Clinical Pharmacy Services An Overview



Agenda

- Introduction- Highmark pharmacist contacts
- GREEN Formulary
- Formulary Options
- Formulary- status and restrictions
- Drug management, Medco/Highmark
- NaviNet Prescription Drug Authorization Submission
- NaviNet denial example
- Questions

Clinical Pharmacy Specialists

Highmark Pharmacy Contacts

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GREEN Formulary Access

<u>http://mydrug.formularies.com</u>

 Provider communication will be mailed in September 2010 directing them to this web site

www.epocrates.com

- Planned for 2011, currently unavailable for Mountain State providers
- e-Rx technology

Formulary Options (Commercial)

<u>Closed</u> – Non-formulary drugs are not covered under the plan
 Currently not a Mountain State plan option

• <u>Open</u> – Generic / Brand-all drugs are covered

- Generic co-insurance / co-payment ex. \$15
- Brand co-insurance / co-payment is higher than generic ex. \$25
- <u>Select / Tiered / Incentive</u> Uses copayment tiers to drive product selection
 - Generics are on the lowest copayment tier ex. \$15
 - Formulary brands are on the middle copayment tier ex. \$25
 - Non-formulary / non-preferred brands are on the highest copayment tier ex. \$50

http://mydrug.formularies.com



Results of Search

Please select a drug from the list below to continue.

- Emular Diovan 160 mg Tab
- Emulay Diovan 320 mg Tab
- Formulary Diovan 40 mg Tab
 - Formulary Diovan 80 mg Tab
- Diovan HCT 160 mg-12.5 mg Tab
- Diovan HCT 160 mg-25 mg Tab
- Diovan HCT 320 mg-12.5 mg Tab
- Diovan HCT 320 mg-25 mg Tab
- Diovan HCT 80 mg-12.5 mg Tab

Example of Formulary Status without Restrictions

1 drug(s) found To view other medications in a therapeutic class, click any class hyperlink in your search results.

Brand Name Generic Name	Therapeutic Class Sub-class	Dose/Strength	Status	Notes & Restrictions
Diovan 80 mg Tab	<u>ANTIHYPERTENSIVE THERAPY</u> <u>ANGIOTENSIN II RECEPTOR</u> <u>BLOCKERS & RENIN INHIBITORS</u>	TABLET 80 MG	F Formulary	



Formulary Status



Formulary Generic Drug⁻ Generic drug covered at generic co-pay



Formulary Brand Drug- Formulary brand drug covered at preferred brand co-pay. If a generic equivalent is available for the formulary brand, then the member may also be responsible for the cost difference between the brand and generic products in addition to their formulary brand co-pay.



Non-formulary Drug- Non-Preferred Non-formulary drugs are not covered for members with a closed formulary. A request for coverage may be submitted by the prescribing physician for members who have tried preferred formulary alternatives. *Members with open or incentive formularies have coverage for non-formulary drugs at the appropriate co-pay/coinsurance based on benefit design.*

Example of Non-Formulary / Non-Preferred Drug



Brand Name <i>Generic Name</i>	Therapeutic Class Sub-class	Dose/Strength	Status	Notes & Restrictions
Crestor 10 mg Tab	CARDIOVASCULAR DRUGS LIPID/CHOLESTEROL LOWERING AGENTS	TABLET 10 MG	NF Non- Formulary	

- Closed- drug not covered
 - Mountain state has no closed option for members
- Open- drug covered at brand co-pay
- Tiered / Incentive- drug covered at highest non-preferred tier

Example of Formulary Status with Restrictions



Drug Search: celebrex 100 mg cap 1 drug(s) found

Brand Name Generic Name	Therapeutic Class Sub-class	Dose/Strength	Status	Notes & Restrictions
Celebrex 100 mg Cap	ANALGESICS COX-2 INHIBITORS	CAPSULE 100 MG	F Formulary	PA Prior Auth



Request for prior authorization <u>must be</u> <u>submitted</u> via NaviNet

Formulary Restrictions



Member Note- Click the Member Note icon next to the drug name for more details.



Prior Authorization- Coverage of this drug is subject to review by the plan and is based on Pharmacy policy



Quality Limits- Limits the amount of drug that a beneficiary may receive in a certain period. Click the Quantity Limit icon next to the drug name for more details.



How to Access Drug Management Criteria



Mountain State web site



Provider resource center – Abbreviated criteria for PA

Example of Management Criteria



Prior authorization requests will be approved if members meet the following criteria:

- Abilify is being prescribed as adjunctive treatment of major depressive disorder in adults (> 18 years old) *AND*
 - The member has tried and failed at least 1 other agent used for treatment of major depressive disorder *OR*
- The member has a diagnosis of schizophrenia OR
- The member has a diagnosis of bipolar disorder OR
 - The member has a diagnosis of autism spectrum disorder.

Who Does What???



- ulletdrug authorization requests
- Current and future MS igodolclaims processor



Currently managing MS • 1/1/11 will manage MS drug authorization requests

NaviNet

- Secure tool
- Reduces faxing, decreases costs, improves efficiency
- Improves decision communication time to providers.

Path of a 🔛 Prior Authorization Submission



- Pharmacy care management representative accesses the request, prepares it for pharmacist review
- Pharmacist reviews and decision is made
- Approvals are then loaded into the system, RX can be filled for the member at the pharmacy
- Denials go to a Highmark Medical Director (physician) for review and final decision
- If denied, prescribing physician and member are notified in a timely manner

The NaviNet Help Desk 1-888-482-8057

When a user pulls up the NaviNet website they are taken to the NaviNet login page. Each user has their own user name and password for NaviNet. This page contains verbiage owned by NaviMedix and is displayed to all of their user's.



