IEHP reviews Code 1 status of specific medications as needed at Pharmacy and Therapeutics Subcommittee meetings.

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11. PHARMACY

E. Co-Payment Requirements

APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

POLICY:

A. IEHP requires that all Healthy Kids Program Members pay a $5.00 co-payment for most prescriptions.

   1. Healthy Kids Members have a $250.00 combined medical and pharmacy annual out-of-pocket maximum per family. Once the family out-of-pocket maximum has been met, an indicator is set on each family member’s eligibility file, which waives the co-payment for the remainder of the benefit year.

PROCEDURES:

There is a co-payment requirement for most prescriptions:

A. Healthy Kids prescription medications (Brand and Generic).

   1. Acute Supply (30-34 day supply) $5.00 per prescription.
   2. Maintenance supply (90-100 day supply) $5.00 per prescription.

B. There are no co-payments for the following medications/products:

   1. Aerochambers and spacers;
   2. Contraceptive drugs and devices;
   3. Diabetic supplies (test strips, lancets, needles/syringes);
   4. Immunizations;
   5. Prenatal vitamins; and

C. The Healthy Kids Program follows the guidelines of the IEHP Formulary with the following exceptions:

   1. Over The Counter (OTC), drugs are not covered (excluding for insulin, diabetic supplies, and OTC pediatric multivitamins).
   2. The Department of Health Care Services (DHCS) Medi-Cal “carve-out” drugs (Psychotropic and anti-HIV virus drugs) are covered by the Healthy Kids Program. The Healthy Kids co-payment requirements apply as stated in “A” above.

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11. PHARMACY

F. Physician Profiling Program

APPLIES TO:

A. This policy applies to all physicians who treat IEHP Healthy Kids Members.

POLICY:

A. IEHP has developed a program to monitor prescribing patterns according to clinically efficacious, cost-effective principles.
B. The Physician Profiling Program increases the physician’s awareness of their own performance relative to peers or established goals.
C. IEHP distributes quarterly physician profiling reports to the top one-hundred (100) prescribers by prescription volume.

PROCEDURES:

A. The Physician Profile contains information on prescription utilization, prescription cost, utilization by specific high volume drug agents, and therapeutic classes.
B. IEHP Clinical Pharmacist evaluates the top one-hundred (100) highest volume prescribers.
C. Each physician profile indicates whether or not that physician is an outlier compared to peers and overall prescribing partners.
D. Physician outliers are defined as follows:
   Bottom 10% in terms of...
   Top 10% in terms of...
   Top 10% in terms of...
   % Generic Rxs
   % Code 1 Drugs
   % DEA Controlled Rxs
   % Prior Authorization Rxs
   % Patients with > 8 Rxs
E. To improve performance, IEHP highlights the meaning of the profiles for the prescribers by defining all the terms in the profile and including sample reports in the mailing packets.
F. IEHP’s Clinical Pharmacist provides an educational outreach program designed to reduce inappropriate drug prescribing. Higher-volume prescribers are targeted through utilization reports.
G. IEHP’s Clinical Pharmacist conducts academic detailing (one-to-one visits) to Providers to disseminate information and increase knowledge in an attempt to change behavior patterns.
11. PHARMACY

F. Physician Profiling Program

H. IEHP reinforces the visits by mailing printed materials to Providers after each academic detailing.
11. PHARMACY

G. Pharmacy Drug Therapy Management (DTM) Program

APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

PURPOSE:

A. To create a Pharmacy Drug Therapy Management (DTM) Program in high cost or relevant disease states.

POLICY:

A. IEHP selects a Specialty Pharmacy through the Request For Proposal (RFP) process. The Specialty Pharmacy must demonstrate a robust drug therapy management (DTM) program that meets IEHP’s expectation.

B. The DTM program should have the following components: promote adherence, assist with prior authorization process, promote appropriate use of drugs according to IEHP Clinical Practice Guidelines, optimize treatment, minimize side effect, increase Members’ quality of life, and decrease overall medical cost.

C. Through the monthly clinical survey, pharmacies shall collect clinical information and alert IEHP of any potential clinical issues. The Specialty Pharmacy shall provide a clinical report on a quarterly basis.

D. The Specialty Pharmacy shall be responsible for all drugs (pharmacy services) under the assigned disease state. All requests from retail pharmacies shall be redirected to the DTM Program immediately.

E. IEHP monitors the program's effectiveness on an ongoing basis. If the program fails to meet IEHP’s expectation, IEHP shall conduct an RFP to select a replacement vendor.

F. Current DTM Programs include Intravenous Immunoglobulin (IVIG), Hepatitis B & C, Multiple Sclerosis, Growth Hormone, Oral Oncology, Home Infusion Pharmacy, Pulmonary Arterial Hypertension, Diabetes, Synagis, Hemophilia, and Rheumatoid Arthritis/Crohn’s/Psoriasis.

G. Members may opt out of the DTM program by calling IEHP Member Services Department. The opt out status will be valid until Member is disenrolled, or until the Member revokes the opt out.

H. Upon dispensing of the first fill of the DTM drug, Members will receive written notice of the DTM program to inform them of their rights to opt out.

I. The following drugs may be exempt from the opt out process:

1. Drugs listed on the Current Drug Shortage Index maintained by the Food and Drug Administration (FDA);
11. PHARMACY

G. Pharmacy Drug Therapy Management (DTM) Program

2. Drugs not available at the network community pharmacy due to manufacturer’s instructions or restrictions;
3. Drugs subject to risk evaluation or management or strategies approved by the FDA; and
4. A special shortage affecting IEHP’s pharmacy network.

PROCEDURES:

A. IEHP identifies a Specialty Pharmacy for each DTM disease state through a Request For Proposal process.
B. The DTM Providers must meet IEHP’s DTM expectation & standard based on each disease management protocol and design.
C. The DTM Providers must communicate findings to IEHP based on the protocol.
D. IEHP Pharmaceutical Services communicates with internal departments based on the real-time triggers (findings) and manage the Members’ conditions proactively.
E. IEHP presents DTM Program reports to the IEHP Pharmacy & Therapeutics Subcommittee on an annual basis.
F. Upon approval or dispensing of the first fill of a DTM drug, Member will receive a notification within thirty (30) days explaining the DTM program and their right to opt out, including the toll-free number and the opt out process.
G. Members may call IEHP Member Services Department to opt out of the DTM program. Opt out period will expire when Member is disenrolled from IEHP.
11. PHARMACY

H. Emergency Department and Hospital Inpatient Discharge Medication Requirement

APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

POLICY:

A. IEHP ensures that Members have timely access to pharmacy services upon discharge from the Emergency Department (ED) or Hospital in-patient unit in emergent situation.

