11. PHARMACY

A. Formulary Management

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare Medicaid Plan)~~ Members.

POLICY:

A. IEHP ensures that the IEHP DualChoice Formulary is reviewed and updated no less than annually, is adequate, and includes a range of drugs in a broad distribution of therapeutic categories and classes that does not substantially discourage enrollment by any group of beneficiaries.[1]

PROCEDURES:

Formulary Management

A. Formulary management decisions are based on scientific evidence and may also be based on pharmacoeconomic considerations that achieve appropriate, safe, and cost-effective drug therapy.[2] 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, and 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 drug administration requirements;
9. Cost comparisons against other drugs available to treat the same medical condition(s);
10. Pharmacoeconomic data; and

[1] Medicare Prescription Drug Benefit Manual, "Chapter 6 - Part D Drugs and Formulary Requirements," Section 30.1.5
[2] ~~Ibid.~~

11. Strength of scientific evidence and standards of practice (assessing peer-reviewed medical literature, pharmacoeconomic studies, outcome research data, and other such information as it determines appropriate).

B. Formulary includes all or substantially all drugs in the immunosuppressant (for prophylaxis of organ transplant rejection), antidepressant, antipsychotic, anticonvulsant, antiretroviral, and antineoplastic classes. "Substantially all" in this context means that all drugs and unique dosage forms in these categories are expected to be included in ~~sponsor~~ the ~~formularies~~formulary, with the following exceptions:[3]

1. Multi-source brands of the identical molecular structure;
2. Extended release products when the immediate-release product is included;
3. Products that have the same active ingredient or moiety; and
4. Dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals).

C. In cases where generic (multi-source) drugs become available and the cost is comparable to similar Formulary drugs within the same class (plus or minus 10%), IEHP Clinical Pharmaceutical Services staff may approve the drug to be added to the IEHP Formulary. The following ~~policy and procedure~~process will be followed:

1. A generic drug that is cost neutral when comparing to another Formulary agent in the same class;
2. The drug was not voted off the Formulary previously because of drug safety concerns; and
3. The added generic drug will be reported back to the next Pharmacy and Therapeutics (P&T) Subcommittee meeting.

~~D. The following Centers for Medicare and Medicaid Services (CMS) excluded drugs may be covered under the IEHP DualChoice expanded formulary:~~

~~5. Over-the-Counter Drugs;~~

~~6. Drugs to treat anorexia;~~

~~7. Weight loss agents;~~

~~8. Agents that are used for the symptomatic relief of cough and cold; and~~

~~9. Prescription vitamins and mineral products (except prenatal vitamins and fluoride).~~

~~J.~~D. In case of a Formulary change, IEHP submits the Formulary file to CMS for approval. IEHP also provides direct written notice to affected Members at least thirty (30) days prior to the effective date of the change; or may provide the Members with a month's supply of the drugs

[3] Medicare Prescription Drug Benefit Manual, "Chapter 6 - Part D Drugs and Formulary Requirements," Section 30.1.5

under the same term as previously allowed and provide written notice of the Formulary change ~~(See Attachments, "Notice of Formulary Change – English" and "Notice of Formulary Change – Spanish" in Section 11)~~. The written notice shall contain the following information:[4]

1. The name of the affected covered Part D Drug;
2. Describe the change of the Formulary status;
3. The reason for the change;
4. Alternative drugs in the same therapeutic category or class; and
5. The means by which Members may obtain a Coverage Determination or exception.

~~K.~~E. CMS may permit to account for new therapeutic uses and newly approved Part D drugs. IEHP shall not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year.[5,6]

~~L.~~F. Except when the FDA deems a Part D drug unsafe or manufacturer removes a Part D drug from the market, IEHP shall not make any changes in the preferred or tiered cost-sharing status, nor remove a drug from the Formulary between the beginning of the annual coordinated election period and the end of the contract year.[7]

~~M.~~G. IEHP notifies its Providers in writing about the Formulary additions, deletions, and modifications to policies and procedures.[8] Monthly Formulary updates are posted online on the IEHP Provider website at www.iehp.org.

~~N.~~H. Requests for Formulary additions should be submitted in writing to the IEHP Pharmaceutical Services Staff for placement on the agenda for the next P&T Subcommittee meeting (see Attachment, "Request for Addition or Deletion of a Drug to the Formulary" in Section 11).

~~O.~~I. To ensure accuracy of claims adjudication and benefit logics (i.e. transition logics) at Point-Of-Sales (POS), IEHP conducts daily claims rejection review. The rejection review identifies any discrepancies or outliers by comparing CMS-approved formulary submission, patients' enrollment status, claims submission condition and submitted claims information. All discrepancies shall be addressed immediately to minimize impact on Members.

Pharmacy and Therapeutics (P&T) Subcommittee

A. On at least an annual basis, the IEHP P&T Subcommittee reviews for clinical appropriateness the practices and policies ~~for~~of- formulary management activities, such as prior authorizations,

[4] Title 42, CFR §423.120(b)(5)
[5] Title 42, CFR §423.120(b)(4)
[6] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.3.1
[7] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.3.2
[8] ~~Title 42, CFR, §423.120(b)(7)~~

step therapies, quantity limitations, generic substitutions, and other drug utilization activities that affect access.[9] For more information on the role and function of the P&T Subcommittee, please see Policy 2E, "Pharmacy and Therapeutics Subcommittee."

B. The P&T Subcommittee meets quarterly or more frequently to update the Formulary by reviewing:

1. Medical literature including clinical trials;
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 or new guidelines;
5. IEHP Provider and Practitioner recommendations for addition or deletion of drugs to the Formulary; and
6. The top ten (10) therapeutic classes and top ten (10) medications that were submitted for prior authorization. IEHP P&T Subcommittee determines if any of the medications or criteria need modifications to improve access, quality and safety of pharmaceutical care.

C. The P&T Subcommittee makes reasonable efforts to review a new drug product or indication approved by the United States Food and Drug Administration (FDA) within ninety (90) days of its release onto the market and decides within one hundred eighty (180) days of its release onto the market, or a clinical justification will be provided if this timeframe is not met.[10]

Formulary Distribution

A. The IEHP Formulary and Treatment Guide, which includes Formulary status and benefit limitations, is available on the IEHP website. A printed version is available to Members and Providers upon request. The IEHP Formulary and Treatment Guide is published in a booklet format annually and mailed to Providers.

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

C. All new IEHP Providers and pharmacists are informed, as part of their orientation materials, that Formulary information is posted online on the IEHP Provider website.[11] Current Providers are notified annually through written communication of online Formulary information and are notified of updates quarterly ~~by~~ via fax following each P&T Subcommittee meeting. Providers can access all Provider communications online at the IEHP website at www.iehp.org.

[9] Ibid.
[10] Medicare Prescription Drug Benefit Manual, "Chapter 6 - Part D Drugs and Formulary Requirements," Section 30.2.5
[11] Ibid.

D. On an annual basis, IEHP notifies the Members regarding the Formulary update schedule through the Member Newsletter. Members also annually receive the Member Handbook providing them instructions to access the IEHP Website to view IEHP's latest Formulary benefits.[12]

[12] Medicare Prescription Drug Benefit Manual, "Chapter 6 - Part D Drugs and Formulary Requirements," Section 30.2.5

11. PHARMACY

A. Formulary Management

~~D.~~

11. PHARMACY

A. Formulary Management

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

11. PHARMACY

B. Coverage Determination

APPLIES TO:

~~B.~~A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

~~B.~~A. IEHP maintains procedures for making timely Coverage Determinations (CD), including requests for exceptions to the~~a~~ formulary, and addressing grievances and appeals that involve coverage determinations.[1]

DEFINITIONS:

~~B.~~A. Coverage Determination (CD) - Any decision made by or on behalf of IEHP with regards the following:[2]

1. A decision not to provide or pay for a Part D drug that is:
    a. Not on the IEHP DualChoice formulary;
    b. Determined not to be medically necessary;
    c. Furnished by an out-of-network pharmacy; or
    d. Otherwise excluded under Section 1862 (a) of the Social Security Act, if applied to Medicare Part D.[3]
2. A decision to provide a CD in an expedited manner, when a delay would adversely affect the health of the Member;
3. Whether a Member has or has not satisfied a prior authorization or other utilization management; or
4. A decision about a formulary exception request.

~~C.~~B. Exception request – A request to obtain a Part D drug that is not included in the IEHP DualChoice formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug.[4]

[1] Title 42 Code of Federal Regulations (CFR) § 423.562
[2] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.2
[3] Social Security Act Section § 1862
[4] https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Exceptions

PROCEDURES:

Coverage Determination Requests

A. The following individuals may request a standard or expedited CD:[5]

1. A Member;
2. A Member's appointed representative on behalf of the Member (See Attachments, "Appointment of Representative – CMS Form 1696" –in threshold languages~~English~~);~~"~~ ~~and "Appointment of Representative – CMS Form 1696 – Spanish" in Section 11);~~ or
3. A prescribing Physician or other prescriber on behalf of the Member.

B. IEHP supplies all Providers with the CD Forms in threshold languages ~~(~~See Attachment~~s~~, "Coverage Determination - Provider & Member" ~~– English" and "Coverage Determination – Provider & Member – Spanish"~~ in Section 11) and instructions for their use. Forms may also be accessed through the website at www.iehp.org. CD and Exception requests may be submitted verbally or in writing, using the Coverage Determination or another form:[6]7

1. A Member or their appointed representative may contact IEHP Member Services Department at (877) 273-IEHP (4347)/TTY (800) 718-4347 during normal business hours (8:00 a.m. to 8:00 p.m. Monday through Friday). The Member or their representative may leave a secure voice message after-hours.
2. A prescribing Physician or other prescriber may submit a CD or Exception request by phone at (909) 890-2049 or (888) 860-1297, by mail to IEHP at P.O. Box 1800, Rancho Cucamonga, CA 91729, through the secure IEHP Provider portal, or by fax to IEHP Pharmaceutical Services at (909) 890-2058. The prescribing Physician or other prescriber may leave a secure voice message after-hours. The Provider will be instructed by the voicemail message to provide all necessary information (~~e.g.~~e.g., Provider identification, Member identification, type of request and whether it is expedited or standard).

C. When a medication with prior authorization (PA) requirements is requested through the point-of-sale system, a message is transmitted to the Pharmacy indicating that the drug is not covered. The pharmacy should notify the Member, the Member's appointed representative, the prescribing Physician or other prescriber to request a CD.[8]

[5] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.6

[6] ~~Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Section 2.12~~

[7] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.7

[8] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.2

D. Requests for cash reimbursements are considered ~~as~~ CD requests. The request may be made up to one (1) year from the date of service. See Policy 11P, "Member Request for Pharmacy Reimbursement" for more information.

E. All CD requests must provide information that support the medical necessity or meet the criteria for prior authorization, as well as previous successful or failed therapies, any allergies, or any other clinical condition when applicable.

F. For information on review of drugs for inclusion and changes to the formulary, please see Policy 11A, "Formulary Management."

Exception Requests

A. A prescribing Physician or other prescriber must provide a supporting statement that the requested prescription drug is medically necessary to treat the Member's disease or medical condition for the reasons listed below. If the supporting statement is provided orally, IEHP may require the prescribing Physician or other prescriber to subsequently provide a written supporting statement.[9]

1. All the covered Part D drugs on IEHP's formulary for treatment for the same condition would not be as effective for the Member as the non-formulary drug, or could have adverse effects for the Member, or both;

2. The number of doses available under a dose restriction for the requested drug has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the Member, and known characteristics of the regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and medical scientific evidence, the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

B. IEHP may apply quantity limits on non-formulary drugs approved through the Exception request process that are based on safety-concerns. The Centers for Medicare and Medicaid Services (CMS) permits the following safety-based quantity limits:[10]

1. Quantity limits based on maximum dosing limits, frequency and/or duration of therapy supported by the United States Food and Drug Administration;

[9] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.5.3

[10] Health Plan Management System (HPMS) Memo, "Use of Safety-Based Quantity Limits on Approved Non-Formulary Drugs," March 12, 2019

2. Quantity limits on topical products in consideration of indication, directions for use, and size of the area being treated; and
3. Quantity limits that support dose optimization that ~~is~~ are intended to promote adherence and ensure safe and appropriate utilization.

Coverage Determination Timeframes

A. Standard CD Requests:[11]

1. Requests for drug benefits:
   a. IEHP notifies the Member, the Member's appointed representative and the prescribing Physician or other prescriber as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours (including weekends and holidays) after receipt of the request.
   b. For Exception requests, IEHP notifies the Member, the Member's representative and the prescribing Physician or other prescriber within seventy-two (72) hours (including weekends and holidays) after receipt of the Physician's supporting statement or fourteen (14) calendar days after receipt of the request, whichever occurs first.[12]
2. Requests for Member reimbursement: Please see Policy 11M, "Member Request for Pharmacy Reimbursement" for more information, including processing timeframes.

B. Expedited CD Requests:[13]

1. IEHP will expedite a CD, as requested by the Member or the Member's appointed representative, if the health plan determines that applying the standard timeframe may seriously jeopardize the Member's life, health, or ability to regain maximum function.
2. IEHP will expedite a CD if the request is made or supported by a Physician, prescribing Physician, or other prescriber who indicates applying the standard timeframe may seriously jeopardize the Member's life, health, or ability to regain maximum function.
3. Requests for reimbursement for covered Part D drugs that were already furnished to the Member may not be expedited.
4. IEHP will make a determination and notify the Member within twenty-four (24) hours of receipt of request (or for an Exception request, within twenty-four (24) hours of receipt

[11] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.5.3
[12] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.5.4
[13] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.8

of the physician's supporting statement) if IEHP determines that the Member's life or health will be seriously jeopardized by waiting for a standard decision.[14]

5. If IEHP denies a Member's or a Member's appointed representative's request for an expedited CD, the request is processed using standard processing timeframes. IEHP:[15]
   a. Provides prompt oral notice to the Member, the Member's appointed representative and the prescribing Physician or other prescriber that the request will be processed under the standard CD;
   b. Informs the Member or their appointed representative of his or her right to have the prescribing Physician resubmit a request for an expedited CD;
   c. Informs the Member or their appointed representative of his or her right to file an expedited grievance if he or she disagrees with IEHP's decision not to expedite the CD;
   d. Provides instructions on IEHP's grievance process and timeframes; and
   e. Mails a written confirmation to the Member within three (3) calendar days after the oral notification. ~~(See Attachments, "Notice of Right to an Expedited Grievance – Pharmacy – English" and "Notice of Right to an Expedited Grievance – Pharmacy - Spanish" in Section 11).~~

C. Failure to make a decision on a CD request and provide notice of the decision within the timeframe required by CMS constitutes an adverse CD. In this case, IEHP forwards the request to the Independent Review Entity (IRE) within twenty-four (24) hours of the expiration of the adjudication timeframe ~~(See Attachments, "Notice of Case Status – English" and "Notice of Case Status - Spanish" in Section 11)~~.[16]

Coverage Determination Review Process

A. All clinical criteria for prior authorization of medications are reviewed and updated at least annually or more often, as needed.

B. A CD will be made when a covered Part D drug is dispensed at a non-participating pharmacy if:[17]
   1. IEHP cannot reasonably expect the Member to obtain such drugs at a participating Pharmacy in a timely manner; and
   2. The Member does not access covered Part D drugs at non-participating pharmacies on a routine basis.

[14] Ibid.
[15] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.8
[16] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.11
[17] 42 CFR § 423.124

C. IEHP Clinical Pharmacists are responsible for reviewing the initial CD. IEHP Clinical Pharmacists have current and unrestricted pharmacist licenses to practice in California.[18]

D. IEHP's compensation plan for Clinical Pharmaceutical Services staff who provides utilization review services does not contain incentives, direct or indirect, for these individuals to deny, limit, or discontinue medically necessary services to any Member.[19]

E. IEHP Pharmaceutical Services staff reviews individual requests by thoroughly surveying the Member's existing medication regimen, previous successful or failed therapies, any allergies, and any other clinical condition when applicable, and either approves, pends, withdraws, dismisses or denies the request.

1. **Approved:** Cases are approved for a twelve (12) month time span (or specific timeframe as dictated by the CMS-approved prior authorization criteria) which will allow for adjudication at the Member's Pharmacy. An approval notice is provided to the Member and the prescribing Physician or other prescriber, as appropriate.

2. **Pended:** There is insufficient information to make a determination on the appropriateness of the request. Additional information will be requested from the prescribing Physician or other prescriber. If no or insufficient information is received, a decision will be made within seventy-two (72) hours for standard request and twenty-four (24) hours for expedited request.[20] For an Exception request, adjudication timeframe does not begin until the plan receives the prescribing Physician or other prescriber's supporting statement.[21]

3. **Withdrawn:** CD or Exception request was submitted to IEHP and subsequently withdrawn at the request of the Member, Member's appointed representative, prescribing Physician or other prescriber.[22]

4. **Dismissed:** Exact duplication of an existing request or a request for a covered formulary medication.

5. **Denied:** Documentation provided did not meet approval guidelines. A denial notice will be provided to the prescribing Physician or other prescriber, and the Member, and/or the Member's appointed representative.

[18] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.9
[19] CCI Three-Way Contract September 2019, Section 2.11
[20] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.10
[21] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.5.2
[22] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.14

F. If IEHP approves an Exception request, IEHP may not require the Member to request approval for a refill, or a new prescription to continue using the Part D prescription drug approved under the exception process for the remainder of the plan year, as long as:[23]

1. The Member remains enrolled in IEHP;
2. The prescribing Physician or other prescriber continues to prescribe the drug; and
3. The drug continues to be considered safe for treating the disease or medical condition.

G. If IEHP approves a CD, IEHP notifies the Member, the Member's appointed representative and prescribing Provider or other prescriber within regulatory timeframes. The approval letter shall include conditions of the approval including, but not limited to:[24]

1. Duration of the approval;
2. Limitations associated with an approval; and/or
3. Any coverage rules applicable to subsequent refills.

H. The IEHP Clinical 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 reviews and signs all denied CDs.[25]

I. As part of the determination process, IEHP Clinical Pharmacist consults with appropriate Specialists for requests involving unusual or clinically complicated conditions.

J. Prior to denying a request, the IEHP Clinical Pharmaceutical Services staff consults with the prescribing Physician to offer an alternative pharmacotherapeutic regimen and to discuss the specific reason for the denial.

K. If IEHP denies a drug benefit, in whole or in part, a denial letter is issued to both Member or their appointed representative and the prescribing Physician or other prescriber.[26] ~~(See Attachments, "Notice of Denial of Prescription Drug Coverage – English," "Notice of Denial of Prescription Drug Coverage – Spanish," "Notice of Redetermination – English," and "Notice of Redetermination – Spanish" in Section 11).~~ The denial letter shall include the following information:[27]

1. Denial notice language in a readable and understandable form;

[23] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.5.5
[24] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.12.2
[25] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.9
[26] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.8
[27] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.12.3

2. The specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and special language requirements, if any;
3. Criteria used in the review process;
4. Procedures for obtaining additional information about criteria used in the review process;
5. Information on the Member's right to appoint a representative to file an appeal on the Member's behalf;
6. Information on the Member's right to a redetermination:
    a. If IEHP denies drug coverage, a description of both the standard and expedited redetermination processes, including the conditions for obtaining an expedited redetermination and the appeals process;
    b. If IEHP denies payment, the notice shall describe the standard redetermination process and the appeals process; and
7. Other notice requirements as specified by CMS.

L. The final authority for obtaining medications not included in the IEHP Formulary rests with IEHP Chief Medical Officer. All documents and written materials are forwarded to the Chief Medical Officer or Medical Director designee for review if an appeal is filed by the prescribing Physician or other prescriber, IPA, Pharmacist, Member, or Member's appointed representative.

M. The Member, Member's appointed representative, the prescribing Physician or other prescriber may request a redetermination if the Member has received an adverse CD. See Section 16, "Grievance and Appeal Resolution System" for more information.