After a user logs in they are taken to Plan Central. The user will have transaction buttons to the left and verbiage owned by Highmark that can be changed on demand. To get to the Prescription Drug workflow the user hovers on Authorization Submission and clicks on the Auth Submission flyout.

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Allowance >	
Procedure Code Inquiry Important Announcements	
Network Provider Inquiry	
Network Facility Inquiry New Funding Source Available to Help Physicians Implement Electronic Prescription Systems:	_
Provider File Management > eligible physicians in the 49 counties of western and central Pennsylvania obtain the latest health information	
Report Inquiry technology for the practice setting. <u>Click here</u> for more information.	
AR Management > Western Region Provider Network Changing for FEP, Effective Jan. 1, 2006: In western Pennsylvania,	
BlueExchange™ (Out-of-Area) > the Federal Employee Program (FEP) PPO product currently utilizes the PremierBlue Shield professional network. Effective with dates of service on or after Jan. 1, 2006, the FEP network will change to Keystone	
Resource Center Health Plan West (KHPW). This change in western Pennsylvania is being made at the request of the FEP	
Blues on Call (sm) program administrators. (Note: PremierBlue Shield will remain the professional network for FEP throughout the remainder of Pennsylvania.)	
Claims Dashboard	
QualityBLDE A special built outlining this charge was indired to KHYW and Premerblue shead providers in western Pennsylvania. Click here to read a copy of this important Special Bulletin.	
Medic Rescue a Participating Ambulance Provider, Effective Nov. 1, 2005: Effective Nov.1, 2005,	
Medic Rescue joins TransCare and Medical Transport Alliance (MTA) as a Highmark participating ambulance provider. View the most current listing of participating ambulance providers via <i>Administrative Reference</i>	
Materials on the Provider Resource Center (see link at left).	
Attention Practitioners in Cambria and Somerset Counties: Provider Relations Representative	
Territory Changes Announced: Network practitioners who are located in Cambria and Somerset counties	~
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The user is taken to the Selection Form where they must choose a referring practitioner, enter a proposed date of service, enter the member info and choose prescription drug from the category drop down (all required fields are cyan blue or present a message to the user).



The user is take to the request form to enter diagnosis, requested drug and medical rationale information. The user also has the option to look the the member's formulary and do a drug name search from this page. Once the user submits from this page data cannot be changed.

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	Request Form	
Patient Information:		
Patient Last Name	Patient First Name:	
Product	Line of Business:	
Group #	PCP:	
Member ID #		
Service Details:		
Proposed Date of Service: 12/12/2007	est	
Diagnosis Codes:		
You may enter or search for up to 3 diagnosis codes. T	Fo add an additional diagnosis code, click the "Add Diagnosis Code" button.	
Diagnosis Code: Optional Search	Description:	
Add Diagnosis Code		
For more information about the Highmark formulary, or to find more information about a particular drug or class of drugs, click here to view the Highmark Medicare Formulary in a new window.		
Additional Information:		
Please enter additional information about the service re	equest in the fields below.	
Requested Drug:		
Submit Save		
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Requested and Alternative Drug info.



The prescription drug search is a contains within search.

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		Select
AMITRIPTYLINE/PERPHENAZINE		Select
AVENTYL		Select
BENTYL		Select
FREESTYLE		Select
FREESTYLE TEST STRIPS		Select
NORTRIPTYLINE		Select
NORTRIPTYLINE HCL		Select
PERPHENAZINE/AMITRIPTYLINE		Select
PRONESTYL		Select
PROTRIPTYLINE		Select
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Contact info and Medical rationale.

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Medical Rationale/Reason for Drug Therapy/Tr	reatment Plan:	
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The Response Form is the last page of the transaction (the receipt of what was entered). At this point no changes to the request can be made by the user.



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Referred From Provider Information: Billing Provider Name: Address: Service Provider: ANDERGON, JAMEE Contact Name: sue Fax Number: 444-222-5555	
Comments:	
Medical Rationale/Reason for Drug Therapy/Treatment Plan:	
This is where the additional medical is listed.	
An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.	=
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NaviNet



Denial Example

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Member ID Number: Patient Name: Product Name:	Patient Date of Birth: Gender: Group Name:
Referral/Authorization Number: D023640216	Date of Service/Admit Date: 01/13/2010
Referral/Authorization Status: DENIED	Last Covered Date:
Referral/Authorization Reason:	Discharge Date:
	Enter Date. 01/13/2010
Primary Diagnosis Code: 733.01 SENILE OSTEOPOROSIS Secondary Diagnosis Code: Tertiary Diagnosis Code:	Number of Visits/Days: 0
Services Description:	
DIAGNOSIS CODE: 733.01 DIAGNOSIS DESCRIPTION: SENILE OSTEOPOROSIC HOSPITAL/ FACILITY STAY: CONTACT NAME: M HOSPITAL/ FACILITY STAY: CONTACT PHONE # DRUG PRIOR AUTH DRUG NAME: BONIVA	
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Wrap Up

- As of 1/1/11 Highmark will be managing MS drug benefit
- Drug formulary can be accessed via
 <u>http://mydrug.formularies.com</u>
- Non-formulary = Non-preferred
- Prior authorization requests must be submitted to Highmark via NaviNet

Questions???

