11. PHARMACY

A. Formulary Management

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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. Pursuant to California Health and Safety Code Section 1374.72, medication(s) used in the treatment of “severe mental illness” diagnosis that are not otherwise specifically carved out to Medi-Cal Fee-For-Service, will be represented on IEHP’s formulary as a “non-capitated drug”.

D. 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.

E. 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.

F. 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.

G. 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.

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.

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.
11. PHARMACY

A. Formulary Management

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

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

N. 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.

O. 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.

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 (Health Plan), Medical Director (Direct) seven clinical pharmacists (representative of the overall IEHP network) and seven practicing physicians (representative of the overall IEHP network) as voting members. The IEHP staff includes the Director of Quality Management, 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;

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;
11. PHARMACY

A. Formulary Management

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,
   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.
11. PHARMACY

A. Formulary Management

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 (http://ww2.iehp.org/IEHP/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.

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INLAND EMPIRE HEALTH PLAN

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IEHP Provider Policy and Procedure Manual

Medi-Cal 07/15 MC_11A.4
11. PHARMACY

B. Prior Authorization For Non-Formulary Medications

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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 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 year from the date of service.

G. Unless specifically noted differently on the PA form, all approvals expire after one 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.
   3. Branded drugs, when generic are available. Exceptions are:
11. PHARMACY

B. Prior Authorization For Non-Formulary Medications

a. Carbamazepine (Tegretol)
b. Digoxin (Lanoxin)
c. Levothyroxine (Levothroid, Synthroid)
d. Phenytoin (Dilantin)
e. Valproic Acid/Divalproex Sodium (Depakene/Depakote)
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.

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.
11. PHARMACY

B. Prior Authorization For Non-Formulary Medications

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 documents the information for logging into the database.

L. After business hours, on weekends, and holidays, pharmacy providers should dispense up to a 3-day supply of formulary and non-formulary medication to IEHP Members when medically necessary. IEHP reimburses pharmacies for any doses dispensed even in the event of a denial of the PA request.

M. 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.
11. PHARMACY

C. Medication Handling Requirements at PCP Sites

APPLIES TO:

A. This policy applies to all Primary Care Physicians who treat IEHP Medi-Cal 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 Primary Care Physician (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 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). Daily temperature logs for freezer and refrigerator must be maintained.

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

K. 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.

L. 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.”
11. PHARMACY

   D. Code 1 Medications

**APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal 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, 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 PA form. Refer to Policy 11B, “Prior Authorization for Non-Formulary Medications.”

F. IEHP reviews Code 1 status of specific medications as needed at Pharmacy and
11. PHARMACY

D. Code 1 Medications

Therapeutics Subcommittee meetings.
11. PHARMACY

E. Physician Profiling Program

APPLIES TO:
A. This policy applies to physicians who treat IEHP Medi-Cal 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 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 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…  % Generic Rxs
   Top 10% in terms of…  % Code 1 Drugs
   % DEA Controlled Rxs
   % Prior Authorization Rxs
   Top 10% in terms of…  % 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.
H. IEHP reinforces the visits by mailing printed materials to providers after each academic detailing.
11. PHARMACY

E. Physician Profiling Program

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11. PHARMACY

F. Pharmacy Reports

**APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal Members.

**POLICY:**

A. IEHP reviews specific pharmacy reports on a monthly basis.
B. The purpose of these reports is to identify high-risk IEHP patients through pharmacy data.
C. IEHP Clinical Pharmacist contacts Members identified through the pharmacy reports and perform clinical intervention. Clinical intervention includes consultation, evaluation, and communications with the Members and/or Providers.

**PROCEDURES:**

A. Pharmacy reports include:
   1. Max dose reports;
   2. Members who use 3 or more pharmacies;
   3. Members who use 3 or more physicians;
   4. Members who obtain same therapy from 3 or more pharmacies/physicians; and
   5. Therapeutic duplication reports on all major therapeutic classes
B. Medication Therapy Management report includes:
   1. Members who use 5 or more chronic medications, including anti-diabetics, anti-convulsants, cardiac, anti-hypertensives, anti-asthmatics, and biologics.
C. All reports include patient’s last and first name, IEHP ID number, gender, date of birth, physician California license number, medication brand name, dosage form, drug strength, service date and quantity.