N. A CD request that is submitted to the Pharmaceutical Services Department using a Coverage Determination form with the word "appeal" or a Part D denial case for the same requested medication with or without additional information in the past sixty (60) days will be deemed as redetermination and forwarded to the IEHP Grievance & Appeals Department for review.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

11. PHARMACY

C. IEHP DualChoice Vaccine Coverage

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. Effective January 1st, 2008, the administration of a Part D covered vaccine is included in the definition of "covered Part D drug" under the Part D statute.[1] IEHP thus ensures that IEHP DualChoice Members have adequate access to Part D vaccines[2] and that vaccines are billed appropriately under the Part D, or Part B (where applicable), benefit.[3]

PROCEDURES:

A. Members may receive Part D vaccine coverage through one (1) of the following options:

1. In-Network Vaccine Distribution – Retail Pharmacy[4]

   a. Members ~~could~~ can obtain a prescription from their Primary Care Provider (PCP) and bring it to a contracted IEHP Pharmacy P~~p~~rovider for filling.

   b. IEHP Pharmacy Providers who register with the Pharmacy Benefit Manager (PBM) as vaccine Providers may provide service and submit claims online as a single claim (both the vaccine serum and the administration cost).

   c. Pharmacy Providers should collect any applicable cost-sharing ~~on~~ for the vaccine and its administration. No Member Reimbursement form is required. The Member's deductible, coinsurance and co-pay ~~will apply~~should be taken into account, if applicable.

2. Out-of-Network - IEHP reimburses the Members directly

   a. Member receives and pays for a Part D covered vaccine through a doctor or other health care Provider (other than the Vaccine Network Pharmacy).

   b. Member needs to bring the Member Reimbursement Form to the health care Provider, complete all the required information and send the Member Reimbursement Form along with the receipt to IEHP. The deductible, coinsurance and co-pay will be factored into the reimbursement, as applicable~~apply~~. Please see Policy 11M, "Member Request for Pharmacy Reimbursement" for more information (See Attachments, "Member Request for Pharmacy Reimbursement – IEHP

[1] Tax Relief and Health Care Act (TRHCA) § 202(b)
[2] ~~Medicare Prescription Drug Manual, "Benefits and Beneficiary Protections," Section 60.2~~
[3] Medicare Prescription Drug Manual, "Benefits and Beneficiary Protections," Section 60.2
[4] Ibid.

DualChoice – English" and "Member Request for Pharmacy Reimbursement – IEHP DualChoice- Spanish" in Section 11).

3. Out-of-Network - Receive vaccination through the physician ~~provider~~Provider.

   a. The Provider may submit claims on behalf of the Member when they provide Part D covered vaccines. The Member may also obtain the vaccine from the Pharmacy and transport the vaccine to the Physician's office for administration. No Member Reimbursement form is required. The deductible, coinsurance and co-pay will apply.

B. When applicable, ~~O~~one (1) cost-sharing amount should be applied to both the vaccine ingredient cost and the administration cost, resulting in one (1) co-pay for the Member, if the vaccines are distributed.

C. The Part D vaccine program generally covers those vaccines not available under Part B. The following vaccines are covered under the Part B Program:

1. Pneumococcal pneumonia vaccine;
2. Influenza virus vaccine;
3. Hepatitis B vaccine for individuals at high or intermediate risk; and
4. Other vaccines (i.e. tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.

D. IEHP's contracted PBM accepts Part D vaccine administration claims from participating pharmacies when submitted in the National Council for Prescription Drug Programs (NCPDP) approved format.[5] IEHP reimburses any Pharmacy that has agreed to provide vaccine administration services.

E. IEHP and the contracted PBM will monitor the Part D vaccine claims. When administration is billed separately from the dispensing of the vaccine, IEHP and the contracted PBM will review existing claims for the presence of a vaccine charge. Should no vaccine charge be present in the claim's history, IEHP will work with the Member to ensure the Member submits a paper receipt for the vaccine and that appropriate reimbursement has been paid.

F. Medicare payment for the COVID-19 vaccine (if Providers do not receive it for free) and its administration will be made through the original fee-for-service Medicare program.

G. All Part D covered vaccines are listed in the IEHP DualChoice Formulary. No prior authorization is required for covered Part D vaccines. All covered Part D vaccines are restricted to be used according to the latest Centers for Disease Control and Prevention (CDC) recommended Adult Immunization Schedule found online at http://www.cdc.gov/vaccines/schedules/hcp/adult.html.

[5] Medicare Prescription Drug Manual, "Benefits and Beneficiary Protections," Section 60.2.2

~~G.~~

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2009
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

11. PHARMACY

C. IEHP DualChoice Vaccine Coverage

11. PHARMACY

D. Claims for Drugs Prescribed or Dispensed by Sanctioned, Excluded and Precluded Providers

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP's contracted Pharmacy Benefit Manager (PBM) will utilize the reference files from the Office of Inspector General (OIG), U.S General Services Administration (GSA) System for Award Management (SAM), and the Department of Healthcare Services (DHCS) Medi-Cal Suspended & Ineligible (S&I) List monthly updates to ensure the PBM claim system remains~~is~~ updated and~~to~~ denies~~block~~ claims submitted by sanctioned, excluded, and precluded Providers.[1,2]

PROCEDURES:

A. IEHP's contracted PBM is responsible for referencing sanctioned, excluded and precluded data and ~~make updates to~~updating their system(s) based on the Centers for Medicare & Medicaid (CMS) requirement, described above. Once updated, all claims related to the sanctioned, excluded and precluded[3] Providers will be denied.[4] IEHP will generate letters to impacted Members.

B. IEHP will monitor the State's Provider licensing department updates.[5] 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.

[1] Title 42 Code of Federal Regulations (CFR) § 422.224(a)
[2] Medicare Managed Care Manual, "Compliance Program Guidelines", Section 50.6.8
~~[3] Center for Medicare & Medicaid Services, "Preclusion List Requirements", December 14, 2018~~
[4] Center for Medicare & Medicaid Services, "Preclusion List Requirements", December 14, 2018
[5] Medicare Managed Care Manual, "Compliance Program Guidelines", Section 50.6.8~~Coordinated Care Initiative (CCI) Three-Way Contract, September 2019, Section 2.4~~

11. PHARMACY

D. Claims for Drugs Prescribed or Dispensed by Sanctioned, Excluded and Precluded Providers

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11. PHARMACY

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

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ 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 in conjunction with the contracted Pharmacy Benefits Manager (PBM) to remove formulary restrictions and implement Formulary edits to allow full 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.[1]

B. At the end of the emergency declaration, IEHP will re~~-implement~~vert the edits and continue to work closely with Members who were~~are~~ displaced or otherwise impacted by the disaster. An emergency declaration ceases to exist 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.[2]

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[1] Medicare Managed Care Manual, "~~Prescription Drug Benefit Manual, "Chapter 5:~~ Benefits and Beneficiary Protections," Section 50.12
[2] Ibid.

11. PHARMACY

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

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11. PHARMACY

F. Coverage Determination - Part B vs. D Determination

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP ensures that drugs for which coverage may be available under Part B or Part D, as it is being prescribed or administered to the Member, are provided under the correct benefit coverage.

PROCEDURES:

A. IEHP's Medicare Pharmacy staff will manage all prior authorizations for Part B vs. Part D Coverage Determinations (CDs) as follows:

1. IEHP's Medicare Clinical Pharmacists will rely upon information submitted by the Pharmacy or Prescriber on the CD Form and medical information included with the prescription, if available, such as diagnosis information or the location where the medication is going to be administered (see Attachment~~s~~, "Coverage Determination – Provider and Member" ~~– English" and "Coverage Determination – Provider and Member – Spanish"~~ in Section 11).
2. IEHP's Medicare Clinical Pharmacists may require the Pharmacy to share the information provided on the prescription to assist in the determination of Part B vs. Part D coverage. IEHP will make a Part B vs. Part D CD based on guidance set forth by the Centers for Medicare and Medicaid Services (CMS).

B. CDs and notifications to the Member or Member's representative and prescribing Physician or other prescriber are made within regulatory timeframes, regardless of benefit determination. For more information on the CD process and requirements, please see Policy 11B, "Coverage Determination."

C. Medications to be considered, and any additional parameters that must be taken into consideration to make a B vs. D Coverage Determination, are as follows:[1]

1. **Durable Medical Equipment Supply Drugs – Infusion Drugs**
   a. Any agent administered in the home via intravenous (IV) drip or push injection would be covered under Medicare Part D.
   b. If the drug is administered using a CMS-approved infusion pump or meets durable medical equipment-maximum allowable cost (DME-MAC) Local Coverage Determination (LCD) criteria, it will be covered by Part B.
   c. The exception to this rule is if the Member resides in a long-term care (LTC) facility

[1] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Appendix C

and the drug is administered via an infusion pump, then the medication is covered under Part D.

2. **Durable Medical Equipment Supply Drugs – Respiratory Drugs**

   a. Any agent administered in the home via a hand-held inhaler would be covered under Medicare Part D.

   b. If the drug's approved administration is through a nebulizer in the home, it will be covered by Part B.

   c. The exception to this rule is if the Member resides in a LTC facility, and the drug is administered via a nebulizer, then the medication is covered under Part D.

3. **Intravenous Immune Globulin (IVIG) provided in the home**

   a. For individuals whose diagnosis is primary immune deficiency disease, IVIG are covered by Part B.

   b. Other indications as approved by IEHP's Medicare Administrative Contractor (MAC) Part B carrier in its LCD will also be covered under Part D.

   c. All other medically accepted indications are covered by the Part D.

4. **Parenteral Nutrition**

   a. Part B coverage for parenteral nutrition is limited to individuals with a non-functioning digestive tract.

   b. For all other medically accepted indications, coverage would be under Part D.

5. **Anti-neoplastic Drugs – ORAL**

   a. Oral anti-neoplastics that have an IV formulation for the same indications are covered under Part B.

   b. All other oral anti-neoplastic agents are covered under Part D.

6. **Anti-emetic Drugs – ORAL**

   a. If a request for a Part B vs. D Coverage Determination is received, the Pharmacist will verify if the use is:

      1) Related to cancer treatment;

      2) A full replacement for intravenous administration; and

      3) Being administered within forty-eight (48) hours of cancer treatment.

      In such instances, the medication will be covered by Part B.

   b. Aprepitant (Emend®) will be covered under Part B when it is given prior to, during or right after chemotherapy. Otherwise, the medication will be covered under Part D. Oral anti-emetic drugs dispensed for use after the forty-eight (48) hours period, or any oral anti-emetic prescribed for conditions other than treatment of the effects of

cancer treatment, will be covered under Part D.

7. **Immunosuppressant Drugs**

   a. If a request for prior authorization is received, the IEHP Pharmaceutical Services staff will verify with the Clinical Pharmacist whether the Member's transplant was covered by Medicare. If the Member had a Medicare-covered transplant, the medication will be covered under Part B; otherwise, the medication will be covered under Part D.[2]

8. **Injectables**

   a. Coverage for B vs. D cannot generally be determined based solely on the drug itself. The IEHP Pharmaceutical Services staff will consider how the drug was "prescribed and dispensed or administered" with respect to the individual. The same drug may be covered under different circumstances either by IEHP's Part D or Part B.

   b. IEHP will cover Part D eligible injectable drugs not covered by Medicare Part B. Most of these are generally self-administered (e.g., Imitrex).

   c. The fact that an injectable is covered under Part B if provided by and administered in a Physician's office or Hospital outpatient setting does not mean IEHP can deny a claim from a Pharmacy solely based on availability of Part B coverage for drugs given in the Physician's office. If, however, a Member submits an out-of-network claim for an injectable drug administered in-office from a Physician's supply, and this drug is covered in that setting by the Part B contractor for that area, such a claim will be denied under Part D by IEHP based on Part B coverage requirements.

   d. If the medication (including injectable) is being obtained at a retail pharmacy, it may be covered under Part D in accordance with the corresponding National Coverage Determination (NCD) or Local Coverage Determination (LCD). If a Physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the Member will obtain the medication from a Pharmacy and have it in their possession until the Member delivers the medication to the Physician office for administration.

9. **Hemophilia Clotting Factors**

   a. Hemophilia clotting factors for hemophilia patients that are not competent to administer such factors to control bleeding without medical assistance, and items related to the administration of such factors, are covered under Part B.

   b. Hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors, are covered under Part D.

[2] Medicare Prescription Drug Benefit ~~Managed Care~~ Manual, "Chapter 14 - Coordination of Benefits," Section 50.15

10. **Pneumococcal Vaccine**
    a. All vaccines must be dispensed and administered in compliance with California state law.
    b. The vaccine and its administration to a Member are covered under Part B.
11. **Hepatitis B Vaccine**
    a. All vaccines must be dispensed and administered in compliance with California state law.
    b. The vaccine and its administration to a Member who is at high or intermediate risk of contracting Hepatitis B are covered under Part B.
    c. The vaccine prescribed to be administered prophylactically will be covered under Part D.
12. **Influenza Vaccine**
    a. All vaccines must be dispensed and administered in compliance with California state law.
    b. The vaccine and its administration to a Member are covered under Part B.
13. **Antigens**
    a. These formulations are usually prepared by a Physician (e.g., an allergist) for a specific patient. The Physician or Physician's nurse generally administers these drugs in the Physician's office. This would be covered under Part B.
14. **Erythropoietin (EPO)**
    a. For an end-stage renal disease (ESRD) patient undergoing dialysis in a facility the EPO claim must be submitted as part of their bundled payment, covered by Part B.
    b. For ESRD patients not receiving dialysis, the EPO prescription can be filled in the retail setting and covered under Part D.

D. **Long Term Care (LTC) Accessibility**[3]

1. IEHP's Medicare Clinical Pharmacists will approve coverage for medically necessary prescription drug treatments for Part D Members who reside in LTC facilities, including dosage forms of drugs that are utilized in the LTC setting, such as unit dose products and liquid, chewable, and parenteral preparations.
2. IEHP will also cover these dosage forms for Part D Members under circumstances in which Part B coverage is not available.

E. **Denials**

[3] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.2.3

1. If the decision is made by the Clinical Pharmacists that the medication will be covered under Medicare Part B, then the Part D Coverage Determination Request is denied as a "Non-Covered Benefit" in the medical management system. A notification will be sent to the Member or Member's representative and prescribing Physician or other prescriber that the medication is denied under Part D but it is covered under Medicare Part B benefit. ~~(See Attachments, "Notice of Denial of Prescription Drug Coverage – English," "Notice of Denial of Prescription Drug Coverage – Spanish," "Notice of Redetermination – English," and "Notice of Redetermination – Spanish" in Section 11).~~

F. IEHP applies beneficiary-level prior authorization requirements on four (4) categories of drugs that are always used for ESRD treatment (access management, anemia management, bone and mineral metabolism, cellular management).[4] These four (4) drug categories are determined by CMS and do not include other drug categories, unless otherwise stated by CMS. If it is determined through routine utilization review or otherwise that a renal dialysis service drug has been inappropriately billed to Part D, IEHP and the ESRD facility will negotiate repayment.

[4] Health Plan Management System (HPMS) Memo, "Two Updates Pertaining to End-Stage Renal Disease (ESRD)-Related Drugs," May 12, 2015

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11. PHARMACY

G. Coordination of Benefits

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP's Coordination of Benefits (COB) program prevents duplication of payments for the same health care services and prevents Medicare from paying as the primary when it is the secondary payer.[1]

B. IEHP and the contracted Pharmacy Benefit Manager (PBM) must comply with all administrative processes and requirements established by Centers for Medicare and Medicaid Services (CMS) to ensure effective exchange of information and coordination between IEHP and Other Health Coverage for:[2]

1. Payment of premiums and coverage; and
2. Payment for supplemental prescription drug benefits for Members enrolled in IEHP and an entity that provides other prescription drug coverage.

DEFINITIONS:

A. True Out-of-Pocket (TrOOP) - Incurred allowable costs that are paid by the beneficiary or by specified third parties on their behalf within the limits of the standard benefit, up to a legislatively specified out-of-pocket threshold.[3]

B. Nx Transactions – Information reporting transaction containing information on a paid supplemental claim and sent by the Part D Transaction Facilitator to the enrollee's Part D plan.[4] The National Council for Prescription Drug Programs (NCPDP) developed this set of transactions that provides a record of a payment, by a plan supplemental to Part D, to a Part D ~~plan~~Plan.

PROCEDURES:

COB Program

A. COB serves as a mechanism to:[5]

1. Collect information from a Member regarding Other Health Coverage; and

[1] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 20
[2] Ibid.
[3] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Appendix F
[4] ~~Ibid.~~Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 30.4.6
[5] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 20

2. Support the tracking and calculating of beneficiaries' "true out-of-pocket" (TrOOP) expenditures.

B. The COB program includes:[6]

1. Enrollment file sharing;
2. Claims processing and payment;
3. Claims reconciliation reports;
4. Third-party reimbursement of out-of-pocket costs;
5. Application of protection against high out-of-pocket expenditures; and
6. Other processes that CMS determines.

Member Responsibilities

A. Members are legally obligated to report information about Other Health Coverage or reimbursement for prescription drugs costs that they have or expect to receive under the Medicare Modernization Act (MMA).[7]

B. Members or other payers have up to thirty-six (36) months from the date on which the prescription for a covered Part D drug was filled to seek reimbursement from IEHP.[8]

IEHP Responsibilities

A. IEHP provides coordination of benefits with the PBM, CMS contracted COB Contractor, and the TrOOP Facilitators.

B. IEHP coordinates benefits with State pharmaceutical assistance programs, other payers, Members and others paying on the Members' behalf for up to thirty-six (36) months from the date on which the prescription for a covered Part D drug was filled.[9]

C. When IEHP receives a Nx transaction but has no supplement payer information on file to identify the payer; IEHP shall attempt to make contact with the Member to identify the payer.[10] IEHP sends the payer information to the COB Contractor via Electronic Correspondence Referral System (ECRS) verification. IEHP must report changes to the COB information and COB Contractor within thirty (30) days of receipt.[11] IEHP shall maintain connectivity with CMS systems to allow direct access to Other Health Coverage status information.[12]

D. IEHP may impose user fees to Other Health Coverage for costs related to coordination of benefits between IEHP and Other Health Coverage under the provision of MMA. The user

[6] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 20
[7] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 40.1
[8] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 50.14.4
[9] Ibid.
[10] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 50.4.1
[11] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 50.3.2
[12] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 50.3.1

fees must be reasonable and related to the IEHP's actual costs of COB with the Other Health Coverage.[13]

E. IEHP shall retroactively adjust claims and TrOOP balances based on prescription drug events and claims records.[14]

F. IEHP's PBM will process claims and track TrOOP in real time.[15]

[13] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 20
[14] Medicare Prescription Drug Benefit Manual, "Chapter 14 – Coordination of Benefits," Section 50.4
[15] Ibid.

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G. Coordination of Benefits

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11. PHARMACY

H. Best Available Evidence

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP provides access to Part D drugs at the correct Low-Income Subsidy (LIS) cost-sharing level when presented with evidence of LIS eligibility, even if IEHP's system and Centers for Medicare and Medicaid Services' (CMS) systems do not yet reflect that eligibility.[1]

DEFINITIONS:

A. Best Available Evidence (BAE) – Documentation used by IEHP to support a favorable change to a low-income subsidy (LIS) eligible Member's LIS status.[2]

B. Institutionalized Individual - A Medicare Advantage (MA)-eligible individual who resides or is expected to reside continuously for ninety (90) days or longer in a:

1. Skilled Nursing Facility (SNF)
2. Nursing Facility (NF)
3. Intermediate Care Facility for individuals with intellectual and developmental disabilities
4. Psychiatric Hospital
5. Rehabilitation Hospital
6. Long Term Care Hospital
7. Swing-Bed Hospital

~~long-term care facility that is either a skilled nursing facility (SNF), nursing facility (NF), or SNF/NF.~~ These individuals are considered long-term institutional residents for purposes of determining ____who can enroll in a special needs plan.[3]

PROCEDURES:

A. This process only applies to Members who are "deemed" eligible for LIS and may not be used for LIS applicants.

B. Payment for institutionalized individuals or SNF residents is made under Medicaid throughout

[1] https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Best_Available_Evidence_Policy
[2] Medicare Prescription Drug Benefit Manual, "Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals," Section 20
[3] Centers for Medicare & Medicaid Services, "Medicare Advantage (MA) Special Needs Plans Guidance," January 19, 2006

a full calendar month. These Members remain deemed for zero co-pay throughout the remainder of the calendar year. IEHP accepts and uses BAE to substantiate the Member's correct LIS cost-sharing level. The institutionalized Members have an indicator of "3" under the LIS level to return copay of zero.