B. Discharge medications (starter pack) may be provided by the Hospital or ED, or be accessed in one of the twenty-four (24) hours pharmacies within the IEHP Pharmacy Network.

C. IEHP allows pharmacists to provide short term supply of formulary medications until the next business day without risk.

D. The pharmacy can bill a seventy-two (72) hour emergency supply while the Prior Authorization (PA) request for the full amount is pending. This is particularly important to consider when the prescription comes in on weekends, the pharmacy is unable to reach a Provider in order to obtain information necessary to submit a PA request, or for any other reason for which a PA approval might be delayed. Please refer to Policy 11B, “Prior Authorization for Non-Formulary Medications,” for more information.

E. IEHP monitors grievance cases and reports (under Access/medication – “Emergency discharge meds” report) to ensure coverage is adequate.

F. IEHP monitors twenty-four (24) hours pharmacy geo-access report bi-annually to ensure coverage is adequate.

G. The twenty-four (24) hour nurse advice line provides twenty-four (24) hour pharmacy locations for Members needing urgent pharmacy services.

PROCEDURES:

A. When the course of treatment provided to an IEHP Member in the ED requires the use of medications, a sufficient quantity of such medications may be provided to the Member to last until the Member can reasonably be expected to have a prescription filled at an IEHP network pharmacy. In the event such pharmacy service is not available in the hospital or ED, IEHP Member may obtain the medication through one of the twenty-four (24) hour Pharmacies.

B. To monitor compliance, on a quarterly basis, IEHP will report grievances related to medication access upon discharge to the Quality Management Committee.

C. On a bi-annual basis, IEHP monitors the Geo Access report to ensure adequate twenty-four (24) hour pharmacy coverage around the contracted hospitals and EDs.
H. Emergency Department and Hospital Inpatient Discharge Medication Requirement

1. The standard is a twenty-four (24) hour pharmacy within ten (10) miles of all hospitals.

2. The Geo-Access Report and list of twenty-four (24) hour pharmacies, which includes pharmacy names, hours, addresses and phone numbers, will be presented to the IEHP Pharmacy and Therapeutics Subcommittee for review.

D. The starter-pack medication label must include the following information:

1. Patient name;

2. Medication name, dosage, and quantity;

3. Direction for use;

4. Date;

5. Name of the prescribing physician;

6. Physician’s signature; and

7. Medication expiration date.

E. Members receiving starter-pack medications must receive medication counseling prior to discharge.

F. The pharmacy receives guaranteed reimbursement for all emergency fills by completing the Prescription Drug Prior Authorization Request Form (See Attachment, “Prescription Drug Prior Authorization Request Form” in Section 11). Emergency claims require documentation of the nature of the emergency situation, which can be in the form of an Emergency Certification Statement. The Emergency Certification Statement must be attached to the claim and include:

1. The nature of the emergency, including relevant clinical information about the patient’s condition;

2. Why the emergency services rendered were considered to be immediately necessary; and

3. The signature of the physician, podiatrist, dentist or pharmacist who had direct knowledge of the emergency

The statement must be comprehensive enough to support a finding that an emergency situation existed. Justification can consist of statements such as: medication is necessary to prevent a break in ongoing treatment, patient has been stabilized and is being discharged from an acute care facility, medication is necessary to prevent patient from being a danger to self or others, etc.

G. Pharmacies can submit an emergency seventy-two (72) hour supply claim without a prompt by the doctor. However it is helpful if the prescriber requests the seventy-two
H. Emergency Department and Hospital Inpatient Discharge Medication Requirement

(72) hours medication in addition to submitting the PA – as a reminder to the pharmacy.
11. PHARMACY

I. Insulin Administration Devices and Diabetes Testing Supplies

APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

POLICY:

A. Insulin and Glucagon Emergency Kit are covered by the IEHP pharmacy benefit.
B. Syringes and needles are the insulin administration devices covered under the IEHP pharmacy benefit. Insulin pen devices require the submission of a Prescription Drug Prior Authorization Request Form (See Attachment, “Prescription Drug Prior Authorization Request Form” in Section 11). See Policy 11B, “Prior Authorization for Non-formulary Medications.”
C. Insulin pumps fall under IPA/Hospital’s financial responsibility.
D. Diabetes testing supplies are covered under the IEHP pharmacy and medical benefit. This includes blood glucose meters, test strips, lancets, urine test tape and tablets, ketone test strips and acetone tablets.

PROCEDURES:

B. Diabetes testing supplies, including glucometer, test strips and lancets may be obtained through retail pharmacies or through IEHP Diabetes Self-Management Program.
C. IEHP covers diabetic testing supplies using the criteria approved by the IEHP Pharmacy and Therapeutics Subcommittee.
D. IEHP Members may participate in IEHP Diabetes Self-Management Program. The program provides test strips, and lancets through mail order vendor. IEHP Providers may refer Members to WeCare Pharmacy (Phone: 1-877-301-0636 or Fax: 909-494-5582). The selected vendor provides comprehensive diabetes care program (diabetes educational materials, outreach program, health fair) to the participants. The selected vendor is required to perform monitoring measures at least on a quarterly basis. The selected vendor is also required to report all measures to IEHP. For more information, please visit the “Diabetes DME Coverage” section under the IEHP Pharmaceutical Services webpage: (https://ww3.iehp.org/en/providers/pharmaceutical-services/clinical-information/diabetes-dme-coverage). Program referral forms and all Provider notifications are available on this page.
11. PHARMACY

I. Insulin Administration Devices and Diabetes Testing Supplies
11. PHARMACY

J. Member Request for Pharmacy Reimbursement

APPLIES TO:
A. This policy applies to all IEHP Healthy Kids Members.

POLICY:
A. IEHP Members may submit Pharmacy Reimbursement Requests to get reimbursement for drugs or services covered by IEHP. All Member Reimbursement Requests are subject to IEHP Pharmacy Prior Authorization process.