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11. PHARMACY

G. Emergency Department and Hospital Inpatient Discharge Medication Requirement

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal 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.
B. Discharge medications (starter pack) may be provided by the Hospital or ED, or be accessed in one of the 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 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 of 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 24 hours pharmacy geo-access report bi-annually to ensure coverage is adequate.
G. The 24-hour nurse advice line provides 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 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 24-hour pharmacy coverage around the contracted hospitals and EDs.

1. The standard is a 24-hour pharmacy within 10 miles of all hospitals.
11. PHARMACY

G. Emergency Department and Hospital Inpatient Discharge Medication Requirement

2. The Geo-Access Report and list of 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 or other 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; or medication is necessary to prevent patient from being a danger to self or others, etc.

G. Pharmacies can submit an emergency 72 hour supply claim without a prompt by the doctor. However it is helpful if the prescriber requests the 72 hours medication in addition to submitting the PA – as a reminder to the pharmacy.
11. PHARMACY

G. Emergency Department and Hospital Inpatient Discharge Medication Requirement

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Medi-Cal
11. PHARMACY

H. Insulin Administration Devices and Diabetes Testing Supplies

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal 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).
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.

PROCEDURE:
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

H. Insulin Administration Devices and Diabetes Testing Supplies
I. Member Request for Pharmacy Reimbursement

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal 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 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 30 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.

INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on file
Original Effective Date: January 1, 2012
Chief Title: Chief Medical Officer
Revision Date: July 1, 2015
11. PHARMACY

J. 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 years.
E. Contracted Pharmacies must update all credential information on the IEHP Pharmacy Exception Request Tool on a biannual basis.

PROCEDURE:
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. 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. NABP number/NPI number;
   4. Name of the Pharmacy owner;
   5. Names and state license numbers for all staff pharmacists and pharmacy
11. PHARMACY

J. Pharmacy Credentialing and Re-Credentialing

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 years. The PBM must notify IEHP when a pharmacy is terminated from the network (voluntarily or involuntarily) within 60 days after termination.

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

---

INLAND EMPIRE HEALTH PLAN

<table>
<thead>
<tr>
<th>Chief Approval:</th>
<th>Signature on file</th>
<th>Original Effective Date:</th>
<th>July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Title:</td>
<td>Chief Medical Officer</td>
<td>Revision Date:</td>
<td></td>
</tr>
</tbody>
</table>
## 11. PHARMACY

### Attachments

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code 1 Medications</td>
<td>11D</td>
</tr>
<tr>
<td>Member Request for Pharmacy Reimbursement</td>
<td>11I</td>
</tr>
<tr>
<td>Prescription Drug Prior Authorization Request Form</td>
<td>11H</td>
</tr>
<tr>
<td>Request for Addition or Deletion of a Drug to the Formulary</td>
<td>2E, 11A</td>
</tr>
</tbody>
</table>
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 indication(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: ____________________
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: This must be filled out completely to ensure HIPAA compliance

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>MI:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address:  
City:  
State:  
Zip Code:  

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

Primary Insurance Name:  
Patient ID Number:  

Secondary Insurance Name:  
Patient ID Number:  

Prescriber Information

First Name:  
Last Name:  
Specialty:  

Address:  
City:  
State:  
Zip Code:  

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):  

Dose/Strength:  
Frequency:  
Length of Therapy/#Refills:  
Quantity:  

Administration:  
☐ Oral/SL  
☐ Topical  
☐ Injection  
☐ IV  
☐ Other:  

Administration Location:  
☐ Patient’s Home  
☐ Long Term Care  
☐ Home Care Agency  
☐ Other (explain):  

☐ Physician’s Office  
☐ Ambulatory Infusion Center  
☐ Outpatient Hospital Care

Pharmacy Name:  
Pharmacy NPI:  
Pharmacy 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.

<table>
<thead>
<tr>
<th>1. Has the patient tried any other medications for this condition?</th>
<th>☐ YES (if yes, complete below)</th>
<th>☐ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication/Therapy</strong>&lt;br&gt;(Specify Drug Name and Dosage)</td>
<td><strong>Duration of Therapy</strong>&lt;br&gt;(Specify Dates)</td>
<td><strong>Response/Reason for Failure/Allergy</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. List Diagnoses:</th>
<th>ICD-9/ICD-10:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.</th>
<th></th>
</tr>
</thead>
</table>

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:** ___________________________

**New 08/13**

**Form 61-211**
## 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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Section 2: Type of claim

- Medical
- Prescription
- Vaccine only
- 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.