C. IEHP accepts BAE at point-of-sale (POS) and updates the eligibility system within forty-eight to seventy-two (48-72) hours of the receipt of the documentation.

D. If the case is urgent, IEHP shall allow a minimum of seventy-two (72) hours' worth of medications until the case is resolved.

1. IEHP accepts any of the following documents to validate the correct LIS cost-sharing level and effective date for Members who should be deemed eligible for LIS 2 (full dual eligible). The document must show that the Member was eligible for Medicaid (IEHP Medi-Cal) during a month after June of the previous calendar year.[4]

   a. A copy of the Member's Medicaid card which includes the Member's name and eligibility date;

   b. A copy of a state document that confirms active Medicaid status;

   c. A printout from the State electronic enrollment file showing Medicaid status;

   d. A screen print from the State's Medicaid systems showing Medicaid status;

   e. Other documentation provided by the State showing Medicaid status;

   f. A report of contact, including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the State staff person who verified the Medicaid status;

   g. A remittance from a long-term care facility showing Medicaid payment for a full calendar month for that individual;[5]

   h. A copy of a state document that confirms Medicaid payment to a long-term care facility for a full calendar month on behalf of the individual;[6]

   i. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month's stay for Medicaid payment purposes;[7]

   j. Supplemental Security Income (SSI) Notice of Award with an effective date;

[4] Medicare Prescription Drug Benefit Manual, "Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals," Section 70.5.2
[5] Health Plan Management System (HPMS) Memo, "Best Available Evidence Policy – Update," August 4, 2008
[6] Ibid.
[7] Ibid.

k. An Important Information letter from the Social Security Administration (SSA) confirming that the beneficiary is automatically eligible for extra help; [8]

l. An application filed by Deemed Eligible confirming that the beneficiary is "…automatically eligible for extra help…" (SSA publication HI 03094.605); or

m. A copy of the Deeming notice pub. No. 11166 (Purple Notice).[9]

2. IEHP accepts any one of the following documents to validate the correct LIS cost-sharing level and effective date for Members who should be deemed eligible for LIS 3. The document must show that the Member was eligible for Medicaid (IEHP Medi-Cal) during a month after June of the previous calendar year.[10]

a. A remittance from the facility showing Medicaid payment for that individual;

b. A copy of a state Medicaid document showing the individual's institutional status;

c. A screen-print from the State's Medicaid systems showing the individual's institutional status;

d. A copy of the Deeming notice – pub. No. 11166 (purple notice);[11]

e. A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and Home and Community-Based Services (HCBS) eligibility date;

f. A copy of a State–approved HCBS Service Plan that includes the beneficiary's name and effective date;

g. A copy of a State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date;

h. Other documentation provided by the State showing HCBS eligibility status; or

i. A State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

E. IEHP updates the systems to reflect the LIS status indicated by the BAE and submits a request to CMS for manual update within sixty (60) days if routine reporting does not correct for deemed Members.[12]

[8] Medicare Prescription Drug Benefit Manual, "Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals," Section 70.6

[9] Medicare Prescription Drug Benefit Manual, "Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals," Section 70.6~~Ibid.~~

[10] Medicare Prescription Drug Benefit Manual, "Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals," Section 70.5.2

[11] Medicare Prescription Drug Benefit Manual, "Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals," Section 70.5.6

[12] Medicare Prescription Drug Benefit Manual, "Chapter 13 – Premium and Cost-Sharing Subsidies for Low-Income Individuals," Section 70.5.4

11. PHARMACY

H. Best Available Evidence

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H. Best Available Evidence

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11. PHARMACY

I. Transition Process

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP provides a transition process for Members whose current drug therapies may not be included in their new Part D plan's formulary, and will effectuate a meaningful transition for the following:[1]

1. New Members into IEHP DualChoice on January 1st of the new year following the previous year's annual coordinated election period;
2. The transition of newly eligible Medicare beneficiaries from other coverage in the new year;
3. The transition of individuals who switch from one plan to another after January 1st of the new year;
4. Enrollees residing in Long-Term Care (LTC) facilities; and
5. Members affected by negative Formulary changes from one (1) contract year to the next.

PURPOSE:

A. To promote continuity of care and avoid interruptions in drug therapy while a switch to a therapeutically equivalent drug or the completion of an Exception request to maintain coverage of an existing drug based on medical necessity reasons can be effectuated.[2]

PROCEDURES:

A. The transition process and requirements apply to:[3]

1. Part D drugs that are not on the IEHP DualChoice Formulary;
2. Part D drugs that were approved for coverage under an exception once the exception expires; and
3. Part D drugs that are on the IEHP DualChoice Formulary but require prior authorization, step therapy, or have an approved quantity limit lower than the beneficiary's current dose, under IEHP utilization management rules.

[1] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4.1
[2] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4
[3] ~~Ibid.~~

B. IEHP assures that all transition processes are applied to a brand-new prescription for a non-formulary drug if it cannot make the distinction between a brand-new prescription for a non-formulary drug and an ongoing prescription for a non-formulary drug at the point-of-sale.[4]

C. IEHP provides a transition supply when the Member requests ~~for~~ a non-formulary drug within ninety (90) days of their enrollment with IEHP DualChoice. If the Member disenrolls from IEHP and re-enrolls during this ninety (90) day transition period, the transition period begins again with the new enrollment date.[5]

D. IEHP assures that in the outpatient (retail) setting, the transition fill of non-formulary Part D drug is for at least a month's fill, unless the prescription is written for a shorter period. In which case, IEHP will allow multiple fills to equal at least a month's supply~~up to a total of thirty-one (31) days (unless the Member presents with a prescription written for less)~~.[6]

E. IEHP assures that in the Long-Term Care (LTC) setting, such as nursing facility or sub-acute care facility, the transition supply of non-formulary Part D drug is for a ~~thirty-one (31) day~~one month fill (unless the Member presents with a prescription written for less than ~~thirty-one (31) days~~a month), with multiple refills as necessary (up to ~~thirty-one (31) days~~a month's supply).[7]

F. IEHP assures that in the Long-Term Care setting, after the transition period has expired, the transition policy provides for a month-long emergency supply of non-formulary Part D drugs (unless the Member presents with a prescription written for less than a month) while an exception or prior authorization is being processed~~after the ninety (90) days transition period has expired, the transition policy provides for a thirty-one (31) day emergency supply of non-formulary Part D drugs (unless the Member presents with a prescription written for less than thirty-one (31) days) while an exception is being processed~~.[8]

G. Under circumstances where the transition policy does not apply, all non-formulary Part D drugs are subject to the coverage determination process. See Policy 11B, "Coverage Determination."

H. Claims will automatically process if the Member and the~~a~~ drug are both eligible for transition. Eligible claims will process and approve upon initial submission and messages will indicate when claims have paid under transition fill rules. The messages will be returned with paid transition fill claims so pharmacies can remind Members of actions that should be taken to ensure access to prescription drugs in accordance with Part D formularies and benefits.

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[4] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4.3

[5] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4.4

[6] Title 42, Code of Federal Regulations (CFR) §423.120(b)(3)(iii) ~~Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4.4.1~~

[7] 83 Federal Register 73 (April 16, 2018) (to be codified at 42 Code of Federal Regulations § 423.120)

[8] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4.6

11. PHARMACY

I. Transition Process

I. If a transition claim fails to process and the Pharmacy believes the IEHP Member and the drug should be eligible under this policy, the Pharmacy should call the IEHP Pharmaceutical Services Department at (888) 860-1297 to request a temporary supply override.

J. IEHP assures that cost-sharing for a temporary supply of drugs provided under its transition process will never exceed the statutory maximum co-payment amounts.[9]

K. IEHP's Pharmacy Benefit Manager (PBM) sends a written notice via U.S. mail to the Member within three (3) business days of adjudicating their first transition fill. ~~(See Attachments, "Prescription Transition Notice – English" and "Prescription Transition Notice - Spanish" in Section 11).~~ IEHP ensures all reasonable efforts are made to notify Prescribers of a transition fill. This CMS Model Transition Notice includes:[10]

1. An explanation of the temporary nature of the transition supply the Member has received;
2. Instructions for working with IEHP and the Member's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary;
3. An explanation of the Member's right to request a formulary exception;
4. A description of the procedures for requesting a Formulary exception; and
5. An explanation of the Member's right to request an appeal if IEHP issues an unfavorable decision on a formulary exception.

L. IEHP ensures continued compliance with these requirements by routinely testing the efficacy of the PBM's transition logic.

[9] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4.9

[10] Medicare Prescription Drug Benefit Manual, "Chapter 6 – Part D Drugs and Formulary Requirements," Section 30.4.10

11. PHARMACY

I. Transition Process

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

11. PHARMACY

J. Pharmacy Access Standards

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP ensures the Retail Pharmacy Access Standards are in accordance with requirements set by Centers for Medicare & Medicaid Services (CMS) which include:[1,~~2~~]

1. In urban areas, at least 90% of enrollees in a plan must, on average, live within two (2) miles of a retail Pharmacy participating in the network;
2. In suburban areas, 90% of enrollees within five (5) miles of a retail Pharmacy participating in the network; and
3. In rural areas, 70% of enrollees within fifteen (15) miles of a retail Pharmacy participating in the network.

B. IEHP ensures Long-Term Care (LTC) Pharmacy Access Standards are in accordance with requirements set by CMS. [3,4,~~5~~]

C. IEHP delegates all pharmacy network contracting responsibilities to the Pharmacy Benefit Management (PBM) Company. When applicable, IEHP contracts with pharmacies, including home infusion and specialty, for health care services such as equipment, nursing, and per diems.

PROCEDURES:

A. IEHP ensures that the hours of operation of all Pharmacy Network Providers are convenient to the population served and do not discriminate against Members. Services are available twenty-four (24) hours a day, seven (7) days a week.

B. IEHP Members may call ~~the~~ IEHP's Member Services Department at (877) 273-IEHP (4347) or access the IEHP Member Portal to find the nearest Pharmacy Provider in our network.

C. IEHP Members may receive ninety (90) day supply of the maintenance medications through retail Pharmacies or mail order Pharmacies.[6]

D. IEHP ensures Members have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when the Members:[7]

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[1] Title 42, Code of Federal Regulations §423.120(a)~~(4)~~
[2] ~~Coordinated Care Initiative (CCI) Three-Way Contract September 2019, Article II~~
[3] Medicare Prescription Drug Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.4
[4] 42 CFR § 423.120
[5] ~~Ibid.~~
[6] Ibid.
[7] Medicare Prescription Drug Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 60.1

1. Cannot reasonably be expected to obtain such drugs at a network pharmacy; and
2. Do not access covered Part D drugs at an out-of-network pharmacy on a routine basis.

E. IEHP does not limit access of Part D drugs to a limited distribution through a subset of network pharmacies, except when necessary, to meet Food and Drug Administration's (FDA) limited distribution requirements or to ensure the appropriate dispensing of Part D drugs that require extraordinary requirements that cannot be met by a network Pharmacy.[8]

F. IEHP may specify, on a drug-by-drug basis, reasonable requirements for network Pharmacies to ensure appropriate handling and dispensing of a particular Part D drug that requires special attention.

G. Any Willing Pharmacy Requirement - IEHP allows and accepts any willing pharmacy that will accept IEHP's standard contracting terms and conditions.[9] IEHP's PBM contracts on behalf of IEHP using standard contracting terms and conditions which include requirements, responsibilities, and reimbursement rates.

H. IEHP contracts with a Mail Order Pharmacy to process mail order requests. Drugs that are on the Maintenance Lists are available through the Mail Order Pharmacy. All mail order requests must be for a ninety (90) day supply of the drug. The Mail Order Pharmacy is not meant for emergency refills. If an emergency refill is needed, the Member will need to refer to their local Pharmacy for the necessary medication.

I. IEHP may arrange delivery of medications from Specialty Pharmacies if a referral is made by a Physician and approved by IEHP. Member will be notified upon delivery by the Specialty Pharmacy.

J. IEHP Members may receive home infusion pharmacy services for infusion drugs if a referral is made by a Physician and approved by IEHP.

Oversight

A. On an annual basis, IEHP assesses the Pharmacy Access Standards with our contracted PBM. If IEHP fails to meet the Pharmacy Access Standards, an investigation will be conducted to identify root cause. IEHP will work with the contracted PBM to remediate any deficiency identified.

B. IEHP assesses and analyzes the Consumer Assessments of Healthcare Providers and Systems (CAHPS) score for Member satisfaction related to access; identifies trends, barriers, and improvement opportunities; develops interventions to address opportunities and evaluates outcome of actions tables.

C. IEHP shall notify CMS and the Department of Health Care Services (DHCS) in writing when material change is expected within IEHP Pharmacy network before the change is in effect.

[8] Medicare Prescription Drug Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.3
[9] Medicare Prescription Drug Manual, "Chapter 5: Benefits and Beneficiary Protections," Section 50.8.1

11. PHARMACY

J. Pharmacy Access Standards

11. PHARMACY

J. Pharmacy Access Standards

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

11. PHARMACY

K. Medication Therapy Management Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP's Medication Therapy Management (MTM) Program is designed to ensure that covered Part D drugs prescribed to targeted Members are appropriately used to optimize therapeutic outcomes through improved medication use. It is also designed to reduce the risk of adverse events, including adverse drug interactions, and to increase Member adherence with prescription medications.[1]

PROCEDURES:

Program Eligibility

A. IEHP's MTM Program is available for Members who meet the following criteria set forth by the Centers for Medicare and Medicaid Services (CMS):[2]

1. Member is likely to incur costs (total drug costs) for Covered Part D drugs that exceed a predetermined level as specified by CMS;
2. Member has multiple chronic diseases, with three (3) chronic diseases being the maximum needed for enrollment; and
3. Member is taking multiple Part D drugs, with two (2) being the minimum and eight (8) being the maximum needed for enrollment.

~~3.~~B. Under the IEHP Drug Management Program (DMP), at risk beneficiaries (ARBs) are auto-enrolled in the MTM program.

~~B.~~C. On a quarterly basis, IEHP identifies and notifies qualified Members by mail or phone as potential candidates for the MTM Program within 60 days of enrollment.[3,4]

Member Participation

[1] Title 42, Code of Federal Regulations (CFR) § 423.153(d)(2)
[2] Ibid.
[3] Health Plan Management System (HPMS) Memo, "CY 2022 Medication Therapy Management Program Guidance and Submission Instructions," April 30, 2021
[4] 42 CFR § 423.153(d)(1)(vi)

11. PHARMACY

K. Medication Therapy Management Program

A. All identified Members, including Members in Long-Term Care (LTC), who are qualified are enrolled into the MTM Program. Members may call IEHP's Member Services Department to disenroll/opt-out[5] from the program.[6]

B. The MTM Program is voluntary. IEHP does not deny a Member access to prescription drugs based on the Member's failure to participate in the MTM Program.

C. Members will be screened for eligibility for the MTM Program every year. IEHP will honor a Member's desire to permanently opt-out of the MTM Program and not re-enroll the Member in future years; however, the Member may seek enrollment into the MTM Program at a later time.

D. In the event ~~If~~ the Member no longer meets one (1) or more of the three (3) eligibility criteria for the program, the Member will remain enrolled in the program for the remainder of the calendar year. They will be reconsidered for eligibility at the beginning of the following calendar year.

IEHP's MTM Program

A. The MTM Program was developed in cooperation with licensed and practicing pharmacists and physicians. Program services are furnished by pharmacists or other qualified Providers that have completed an appropriate training program as determined by IEHP.[7]

B. The MTM Program distinguishes between services in ambulatory and institutional settings.[8]

C. The MTM Program includes the following components:[9],[10]

1. Annual Comprehensive Medication Review (CMR):
    a. Medication review, at a minimum, on an annual basis;
    b. Interactive, person-to-person or telehealth consultation; and
    c. Individualized, written summary of consultation or recommended medication action plan.

    If the Member is offered annual CMR and is unable to accept the offer to participate, the pharmacist or other qualified Provider may perform the CMR with the Member's prescriber, caregiver, or other authorized individual.

2. Quarterly Targeted Medication Review (TMR):[11]

[5] ~~Ibid.~~~~42 CFR § 423.153(d)~~
[6] 42 CFR § 423.153(d)
[7] 42 CFR § 423.153(d)
[8] Ibid.
[9] 42 CFR § 423.153(d)(1)(vii)(B)(2)~~Ibid.~~
[10] Medicare Prescription Drug Benefit Manual Chapter 7 "Medication Therapy Management and Quality Improvement Program," Section 30.3
[11] 42 CFR § 423.153(d)(1)(vii)(C)

a. Individualized, written "take-away" materials such as personal medication record, reconciled medication list, action plan, recommendations for monitoring, education, or self-management; and

b. Follow-up interventions as necessary after initial TMR.

3. Medication Therapy Review:
   a. Assesses the appropriateness of the current medication therapy;
   b. Interviews (i.e. phone, interactive, etc.) with Members to ensure the adherence and appropriateness of the dose and dosing regimen of each medication;
   c. Checks for therapeutic duplications;
   d. Interprets, monitors and assesses patient laboratory results;
   e. Checks for drug to disease interactions and drug-drug interactions;
   f. Checks for contraindications and adverse effects; and
   g. Checks for over-utilization and under-utilization.
4. The pharmacist or other qualified Provider reviews the Member's medications, history and any information collected from the Member's questionnaire and conducts interactive person-to-person or telehealth comprehensive medication review.
5. A medication action plan:
   a. Develops a modification/recommendation plan based on the Member interviews, medication record evaluation and patient assessment.[12]
6. Intervention and referral:
   a. Provides education and training on the appropriate use of medications and monitoring devices;
   b. Provides information regarding safe disposal of prescription drugs that are controlled substances, including opioids;
   ~~b.~~c. Emphasizes the importance of medication adherence and understanding of the treatment goals; and
   ~~c.~~d. Communicates with the physician or other health care Providers on the findings when appropriate.
7. Documentation and follow up:
   a. The pharmacist or other qualified Provider documents all interventions on the CMS MTM Standard form.

[12] 42 CFR § 423.153(d)(1)(vii)(D)

D. The MTM Programs are coordinated with the Member's Individual Care Plan.[13]

Monitoring and Oversight

A. The MTM Program and all mid-year changes to the program must be approved by CMS.

B. IEHP evaluates and measures the effectiveness of the MTM Program through:[14]

1. Statistics on individual Members according to the Member medication profiles- the adoption of recommended treatment regimen, the number of chronic medications, and projected annual pharmacy expenditures per Member;
2. Statistics on the overall MTM Program- Number of changes in medication regimens, average number of chronic medications per Member, average projected annual pharmacy expenditures per Member;
3. Financial impact – pharmacy cost changes;
4. Member satisfaction surveys; and
5. CMR completion rate.

[13] 42 CFR § 423.153(d)(4)

[14] HPMS Memo, "CY 2022 Medication Therapy Management Program Guidance and Submission Instructions," April 30, 2021

11. PHARMACY

K. Medication Therapy Management Program

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

11. PHARMACY

L. Insulin Administration Devices and Diabetes Testing Supplies

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. Diabetes testing supplies are covered under both the IEHP pharmacy and medical benefit. This includes, but is not limited to, blood glucose meters, test strips, lancets, and ketone test strips.