PROCEDURE:
A. Members must submit the Pharmacy Reimbursement Request form (See Attachment, “Member Request for Pharmacy Reimbursement” in Section 11), a copy of the cash register receipt, and a copy of the pharmacy print out to IEHP for review.
B. The Pharmacy print out must contain pharmacy name, address, phone, medication name, strength and form, the national drug code (NDC), date of service, Prescriber’s full name, quantity, and the total amount paid.
C. The Request form must be submitted within one (1) year from the date of service.
D. The Request form must be signed by the Member.
E. All Requests will be evaluated based on the medical necessity and the justification of the request within fourteen (14) days upon the receipt of the request.
F. If IEHP denies the Member Reimbursement Request, the Member will receive a denial notification from IEHP.
G. If a Member has shown a pattern of by passing Pharmacy Prior Authorization Request process, IEHP may notify the Member of the denials of all future reimbursement requests.
11. PHARMACY

K. Pharmacy Credentialing and Re-Credentialing

APPLIES TO:

A. This policy applies to all pharmacies in the IEHP pharmacy network.

POLICY:

A. IEHP delegates all pharmacy credentialing and re-credentialing to a contracted Pharmacy Benefit Management (PBM) company.
B. The contracted PBM must have credentialing and re-credentialing policies and procedures that meet IEHP standards.
C. The PBM must credential all pharmacies prior to inclusion in the IEHP pharmacy network.
D. The PBM must re-credential all pharmacies every two (2) years.
E. Contracted Pharmacies must update all credential information on the IEHP Pharmacy Prior Authorization Request Tool on a biannual basis.

PROCEDURES:

A. The PBM is responsible for ensuring that all network pharmacies are qualified, properly licensed, and maintain appropriate levels of malpractice insurance.
B. The PBM is also responsible for monitoring the performance of all IEHP network pharmacies and is responsible for promptly notifying IEHP once the PBM is aware of any breach of the pharmacy’s obligations. This could include:
   1. License surrender, revocation or suspension;
   2. Drug Enforcement Agency (DEA) license surrender, revocation or suspension;
   3. Loss of malpractice insurance
C. The PBM must credential all pharmacies prior to adding them to the IEHP pharmacy network.
D. A copy of the credentialing form must be sent to IEHP to be filed in the pharmacy file.
E. Information collected and verified (when appropriate) includes, at a minimum:
   1. Date of application;
   2. Pharmacy name, address, telephone number, and hours of operation;
   3. National Association of Boards of Pharmacy (NABP) number/National Provider Identifier (NPI) number;
   4. Name of the Pharmacy owner;
11. PHARMACY

K. Pharmacy Credentialing and Re-Credentialing

5. Names and state license numbers for all staff pharmacists and pharmacy technicians;
6. Malpractice history;
7. Financial viability;
8. Tax identification number;
9. Pharmacy state licensure number;
10. Expiration dates for all active state licenses;
11. DEA number and expiration date;
12. Medicare identification/provider number;
13. Languages, other than English, spoken fluently by the staff; and
14. Signature of Pharmacy manager or owner.

F. The PBM must re-credential all IEHP network pharmacies every two (2) years. The PBM must notify IEHP when a pharmacy is terminated from the network (voluntarily or involuntarily) within sixty (60) days after termination.

G. Pharmacies must provide updated credentialing information via IEHP Pharmacy Prior Authorization Request Tool on a biannual basis.

INLAND EMPIRE HEALTH PLAN

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<th>Signature on file</th>
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<th>July 1, 2013</th>
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<td>Chief of Medical Services</td>
<td>Revision Date:</td>
<td>January 1, 2016</td>
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L. Claims for Drugs Prescribed or Dispensed by Excluded Providers

**APPLIES TO:**

A. This policy applies to all IEHP Healthy Kids Members.

**POLICY:**

A. IEHP will reference to the Office of Inspector General (OIG) monthly updates and update the system to block claims submitted by the sanctioned Providers.

B. IEHP will reference to the State licensing department to confirm Provider, licensure and to receive notices of any actions related to termination, revocation or restriction of a Provider’s license to practice. IEHP will update the system to block claims submitted by the sanctioned Providers (Non-Medicare Members).

**PROCEDURES:**

A. IEHP will reference to the Office of Inspector General (OIG) monthly updates and update the system to block claims submitted by the sanctioned Providers.

B. IEHP will send a letter to Members who received Part D covered drugs prescribed or dispensed by a Provider on the List of Excluded Individuals and Entities (LEIE) (See Attachment, “Part D Excluded Provider Letter” in Section 11). The letter will alert the Member that future medication fills will no longer be covered because the prescriber or pharmacy is being excluded from participation in the Medicare Program based on OIG findings.

C. IEHP’s contracted Pharmacy Benefit Manager (PBM) updates the system based on the Centers for Medicare & Medicaid Services (CMS) requirement described above. Once updated, all claims related to the sanctioned Providers will be denied. A weekly report is generated and sent to IEHP. IEHP will generate letters to Members who appear on the report (See Attachment, “Part D Excluded Provider Letter” in Section 11).

D. The following payment sources for Covered Part D Drugs CANNOT be counted toward a Member’s “true-out-of-pocket” (TrOOP) threshold:

1. Group Health Plan
2. Government programs (i.e. Tricare, Veterans Affair)
3. Workers’ compensation
4. Automobile, no-fault, or liability insurances
5. Supplemental benefit portions of a Medicare Part D plan

E. Payments made for the following drugs CANNOT be counted towards a Member’s TrOOP Threshold:
11.  PHARMACY

L.  Claims for Drugs Prescribed or Dispensed by Excluded Providers

1.  Drugs that are not Covered Part D Drugs, and that have not been approved for use through an Appeals or Grievance process;
2.  Drugs purchased outside the United States
3.  Over-the-counter drugs and other Part D excluded drugs.

F.  IEHP will coordinate with the Pharmacy Benefit Management Company on the TrOOP Expenditure calculation. Any adjustment notice received through the coordination of benefits process will be transferred to the PBM for recalculation of the Member’s TrOOP Expenditures.

G.  In case an erroneous payment is made due to inaccurate or incomplete information regarding a Member’s TrOOP Expenditures, IEHP may recover the costs directly from the Member.

H.  An Explanation of Benefits (EOB) will be provided to the Member when a Member disenrolls from IEHP. The EOB should contain information of TrOOP Expenditures status and gross drug spend balances as of the effective date of the disenrollment, and periodically thereafter as required to provide updates on late claims.