PROCEDURES:

A. IEHP ensures coverage for the following as pharmacy benefit:

1. Insulin and Glucagon Emergency Kits;
2. Syringes and needles utilized as insulin administration devices.~~;~~[1,2] ~~and~~

B. Diabetes testing supplies may be obtained through retail Pharmacies.

C. Requests for insulin pen devices for Members with special medical needs are subject to the Coverage Determination process. See Policy 11B, "Coverage Determination" for more information.

D. IEHP covers diabetic testing supplies using the criteria approved by the IEHP Pharmacy and Therapeutics Subcommittee.

[1] Title 42 Code of Federal Regulations (CFR) § 423.100
[2] Health Plan Management System (HPMS) Memo, "Medical Supplies Associated with the Injection of Insulin," January 5, 2018

11. PHARMACY

L. Insulin Administration Devices and Diabetes Testing Supplies

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2009
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

11. PHARMACY

M. Member Request for Pharmacy Reimbursement

APPLIES TO:

A. This policy applies to all IEHP DualChoice ~~Cal MediConnect Plan (Medicare – Medicaid Plan)~~ Members.

POLICY:

A. IEHP Members or their appointed representative, which may be the prescribing physician or other prescriber, may submit Direct Member Reimbursement (DMR) requests to IEHP for drugs that the Member believes he or she was incorrectly charged.[1]

PROCEDURES:

A. All DMR requests are considered Coverage Determination (CD) requests and are subject to the same evaluation standards. All requests will be evaluated based on the medical necessity. See Policy 11B, "Coverage Determination" for more information.

B. Members must submit a written request for reimbursement and ~~must include~~must include proof of payment. ~~The Member may, but is not required to, use the Pharmacy Reimbursement Request form, which is available in threshold languages (See Attachments, "Member Request for Pharmacy Reimbursement – IEHP DualChoice – English," and "Member Request for Pharmacy Reimbursement – IEHP DualChoice – Spanish," "Member Request for Pharmacy Reimbursement – IEHP DualChoice – Chinese, and ""Member Request for Pharmacy Reimbursement – IEHP DualChoice – Vietnamese" in Section 11).~~

C. The prescribing Physician may only submit the request if acting on behalf of the Member.

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

E. IEHP will notify the Member, or the Member's representative, and the prescribing Physician, or other Prescriber (when applicable), of the Plan's decision no later than fourteen (14) calendar days ~~of~~ from the date of receipt of the written request.[2]

1. If the DMR request is denied by IEHP, the Member, or Member's representative, and the prescribing Physician, or other Prescriber (when applicable), will receive a denial notification. ~~(See Attachments, "Notice of Denial of Prescription Drug Coverage – English," "Notice of Denial of Prescription Drug Coverage – Spanish," "Notice of Redetermination – English," and "Notice of Redetermination – Spanish" in Section 11).~~

2. If the DMR request is approved, the Member, or Member's representative, and the prescribing Physician, or other Prescriber (when applicable), will receive an approval

[1] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.6
[2] Title 42 of Code of Federal Regulations (CFR) § 423.568(c)

notification and the reimbursement check will be mailed directly to the Member by IEHP or its Pharmacy Benefit Manager within the fourteen (14) calendar day timeframe.

F. IEHP Clinical Pharmacy Staff will make reasonable and diligent efforts to obtain any missing supporting information within the fourteen (14) calendar day timeframe, including outreaching to the Pharmacy and/or prescribing Physician, as applicable.

G. IEHP may also approve a payment request by approving drugs retrospectively or due to a decision by the Independent Review Entity (IRE), which must be authorized within seventy-two (72) hours.[3] The Pharmacy processes the approved medication and provides a refund to the Member. IEHP may approve payment directly to the Member if the Member is unable to return to the dispensing Pharmacy.

[3] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 90

11. PHARMACY

M. Member Request for Pharmacy Reimbursement

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2011
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

11. PHARMACY

N. Pharmacy Credentialing and Re-Credentialing

APPLIES TO:[LN1]

A. This policy applies to all Pharmacies in the IEHP Pharmacy network.

POLICY:

A. IEHP delegates all pharmacy credentialing and re-credentialing activities to its contracted Pharmacy Benefit Manager (PBM). The contracted PBM must have credentialing and recredentialing policies and procedures that meet IEHP standards.

PROCEDURES:

A. The contracted PBM must credential all pharmacies prior to inclusion in the IEHP Pharmacy network. The contracted PBM is responsible for ensuring that all network Pharmacies are qualified, properly licensed, and maintain appropriate levels of malpractice insurance.

B. The contracted PBM must recredential all IEHP network Pharmacy Providers 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.

C. The contracted PBM is also responsible for monitoring the performance of all IEHP network Pharmacy Providers. The PBM must promptly notify IEHP ~~once~~ when the PBM becomes aware of any breach of the contracted Pharmacy's obligations. The Medicare Advantage (MA) Organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list.[1,2] The MA organizations should check the Office of the Inspector General (OIG) Web site at https://oig.hhs.gov/exclusions/index.asp for the listing of excluded providers and entities. This includes, but is not limited to, the following:

   1. License surrender, revocation or suspension;
   2. Drug Enforcement Agency (DEA) license surrender, revocation or suspension; and
   3. Loss of malpractice insurance.

~~D.~~ Network Pharmacy Providers must update the credentialing information via IEHP's online portal on a bi-annual basis.

D.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2013

[1] The Social Security Act §1862(e)(1)(B)
[2] Prescription Drug Benefit Manual, "Chapter 9 – Compliance Program Guidelines," Section 50.6.8

11. PHARMACY

N. Pharmacy Credentialing and Re-Credentialing

Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

11. PHARMACY

O. Drug Management Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. All Part D sponsors must exercise a Drug Management Program (DMP), consistent with section 2004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (SUPPORT Act).[1]

PURPOSE:

A. To carry out an effective DMP that addresses overutilization of frequently abused drugs (FADs) while maintaining access to such drugs, as medically necessary.

DEFINITIONS:

A. Frequently Abused Drugs (FADs) – A controlled substance that the Secretary determines, based on several factors, is frequently abused or diverted.[2] For the purposes of this policy, opioids (except buprenorphine for medication-assisted treatment [MAT] and injectables) and benzodiazepines are FADs.

B. Potential At-Risk Beneficiary (PARB) – A Part D beneficiary who Centers for Medicare and Medicaid Services (CMS) believes is potentially at the highest risk of opioid-related adverse events or overdose. PARBs are not exempted from DMPs, meet the clinical guidelines described at 42 CFR § 423.153(f)(16), or who were identified as a PARB by the sponsor of the beneficiary's immediately prior Part D plan under its DMP and such identification was not terminated before disenrollment.[3]

C. At-Risk Beneficiary (ARB) – A beneficiary who meets the clinical guidelines described at 42 CFR § 423.153(f)(16), is not exempted from DMPs, and is identified to be at-risk by their Part D plan sponsor under its DMP, or who was identified as an ARB by the sponsor of the beneficiary's immediately prior Part D plan under its DMP and such identification had not been terminated before disenrollment.[4]

D. Overutilization Monitoring System (OMS) Criteria – Standards used by CMS to identify PARBs and ARBs. These standards are based on a beneficiary's level of opioid use or history of an opioid-related overdose.[5]

[1] Health Plan Management System (HPMS) Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 1
[2] Title 42 of the Code of Federal Regulations (CFR) § 423.100
[3] 42 CFR §423.100
[4] Ibid.
[5] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 4.1

PROCEDURES:

Member Identification

A. IEHP identifies PARBs and ARBs via:[6]

1. MARx's Daily Transaction Reply Report (DTRR) – Identifies newly enrolled beneficiaries who were declared PARBs and/or ARBs by their previous Part D plan;
2. OMS' quarterly PARB report – identifies Part D Members who meet OMS' PARB criteria;
3. Internal claims data;
4. Internal review of Members against OMS' PARB and ARB criteria; and
5. Care coordination with the Member's previous Part D plan.

B. A beneficiary is automatically exempt from the DMP if the beneficiary:[7]

1. Is being treated for active cancer-related pain;
2. Has elected to receive hospice care or is receiving non-hospice palliative or end-of-life care;
3. Is a resident of a long-term care (LTC) facility, a facility described in section 1905(d) of the Act, or another facility for which FADs are dispensed for residents through a contract with a single pharmacy; or
4. Has sickle cell disease.

Case Management

A. IEHP conducts case management of newly identified PARBs and ARBs to verify the prescribers of FADs for PARBs, request the prescribers confirm whether they believe the Member in question to be at risk for abuse or misuse of FADs and if so, to agree on a drug coverage limitation, as appropriate.

1. Newly enrolled Members who were previously identified as a PARB or an ARB by their previous Part D plan will not undergo an initial case management. Instead, IEHP may reach out to their previous plan and request the Member's DMP information.[8]

[6] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 2
[7] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 5
[8] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 7.2.2

B. Case Management is conducted by clinical staff or other appropriate health care professionals with sufficient expertise to conduct medical necessity reviews related to potential opioid overutilization.[9]

C. Written notification is sent to the Member's Prescriber(s) informing them that the Member in question may qualify for IEHP's DMP because they meet OMS' criteria. The Prescriber may provide documentation regarding the Member's treatment demonstrating why they do or do not believe the Member is an ARB.

1. IEHP may "Wait and See" if the Prescriber(s) adjust their care of the PARB and whether this results in the Member no longer meeting the OMS criteria. The "Wait and See" approach is used on a case-by-case basis, as appropriate, prior to initiating the three (3) outreach attempts.[10]

Drug Coverage Limitations

A. Prescriber Limitations – IEHP will obtain consensus from a provider prescribing FADs to the Member in question, agreeing to serve as the Member's designated Prescriber(s) of FADs and implement the outlined prescriber limitations. This agreement also serves as the Prescribers' agreement with the proposed coverage limitation.[11] A Member may have more than one designated Prescriber of FADs, but no less than one (1).

B. Pharmacy Limitation – If a Prescriber does not respond to the written notification and request to serve as the Member's designated Prescriber of FADs, the Plan will follow-up with three (3) outreach attempts to the Prescriber(s) within a span of ten (10) business days.[12] If no response is received, the Prescriber(s) will be considered non-responsive. If no response is received from any of the Prescribers, IEHP's clinical staff may implement a beneficiary-specific point of sale (POS) claim edit if the Member is determined to be an ARB.

Member Notification

A. Initial Notice – Upon completion of case management, IEHP sends the Member an Initial Notice, in accordance with requirements outlined in 42 CFR § 423.153(f)(5-8).

1. Newly enrolled Members who were a part of their previous Part D Plan's DMP are exempt from receiving an Initial Notice from IEHP as long as their previous plan's coverage limitations of FADs was shared with IEHP and remains up-to-date and in effect. In instances where IEHP intends to change the Member's coverage limitations, an Initial Notice will be mailed.

[9] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 7.1

[10] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 7.2

[11] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 7.4.1

[12] Ibid.

2. Members have thirty (30) days from the date of the Initial Notice to submit any relevant information including, but not limited to, Member's preferred prescriber(s) of FADs, and information that may be material to the Plan's determination of whether the Member is an ARB.[13]

~~2.~~3. If IEHP learns that the ~~beneficiary~~Member is exempt after sending the Initial Notice, IEHP will inform the ~~beneficiary~~Member that IEHP has become aware that the beneficiary is exempt and that the Initial Notice is rescinded.~~25~~[14]

B. Second Notice – If IEHP determines a Member is in fact an ARB, the Plan will send the Member a Second Notice informing them of their participation in the Plan's DMP and of their right to a redetermination of their at-risk determination, no later than sixty (60) days following the date of the Initial Notice.[15]

1. IEHP may send the Second Notice to newly enrolled Members who were a part of their previous Part D Plan's DMP immediate as long as their previous plan's coverage limitations of FADs remains up to date with the same prescriber or pharmacy.
2. A Second Notice is also sent to existing ARBs whose coverage limitation of FADs are extended for an additional year.
3. Members have sixty (60) days from the date of the Second Notice to request a redetermination.[16]
4. Redeterminations are conducted by the Grievance & Appeals Department. Please refer to Section 16, "Grievance and Appeals Resolution System" for more information.
5. Cases resulting in an adverse redetermination decision are automatically forwarded to the Independent Review Entity (IRE) for review.[17]

C. Retraction Notice – If IEHP determines ~~a~~the Member ~~is~~to be exempt from the Plan's DMP and less than ~~thirty (~~30~~)~~ days has passed since the Initial Notice, the Member will receive a Retraction Notice informing them of such.[18]~~25~~

~~C.~~D. Alternative Second Notice – If IEHP determines a Member is not an ARB and will not experience coverage limitations of FADs under the Plan's DMP, the Member will receive an Alternative Second Notice informing them of such.[19] Alternative Second Notices are mailed not less than ~~thirty (~~30~~)~~ days after the date of the Initial Notice and not more than the earlier

[13] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 8.1
[14] HPMS Memo, "Correction - Contract Year 2023 Part D Drug Management Program Guidance," April 20, 2023. Section 11.2
[15] 42 CFR § 423.153(f)(6)
[16] 42 CFR § 423.580
[17] 42 CFR § 423.590(i)
[18] HPMS Memo, "Correction - Contract Year 2023 Part D Drug Management Program Guidance," April 20, 2023. Section 11.2
[19] 42 CFR § 423.153(f)(7)

orf the date the pPlan makes the relevant determination or ~~as soon as possible, but no later than sixty (~~60~~)~~ days ~~following~~ after the date of the Initial Notice.[20]

~~D.~~E. Copies of the notices are shared with the Member's designated Prescriber(s) of FADs.

Member's Preferences & Considerations for Reasonable Access

A. When determining a Member's designated Prescriber(s) of FADs and dispensing pharmacy(ies), IEHP takes into account a several factors, including, but not limited to the following, to avoid any undue negative impact to the Member's access to care:[21]
   1. Member's preferences;
   2. Member's predominant usage of a prescriber or pharmacy, or both, for FADs;
   3. Member's health conditions;
   4. Geographic location; and
   5. Reasonable travel time.

B. If a Member does not indicate their preference or if the preferred Prescriber does not agree to be the Member's designated Prescriber of FADs, IEHP will assign an alternative provider to be the designated Prescriber of FADs, based on the considerations noted above. A Member may have multiple designated prescribers, as necessary, to ensure adequate access to care.

C. An out-of-network Pharmacy and/or Prescriber may be designated as a Member's Prescriber/Pharmacy of FADs, if the Member does not have reasonable access to contracted providers who can assist with the DMP.[22]

D. Selected Prescribers and pharmacies have the right to refuse participation in a Member's DMP. Only providers who agree to serve as a Member's designated prescriber of FADs will be included in the respective Member's DMP.

Length of Coverage Limitations

A. A Member's ARB status and their consequent coverage limitation is effective the date of the Second Notice and typically lasts one (1) year.[23]

B. Participation in a DMP may end sooner if the Member no longer meets OMS criteria or if they demonstrate that they are no longer likely to be at risk for abuse or misuse of FADs without the limitation, through a subsequent determination or a successful appeal.

[20] HPMS Memo, "Correction - Contract Year 2023 Part D Drug Management Program Guidance," April 20, 2023. Section 11.2

[21] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 9.2

[22] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 9.3

[23] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 10

C. A Member's ARB status may also be extended for an additional year if determined to be clinically necessary by their prescriber(s) or, if non-responsive, by IEHP's clinical staff.[24,25]

1. IEHP mails Members another Second Notice to inform them of their ARB extension. If the Member does not agree with the extension, they may request a redetermination.

Care Coordination

A. The Pharmacy Department completes requests from other Part D sponsors for information about PARBs and ARBs who recently disenrolled from IEHP's DualChoice product. All relevant information and communications regarding the beneficiary's PARB or ARB determination are securely transferred as soon as possible, but no later than two (2) weeks from the date of the request.

1. These file transfers are documented in the former Member's profile in the medical management system.

B. IEHP identifies newly enrolled PARBs and ARBs via the DTRR and uses CMS' Part D Overutilization Contact List to request the Members' PARB/ARB information from their previous Part D sponsor.

C. The Pharmacy department uses internal systems to maintain other Member-facing departments informed of confirmed ARB Members and facilitate appropriate coordination of care.

Reporting

A. IEHP reports the following information via MARx to assist with care coordination of a Member:[26]

1. The date of the Initial Notice to a PARB (Notification start date);
2. The date of the Second Notice to an ARB (Implementation start date; and
3. The date that IEHP terminates an "active CARA status," or the date of the Model Part D Drug Management Program ~~Treatraction~~Retraction Notice of Exempted Beneficiaries.[25] This may includ~~cing~~ terminating an ARB's coverage limitation(s) sooner than the original termination date.

B. IEHP reports case management status updates for the following PARB & ARB to OMS within ~~thirty (~~30~~)~~ days of receiving OMS' PARB report:[27]

[24] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022, Section 10.3
[25] 42 CFR § 423.153(f)(14)(ii)(B)
[26] HPMS Memo, "Contract Year 2023 Part D Drug Management Program Guidance," November 28, 2022Section 11.2
[27] Ibid.
~~[25] HPMS Memo, "CORRECTION - Contract Year 2023 Part D Drug Management Program Guidance," April 20, 2023. Section 11.2.~~

1. Each PARB & ARB enrolled with the Plan, who was listed in the OMS PARB report;
2. Each PARB identified internally by the Plan; and
3. Each PARB & ARB identified by the Member's previous plan, who has a Transaction Reply Code (TRC) 376 (New Enrollee CARA Status Notification) from the DTRR.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2022
Chief Title: Chief Medical Officer	**Revision Date:**	~~January~~ April ~~1~~20, 2023

11. PHARMACY

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Appointment of Representative - CMS Form 1696 – English	11B
Appointment of Representative – CMS Form 1696 – Spanish	11B
Appointment of Representative - CMS Form 1696 – Chinese	11B
Appointment of Representative - CMS Form 1696 – Vietnamese	11B
Coverage Determination Form - Provider and Member – English	11B, 11F
Coverage Determination Form - Provider and Member – Spanish	11B, 11F
Coverage Determination Form - Provider and Member – Chinese	11B, 11F
Coverage Determination Form - Provider and Member – Vietnamese	11B, 11F
~~Member Request for Pharmacy Reimbursement – IEHP DualChoice – English~~	~~11C, 11M~~
~~Member Request for Pharmacy Reimbursement – IEHP DualChoice - Spanish~~	~~11C, 11M~~
~~Notice of Case Status - English~~	~~11B~~
~~Notice of Case Status - Spanish~~	~~11B~~
~~Notice of Case Status – Chinese~~	~~11B~~
~~Notice of Case Status – Vietnamese~~	~~11B~~
~~Notice of Denial of Prescription Drug Coverage - English~~	~~11B, 11F, 11M~~
~~Notice of Denial of Prescription Drug Coverage - Spanish~~	~~11B, 11F, 11M~~
~~Notice of Denial of Prescription Drug Coverage – Chinese~~	~~11B, 11F, 11M~~
~~Notice of Denial of Prescription Drug Coverage – Vietnamese~~	~~11B, 11F, 11M~~
~~Notice of Formulary Change – English~~	~~11A~~
~~Notice of Formulary Change – Spanish~~	~~11A~~
Notice of Redetermination – English	11B, 11F, 11M
Notice of Redetermination – Spanish	11B, 11F, 11M
Notice of Redetermination – Chinese	11B, 11F, 11M
Notice of Redetermination – Vietnamese	11B, 11F, 11M
~~Notice of Right to an Expedited Grievance – Pharmacy - English~~	~~11B~~
~~Notice of Right to an Expedited Grievance – Pharmacy - Spanish~~	~~11B~~
Part D Excluded Provider Letter - English	11D
Part D Excluded Provider Letter - Spanish	11D

11. PHARMACY

Attachments

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

Departamento de Salud y Servicios Humanos
Centros de Servicios de Medicare y Medicaid

Formulario Aprobado
No. OMB 0938-0950

Nombramiento de un Representante

Nombre de la Parte	Numero de Medicare (beneficiario como parte) o identificador Nacional del Proveedor (proveedor o suplidor como parte)

Sección 1: Nombramiento de un Representante

Para ser completado por la parte que busca representación (i.e., el beneficiario de Medicare, el proveedor o suplidor):

Yo nombro a _____ para actuar como representante en relación con mi reclamación o derecho en virtud del título XVIII de la Ley del Seguro Social (la Ley) y sus disposiciones relacionadas al título XI de la Ley. Autorizo a este individuo a realizar cualquier solicitud; presentar u obtener pruebas; obtener información sobre apelaciones; y recibir toda notificación sobre mi reclamación, apelación, queja o solicitud en mi representación. Entiendo que podría divulgarse la información médica personal sobre mi solicitud al representante indicado a continuación.