I.  IEHP’s contracted Pharmacy Benefit Management Company will process claims and track TrOOP in real time.

J.  For Non-Medicare Members, IEHP will monitor the State’s Provider licensing department updates. Providers whose licenses are terminated, revoked, or suspended by the State of California are not eligible to write prescriptions for IEHP Members. IEHP will block the National Provider Identifiers (NPIs) listed on the sanctioned Provider list.
11. PHARMACY

M. Hepatitis B & C – Center of Excellence Program

APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

POLICY:

A. The Hepatitis Center of Excellence (COE) is created due to the new oral Hepatitis C treatment. Evaluation of treatment options for Hepatitis C is complex. Although the efficacy rate is deemed to be superior to the traditional standard of care, not all Hepatitis C patients should receive the triple therapy treatment without proper evaluation. Current American Association for the Study of Liver Diseases (AASLD) guideline is unclear which group of patients is appropriate for triple therapy. Clinicians should be aware of the potential serious side effects caused by the new protease inhibitors. In addition, treatment-resistant Hepatitis B cases are increasing and must be evaluated appropriately.

B. The COE is directed by an experienced transplant hepatologist. At least two (2) years of experience with the new oral therapies is needed for the transplant hepatologist.

C. All Hepatitis B & C referrals or treatment requests shall be directed to the COE. All prescriptions / treatment must be evaluated by the transplant hepatologist at the COE.

D. Prescriptions shall be provided in conjunction with the Hepatitis B & C Program. A Pharmacy designated by the COE shall provide all Hepatitis B & C treatment according to the prescription order.

PURPOSE:

A. To create a Center of Excellence (COE) to which Members may be referred for treatment of Hepatitis B & C.

PROCEDURES:

A. All referrals and Pharmacy Exception Requests for Hepatitis B & C must be redirected to the COE.

B. The Pharmacy or Utilization Management (UM) department will make arrangements for Members to see the transplant hepatologist at the COE. Members will be monitored at the COE if treatment is initiated.

C. All prescriptions must be initiated by the hepatologists at the COE and fulfilled by the designated pharmacy at the COE for monitoring purpose.
11. PHARMACY

M. Hepatitis B & C – Center of Excellence Program

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INLAND EMPIRE HEALTH PLAN
N. Notification of Prior Authorization/Coverage Determination Denial and Modification – Non-Medicare

APPLIES TO:
A. This policy applies to all IEHP Healthy Kids Members.

POLICY:
A. IEHP notifies Members of denial or modification of Pharmacy Prior Authorization Requests, in accordance with the California Code of Regulations (Cal. Code Regs., tit. 22, §§ 51014.1, 53261, and 53894; tit. 28, §§ 1300.67.241.) by providing written notification to Members and/or their authorized representative.
B. IEHP ensures that a denial and modification of a Pharmacy Prior Authorization Request, in no way jeopardizes a Member’s health and welfare and every effort is made to continue optimal coverage of the Member’s pharmaceutical needs at the appropriate level of care.

PROCEDURES:
A. Pharmacy Prior Authorization Requests for pharmaceuticals are initiated by prescribing physicians or pharmacists by submitting the Pharmacy Prior Authorization Request Form via the IEHP website at www.iehp.org, fax or phone. The Clinical Pharmaceutical Services staff evaluates medical necessity and approves or denies the completed request within twenty-four (24) hours. Please see Policy 11B, “Prior Authorization for Non-Formulary Medications,” for further information.
B. IEHP Pharmacy Program Specialists provide formulary alternatives based on the approved Clinical Practice Guidelines and Criteria. IEHP modifies the requests to formulary alternatives with the approval from the Physicians. IEHP may deny the requests if no justification is submitted.
C. Prior to denying a request, the IEHP Clinical Pharmacist consults with the prescribing physician to offer an alternative pharmacotherapeutic regimen, and to discuss the specific reason for the denial.
D. The IEHP Pharmaceutical Services staff discusses the requests that are found to be medically unjustifiable with the Clinical Pharmacist prior to denying them. The IEHP Clinical Pharmacist signs all denied Pharmacy Prior Authorization Requests.
E. The final authority for obtaining medications not included in the IEHP formulary rests with IEHP’s Chief Medical Officer. All documents and written materials are forwarded to the Chief Medical Officer for review if an appeal of the denial is filed by the prescribing physician, IPA, pharmacist, patient, or patient’s responsible party.
F. IEHP faxes the denied and modified Pharmacy Prior Authorization Request to the prescribing physician and pharmacy Provider within twenty-four (24) hours of the denial.
11. PHARMACY

N. Notification of Prior Authorization/Coverage Determination Denial and Modification – Non-Medicare

G. IEHP notifies Members of denial and modification of Pharmacy Prior Authorization Request within two (2) working days of decision in writing by the Pharmacy staff (See Attachment, “Denial Letter – Healthy Kids” in Section 11).

H. IEHP sends copies of the Member denial letter to the prescribing physician and pharmacist within forty-eight (48) hours of the denial.

I. Notification of Pharmacy Prior Authorization Request denial letter contains the specific reason for decision, as well as all pertinent information for the appeals process, including how to file an expedited review.

J. Members have the right to appeal any denial to IEHP through the IEHP Grievance Department or in the case of Medi-Cal Members they can request a Fair Hearing. The Member’s rights are delineated in the denial letter. Please see the Grievance Manual for further information.

REFERENCES:

A. 22 California Code of Regulations §§ 51014.1, 53261 and 53894

B. 28 California Code of Regulations § 1300.67.241
11. PHARMACY

O. Pharmacy Access During a Federal Disaster or Other Public Health Emergency Declaration

APPLIES TO:

A. This policy applies to all IEHP Healthy Kids Members.

POLICY:

A. IEHP monitors the Federal Emergency Management Agency (FEMA) for issuance of Presidential major disaster declarations and the Department of Health and Human Services (DHHS) website for public health emergency declarations.

B. IEHP will guarantee immediate refills of medications to any Members located in an “emergency area,” as defined by FEMA announcements.

PROCEDURES:

A. IEHP works with the contracted Pharmacy Benefit Manager (PBM) to remove “Refill Too Soon” edit or implement edits to allow emergency access to medications for Members whose primary residence is located in the geographic area identified in the declarations, regardless of the location at which they are attempting to obtain a refill.

B. At the end of the emergency declaration (when DHHS announces that the public health emergency no longer exists or upon the expiration of the ninety (90) day period beginning from the initial declaration; or when FEMA announces the closure of Presidential disaster declarations), IEHP will re-implement the “Refill Too Soon” edits and continue to work closely with Members who are displaced or otherwise impacted by the disaster.

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IEHP Provider Policy and Procedure Manual 01/16
HK
# 11. PHARMACY

Attachments

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<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<td>Code 1 Medications</td>
<td>11D</td>
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<td>Denial Letter – Healthy Kids</td>
<td>11N</td>
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<tr>
<td>Member Request to Pharmacy Reimbursement</td>
<td>11J</td>
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<tr>
<td>Prescription Drug Prior Authorization Request Form</td>
<td>11B, 11I</td>
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<tr>
<td>Request for Addition or Deletion of a Drug to the Formulary</td>
<td>2E, 11A</td>
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NOTICE OF ACTION
About Your Treatment Request
(NOTIFICACIÓN DE ACCIÓN
Sobre su solicitud para Tratamiento)

[Date]

[Member’s Name] [Member’s DOB]:
[Address] [Member’s I.D. Number]:
[City, State Zip] [Requesting Provider’s Name]:
[Health Plan Name]:

RE: [service requested]
[Provider Organization Tracking Number]:

[insert name of requesting provider] has asked (ha pedido a) [name of IPA] to approve (que apruebe) [insert type of treatment requested]. This request is (Esta solicitud fue) [Insert Denied (Negada), Modified (Modificada) or Terminated (Terminada)] because (porque):

[FOR MEDICAL NECESSITY DENIALS INSERT THE FOLLOWING TEXT]
The service or item requested was reviewed by our doctor and it has been determined that the requested item or service is not medically necessary. This decision has been made because: (El servicio o artículo solicitado fue revisado por nuestro doctor y a sido determinado que no es médicamente necesario. Esta decisión fue tomada porque):

[Insert a clear and concise explanation of the reasons for the decision or alternatives provided, or reason for terminating service. The detail must contain a citation/description of the criteria or guidelines used, including the plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity].

[FOR BENEFIT COVERAGE DENIALS INSERT THE FOLLOWING TEXT (For Exclusions Only)]
The requested service or item is not covered under your benefits with IEHP. This decision has been made because: (El servicio o artículo solicitado no es cubierto bajo sus beneficios con IEHP. Esta decisión fue tomada porque):

[Insert section, i.e. exclusions and limitations section] and [Insert a citation of the specific regulations supporting the action, i.e. Title 22, section #XXXXX, or section of the IEHP Member Handbook/Evidence of Coverage (EOC)].

Please refer to your “Member Handbook”/EOC for additional benefit coverage information. (Por favor consulte a su “Manual de Miembros”/EOC para información adicional sobre beneficios cubiertos.)

[FOR CALIFORNIA CHILDREN SERVICES (CCS), INSERT THE FOLLOWING TEXT]:
The requested service is a benefit under IEHP. However, because the Member has an open active case with the California Children Services (CCS) Program, CCS covers this request. To access this service, please contact your doctor or call your local CCS office at 800-[insert #]. Dr. [insert name]’s office has been given the telephone number to contact CCS for authorization. Please follow-up with your doctor’s office. (El servicio solicitado es un beneficio bajo IEHP. Sin embargo, porque el Miembro tiene un caso abierto y activo con el Programa California Children Services (CCS), esta petición es cubierta por CCS. Para obtener acceso a este
servicio, por favor llame a su doctor o llame a su oficina local de CCS al 800-[insert #]. A la oficina del Dr. [insert name] se le ha dado el numero de teléfono para contactar a CCS para una autorización. Por favor acuda a la oficina de su doctor.)

If you need the above explanation translated, please contact: (Si necesita la explicación anterior traducida, favor de llamar a:)

[IPA Name]
[IPA Address]
[IPA Phone Number]

You may appeal this decision. The enclosed ‘Your Rights’ information notice tells you how. It also tells you where to go to get help, including free legal help. (Usted puede apelar esta decisión. La información incluida “Sus Derechos” le dice como. También le dice como obtener ayuda, incluyendo ayuda legal gratuita.)

This notice does not affect any other services you are receiving from IEHP. (Esta notificación no afecta cualquiera otros servicios que usted recibe de IEHP.)

Sincerely,

[IPA Representative]
Enclosed: “Your Rights” Under Managed Care (Adjunto: ”Sus Derechos” Bajo Administración de Cuidado a la Salud)
cc: Requesting Provider
PCP
IEHP
You may appeal this decision. This notice tells you how. It also tells you where to go to get help, including free legal help. (Usted puede apelar esta decisión. Esta notificación le dice cómo hacerlo. También le dice a donde ir para recibir ayuda, incluyendo ayuda legal gratuita.)

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY (SI USTED NO ESTÁ DE ACUERDO CON ESTA DECISIÓN, USTED PUEDE):**

- **FILE A GRIEVANCE WITH YOUR HEALTH PLAN. SEE “GRIEVANCE” SECTION. (PRESENTAR UNA QUEJA CON SU PLAN DE SALUD. VEA LA SECCIÓN “QUEJAS”.)**
- **ASK FOR AN “INDEPENDENT MEDICAL REVIEW (IMR) SEE “INDEPENDENT MEDICAL REVIEW” SECTION. (PEDIR UNA REVISIÓN MÉDICA INDEPENDIENTE (IMR) - SIGLAS EN INGLÉS) VEA LA SECCIÓN “REVISIÓN MÉDICA INDEPENDIENTE”)**

You may have to file a grievance with your health plan before you can ask for an IMR, except in some cases. (**Puede ser que usted tenga que presentar una queja con su plan de salud antes de que usted pueda pedir una Revisión Médica Independiente, excepto en algunos casos**)

You will not have to pay for any of these services. (**Usted no tendrá que pagar por ninguno de estos servicios.**)

**GRIEVANCES (QUEJAS)**

You may ask for a grievance by:

- Calling IEHP at 1-800-440-IEHP (4347)/TTY 1-800-718-4347, or
- Fax your grievance to (909) 890-2168, or
- Send a letter to P.O. Box 1800 Rancho Cucamonga, CA 91729-1800, or
- In person at 10801 6th St., Suite 120, Rancho Cucamonga, CA 91730, or
- Via the IEHP Web site at www.iehp.org.