Firma dela Parte Solicitando Representación		Fecha
Dirección		Número de teléfono (con código de área)
Ciudad	Estado	Código Postal
Correo electrónico (opcional)		

Sección 2: Aceptación del Nombramiento

Para ser completado por el representante:

Yo, _____, acepto por la presente el nombramiento antes mencionado. Certifico que no se me ha descalificado, suspendido o prohibido mi desempeño profesional ante el Departamento de Salud y Servicios Humanos (HHS en inglés); que no estoy en calidad de empleado actual o anteriormente de los Estados Unidos, descalificado para actuar como representante del participante; y que reconozco que todo honorario podría estar sujeto a revisión y aprobación de la Secretaría.

Me desempeño como _____

(Situación profesional o relación con la parte, por ejemplo: abogado, pariente, etc.)

Firma del representante		Fecha
Dirección		Número de teléfono (con código de área)
Ciudad	Estado	Código Postal
Correo electrónico (opcional)		

Sección 3: Renuncia al Cobro de Honorarios por Representación

Instrucciones: El representante debe completar esta sección si se lo requieren o si renuncia al cobro de honorarios por representación. (Los proveedores o suplidores que representen a un beneficiario y le hayan brindado artículos o servicios no pueden cobrar honorarios por representación y **deben** completar esta sección).

Renuncio a mi derecho de cobrar un honorario por representar a _____ ante el Secretario(a) del HHS.

Firma	Fecha

Sección 4: Renuncia al Pago por Artículos o Servicios en Cuestión

Instrucciones: Los proveedores o suplidores que actúan como representantes de beneficiarios a los que les brindaron artículos o servicios deben completar esta sección si la apelación involucra un tema de responsabilidad en virtud de la sección 1879(a)(2) de la Ley. (La sección 1879(a)(2) en general se aborda si un proveedor, suplidor o beneficiario no tenía conocimiento o no se podía esperar razonablemente que supiera que los artículos o servicios en cuestión no estarían cubiertos por Medicare).

Renuncio a mi derecho de cobrar al beneficiario un honorario por los artículos o servicios en cuestión en esta apelación si está pendiente una determinación de responsabilidad bajo la sección 1879(a)(2) de la Ley.

Firma	Fecha

Cobro de Honorarios por Representación de Beneficiarios ante el Secretario(a) del HHS

Un abogado u otro representante de un beneficiario, que desee cobrar un honorario por los servicios prestados en relación con una apelación ante el Secretario(a) del HHS (i.e., una audiencia con un Juez de Derecho Administrativo (ALJ en inglés) o la revisión de un abogado adjudicador por la Oficina de Audiencias y Apelaciones de Medicare (OMHA en inglés), una revisión con el Consejo de Apelaciones de Medicare o un proceso ante OMHA o el Consejo de Apelaciones de Medicare como resultado de una orden de remisión de la Corte de Distrito Federal) debe por ley obtener aprobación para recibir un honorario de acuerdo con 42 CFR §405.910(f).

Mediante este formulario, "Solicitud para Obtener un Honorario por Concepto de Representación" se obtiene la información necesaria para solicitar el pago de honorario. Debe ser completado por el representante y presentado con la solicitud para audiencia con el ALJ revisión de OMHA o revisión del Consejo de Apelaciones de Medicare. La aprobación de honorarios para el representante no es necesaria si: (1) el apelante es representado por un proveedor o suplidor; (2) prestados en calidad oficial como un tutor legal, comité o cargo similar representante designado por el tribunal y con la aprobación del tribunal del honorario en cuestión; (3) el honorario es por representación del beneficiario ante la corte de distrito federal; o (4) el honorario es por representación del beneficiario en una redeterminación o reconsideración. Si el representante desea renunciar al cobro de un honorario, puede hacerlo. La sección 3 en la primera página de este formulario puede usarse para ese propósito. En algunas instancias, según se indica en el formulario, no se cobrará el honorario por concepto de representación.

Aprobación de Honorarios

El requisito para la aprobación de honorarios garantiza que el representante recibirá una remuneración justa por los servicios prestados ante HHS en nombre de un beneficiario y brinda al beneficiario la seguridad de que los honorarios sean razonables. Para la aprobación de un honorario solicitado, OMHA o el Consejo de Apelaciones de Medicare considera la clase y el tipo de servicios prestados, la complejidad del caso, el nivel de pericia y capacidad necesaria para la prestación de servicios, la cantidad de tiempo dedicado al caso, los resultados alcanzados, el nivel de revisión administrativa al cual el representante llevó la apelación y el monto del honorario solicitado por el representante.

Conflicto de Interés

Las secciones 203, 205 y 207 del título XVIII del Código de Estados Unidos consideran como un delito penal cuando ciertos funcionarios, empleados y antiguos funcionarios y empleados de los Estados Unidos prestan ciertos servicios en temas que afectan al Gobierno, ayudan o asisten en el procesamiento de reclamaciones contra los Estados Unidos. Los individuos con un conflicto de interés quedarán excluidos de ser representantes de los beneficiarios ante HHS.

Dónde Enviar este Formulario

Envíe este formulario al mismo lugar que está enviando (o ha enviado) su: apelación si está solicitando una apelación, queja o protesta si está solicitando una queja o protesta, o determinación o decisión inicial si está solicitando una determinación o decisión inicial. Si necesita ayuda, comuníquese con 1-800-MEDICARE (1-800-633-4227) o con su plan de Medicare. Usuarios TTY debe llamar al 1-877-486-2048.

Usted tiene derecho a obtener la información de Medicare en un formato accesible, como en letra grande, Braille o audio. También tiene el derecho de presentar una queja si piensa que ha sido discriminado. Visite https://www.cms.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html o llame al 1-800-MEDICARE para más información.

MEDICARE 處方藥承保裁決要求

您可以郵寄或傳真本表格給我們：

地址：
IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

傳真號碼：
(909) 890-5877

您也可以致電向我們提出承保裁決要求，電話 1-877-273-IEHP (4347) (聽語障專線 1-800-718-4347)，服務時間為每週 7 天 (包括假日)，上午 8 時至晚上 8 時 (太平洋標準時間 (PST))，或透過我們的網站提出要求，網址 www.iehp.org。

誰可以提出要求：您的開立處方者可以代表您向我們提出承保裁決要求。如果您想請其他人 (例如家人或朋友) 代您提出要求，該人士必須是您的代表。請與我們聯絡，瞭解如何指定代表。

會員資訊

會員姓名		出生日期
會員地址		
城市	州	郵遞區號
電話	會員卡號碼	

若提出本要求的人不是會員或開立處方者本人，才需要填寫以下部分：

提出要求者姓名		
提出要求者和會員的關係		
地址		
城市	州	郵遞區號
電話		

由會員或其開立處方者以外人士所提出要求的代表委任文件：

請附上證明文件，證實該人士有權代表會員 (填妥的代表授權書 CMS-1696 或具同等效力的書面文件)。如需更多關於委任代表的資訊，請聯絡您的計畫或 1-800-Medicare。

您所要求的處方藥名稱 (若已知劑量和每個月所要求的數量，請一併列出)：

承保裁決要求類型

☐ 我需要的藥物未列於計畫承保藥物清單 (處方一覽表例外處理)。*****

☐ 我一直有在使用先前列於計畫承保藥物清單的藥物，但該藥物在計畫年度期間正要或已經從該清單移除 (處方一覽表例外處理)。*****

☐ 我要求為開立處方者所開立的處方藥物取得事先授權。*

☐ 計畫規定我必須先試另一種藥物才能取得開立處方者所開立的處方藥物，我要求對此規定進行例外處理 (處方一覽表例外處理)。*

☐ 我要求對計畫限制我能取得的藥量 (數量限制) 進行例外處理，這樣我才能取得開立處方者所開立處方的藥量 (處方一覽表例外處理)。*

☐ 我的藥物計畫針對開立處方者所開立的處方藥物收取的共付額高於另一種可治療我的病況的藥物，而我希望支付較低的共付額 (層級例外處理)。*****

☐ 我一直有在使用先前列於較低共付額層級的藥物，但該藥物正要或已經移到較高共付額層級 (層級例外處理)。*****

☐ 我的藥物計畫針對應該承保的藥物向我收取較高的共付額。

☐ 我希望針對我自費支付的承保處方藥取得補償。

***備註：如果您要求進行處方一覽表或層級例外處理，您的開立處方者必須為您的要求提供佐證聲明。需要取得事先授權 (或須遵守任何其他使用管理規定) 的要求可能需有佐證資訊。您的開立處方者得使用隨附的「例外處理要求或事先授權之佐證資訊」來為您的要求提供佐證。**

我們應該考慮的額外資訊 *(請附上任何佐證文件)*：

重要備註：特急決定

如果您或您的開立處方者認為，等候 72 小時才做標準決定可能會使您的生命、健康或恢復身體最佳機能的能力嚴重受損，您可以要求特急 (快速) 決定。如果您的開立處方者指出，等候 72 小時可能會使您的健康嚴重受損，我們將會自動在 24 小時內做出決定。如果您沒有取得您的開立處方者就特急要求所提供的佐證，我們將會判定您的個案是否需要快速決定。如果您欲要求我們償還您已取得之藥物的費用，您不得要求特急承保裁決。

☐如果您認為您需要在 24 小時內得到決定，請勾選此方框 (如果您有獲得開立處方者的佐證聲明，請連同此要求一起附上)。

簽名：	**日期：**

例外處理要求或事先授權之佐證資訊

處方一覽表和層級例外處理要求必須有開立處方者的佐證聲明方可處理。事先授權要求可能需有佐證資訊。

☐要求特急審查：勾選此方框並在下方簽名，即表示本人證明採用 72 小時標準審查期限可能會使會員的生命、健康或恢復身體最佳機能的能力嚴重受損。

開立處方者資訊		
姓名		
地址		
城市	州	郵遞區號
診所電話	傳真	
開立處方者簽名		日期

診斷和醫療資訊		
藥物：	劑量和用藥途徑：	頻率：

開始用藥日期： ☐ **新開始**	預計治療時間長度：	每 30 天的數量
身高 / 體重：	藥物過敏：	

診斷 - 請列出使用所要求藥物治療的所有診斷以及對應的國際疾病分類第十版 (ICD-10) 代碼。 (如果使用所要求藥物治療的病況是一種症狀 (例如：厭食症、體重減輕、呼吸急促、胸痛、噁心等)，請提供導致該症狀的診斷 (若已知))	**ICD-10 代碼**
其他相關診斷：	**ICD-10 代碼**

用藥史：(用於治療需要所要求藥物治療的病況)

嘗試過的藥物 (如果問題出在數量限制，請列出嘗試過的單位劑量 / 總計每日劑量)	**藥物試用日期**	**先前的藥物試用結果** **失敗與無法耐受 (請說明)**

對於需要所要求藥物治療的病況，會員目前的藥物療程為何？

藥物安全

所要求的藥物是否有任何**食品藥物管理局 (FDA) 註明的禁忌症**？	☐ 是 ☐ 否
將所要求的藥物加入會員目前的藥物療程是否有任何**藥物交互作用**的疑慮？	☐ 是 ☐ 否

如果上述任一問題的答案為「是」，請 (1) 說明問題、(2) 討論上述疑慮之外的效益和潛在風險，以及 (3) 擬定監測計畫以確保安全性

老年人用藥的高風險管控

如果會員年齡超過 65 歲，您認為對這位老年病患而言，所要求藥物的治療效益是否大於潛在風險？

☐ 是 ☐ 否

鴉片類藥物 – (如果所要求的藥物是鴉片類藥物，請填寫以下問題)

每日累積嗎啡等效劑量 **(MED)** 為何？ _____ 毫克 / 天

您是否知道此會員有其他鴉片類藥物開立處方者？ ☐ 是 ☐ 否

如為「是」，請說明。

所述的每日 MED 劑量是否為醫療所需？ ☐ 是 ☐ 否

較低的每日 MED 總劑量是否不足以控制會員的疼痛？ ☐ 是 ☐ 否

要求理由

☐ **替代藥物為禁忌藥物，或先前嘗試過但有不良結果 (例如：毒性、過敏)，或治療失敗** [如果尚未在表格稍早的「用藥史」部分中註明，請在下方指明：(1) 嘗試過的藥物和藥物試用結果；(2) 如果發生不良結果，請列出藥物和各種藥物的不良結果；(3) 如果治療失敗，請列出試用藥物的最大劑量和治療時間長度；(4) 若有禁忌症，請列出首選藥物 / 其他處方一覽表藥物為禁忌藥物的具體原因]

☐ **病患使用目前藥物情況穩定；改變藥物有發生重大不良臨床結果的高風險** 必須具體說明任何預期的重大不良臨床結果，以及為何會預期發生重大不良結果 - 例如病況一直難以控制 (已嘗試過許多藥物、需要多種藥物來控制病況)、病患在先前病況未獲得控制時曾發生重大不良結果 (例如：住院或經常急性就醫、心臟病發作、中風、跌倒、身體機能狀態嚴重受限、過度疼痛和痛苦) 等。

☐ **不同劑型和 / 或較高劑量為醫療所需** [請在下方指明：(1) 嘗試過的劑型和 / 或劑量以及藥物試用結果；(2) 說明醫療上的理由，(3) 包括為何不該降低用藥頻率並提高劑量 (若有較高劑量)]

☐ **要求處方一覽表層級例外處理** 如果尚未在表格稍早的「用藥史」部分中註明，請在下方指明：(1) 嘗試過的處方一覽表藥物或首選藥物以及藥物試用結果；(2) 如果發生不良結果，請列出藥物和各種藥物的不良結果；(3) 如果治療失敗 / 治療效果不如所要求的藥物，請列出試用藥物的最大劑量和治療時間長度；(4) 若有禁忌症，請列出首選藥物 / 其他處方一覽表藥物為禁忌藥物的具體原因]

☐ **其他** (請在下方說明)

必要的說明_____

_____

_____

_____

_____

_____

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:
IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Fax Number:
(909) 890-5877

You may also ask us for a coverage determination by phone at 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays (TTY) 1-800-718-4347) or through our website at www.iehp.org.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Member's Information

Member's Name		Date of Birth
Member's Address		
City	State	Zip Code
Phone	Member's Member ID #	

Complete the following section ONLY if the person making this request is not the member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than member or the member's prescriber:

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*****

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*****

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*****

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*****

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider *(attach any supporting documents)*:

_____

_____

_____

_____

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐**CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature:	**Date:**

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐**REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
Date Started: ☐ **NEW START**	Expected Length of Therapy:	Quantity per 30 days
Height/Weight:	Drug Allergies:	
DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. **(**If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)		**ICD-10 Code(s)**
Other RELEVANT DIAGNOSES:		**ICD-10 Code(s)**

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	DATES of Drug Trials	RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)

What is the member's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY

Any **FDA NOTED CONTRAINDICATIONS** to the requested drug? ☐ **YES** ☐ **NO**

Any concern for a **DRUG INTERACTION** with the addition of the requested drug to the member's current drug regimen? ☐ **YES** ☐ **NO**

If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety

HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY

If the member is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ **YES** ☐ **NO**

OPIOIDS – (please complete the following questions if the requested drug is an opioid)

What is the daily cumulative Morphine Equivalent Dose **(MED)**? _____ **mg/day**

Are you aware of other opioid prescribers for this member? ☐ **YES** ☐ **NO**
If so, please explain.

Is the stated daily MED dose noted medically necessary? ☐ **YES** ☐ **NO**

Would a lower total daily MED dose be insufficient to control the member's pain? ☐ **YES** ☐ **NO**

RATIONALE FOR REQUEST

☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]

☐ **Request for formulary tier exception** Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐ **Other** (explain below)

Required Explanation _____

_____

_____

_____

_____

_____

SOLICITUD DE DETERMINACIÓN DE COBERTURA DE MEDICAMENTOS RECETADOS DE MEDICARE

Puede enviarnos este formulario por correo o por fax:

Dirección:
IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Número de Fax:
(909) 890-5877

Usted también puede solicitarnos una determinación de cobertura por teléfono al 1-877-273-IEHP (4347), 8am - 8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos (TTY) 1-800-718-4347), o a través de nuestro sitio web en www.iehp.org.

Quién Puede Realizar una Solicitud: El profesional que le receta medicamentos puede solicitarnos una determinación de cobertura en nombre de usted. Si desea que otra persona (como un familiar o un amigo) realice una solicitud por usted, esa persona debe ser su representante. Comuníquese con nosotros para obtener información sobre cómo designar a un representante.

Información del Miembro

Nombre del Miembro		Fecha de Nacimiento
Dirección del Miembro		
Ciudad	Estado	Código Postal
Teléfono	N.º de Identificación de Miembro del Miembro	

Complete la siguiente sección ÚNICAMENTE si quien realiza esta solicitud no es el Miembro ni el profesional que receta medicamentos

Nombre del Solicitante		
Relación del Solicitante con el Miembro		
Dirección		
Ciudad	Estado	Código Postal
Teléfono		

Documentación de representación para solicitudes realizadas por una persona que no sea el Miembro o el profesional que emite las recetas del Miembro:

Adjunte documentación que demuestre la autorización para representar al Miembro (un Formulario de Autorización de Representación CMS-1696 completado o un documento escrito equivalente). Para obtener más información sobre cómo designar a un representante, comuníquese con su plan o al 1-800-Medicare.

Nombre del medicamento con receta que solicita (si es posible, incluya la concentración y la cantidad solicitada por mes):

Tipo de Solicitud de Determinación de Cobertura

☐ Necesito un medicamento que no está en la lista de medicamentos cubiertos del plan (excepción a la lista de medicamentos cubiertos).*****

☐ Estuve usando un medicamento que anteriormente estaba incluido en la lista de medicamentos cubiertos del plan, pero se retirará o se retiró de esta lista durante el año del plan (excepción a la lista de medicamentos cubiertos).*****

☐ Solicito la autorización previa para el medicamento que me recetó el profesional que emite las recetas médicas.*

☐ Solicito una excepción al requisito de que pruebe con otro medicamento antes de obtener el medicamento que me recetó el profesional que emite las recetas médicas (excepción a la lista de medicamentos cubiertos).*

☐ Solicito una excepción al límite del plan en la cantidad de pastillas (límite de cantidad) que puedo recibir para poder obtener la cantidad de pastillas que me recetó el profesional que emite recetas médicas (excepción a la lista de medicamentos cubiertos).*

☐ Mi plan de medicamentos cobra un copago más alto por el medicamento que me recetó el profesional que emite recetas médicas que el que cuesta otro medicamento que trata mi condición, y quiero pagar el copago más bajo (excepción al nivel).*****

☐ Estuve usando un medicamento que anteriormente estaba incluido en un nivel de copago más bajo, pero que se pasará o ha pasado a un nivel de copago más alto (excepción al nivel).*****

☐ Mi plan de medicamentos me cobró un copago más alto por un medicamento de lo que debería haber cobrado.

☐Deseo que me reembolsen un medicamento recetado cubierto que pagué de mi bolsillo.