Your doctor will have grievance forms. IEHP will review its decision based on your grievance and you will get an answer within 30 days. If you think that waiting 30 days will harm your health, be sure to say why when you ask for your grievance. Then you might be able to get an answer within 72 hours.

(Usted puede presentar una queja:

- **Llamando a IEHP al -800-440-IEHP (4347)/TTY 1-800-718-4347, o**
- **Por fax al (909) 890-2168, o**
- **Envíe una carta a P.O. Box 1800 Rancho Cucamonga, CA 91729-1800, o**
- **En persona al 10801 6th St., Suite 120, Rancho Cucamonga, CA 91730, o**
- **Por la red de Internet de IEHP al www.iehp.org.**

Su doctor tiene formularios de quejas. IEHP revisará su decisión basado en su queja y usted recibirá una respuesta dentro de 30 días. Si usted piensa que esperar 30 días perjudicará su...
You have the right to submit to IEHP written comments, documents, or other information relevant to your grievance. (Usted tiene el derecho de proveer a IEHP comentarios escritos, documentos, u otra información referente a su queja)

You have the right to choose anyone to file your grievance for you, including parents, guardians, conservators, relatives, or other designee. In addition, you have the right to have anyone you appoint represent you during the grievance process. (Usted tiene el derecho de escoger a cualquier persona para que presente su queja por usted, incluyendo padres, tutores, conservadores, familiares, u otra persona designada. Además, usted tiene el derecho de seleccionar a cualquier persona para que lo represente durante el proceso de queja).

EXPEDITED REVIEW (URGENT GRIEVANCE) (REVISIÓN RÁPIDA (QUEJA URGENTE))
You have the right to an expedited review and resolution of your urgent grievance within 72 hours, if the normal time frame for the decision making process would be detrimental to your life, or health or jeopardize your ability to regain maximum functions. An urgent medical condition involves imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function. This also includes services you are currently receiving. You can call IEHP at 1-800-440-IEHP (4347)/TTY 1-800-718-4347 and request an expedited review of your grievance. (Usted tiene el derecho a una revisión rápida y resolución a su queja urgente dentro de 72 horas, si su condición medica envuelve una seria amenaza a su salud, incluyendo, pero sin ser limitado a dolor severo, el potencial de la pérdida de su vida o una función mayor del cuerpo. Esto también incluye servicios que todavía está recibiendo. Usted puede llamar a IEHP al 1-800-440-IEHP(4347)/TTY 1-800-718-4347 y pedir una revisión urgente de su queja.)

DEPARTMENT OF MANAGED HEALTH CARE (DMHC – siglas en inglés)
(DEPARTAMENTO DE ADMINISTRACIÓN DE CUIDADO MÉDICO)
“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-800-440-IEHP (4347)/TTY 1-800-718-4347) and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.”

(El Departamento de Administración de Cuidado Médico es responsable de regular los planes de servicio de cuidado de salud. Si tiene una queja contra su plan de salud, debe de llamar primero a su plan de salud, IEHP al (1-800-440-IEHP (4347)/TTY 1-800-718-4347) y usar su proceso de resolución de quejas antes de comunicarse con el Departamento. Utilizando el proceso de quejas del plan no le previene el uso de cualquier otro remedio provisto por la ley.)
Si tiene una queja que envuelve una emergencia, una queja que no ha sido resuelta satisfactoriamente por el plan, o su queja sigue sin resolución por más de 30 días, usted puede llamar al Departamento para asistencia. También puede que usted sea elegible para una Revisión Médica Independiente. Si su caso es elegible para una Revisión Médica Independiente, el proceso proveerá una revisión imparcial de las decisiones médicas hechas por un plan de salud relacionado con el servicio o tratamiento propuesto para el cuidado médico que se está necesitando, las decisiones de cobertura para terapia o tratamiento experimental o de investigación y aclarará el conflicto financiero para servicios urgentes o de emergencia. El Departamento tiene un número de teléfono gratuito (1-888-HMO-2219) y para las personas con impedimentos auditivos y del habla pueden usar el (1-877-688-9891) para comunicarse con el Departamento. La red del Internet del Departamento (http://www.hmohelp.ca.gov) tiene los formularios de quejas y las instrucciones disponibles en línea.)

INDEPENDENT MEDICAL REVIEW (IMR) (REVISIÓN MÉDICA INDEPENDIENTE (IMR) - siglas en inglés)
You may ask for an IMR if you believe that your item or service was incorrectly denied (Usted puede pedir un IMR si usted cree que el artículo o servicio fue negado incorrectamente).

Ask for your IMR (Pida un IMR):
• 30 days after you file a grievance with IEHP, (30 días después de que presente su queja con IEHP, o) or
• as soon as your grievance is denied, if that comes sooner. (Tan pronto como su queja sea negada, si esto pasa primero).

The eligibility for IMR is as follows (La elegibilidad para un IMR es la siguiente):

1. Your Doctor recommended a health care service as medically necessary (Su Doctor recomendó u servicio médico como médico necesaria); or
2. You have received urgent care or emergency services that a provider determined was medically necessary (Ud. ha recibido servicio de urgencia o de emergencia que un proveedor determinó que era médico necesaria); or
3. You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek an independent medical review (A Ud. se le ha visto por un proveedor dentro del plan por una diagnosis o tratamiento de la condición médica para la que Ud. solicita un IMR); or
4. The disputed health care service has been denied, modified, or delayed by IEHP or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary (Los servicios disputados han sido negados, modificados, o demorados por IEHP o uno de sus proveedores afiliados, todo o en parte porque el tratamiento no es médico necesaria); or
5. You have filed a grievance with IEHP and IEHP has determined to agree with the denial decision or your grievance remains unresolved for 30 days. (Ud. ha sometido una queja con IEHP y IEHP esta de acuerdo con la decisión de negar el servicio médico o su queja se mantiene sin resolver por más de 30 días).

If your grievance requires expedited review, you may immediately submit your grievance to the Department of Managed Health Care (DMHC). (Si su queja requiere revisión urgente, usted puede inmediatamente someter su queja a Departamento de Cuidados Médicos (DMHC))

You must ask for the IMR within 6 months after your grievance has been denied. (Usted debe de pedir el IMR dentro de 6 meses después de que su queja fue negada).
• To ask for an IMR, call the Department of Managed Health Care (DMHC) at 1-888-466-2219. If you have trouble hearing or speaking, call 1-877-688-9891 (TDD), or the California Relay Service at 1-800-735-2929 (TDD) and www.IP-relay.com. (Para pedir un IMR, llame al Departamento de Administración de Cuidado Medico (DMHC) – siglas en inglés) al 1-888-466-2219. Si usted tiene problemas para oir o hablar, llame al 1-877-688-9891 (TDD) o).

The DMHC also has an Internet website with forms and instructions at (El DMHC también tiene un sitio de Internet con formularios e instrucciones) http://www.hmohelp.ca.gov.

EXPERIMENTAL INVESTIGATIONAL THERAPIES (TERAPIA EXPERIMENTAL O DE INVESTIGACIÓN)

EXTERNAL INDEPENDENT REVIEW (REVISIÓN INDEPENDIENTE EXTERNA): If you qualify, you can request an external independent review for denied experimental or investigational therapy or treatment. To qualify your doctor must certify that you have a life-threatening or seriously debilitating condition for which:

• Standard therapies have not been effective in improving your condition (Las terapias comunes no han sido efectivas para mejorar su condición);
• Standard therapies would not be medically appropriate for you (Las terapias comunes no serían médicamente apropiadas para usted); or
• There is no more beneficial standard therapy covered by IEHP than the therapy proposed by your doctor (No hay otras terapias comunes disponibles que le serían beneficiales y que estuvieran cubiertas por IEHP, nada más las que fueron propuestas por su doctor).

You are not required to participate in IEHP’s Grievance Process before requesting an independent review for experimental or investigational therapies. You may contact IEHP at 1-800-440-IEHP (4347) for more information regarding the external independent review process, or request an application form. (Usted no está obligado a participar en el Proceso de Quejas de IEHP antes de pedir una revisión independiente para terapias experimentales o de investigación. Usted puede llamar a IEHP al 1-800-440-IEHP (4347) para más información acerca del proceso de revisión independiente.)

In addition to the External Independent Review, you have the right to request an IMR if your treatment is “experimental” or “investigational,” or your health may be seriously harmed without it. You may ask for an IMR right away. See above information regarding the IMR process. (Adicionalmente a su derecho a una revisión independiente, usted tiene derecho de pedir un IMR, si su tratamiento es “experimental”, “de investigación”, o su salud puede ser seriamente perjudicada sin el tratamiento. Usted puede pedir un IMR inmediatamente. Vea la información arriba acerca del proceso para IMR)

If your case qualifies for an IMR, your medical records will be sent to an IMR doctor outside the health plan who will say whether he/she agrees that the treatment is necessary. You will receive the decision on your IMR within 30 days, or within 3 to 7 days if your treatment is “experimental”, “investigational,” or your health may be seriously harmed without it. (Si su caso califica para un IMR, sus expedientes médicos serán enviados a un doctor fuera de su plan de salud quien dirá si el o ella está de acuerdo que el tratamiento es necesario. Usted recibirá la decisión acerca de su IMR dentro de 30 días, o dentro de 3 a 7 días si su tratamiento es “experimental”, “de investigación”, o su salud puede ser perjudicada seriamente si no lo
The DMHC is in charge of making sure all managed care health plans do what the law says they should do. You may call them with any complaints you have about us. *(El DMHC está encargado de asegurar que todos los planes de salud hagan lo que la ley dice que deben hacer. Usted puede llamarles con cualquier queja que tenga acerca de nosotros).*

**OTHER INFORMATION (OTRA INFORMACIÓN)**
IEHP wants to try to help you with your problem, so we hope you will call us first. *(IEHP quiere tratar de ayudarle con su problema, por lo tanto esperamos que usted nos llame a nosotros primero)*

**CRITERIA USED TO MAKE THIS DECISION (PAUTA USADA PARA HACER ESTA DECISION)**
To obtain a free copy of the specific utilization criteria, benefits provisions, guideline, protocol, or other similar criterion used in this decision, please write or call: *(Para una copia gratuita específica del criterio de utilización, provisiones de beneficios, guías de protocolo, u otro criterio similar usado en esta decisión, por favor escriba o llame al:)*

IPA NAME
IPA ADDRESS
IPA TELEPHONE NUMBER
# CODE 1 DESCRIPTIONS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amantadine (Symmetrel®)</td>
<td>Restricted to use in the prevention or treatment of influenza A.</td>
</tr>
<tr>
<td>Bromocriptine Mesylate (Parlodel®)</td>
<td>Reserved for the treatment of amenorrhea, galactorrhea and acromegaly.</td>
</tr>
<tr>
<td>Cefaclor (Ceclor®)</td>
<td>Reserved for use after failure of first line antibiotic (see amoxicillin tr/potassium clavulanate).</td>
</tr>
<tr>
<td>Cefdinir (Omnicef®)</td>
<td>Restricted to use after failure of first line antibiotic therapy.</td>
</tr>
<tr>
<td>Cefixime (Suprax®)</td>
<td>Suspension - Restricted to use after failure of first line antibiotic therapy. Tablet – reserved for the treatment of STDs</td>
</tr>
<tr>
<td>Ceftibuten (Cedax®)</td>
<td>Restricted to use after failure of first line antibiotic therapy.</td>
</tr>
<tr>
<td>Desmopressin (DDAVP®)</td>
<td>Restricted to use in the management of primary nocturnal enuresis.</td>
</tr>
<tr>
<td>Misoprostol (Cytotec®)</td>
<td>Restricted to use as adjunct therapy with Mifepristone (Mifeprex) as abortifacient. Limit 2 (200mcg) tablets; reserved for use as adjunct therapy only, concurrent NSAID required.</td>
</tr>
<tr>
<td>Morphine Sulfate (MS Contin®)</td>
<td>Restricted to use in the treatment of cancer and palliative pain control.</td>
</tr>
<tr>
<td>Olopatadine HCL (Patanol®)</td>
<td>Restricted to use after first line therapy failure or prescribed by an ophthalmologist or optometrist (first line therapy include Naphcon-A, Opcon-A, Vasocon-A, and Crolom).</td>
</tr>
<tr>
<td>Paromomycin (Humatin®)</td>
<td>Restricted to use in acute and chronic intestinal amebiasis.</td>
</tr>
<tr>
<td>Rifabutin (Mycobutin®)</td>
<td>Restricted to use in the prevention of disseminated Mycobacterium Avium Complex (MAC) disease in patients with advanced HIV infection.</td>
</tr>
<tr>
<td>Tretinoin (Retin-A®)</td>
<td>Restricted to use in the treatment of acne vulgaris.</td>
</tr>
</tbody>
</table>
## Inland Empire Health Plan
### Pharmacy Reimbursement Request

### Section 1: Member Information

<table>
<thead>
<tr>
<th>Member Last Name</th>
<th>First Name</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member ID</td>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Street address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 2: Type of claim

- Medical
- Vaccine only
- Injection
- Prescription
- Vaccine and injection
- Injection

### Section 3: Instructions

Submit this claim form, a copy of the receipt and Pharmacy print out to IEHP.