***NOTA: Si usted solicita una excepción a la lista de medicamentos cubiertos o al nivel, el profesional que le receta medicamentos DEBE proporcionar una declaración que respalde su solicitud. Las solicitudes que están sujetas a autorización previa (o a cualquier otro requisito de administración de la utilización) pueden requerir información de respaldo. El profesional que le receta medicamentos puede usar la "Información de Respaldo para una Solicitud de Excepción o Autorización Previa" adjunta para respaldar su solicitud.**

Información adicional que debemos considerar *(adjunte cualquier documento de respaldo):*

_____

_____

_____

_____

Nota Importante: Decisiones Aceleradas

Si usted o el profesional que le receta medicamentos consideran que una espera de 72 horas para una decisión estándar podría afectar gravemente su vida, su salud o su capacidad para recuperar una función por completo, usted puede solicitar una decisión acelerada (rápida). Si el profesional que le receta medicamentos indica que una espera de 72 horas podría afectar gravemente su salud, automáticamente le informaremos de nuestra decisión dentro de las 24 horas. Si usted no obtiene la declaración de respaldo del profesional que le receta medicamentos para una solicitud acelerada, nosotros decidiremos si su caso requiere una decisión rápida. No puede solicitar una determinación de cobertura acelerada si nos pide que le reembolsemos un medicamento que ya recibió.

☐ **MARQUE ESTA CASILLA SI CREE QUE NECESITA UNA DECISIÓN DENTRO DE LAS 24 HORAS (si tiene una declaración de respaldo del profesional que le receta medicamentos, adjúntela a esta solicitud).**

Firma:	**Fecha:**

Información de Respaldo para una Solicitud de Excepción o Autorización Previa

Las solicitudes de EXCEPCIÓN A LA LISTA DE MEDICAMENTOS CUBIERTOS y AL NIVEL no pueden procesarse sin una declaración de respaldo de un profesional que receta medicamentos. Las solicitudes de AUTORIZACIÓN PREVIA pueden requerir información de respaldo.

☐**SOLICITUD DE REVISIÓN ACELERADA: Al marcar esta casilla y firmar a continuación, certifico que aplicar el plazo de revisión estándar de 72 horas podría poner en grave peligro la vida o la salud del Miembro o la capacidad del Miembro de recuperar las funciones por completo.**

Información sobre el Profesional que Receta Medicamentos		
Nombre		
Dirección		
Ciudad	Estado	Código Postal
Teléfono del consultorio	Fax	
Firma del Profesional que Receta Medicamentos		Fecha

Diagnóstico e Información Médica		
Medicamentos:	Concentración y Vía de Administración:	Frecuencia:
Fecha de Inicio: ☐ **NUEVO INICIO**	Duración Prevista del Tratamiento:	Cantidad por 30 días
Estatura/Peso:	Alergias a Medicamentos:	

DIAGNÓSTICO: Por favor, indique todos los diagnósticos que se tratarán con el medicamento solicitado y los códigos de Clasificación Internacional de Enfermedades ICD-10 correspondientes. (Si la condición que se tratará con el medicamento solicitado es un síntoma, p. ej., anorexia, pérdida de peso, falta de aire, dolor en el pecho, náuseas, etc., proporcione el diagnóstico que causa el/los síntoma/s si es posible)	**Código/s ICD-10**
Otros DIAGNÓSTICOS RELEVANTES:	**Código/s ICD-10**

HISTORIAL DE MEDICAMENTOS: (para el tratamiento de la/s condición/condiciones que requieren el medicamento solicitado)

MEDICAMENTOS PROBADOS (si el límite de cantidad es un problema, indique la dosis individual/dosis diaria total probada)	**FECHAS de Pruebas de Medicamentos**	**RESULTADOS de pruebas de medicamentos anteriores FALTA DE EFICACIA frente a INTOLERANCIA (explique)**

¿Cuál es el régimen actual de medicamentos del Miembro para la/s condición/condiciones que requiere/n el medicamento solicitado?

SEGURIDAD DEL MEDICAMENTO

¿Alguna **CONTRAINDICACIÓN OBSERVADA POR LA FDA** para el medicamento solicitado? ☐ **SÍ** ☐ **NO**

¿Alguna inquietud por una **INTERACCIÓN DE MEDICAMENTOS** al agregar el medicamento solicitado al régimen actual de medicamentos del Miembro? ☐ **SÍ** ☐ **NO**

Si la respuesta a cualquiera de las dos preguntas indicadas arriba es sí, por favor, 1) explique el problema, 2) analice los beneficios frente a los posibles riesgos a pesar de la inquietud indicada, y 3) el plan de control para garantizar la seguridad

ADMINISTRACIÓN DE MEDICAMENTOS DE ALTO RIESGO EN ADULTOS MAYORES

Si el Miembro tiene más de 65 años, ¿considera usted que los beneficios del tratamiento con el medicamento solicitado superan los posibles riesgos en este paciente adulto mayor? ☐ **SÍ** ☐ **NO**

OPIOIDES – (por favor, complete las siguientes preguntas si el medicamento solicitado es un opioide)

¿Cuál es la Dosis Equivalente de Morfina ***(Morphine Equivalent Dose, MED)*** acumulada? _____ **mg/día**

¿Conoce a otros profesionales que recetan medicamentos opioides para este Miembro?
☐ **SÍ** ☐ **NO**
Si es así, por favor, explique.

¿La dosis MED diaria indicada es médicamente necesaria? ☐ **SÍ** ☐ **NO**

¿Una dosis MED diaria total más baja sería insuficiente para controlar el dolor que presenta el Miembro?

☐ **SÍ** ☐ **NO**

FUNDAMENTO DE LA SOLICITUD

☐ **Medicamento/s alternativo/s contraindicado/s o probado/s anteriormente, pero con resultado adverso, p. ej., toxicidad, alergia o falta de eficacia terapéutica** [Especifique a continuación si aún no se indicó en la sección HISTORIAL DE MEDICAMENTOS anterior en el formulario: (1) Medicamento/s probado/s y resultados de la/s prueba/s de medicamentos (2) si el resultado es adverso, enumere el/los medicamento/s y el resultado adverso de cada uno, (3) si se trata de falta de eficacia terapéutica, indique la dosis máxima y la duración del tratamiento para el/los medicamento/s probado/s, (4) si tiene contraindicaciones, por favor, indique el motivo específico por el que el/los medicamento/s preferido/s u otro/s medicamento/s de la lista de medicamentos cubiertos está/n contraindicado/s]

☐ **El paciente se encuentra estable con el/los medicamento/s actual/es; alto riesgo de resultado clínico adverso significativo con el cambio de medicamento** Se requiere una explicación específica de cualquier resultado clínico adverso significativo anticipado y por qué se esperaría un resultado adverso significativo, p. ej., la condición ha sido difícil de controlar (se probaron muchos medicamentos, se requieren múltiples medicamentos para controlar la condición), el paciente obtuvo un resultado adverso significativo cuando la condición no se controló previamente (p. ej., hospitalización o visitas médicas frecuentes o para casos agudos, ataque cardíaco, derrame cerebral, caídas, limitación significativa del estado funcional, dolor excesivo y sufrimiento), etc.

☐ **Necesidad médica para una formulación diferente de la dosis y/o dosis más alta** [Especifique a continuación: (1) Formulación/Formulaciones de dosis y/o dosis probadas y resultado de la/s prueba/s de medicamentos; (2) explique el motivo médico (3) incluya por qué la dosis de menor frecuencia con una concentración más alta no es una opción —si existe una concentración más alta—]

☐ **Solicitud de excepción a la lista de medicamentos cubiertos o al nivel** Especifique a continuación si no se indicó en la sección HISTORIAL DE MEDICAMENTOS antes en el formulario: (1) medicamento/s preferido/s o de la lista de medicamentos cubiertos probado/s y resultados de la/s prueba/s de medicamentos (2) si el resultado es adverso, enumere el/los medicamento/s y el resultado adverso de cada uno, (3) si se trata de falta de eficacia terapéutica/no tan eficaz como el medicamento solicitado, indique la dosis máxima y la duración del tratamiento para el/los medicamento/s probado/s, (4) si tiene contraindicaciones, por favor, indique el motivo específico de por qué el/los medicamento/s preferido/s u otro/s medicamento/s de la lista de medicamentos cubiertos está/n contraindicado/s]

☐ **Otro** (explique a continuación)

Explicación Requerida _____

_____

_____

_____

_____

_____

YÊU CẦU XÁC ĐỊNH KHOẢN ĐÀI THỌ THUỐC KÊ THEO TOA CỦA MEDICARE

Có thể gửi mẫu đơn này cho chúng tôi qua đường bưu điện hoặc fax:

Địa chỉ:
IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Số fax:
(909) 890-5877

Quý vị cũng có thể yêu cầu chúng tôi xác định khoản đài thọ qua điện thoại theo số 1-877-273-IEHP (4347), 8 giờ sáng - 8 giờ tối (PST), 7 ngày trong tuần, kể cả các ngày lễ (TTY) 1-800-718-4347) hoặc thông qua trang web của chúng tôi tại www.iehp.org.

Ai có thể đưa ra yêu cầu: Người kê toa của quý vị có thể thay mặt quý vị yêu cầu chúng tôi xác định khoản đài thọ. Nếu quý vị muốn một cá nhân khác (chẳng hạn như thành viên trong gia đình hoặc bạn bè) giúp quý vị đưa ra yêu cầu, thì người đó phải là người đại diện của quý vị. Liên hệ với chúng tôi để tìm hiểu cách chỉ định một người đại diện.

Thông tin hội viên

Tên hội viên		Ngày sinh
Địa chỉ của hội viên		
Thành phố	Tiểu bang	Mã zip
Điện thoại	Số ID hội viên của hội viên	

CHỈ hoàn thành phần sau nếu người đưa ra yêu cầu này không phải hội viên hoặc người kê toa:

Tên người yêu cầu:		
Mối quan hệ của người yêu cầu với hội viên		
Địa chỉ		
Thành phố	Tiểu bang	Mã Zip
Điện thoại		

Giấy tờ, tài liệu chứng minh thẩm quyền đại diện mà một người nào đó không phải là hội viên hoặc người kê toa của hội viên cần có để yêu cầu kháng cáo:

Đính kèm giấy tờ, tài liệu chứng minh thẩm quyền để đại diện cho hội viên (Mẫu đơn cho phép đại diện CMS-1696 điền đầy đủ hoặc văn bản tương đương). Để biết thêm thông tin về

việc chỉ định một người đại diện, hãy liên hệ với chương trình của quý vị hoặc 1-800-Medicare.

Tên loại thuốc kê theo toa quý vị đang yêu cầu (bao gồm liều lượng và số lượng được yêu cầu mỗi tháng, nếu biết):

Loại yêu cầu xác định khoản đài thọ

☐ Tôi cần một loại thuốc không nằm trong danh sách thuốc được đài thọ của chương trình (ngoại lệ theo danh mục thuốc).*****

☐ Tôi đã và đang sử dụng một loại thuốc trước đây có trong danh sách thuốc được đài thọ của chương trình, nhưng sắp bị loại hoặc đã bị loại khỏi danh sách này trong năm chương trình (trường hợp ngoại lệ về thuốc trong danh mục).*****

☐ Tôi yêu cầu sự cho phép trước đối với loại thuốc mà người kê toa của tôi đã kê.*

☐ Tôi yêu cầu một trường hợp ngoại lệ đối với yêu cầu rằng tôi phải thử một loại thuốc khác trước khi nhận loại thuốc mà người kê toa cho tôi đã kê (trường hợp ngoại lệ về thuốc trong danh mục).*

☐ Tôi yêu cầu một trường hợp ngoại lệ đối với giới hạn số lượng thuốc (giới hạn số lượng) của chương trình mà tôi có thể nhận, do đó tôi có thể nhận được số lượng thuốc mà người kê toa của tôi đã kê (trường hợp ngoại lệ về thuốc trong danh mục).*

☐ Chương trình thuốc của tôi tính khoản tiền đồng trả cho loại thuốc mà người kê toa của tôi đã kê cao hơn khoản tiền tính phí cho một loại thuốc khác điều trị bệnh trạng của tôi và tôi muốn thanh toán khoản tiền đồng trả thấp hơn (trường hợp ngoại lệ về bậc thuốc).*****

☐ Tôi đã và đang sử dụng một loại thuốc mà trước đây được đưa vào bậc khoản tiền đồng trả thấp hơn, nhưng sắp được chuyển sang hoặc đã được chuyển sang bậc khoản tiền đồng trả cao hơn (trường hợp ngoại lệ về bậc thuốc).*****

☐ Chương trình thuốc của tôi đã tính phí khoản tiền đồng trả cho một loại thuốc cao hơn mức vốn có.

☐Tôi muốn được bồi hoàn cho loại thuốc kê theo toa được đài thọ mà tôi đã tự bỏ tiền túi ra thanh toán.

***LƯU Ý: Nếu quý vị đang yêu cầu một trường hợp ngoại lệ về thuốc trong danh mục hoặc về bậc thuốc, người kê toa của quý vị PHẢI cung cấp một giấy chứng nhận đồng ý hỗ trợ yêu cầu của quý vị. Các yêu cầu phải được cho phép trước (hoặc tuân theo bất kỳ yêu cầu quản lý sử dụng nào khác) và có thể đòi hỏi thông tin hỗ trợ. Người kê toa của quý vị có thể sử dụng "Thông tin hỗ trợ đối với yêu cầu về trường hợp ngoại lệ hoặc cho phép trước" đính kèm để hỗ trợ yêu cầu của quý vị.**

Thông tin bổ sung mà chúng tôi nên cân nhắc *(đính kèm bất kỳ giấy tờ, tài liệu hỗ trợ nào)*:

_____

_____

_____

_____

Lưu ý quan trọng: Quyết định được giải quyết nhanh

Nếu quý vị hoặc người kê toa của quý vị cho rằng việc chờ đợi trong 72 giờ cho quyết định tiêu chuẩn có thể gây tổn hại nghiêm trọng đến tính mạng, sức khỏe hoặc ảnh hưởng đến khả năng có thể hồi phục chức năng tối đa của quý vị, quý vị có thể yêu cầu một quyết định được giải quyết nhanh (gấp). Nếu người kê toa của quý vị cho biết rằng việc chờ đợi trong 72 giờ có thể gây tổn hại nghiêm trọng đến sức khỏe của quý vị, chúng tôi sẽ tự động đưa ra quyết định cho quý vị trong vòng 24 giờ. Nếu quý vị không nhận được sự hỗ trợ từ người kê toa đối với yêu cầu được giải quyết nhanh, chúng tôi sẽ quyết định xem liệu trường hợp của quý vị có cần quyết định gấp hay không. Quý vị không thể yêu cầu quyết định được giải quyết nhanhnhanh về khoản đài thọ nếu quý vị đang yêu cầu chúng tôi hoàn lại tiền cho quý vị đối với loại thuốc mà quý vị đã nhận.

☐**ĐÁNH DẤU VÀO Ô NÀY NẾU QUÝ VỊ CHO RẰNG QUÝ VỊ CẦN QUYẾT ĐỊNH TRONG VÒNG 24 GIỜ (nếu quý vị có giấy chứng nhận đồng ý hỗ trợ từ người kê toa, hãy đính kèm với yêu cầu này).**

Chữ ký:	**Ngày:**

Thông tin hỗ trợ cho yêu cầu về trường hợp ngoại lệ hoặc cho phép trước

Không thể xử lý các yêu cầu về TRƯỜNG HỢP NGOẠI LỆ VỀ THUỐC TRONG DANH MỤC và VỀ BẬC THUỐC mà không có giấy chứng nhận đồng ý hỗ trợ của người kê toa. Các yêu cầu về CHO PHÉP TRƯỚC có thể đòi hỏi thông tin hỗ trợ.

☐**YÊU CẦU DUYỆT XÉT NHANH: Bằng cách đánh dấu vào ô này và ký tên bên dưới, tôi xác nhận rằng việc áp dụng khung thời gian duyệt xét tiêu chuẩn 72 giờ có thể gây nguy hiểm nghiêm trọng đến tính mạng hoặc sức khỏe của hội viên hoặc khả năng hồi phục chức năng tối đa của hội viên.**

Thông tin về người kê toa		
Tên		
Địa chỉ		
Thành phố	Tiểu bang	Mã Zip
Điện thoại văn phòng	Fax	
Chữ ký của người kê toa		Ngày

Thông tin chẩn đoán và y khoa		
Thuốc:	Liều lượng và lộ trình quản lý:	Tần suất:
Ngày bắt đầu: ☐ **KHỞI ĐẦU MỚI**	Thời gian điều trị dự kiến:	Số lượng mỗi 30 ngày
Chiều cao/Cân nặng:	Dị ứng thuốc:	

CHẨN ĐOÁN – Vui lòng liệt kê tất cả các chẩn đoán đang được điều trị bằng thuốc theo yêu cầu và các mã ICD-10 tương ứng. **(**Nếu bệnh trạng đang được điều trị bằng thuốc theo yêu cầu là một triệu chứng, ví dụ như chán ăn, sụt cân, hụt hơi, đau ngực, buồn nôn, v.v., hãy cho biết chẩn đoán gây ra (các) triệu chứng đó nếu biết)	**(Các) Mã ICD-10**
CÁC CHẨN ĐOÁN CÓ LIÊN QUAN khác:	**(Các) Mã ICD-10**

TIỀN SỬ DÙNG THUỐC: (để điều trị (các) bệnh trạng cần dùng thuốc theo yêu cầu)

NHỮNG LOẠI THUỐC ĐÃ THỬ (nếu giới hạn số lượng là một vấn đề, hãy liệt kê liều đơn vị/tổng liều hàng ngày đã thử)	**NGÀY thử nghiệm thuốc**	**CÁC KẾT QUẢ của những thử nghiệm thuốc trước đây KHÔNG THÀNH CÔNG so với KHÔNG DUNG NẠP (vui lòng giải thích)**

Phác đồ thuốc hiện tại của hội viên đối với (các) bệnh trạng đòi hỏi thuốc theo yêu cầu là gì?

AN TOÀN VỀ THUỐC

Có bất kỳ **CHỐNG CHỈ ĐỊNH NÀO THEO LƯU Ý CỦA FDA** đối với loại thuốc được yêu cầu không?
☐ CÓ ☐ KHÔNG

Có bất kỳ quan ngại gì về **SỰ TƯƠNG TÁC GIỮA THUỐC** với việc bổ sung thuốc được yêu cầu vào phác đồ thuốc hiện tại của hội viên không? **☐ CÓ ☐ KHÔNG**

Nếu câu trả lời cho một trong các câu hỏi nêu trên là có, vui lòng 1) giải thích vấn đề, 2) thảo luận về các lợi ích và rủi ro tiềm ẩn bất chấp mối quan ngại đã được lưu ý và 3) kế hoạch giám sát để đảm bảo an toàn

QUẢN LÝ RỦI RO CAO CỦA THUỐC ĐỐI VỚI NGƯỜI CAO TUỔI

Nếu hội viên trên 65 tuổi, quý vị có cảm thấy rằng các lợi ích của việc điều trị bằng loại thuốc theo yêu cầu cao hơn những rủi ro tiềm ẩn ở bệnh nhân cao tuổi này không? **☐ CÓ ☐ KHÔNG**

OPIOIDS - (vui lòng hoàn thành các câu hỏi sau nếu loại thuốc được yêu cầu là opioid)

Liều lượng morphine tương đương **(Morphine Equivalent Dose, MED)** tích lũy hàng ngày là bao nhiêu? _____ **mg/ngày**

Quý vị có biết về những người kê toa khác đã kê opioid cho hội viên này không? **☐ CÓ ☐ KHÔNG**
Nếu có vui lòng giải thích.

Liều MED hàng ngày đã nêu có cần thiết về mặt y tế không? **☐ CÓ ☐ KHÔNG**
Tổng liều MED hàng ngày thấp hơn có đủ để kiểm soát cơn đau của hội viên không? **☐ CÓ ☐ KHÔNG**

CƠ SỞ LÝ LUẬN ĐỂ YÊU CẦU

☐ **(Các) loại thuốc thay thế bị chống chỉ định hoặc đã thử trước đó, nhưng gây kết quả bất lợi, ví dụ: nhiễm độc, dị ứng hoặc điều trị không thành công** [Ghi rõ bên dưới nếu chưa được ghi chú trong phần TIỀN SỬ DÙNG THUỐC trước đó trong mẫu đơn: (1) (Các) loại thuốc đã thử và kết quả của (các) thử nghiệm thuốc (2) nếu gặp kết quả bất lợi, hãy liệt kê (các) loại thuốc và kết quả bất lợi tương

ứng với mỗi loại, (3) nếu điều trị không thành công, hãy liệt kê liều và thời gian điều trị tối đa tương ứng với (các) thuốc đã dùng thử, (4) nếu có (các) chống chỉ định, vui lòng liệt kê lý do cụ thể tại sao (các) thuốc ưu tiên/(các) thuốc trong danh mục thuốc khác bị chống chỉ định]

☐ **Bệnh nhân ổn định sau khi dùng (các) loại thuốc hiện tại; có nguy cơ cao gặp kết quả lâm sàng bất lợi đáng kể khi thay đổi thuốc** Cần giải thích cụ thể về kết quả lâm sàng bất lợi đáng kể theo dự liệu và tại sao lại cần dự kiến về kết quả bất lợi đáng kể – ví dụ: bệnh trạng khó kiểm soát (dùng nhiều loại thuốc, dùng cùng lúc nhiều thuốc để kiểm soát bệnh trạng), bệnh nhân gặp kết quả bất lợi đáng kể khi bệnh trạng trước đó không được kiểm soát (ví dụ như nhập viện hoặc thường xuyên thăm khám về bệnh cấp tính, đau tim, đột quỵ, ngã, hạn chế đáng kể về trạng thái chức năng, đau đớn và chịu đựng quá sức), v.v.

☐ **Nhu cầu y tế đối với các dạng bào chế khác nhau và/hoặc liều lượng cao hơn** [Ghi rõ bên dưới: (1) (Các) dạng bào chế và/hoặc (các) liều lượng đã thử và kết quả của (các) thử nghiệm thuốc; (2) giải thích lý do y tế (3) bao gồm lý do tại sao không chọn dùng thuốc ít thường xuyên hơn với liều lượng cao hơn - nếu có thuốc với liều lượng cao hơn]

☐ **Yêu cầu về trường hợp ngoại lệ về bậc thuốc trong danh mục thuốc** Ghi rõ bên dưới nếu chưa được ghi chú trong phần TIỀN SỬ DÙNG THUỐC trước đó trong mẫu đơn: (1) (các) loại thuốc theo danh mục thuốc hoặc (các) loại thuốc ưu tiên đã thử và kết quả của (các) thử nghiệm thuốc (2) nếu có kết quả bất lợi, hãy liệt kê (các) loại thuốc và kết quả bất lợi tương ứng với mỗi loại, (3) nếu điều trị không thành công/không hiệu quả do loại thuốc được yêu cầu, hãy liệt kê liều lượng và thời gian điều trị tối đa đối với (các) loại thuốc đã thử, (4) nếu có (các) chống chỉ định, vui lòng liệt kê lý do cụ thể tại sao (các) loại thuốc được ưu tiên/(các) thuốc trong danh mục thuốc khác bị chống chỉ định]

☐ **Khác** (vui lòng giải thích bên dưới)

Giải thích bắt buộc _____

_____

_____

_____

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_____

Medicare 處方藥拒絕決定重新裁決要求

由於 IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) 拒絕您的處方藥承保 (或給付) 要求，因此您有權要求我們針對我們的決定進行重新裁決 (上訴)。從 Medicare 處方藥承保拒絕通知日開始算起，您有 60 天的時間可以向我們提出重新裁決要求。您可透過郵寄或傳真將本表格傳送給我們：

地址：
IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

傳真號碼：
(909) 890-5748

您也可透過我們的網站 ***www.iehp.org*** 向我們提出上訴要求。特急上訴要求可透過電話提出，電話 **1-877-273-IEHP (4347)**，服務時間為每週 7 天 (包括假日)，上午 8 時至晚上 8 時 (太平洋標準時間 (PST)) 。聽語障專線使用者請撥 **1-800-718-4347**。

誰可提出要求：您的處方開立者可代您向我們提出上訴要求。如果您想請其他人 (例如家人或朋友) 替您提出上訴要求，該人士必須是您的代理人。請與我們聯絡以瞭解如何指定代理人。

計畫參加者資訊

計畫參加者姓名 _____ 出生日期 _____

計畫參加者地址 _____

城市 _____ 州 _____ 郵遞區號 _____

電話 _____

計畫參加者會員卡號碼 _____

僅有在提出要求的人士非計畫參加者的情況下才需填寫下列部分：

要求者姓名 _____

要求者與計畫參加者的關係 _____

地址 _____

城市 _____ 州 _____ 郵遞區號 _____

電話 _____

由計畫參加者或計畫參加者之處方開立者以外的人士提出上訴要求時的代理人證明文件：

如果未在承保裁決等級提出，請附上證明文件證實有獲得授權可以代表計畫參加者 (填妥的代理人授權書表格 CMS-1696 或具有同等效力的書面文件)。如需有關指定代理人的進一步資訊，請與您的計畫聯絡或撥打 1-800-Medicare。

您所要求的處方藥：

藥物名稱：_____單位含量 / 藥量 / 劑量：_____

您是否曾在上訴待審期間購買該藥物？☐ 是 ☐ 否

如回答「是」：
購買日期：_____支付金額：$ _____ (請附上收據副本)

藥房名稱及電話號碼：_____

處方開立者資訊

姓名 _____

地址 _____

城市 _____ 州 _____ 郵遞區號 _____

診所電話 _____ 傳真 _____

診所聯絡人 _____

重要注意事項：特急決定

如果您或您的處方開立者認為等候標準決定 7 天的時間可能會使您的生命、健康或恢復身體最佳機能的能力嚴重受損，您可提出特急 (快速) 決定要求。如果您的處方開立者指出等候 7 天的時間可能會使您的健康嚴重受損，我們將會自動在 72 小時內告知您我們的決定。如果您沒有取得處方開立者就特急上訴所提供的佐證，我們將會判定您的個案是否需要獲得快速決定。如果您想要求我們償付您已獲得之藥物的費用，您不得提出特急上訴要求。

☐ **如果您認為自己需要在 72 小時內獲得決定，請勾選此方框 (如果您持有處方開立者的佐證聲明，請隨附於此要求中)。**

請說明您提出上訴的理由。必要時請加頁說明。請附上您認為可能對您個案有幫助的任何額外資訊，例如處方開立者的聲明及相關病歷。您可能可以參閱我們在 Medicare 處方藥承保拒絕通知中所提供的說明，並請您的處方開立者針對計畫拒絕函或其他計畫文件中所述的計畫承保標準 (如有) 提供解釋。我們需要您處方開立者的意見，以說明為何您無法滿足計畫的承保標準及 / 或為何計畫所規定的藥物對您而言不具有醫療適當性。

_____

_____

_____

上訴要求者 (計畫參加者或代理人) 簽名：

_____ **日期：** _____

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) 是與 Medicare 和 Medi-Cal 均簽有合約的健保計畫，為計畫參加者提供兩種方案的福利。

Request for Redetermination of Medicare Prescription Drug Denial

Because IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Fax Number:
(909) 890-5866

You may also ask us for an appeal through our website at www.iehp.org.

Expedited appeal requests can be made by phone at 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays (TTY) 1-800-718-4347).

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Member's Information

Member's Name _____ Date of Birth _____

Member's Address _____

City _____ State _____ Zip Code _____

Phone _____

Member ID Number _____

Complete the following section ONLY if the person making this request is not the member:

Requestor's Name _____

Requestor's Relationship to Member _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than member or the member's prescriber:

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

Prescription drug you are requesting:

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? ☐ Yes ☐ No

If "Yes":
Date purchased: _____ Amount paid: $ _____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions
If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

_____

_____

_____

Signature of person requesting the appeal (the member or the representative):

_____ **Date:** _____

Solicitud de Redeterminación de la Denegación de Medicamentos Recetados de Medicare

Debido a que IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) denegó su solicitud de cobertura (o de pago) de un medicamento recetado, usted tiene derecho a solicitarnos una redeterminación (apelación) de nuestra decisión. Tiene 60 días a partir de la fecha de nuestro Aviso de Denegación de la Cobertura de Medicamentos recetados de Medicare para solicitarnos una redeterminación. Puede enviarnos este formulario por correo o por fax:

Dirección:	Número de Fax:
IEHP DualChoice P.O. Box 1800 Rancho Cucamonga, CA 91729-1800	(909) 890-5866

También puede solicitarnos una apelación a través de nuestro sitio web en www.iehp.org.

Las solicitudes de apelaciones aceleradas pueden realizarse por teléfono al 1-877-273-IEHP (4347), 8am - 8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos (TTY) 1-800-718-4347).

Quién Puede Realizar una Solicitud: El profesional que le receta medicamentos puede solicitarnos una apelación en su nombre. Si usted desea que otra persona (como un familiar o un amigo) solicite una apelación por usted, esa persona debe ser su representante. Comuníquese con nosotros para obtener información sobre cómo designar a un representante.

Información del Miembro

Nombre del Miembro _____ Fecha de Nacimiento _____

Dirección del Miembro _____

Ciudad _____ Estado _____ Código Postal _____

Teléfono _____

Número de Identificación de Miembro _____

Complete la siguiente sección ÚNICAMENTE si quien realiza esta solicitud no es el Miembro:

Nombre del Solicitante _____

Relación del Solicitante con el Miembro _____

Dirección _____

Ciudad _____ Estado _____ Código Postal _____

Teléfono _____

Documentación de representación para solicitudes de apelación realizadas por una persona que no sea el Miembro o el profesional que receta los medicamentos del Miembro:

Adjunte documentación que demuestre la autorización para representar al Miembro (un Formulario de Autorización de Representación CMS-1696 completado o un documento escrito equivalente) si dicha documentación no se presentó en el nivel de determinación de cobertura. Para obtener más información sobre cómo designar a un representante, comuníquese con su plan o al 1-800-Medicare.

Medicamento recetado que solicita:

Nombre del medicamento:_____ Concentración/cantidad/dosis:_____

¿Ya compró el medicamento que está en espera de la apelación? ☐ Sí ☐ No

Si la respuesta es “Sí”:
Fecha en que lo compró: _____Cantidad pagada: $ _____ (adjunte una copia del recibo)

Nombre y número de teléfono de la farmacia: _____

Información sobre el profesional que receta medicamentos

Nombre _____

Dirección _____

Ciudad _____ Estado _____ Código Postal _____

Teléfono del Consultorio _____ Fax _____

Persona de Contacto del Consultorio _____

Nota Importante: Decisiones Aceleradas
Si usted o el profesional que le receta medicamentos consideran que una espera de siete días para una decisión estándar podría afectar gravemente su vida, su salud o su capacidad para recuperar una función por completo, usted puede solicitar una decisión acelerada (rápida). Si su profesional que le receta medicamentos indica que una espera de siete días podría afectar gravemente su salud, automáticamente le informaremos de nuestra decisión dentro de las 72 horas. Si usted no obtiene la declaración de respaldo del profesional que le receta medicamentos para una apelación acelerada, nosotros decidiremos si su caso requiere una decisión rápida. No puede solicitar una apelación acelerada si nos pide que le reembolsemos un medicamento que ya recibió.

☐ **MARQUE ESTA CASILLA SI CREE QUE NECESITA UNA DECISIÓN DENTRO DE LAS 72 HORAS (si tiene una declaración de respaldo del profesional que le receta medicamentos, adjúntela a esta solicitud).**

Por favor, explique los motivos por los que presenta su apelación. Adjunte páginas adicionales si es necesario. Adjunte cualquier información adicional que considere que pueda ayudar con su caso, como una declaración de parte del profesional que le receta medicamentos y los registros médicos pertinentes. Le recomendamos que consulte la explicación que brindamos en el Aviso de Denegación de la Cobertura de Medicamentos Recetados de Medicare y que el profesional que le emite la receta médica satisfaga los criterios de cobertura del Plan, si corresponde, según lo indicado en la carta de denegación del Plan o en otros documentos del Plan. Se necesitará la opinión del profesional que le receta medicamentos para explicar por qué usted no puede cumplir con los criterios de cobertura del Plan y/o por qué los medicamentos requeridos por el Plan no son médicamente apropiados para usted.

_____

_____

_____

Firma de la persona que solicita la apelación (el Miembro o representante):

_____ **Fecha:** _____

Yêu cầu xem xét lại quyết định từ chối đài thọ thuốc theo toa Medicare

Do chúng tôi, Chương trình IEHP DualChoice Cal MediConnect (Chương trình Medicare-Medicaid) đã từ chối yêu cầu đài thọ (hoặc thanh toán) thuốc theo toa của quý vị, quý vị có quyền yêu cầu chúng tôi xem xét lại (kháng cáo) quyết định này. Quý vị có 60 ngày kể từ ngày nhận được Thông báo về quyết định từ chối đài thọ thuốc theo toa Mecidare này để yêu cầu chúng tôi xem xét lại. Mẫu đơn này có thể được gửi đến cho chúng tôi qua đường bưu điện hoặc fax:

Địa chỉ:
IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Số fax:
(909) 890-5748

Quý vị cũng có thể yêu cầu một đơn kháng cáo thông qua trang web của chúng tôi tại ***www.iehp.org***. Yêu cầu kháng cáo được giải quyết nhanh có thể được thực hiện qua điện thoại theo số **1-877-273-IEHP (4347)**, từ 8 giờ sáng đến 8 giờ tối (PST), 7 trong tuần, bao gồm cả ngày lễ. Người dùng TTY xin gọi số **1-800-718-4347**.

Ai có thể đưa ra yêu cầu: Người kê toa của quý vị có thể yêu cầu đơn kháng cáo thay cho quý vị. Nếu quý vị muốn một cá nhân khác (như một thành viên trong gia đình hoặc một người bạn) yêu cầu kháng cáo thay cho mình, cá nhân đó phải là người đại diện của quý vị. Hãy liên hệ với chúng tôi để biết cách chỉ định một người đại diện.

Thông tin về người ghi danh

Tên người ghi danh _____ Ngày sinh _____

Địa chỉ của người ghi danh _____

Thành phố _____ Tiểu bang _____ Mã zip _____

Điện thoại _____

Số ID hội viên của người ghi danh _____

Hãy hoàn thành mục sau đây CHỈ KHI người đưa ra yêu cầu không phải là người ghi danh:

Tên người yêu cầu _____

Mối quan hệ của người yêu cầu với người ghi danh _____

Địa chỉ _____

Thành phố _____ Tiểu bang _____ Mã zip _____

Điện thoại _____

Tài liệu đại diện cho các yêu cầu kháng cáo được thực hiện bởi một người không phải là người ghi danh hoặc người kê toa của người ghi danh:

Đính kèm giấy tờ, tài liệu chứng nhận thẩm quyền đại diện cho người ghi danh (Mẫu đơn cho phép đại diện CMS-1696 điền đầy đủ, hoặc văn bản tương đương) nếu giấy tờ này chưa được nộp ở cấp xác định khoản đài thọ. Để biết thêm thông tin về cách chỉ định một đại diện, vui lòng liên hệ với chương trình bảo hiểm của quý vị hoặc 1-800-Medicare.

Thuốc kê toa mà quý vị đang yêu cầu:

Tên thuốc: _____Hàm lượng/ độ mạnh/số lượng/liều: _____

Quý vị đã mua thuốc đang chờ kháng cáo chưa? □ Rồi □ Chưa

Nếu "Đã mua":
Ngày mua: _____Khoản tiền đã thanh toán: $ _____ (đính kèm bản sao biên lai)

Tên và số điện thoại của nhà thuốc: _____

Thông tin người kê toa

Tên _____

Địa chỉ _____

Thành phố _____ Tiểu bang _____ Mã zip _____

Số điện thoại văn phòng _____ Số fax _____

Người liên hệ tại văn phòng _____

Lưu ý quan trọng: Quyết định được giải quyết nhanh

Nếu người kê toa của quý vị cho rằng việc đợi 7 ngày để có được quyết định tiêu chuẩn có thể gây tổn hại nghiêm trọng đến tính mạng, sức khỏe hoặc ảnh hưởng đến khả năng có thể phục hồi chức năng tối đa của quý vị, quý vị có thể yêu cầu một quyết định được giải quyết nhanh (gấp). Nếu người kê toa của quý vị cho rằng việc đợi 7 ngày có thể gây tổn hại nghiêm trọng đến sức khỏe của quý vị, chúng tôi sẽ tự động gửi quyết định cho quý vị trong vòng

72 giờ. Nếu quý vị không có được sự hỗ trợ của người kê toa để có đơn kháng cáo được giải quyết nhanh, chúng tôi sẽ quyết định liệu trường hợp của quý vị có cần một quyết định gấp hay không. Quý vị không thể yêu cầu một kháng cáo được giải quyết nhanh nếu quý vị yêu cầu chúng tôi thanh toán lại cho quý vị đối với thuốc mà quý vị đã nhận.

☐ HÃY ĐÁNH DẤU VÀO Ô NÀY NẾU QUÝ VỊ CHO RẰNG MÌNH CẦN MỘT QUYẾT ĐỊNH TRONG VÒNG 72 GIỜ (Nếu quý vị có văn bản hỗ trợ từ người kê toa, vui lòng hãy đính kèm cùng yêu cầu này).

Vui lòng nêu lý do kháng cáo. Đính kèm thêm trang, nếu cần thiết. Hãy đính kèm thông tin bổ sung mà quý vị cho rằng có thể hỗ trợ cho trường hợp của mình, như thư chứng nhận từ người kê toa hoặc hồ sơ y tế liên quan. Quý vị có thể muốn tham khảo lời giải thích chúng tôi cung cấp trong Thông báo về quyết định từ chối đài thọ thuốc theo toa Mecidare và yêu cầu người kê toa của quý vị xử lý tiêu chí đài thọ của Chương trình bảo hiểm, nếu có, như được nêu ở trong thư từ chối của thư chứng nhận từ Chương trình bảo hiểm khác. Sẽ cần có ý kiến đóng góp của người kê toa của quý vị để giải thích lý do tại sao quý vị không thể đáp ứng được tiêu chí đài thọ Chương trình bảo hiểm và/hoặc tại sao loại thuốc bắt buộc trong Chương trình bảo hiểm lại không phù hợp về mặt y tế với quý vị.

_____

_____

_____

Chữ ký của người yêu cầu kháng cáo (người ghi danh hoặc người đại diện):

_____ Ngày: _____

Chương trình IEHP DualChoice Cal MediConnect (Chương trình Medicare-Medicaid) là Chương trình bảo hiểm y tế có hợp đồng với cả Medicare và Medi-Cal để cung cấp quyền lợi của cả hai chương trình cho người ghi danh.

<DATE>

<MEMBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <MEMBER NAME>:

This letter is to inform you that we can no longer cover prescription medications effective <Effective Date of OIG Exclusion> that are [*Insert one* <prescribed> < dispensed><>distributed><manufactured>] by [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>]. This includes new prescriptions, as well as any refills left on the prescriptions(s) you are currently taking.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) cannot cover medications [*Insert one* <prescribed> < dispensed><distributed> <manufactured>] by [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>] because he/she/it has been excluded from participation in all federal health care programs as of <Effective Date of Exclusion>, including the Medicare program, by the U.S. Department of Health and Human Services' Office of Inspector General (OIG). Medicare plans are prohibited from making payment for prescriptions prescribed, dispensed, or furnished by excluded individuals and entities. For more information about exclusions, you may visit the OIG's website at http://oig.hhs.gov/fraud/exclusions.asp.

{Sponsors should insert at least one of the three sentences below.}
[Please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347) (TTY users should call 1-800-718-4347) if you need assistance finding another <pharmacy>.] [Please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347) (TTY users should call 1-800-718-4347) if you need assistance finding another provider in your area who can prescribe your medications.] [Please call your prescriber if you need assistance finding another medication.] If you have further questions regarding the status of your prescription(s), we are available from 8am – 8pm (PST) 7 days a week, including holidays. TTY users should call 1-800-718-4347. The call is free.