### Section 4: Required information for claim process

Your claim receipt/Pharmacy print out must contain the following information in order to be processed for payment. If below the information is not received, your claim cannot be processed and will be denied for missing information.

- Pharmacy name, address, phone
- Medication quantity
- Medication name, strength and form
- Total amount paid for medication
- Date of service (must be within 1 year)
- National Drug Code (NDC)
- Prescriber full name

### Section 5: Reason for request

### Section 6: Signature

The above statements and attachments are true and complete to the best of my knowledge.

X ____________________________    ____________________________

Signature                                                                                   Date

Claim submission is not a guarantee of payment. Non-Formulary medications are subject to prior authorization. Claim must be submitted within 1 year from the Date of Service.

**Claim Mailing Address:**
IEHP Member Services Department  
P.O. Box 1800  
Rancho Cucamonga  
CA 91729-1800

**Questions?**
Call IEHP Member Services:
1-800-440-IEHP (4347)  
8:00a.m.-8:00p.m. (PST)  
TTY/TDD users should call 1-800-718-4347

**Legal Notice:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties.
**Prescription Drug Prior Authorization Request Form**

**Plan/Medical Group Name:** Inland Empire Health Plan  
**Plan/Medical Group Phone#:** (888) 860-1297  
**Plan/Medical Group Fax#:** (909) 890-2058

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g., chart notes or lab data, to support the prior authorization request.

### Patient Information

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>Mi:</th>
<th>Phone Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

Date of Birth:  
- [ ] Male  
- [ ] Female  
Circle unit of measure:  
- Height (in/cm): _______  
- Weight (lb/kg): _______

Allergies: 

Patient’s Authorized Representative (if applicable):  
Authorized Representative Phone Number: ________

### Insurance Information

<table>
<thead>
<tr>
<th>Primary Insurance Name:</th>
<th>Patient ID Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Secondary Insurance Name:</th>
<th>Patient ID Number:</th>
</tr>
</thead>
</table>

### Prescriber Information

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>Specialty:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

Requestor (if different than prescriber):  
Office Contact Person: ________

NPI Number (individual):  
Phone Number: ________

DEA Number (if required):  
Fax Number (in HIPAA compliant area): ________

Email Address: ________

### Medication / Medical and Dispensing Information

Medication Name: ________

- [ ] New Therapy  
- [ ] Renewal  
If Renewal: Date Therapy Initiated: ________  
Duration of Therapy (specific dates): ________

How did the patient receive the medication?  
- [ ] Paid under Insurance Name: ________  
Prior Auth Number (if known): ________  
- [ ] Other (explain): ________

<table>
<thead>
<tr>
<th>Dose/Strength:</th>
<th>Frequency:</th>
<th>Length of Therapy/#Refills:</th>
<th>Quantity:</th>
</tr>
</thead>
</table>

Administration:  
- [ ] Oral/SL  
- [ ] Topical  
- [ ] Injection  
- [ ] IV  
- [ ] Other: ________

Administration Location:  
- [ ] Patient’s Home  
- [ ] Long Term Care  
- [ ] Home Care Agency  
- [ ] Other (explain): ________

- [ ] Physician’s Office  
- [ ] Home Care Agency  
- [ ] Other (explain): ________

- [ ] Ambulatory Infusion Center  
- [ ] Outpatient Hospital Care  
- [ ] Other (explain): ________

Pharmacy Name: ____________________________  
Pharmacy NPI: ____________________________  
Phone Number: ____________________________  
Fax Number: ____________________________

*For Pharmacy Use ONLY*
**PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM**

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. **Has the patient tried any other medications for this condition?**
   - ☐ YES (if yes, complete below)
   - ☐ NO

<table>
<thead>
<tr>
<th>Medication/Therapy</th>
<th>Duration of Therapy</th>
<th>Response/Reason for Failure/Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Specify Drug Name and Dosage)</td>
<td>(Specify Dates)</td>
<td></td>
</tr>
</tbody>
</table>

2. **List Diagnoses:**

<table>
<thead>
<tr>
<th>ICD-9/ICD-10:</th>
</tr>
</thead>
</table>

3. **Required clinical information - Please provide all relevant clinical information to support a prior authorization review.**

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

---

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** ____________________________ **Date:** ____________________________

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**Plan Use Only:**

- ☐ Approved
- ☐ Denied

**Comments/Information Requested:** ____________________________

---

**Pharmacy Name:** ________________________________________

**Pharmacy NPI:** ________________________________________

**Phone Number:** ________________________________________

**Fax Number:** ________________________________________

*For Pharmacy Use ONLY*
REQUEST FOR ADDITION OR DELETION
OF A DRUG TO THE FORMULARY

GENERIC NAME: ______________________  BRAND NAME: ______________________

MANUFACTURER(S): ______________________

DOSAGE FORM: ______________________

Pharmacological Classification: ______________________

Indications: ______________________

What similar drugs are currently available? ______________________

What therapeutic advantage(s) does this drug have over the standard drug therapy? ______________________

In how many patients do you expect this drug to be used during the next six months? ______________________

What drug(s) currently used for this/these indications(s) may be deleted if this product is added to the formulary? ______________________

Should use of this drug be restricted to certain physicians or institutions because of the potential for misuse, high cost, or toxicity? ______________________

REQUESTER’S NAME: ______________________

ADDRESS & TELEPHONE: ______________________

SIGNATURE OF REQUESTER: ______________________  DATE: ______________________