Sincerely,

<Plan Representative>

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

Last Updated <Date>

<DATE>

<MEMBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

Estimado/a <MEMBER NAME>:

El motivo de esta carta es para informarle que, a partir del <Effective Date of OIG Exclusion> no podremos seguir cubriendo los medicamentos recetados que sean [*Insert one* <recetados> < despachados><>distribuidos><fabricados>] por [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>]. Tampoco podremos cubrir nuevas recetas ni resurtidos restantes de los medicamentos recetados que usted toma actualmente.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) no puede cubrir medicamentos [*Insert one* <recetados> <despachados><distribuidos> <fabricados>] por [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY> <NAME OF DISTRIBUTOR><NAME OF MANUFACTURER>] porque este/a ha sido excluido/a de participar en todos los programas federales de atención médica a partir del <Effective Date of Exclusion>, incluido el programa Medicare, por la Oficina del Inspector General (Office of Inspector General, OIG) del Departamento de Salud y Servicios Humanos de los Estados Unidos. Los planes de Medicare tienen prohibido hacer pagos por los medicamentos que sean recetados, despachados o suministrados por personas y entidades excluidas. Para obtener más información sobre las exclusiones, puede visitar el sitio web del OIG en http://oig.hhs.gov/fraud/exclusions.asp.

{Sponsors should insert at least one of the three sentences below.}
[Por favor, llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347) (los usuarios de TTY deben llamar al 1-800-718-4347) si necesita ayuda para encontrar otra <farmacia>.] [Por favor, llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347) (los usuarios de TTY deben llamar al 1-800-718-4347) si necesita ayuda para encontrar otro proveedor en su área que pueda recetarle sus medicamentos.] [Por favor, llame al profesional que le receta si necesita ayuda para encontrar otro medicamento.] Si tiene más preguntas sobre el estado de sus recetas, estamos disponibles de 8am-pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. La llamada es gratuita.

Atentamente,

<Plan Representative>

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.

Última actualización: <Date>

<Print_Date>

IEHP
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Return Service Requested

<MEMBER FIRST NAME> <MEMBER LAST NAME>
<ADDRESS LINE 1>
<ADDRESS LINE 2>
<ADDRESS LINE 3>
<City> <ST> <ZIP>

YOUR DRUG(S) IS NOT ON OUR LIST OF COVERED DRUGS (FORMULARY) OR IS SUBJECT TO CERTAIN LIMITS

Dear <MEMBER FIRST NAME> <MEMBER LAST NAME>:

We want to tell you that IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) has provided you with a temporary supply of the following prescription[s]:

<name of drug1>
<name of drug2>
<name of drug3>
<name of drug4>
<name of drug5>

This drug[s] is either not included on our list of covered drugs (called our formulary), or it's included on the formulary but subject to certain limits, as described in more detail later in this letter. IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is required to provide you with a temporary supply of this drug[s]. If your prescription is written for fewer than <XX> days, we'll allow multiple fills to provide up to a maximum of <XX> days of medication.

It's important to understand that this is a temporary supply of this drug(s). Well before you run out of this drug[s], you should speak to IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) and/or the prescriber about:

- changing the drug[s] to another drug[s] that is on our formulary; or
- requesting approval for the drug[s] by demonstrating that you meet our criteria for coverage; or
- requesting an exception from our criteria for coverage.

When you request approval for coverage or an exception from coverage criteria, these are called coverage determinations. Don't assume that any coverage determination, including any exception, you have requested or appealed has been approved just because you receive more fills of a drug. If we approve coverage, then we'll send you another written notice.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at 1-877-273-4347. TTY users should call 1-800-718-4347. Live representatives are available from 8am - 8pm (PST), 7 days/wk including holidays. You can ask us for a coverage determination at any time. **Instructions on how to change your current prescription[s], how to ask for a coverage determination, including an exception, and how to appeal a denial if you disagree with our coverage determination are discussed at the end of this letter.**

The following is a specific explanation of why your drug[s] <is/are> not covered or <is/are> limited.

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is not on our formulary. We will not continue to pay for this drug after you have received the maximum <XX> days' temporary supply that we are required to cover, unless you obtain a formulary exception from us.]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is not on our formulary. In addition, we could not provide the full amount that was prescribed, because we limit the amount of this drug that we provide at one time. This is called a quantity limit and we impose such limits for safety reasons. In addition to imposing quantity limits as this drug is dispensed for safety reasons, we will not continue to pay for this drug after you have received the maximum <XX> days' supply that we are required to cover unless you obtain a formulary exception from IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan).]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is on our formulary, but requires prior authorization. Unless you obtain prior authorization from us by showing us that you meet certain requirements, or we approve your request for an exception to the prior authorization requirements, we will not continue to pay for this drug after you have received the maximum <XX> days' temporary supply that we are required to cover.]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is on our formulary. However, we will generally only pay for this drug if you first try other drug(s), specifically <Insert Step drug(s)>, as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe, effective, and lower cost drug before progressing to other more costly drugs. Unless you try the other drug(s) on our formulary first, or we approve your request for an exception to the step therapy requirement, we will not continue to pay for this drug after you have received the maximum <XX> days' temporary supply that we are required to cover.]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is on our formulary. However, we will generally only pay for this drug if you first try a generic version of this drug. Unless you try the generic drug on our formulary first, or we approve your request for an exception, we will not continue to pay for this drug after you have received the maximum <XX> days' temporary supply that we are required to cover.]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is on our formulary and is subject to a quantity (QL). We will not continue to provide more than what our QL permits, which is <XX> unless you obtain an exception from IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan).]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is not on our formulary. We will cover this drug for <XX> days while you seek to obtain a formulary exception from IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan). If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is on our formulary and requires prior authorization. We will cover this drug for <XX> days while you seek to obtain coverage by showing us that you meet the prior authorization requirements. You can also ask us for an exception to the prior authorization requirements if you believe they should not apply to you for medical reasons.]

[Name of Drug: <DrugName>
Date Filled: <FillDate>
Reason for Notification: This drug is on our formulary, but will generally be covered only if you first try certain other drugs as part of our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for <XX> days while you seek to obtain coverage by showing us that you meet the step therapy criteria. You can also ask us for an exception to the step therapy requirement if you believe it should not apply to you for medical reasons.]

How do I change my prescription?

If your drug[s] is not on our formulary, or is on our formulary, but we have placed a limit on it, then you can ask us what other drug[s] used to treat your medical condition is on our formulary, ask us to approve coverage by showing that you meet our criteria, or ask us for an exception. We encourage you to ask your prescriber if this other drug[s] that we cover is an option for you. You have the right to request an exception from us to cover your drug[s] that was originally prescribed. If you ask for an exception, your prescriber will need to provide us with a statement explaining why a prior authorization, quantity limit, or other limit we have placed on your drug is not medically appropriate for you.

How do I request coverage determination, including an exception?

You or your prescriber may contact us to request a coverage determination, including an exception. IEHP DualChoice, IEHP Pharmaceutical Services Department, P.O. Box 1800, Rancho Cucamonga, CA, 91729-1800, Fax 909-890-2058, and Phone 1-877-273-4347.

If you are requesting coverage of a drug that is not on our formulary, or an exception to a coverage rule, your prescriber must provide a statement supporting your request. It may be helpful to bring this notice with you to the prescriber or send a copy to his or her office. If the exception request involves a drug that is not on our formulary, the prescriber's statement must indicate that the requested drug is medically necessary for treating your condition, because all of the drugs on our formulary would be less effective as the requested drug or would have adverse effects for you. If the exception request involves a prior authorization or other coverage rule we have placed on a drug that is on our formulary, the prescriber's statement must indicate that the coverage rule wouldn't be appropriate for you given your condition or would have adverse effects for you.

We must notify you of our decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request, from when we receive your request. For exceptions, the timeframe begins when we obtain your prescriber's statement. Your request will be expedited if we determine, or your prescriber tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

What if my request for coverage is denied?

If your request for coverage is denied, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must request this appeal within 60 calendar days from the date of our written decision on your coverage determination request. [You must file a standard request in writing.] [We accept standard requests by phone and in writing.] We accept expedited requests by phone and in writing. IEHP DualChoice, IEHP Pharmaceutical Services Department, P.O. Box 1800, Rancho Cucamonga, CA, 91729-1800, Fax 909-890-2058, and Phone 1-877-273-4347.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at 1-877-273-4347 8am - 8pm (PST), 7 days/wk including holidays. TTY users should call 1-800-718-4347. Live representatives are available from 8am - 8pm (PST), 7 days/wk including holidays. You can ask us for a coverage determination at any time. You can also visit our website at www.iehp.org.

Sincerely,

IEHP Pharmaceutical Services Department

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

H5355_001_HSRX_20002 Accepted (11/20/2019)

<Print_Date>

IEHP
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

Return Service Requested

<MEMBER FIRST NAME> <MEMBER LAST NAME>
<ADDRESS LINE 1>
<ADDRESS LINE 2>
<ADDRESS LINE 3>
<City> <ST> <ZIP>

SU(S) MEDICAMENTO(S) NO ESTÁ(N) EN NUESTRA LISTA DE MEDICAMENTOS CUBIERTOS (FORMULARIO) O ESTÁ(N) SUJETO(S) A CIERTOS LÍMITES

Estimado/a <MEMBER FIRST NAME> <MEMBER LAST NAME>:

Deseamos informarle que IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) le ha proporcionado un suministro temporal del/de los siguiente[s] medicamento[s] con receta: <list medication[s] here>:

<name of drug1>
<name of drug2>
<name of drug3>
<name of drug4>
<name of drug5>

Este/estos medicamento[s] o bien no está[n] incluido[s] en nuestra lista de medicamentos cubiertos (denominada Formulario), o bien sí está[n] incluido[s] en el Formulario, pero está[n] sujeto[s] a ciertos límites, como se detalla más adelante en esta carta. IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) debe proporcionarle un suministro temporal de este/estos medicamento[s]. Si su receta está indicada para menos días que <XX> días, permitiremos que realice múltiples resurtidos por un máximo de <XX> del medicamento.

Es importante que usted entienda que este es un suministro temporal de este/estos medicamento(s). Mucho antes de que este/estos medicamento[s] se termine[n], debe comunicarse con IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) o con la persona autorizada a dar recetas para:

- cambiar el/los medicamento[s] por otro[s] que esté[n] en nuestro formulario,

- solicitar la aprobación del/de los medicamento[s], demostrando que cumple con nuestros criterios de cobertura,
- solicitar una excepción a nuestros criterios de cobertura.

Cuando solicita la aprobación para la cobertura o una excepción a los criterios de cobertura, eso se denomina determinaciones de cobertura. No debe asumir que las determinaciones de cobertura, incluidas las excepciones, que usted solicitó o apeló fueron aprobadas solo porque obtiene más resurtidos de un medicamento. Si aprobamos la cobertura, le enviaremos otro aviso por escrito.

Si necesita asistencia para solicitar una determinación de cobertura, incluida una excepción, o si desea obtener más información sobre cuándo cubriremos un suministro temporal para un medicamento, comuníquese con nosotros al 1-877-273-4347. Los usuarios de TTY deben llamar al 1-800-718-4347. Los representantes en persona están disponibles de 8am – 8pm (hora del Pacífico), 7 dias de la semana incluidos festivos. Puede pedirnos que tomemos una determinación de cobertura en cualquier momento. **Al final de la carta, encontrará las instrucciones sobre cómo cambiar su[s] medicamento[s] con receta, cómo solicitar una determinación de cobertura, incluida una excepción, y cómo apelar una denegación si no está de acuerdo con nuestra determinación de cobertura.**

La siguiente es una explicación concreta de por qué su[s] medicamento[s] no <está/están> cubierto[s] o <está/están> limitado[s].

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento no se encuentra en nuestro Formulario. No seguiremos pagando este medicamento después de que haya recibido el suministro temporal para <XX> días como máximo que estamos obligados a cubrir, a menos que obtenga una excepción al Formulario <adicional> por nuestra parte.]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento no se encuentra en nuestro Formulario. Además, no pudimos brindar la cantidad recetada completa porque limitamos la cantidad de este medicamento que brindamos una sola vez. Esto se llama límite de cantidad y establecemos dichos límites por motivos de seguridad. Además de establecer límites sobre la cantidad de este medicamento que se entrega por razones de seguridad, no seguiremos pagando este medicamento después de que haya recibido el suministro para <XX> días como máximo que estamos obligados a cubrir, a menos que obtenga una excepción al Formulario por parte de IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento se encuentra en nuestro Formulario, pero requiere autorización previa. A menos que obtenga autorización previa de nuestra parte demostrando que cumple con ciertos requisitos, o que aprobemos su solicitud para una excepción a los requisitos de la autorización previa, no continuaremos pagando por este medicamento después de que haya recibido el suministro temporal para <XX> días como máximo que estamos obligados a cubrir.]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento se encuentra en nuestro Formulario. Sin embargo, en general, solo pagaremos este medicamento si primero prueba otro(s) medicamento(s), concretamente <Insert Step drug(s)>, como parte de lo que llamamos programa de tratamiento escalonado. El tratamiento escalonado consiste en la práctica de comenzar el tratamiento con medicamentos con lo que consideramos ser un medicamento seguro, eficaz y de menor costo, antes de pasar a otros medicamentos más costosos. A menos que pruebe otro(s) medicamento(s) de nuestro Formulario primero, o que aprobemos su solicitud para una excepción a los requisitos del tratamiento escalonado, no continuaremos pagando por este medicamento después de que haya recibido el suministro temporal para <XX> días como máximo que estamos obligados a cubrir.]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento se encuentra en nuestro Formulario. Sin embargo, en general, solo pagaremos este medicamento si primero prueba una versión genérica de este. A menos que pruebe el medicamento genérico de nuestro Formulario primero, o que aprobemos su solicitud para una excepción, no continuaremos pagando por este medicamento después de que haya recibido el suministro temporal para <XX> días como máximo que estamos obligados a cubrir.]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento está en nuestro Formulario y está sujeto al límite de cantidad (QL). No continuaremos brindando más de lo que permitan nuestros límites de cantidad, que es <XX>, a menos que obtenga una excepción de IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan).]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento no se encuentra en nuestro Formulario. Cubriremos este medicamento durante <XX> días mientras usted trata de obtener una excepción al Formulario de parte de IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan). Si se encuentra en el proceso de búsqueda de una excepción, consideraremos permitir una cobertura continua hasta que se tome una decisión.]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento se encuentra en nuestro Formulario y requiere autorización previa. Cubriremos este medicamento durante <XX> días mientras trata de obtener cobertura, demostrando que cumple con los requisitos para autorización previa. También puede solicitarnos una excepción a los requisitos para una autorización previa si considera que no deberían aplicarse a usted por razones médicas.]

[Nombre del medicamento: *<DrugName>*
Fecha de obtención: *<FillDate>*
Motivo de aviso: este medicamento se encuentra en nuestro Formulario, pero en general, tendrá cobertura solo si primero prueba con otros medicamentos, como parte de nuestro programa de

tratamiento escalonado. El tratamiento escalonado consiste en la práctica de comenzar el tratamiento con medicamentos con lo que consideramos ser un medicamento seguro y eficaz, y de menor costo, antes de pasar a otros medicamentos más costosos. Cubriremos este medicamento durante <XX> días mientras trata de obtener cobertura, demostrando que cumple con los criterios del tratamiento escalonado. También puede solicitarnos una excepción al requisito para un tratamiento escalonado si considera que no debería aplicarse a usted por razones médicas.]

¿Cómo cambio mi medicamento con receta?

Si su[s] medicamento[s] no se encuentra[s] en nuestro Formulario, o está[n] en nuestro Formulario pero hemos establecido un límite sobre este/estos, puede consultarnos qué otro[s] medicamento[s] utilizado[s] para tratar su afección médica está[n] en nuestro Formulario, solicitarnos que aprobemos la cobertura demostrando que cumple con nuestros criterios, o solicitar una excepción. Le recomendamos que consulte con la persona autorizada a dar recetas si otro[s] medicamento[s] que cubrimos es/son una opción para usted. Tiene derecho a solicitarnos una excepción para que cubramos el/los medicamento[s] que fue[ron] recetado[s] originalmente. Si solicita una excepción, la persona autorizada a dar recetas deberá proporcionarnos una declaración en la que explique por qué una autorización previa, el límite de cantidad u otro límite que hayamos establecido para ese medicamento no son apropiados desde el punto de vista médico para usted.

¿Cómo solicito una determinación de cobertura, incluida una excepción?

Usted o la persona autorizada a dar recetas deberá contactarse con nosotros para solicitar una determinación de cobertura, incluida una excepción. IEHP DualChoice, IEHP Pharmaceutical Services Department, P.O. Box 1800, Rancho Cucamonga, CA, 91729-1800, Fax 909-890-2058, y Teléfono 1-877-273-4347.

Si solicita cobertura para un medicamento que no está en nuestro Formulario, o para una excepción a la norma de cobertura, la persona autorizada a dar recetas debe proporcionar una declaración que respalde su solicitud. Puede ser útil que lleve este aviso cuando visite a la persona autorizada a dar recetas o que envíe una copia a su consultorio. Si la solicitud de excepción involucra un medicamento que no está en nuestro Formulario, la declaración de la persona autorizada a dar recetas debe indicar que el medicamento solicitado es médicamente necesario para tratar su afección, porque ninguno de los medicamentos del Formulario tendría resultados tan buenos como el medicamento solicitado o porque estos podrían tener efectos adversos para usted. Si la solicitud de excepción implica una autorización previa u otra norma de cobertura que hayamos establecido sobre un medicamento del Formulario, la declaración de la persona autorizada a dar recetas debe indicar que la norma de cobertura no sería apropiada dada su afección o porque podría tener efectos adversos para usted.

Debemos notificarle sobre nuestra decisión dentro de las 24 horas si la solicitud ha sido acelerada, o dentro de las 72 horas si la solicitud es estándar, desde el momento en que recibimos su solicitud. En caso de excepciones, el plazo comienza cuando recibimos la declaración de la persona autorizada a dar recetas. Su solicitud será acelerada si determinamos, o si la persona autorizada a dar recetas nos informa, que su vida, salud o capacidad para recuperar la función máxima pueden estar seriamente en peligro por esperar una solicitud estándar.

¿Qué sucede si mi solicitud de cobertura es rechazada?

Si su solicitud de cobertura es rechazada, usted tiene el derecho de apelar pidiendo una revisión de la decisión anterior, lo que se denomina una redeterminación. Debe solicitar este recurso en un plazo de 60 días calendario a partir de la fecha de nuestra primera decisión por escrito de su solicitud de determinación de cobertura. [Debe presentar por escrito una solicitud estándar.] [Aceptamos solicitudes estándares por teléfono y por escrito.] Aceptamos solicitudes aceleradas por teléfono y por escrito. IEHP DualChoice, IEHP Pharmaceutical Services Department, P.O. Box 1800, Rancho Cucamonga, CA, 91729-1800, Fax 909-890-2058, y Teléfono 1-877-273-4347.

Si necesita asistencia para solicitar una determinación de cobertura, incluida una excepción, o si desea obtener más información sobre cuándo cubriremos un suministro temporal para un medicamento, comuníquese con nosotros al 1-877-273-4347, 8am – 8pm (hora del Pacífico), 7 dias de la semana incluidos festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. Los representantes en persona están disponibles de 8am – 8pm (hora del Pacífico), 7 dias de la semana incluidos festivos. Puede pedirnos que tomemos una determinación de cobertura en cualquier momento. También puede visitar nuestro sitio web en www.iehp.org.

Atentamente,

IEHP Pharmaceutical Services Department

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene un contrato con ambos Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.

H5355_001_HSRX_20002_S Accepted (11/20/2019)

INLAND EMPIRE HEALTH PLAN

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:** _____