

Procedures that support safe prescribing



Your plan sponsor provides you with Inter-County Hospitalization Plan, Inc. and Inter-County Health Plan, Inc. (Inter-County) benefits that are administered by AmeriHealth Administrators and include a prescription drug benefit plan. FutureScripts®, an independent Pharmacy Benefits Manager (PBM), administers your prescription plan. As your plan's PBM, FutureScripts is responsible for providing a network of participating pharmacies, administering pharmacy benefits, and providing customer service to plan members and health care providers.

PRIOR AUTHORIZATION

Your health benefits program requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on: clinical data; information submitted by the plan member's prescribing physician; and the plan member's available prescription drug therapy history. Their review includes a determination that: there are no drug interactions or contraindications; that dosing and length of therapy are appropriate; and that other drug therapies, if necessary, were utilized.

Without prior authorization, the plan member's prescription will not be covered at your health benefits program's retail or mail order pharmacy. (See *96-hour Temporary Supply Program* in this document.) The prior authorization process may take up to two working days once FutureScripts receives complete information from the prescribing physician. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a plan member to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

DRUGS THAT REQUIRE PRIOR AUTHORIZATION

Currently, the drugs listed below are part of the prior authorization program. Prior authorization applies to all formulations of these specific drugs, including, but not limited to, tablet, capsule, and oral suspension.

Because prescription drug programs vary by group, the inclusion of a drug in this list does not imply coverage. This list is subject to change. Please call 1-888-678-7013 for any questions about your prescription drug benefit.

AcipHex®	Aplenzin™	Cayston™	Effient™
Actiq®	Atacand®/Atacand HCT®	Celebrex®	Embeda™
Adcirca™	Avapro®/Avalide®	Cesamet®	Enbrel®
Afinitor®	Avidoxy™ DK	Cialis®	Exalgo™
Alodox™	AZOR™	Cimzia®	Exforge®
Altanax™	Banzel™	Colcrys™	Exforge HCT®
Alvesco®	Benicar®/Benicar HCT®	Cozaar®/Hyzaar®	Exjade®
Ambien CR®	Bepreve™	Crestor®	Fanapt™
Amevive™	BiDil®	Cymbalta®	Fentora®
Ampyra™	Botox®	Daytrana™	Fibricor™
AMRIX®	Byetta®	Diovan®/Diovan HCT®	Flector® Patch
Apidra®	Caduet®	Edex®	Forteo™
Apidra® SoloSTAR®	Caverject®	Edluar™	Gleevec®

Glumetza™	Nucynta™	Rozerem™	Thalomid®
Humalog®	NutriDox™	Ryzolt™	Toviaz™
Humira®	Nuvigil®	Sabril®	Treximet™
Humulin®	Oforta™	Samsca™	Trilipix™
HYCAMTIN® Capsules	Omnaris™	Saphris®	Twynsta®
Intuiv™	Onglyza™	Savella™	Tykerb®
Invega™	Onsolis™	Seroquel XR®	Tyvaso™
Iressa®	Opana®	Simcor®	Uloric®
Janumet™	Oracea®	Simponi™	Ultram® ER
Januvia™	Pataday™	Singulair®	Valturna
Kapidex™	Pennsaid®	Sprycel®	Vectical™
Keppra XR™	PrandiMet™	Suboxone®	Veramyst™
Kineret®	Prevacid®	Subutex®	Viagra®
Levitra®	Prevacid/NapraPAC®	Sumavel™	Victoza®
Lipitor®	Prilosec® Suspension	Sutent®	Vimpat™
Lunesta®	Pristiq™	Symbicort®	Voltaren® Gel
Lyrica®	Protonix®	Symlin®	Votrient™
Magnacet™	Provigil®	Synagis®	Vytorin®
Micardis®/Micardis	Pylera™	Taclonex®	Vyvanse™
HCT®	Qalaaquin®	Taclonex Scalp®	Xenazine™
Mirapex ER®	Ranexa®	Suspension	Xyzal®
Mobic®	Raptiva®	Tarceva®	Zelapar®
MUSE®	ReliOn®/Novolin®	Tasigna®	Zipsor™
Myobloc®	Renvela®	Tekturna®/Tekturna	Zmax™
Nexavar®	Requip® XL™	HCT®	Zolinza®
Nexium®	Revatio™	Temodar® Oral	Zyvox®
Noxafil®	Revlimid®	Teveten®/Teveten HCT®	

All diabetic test strips require prior authorization *except* the following: Autodisc® Test Strips; Breeze® Test Strips; Contour® Test Strips; FreeStyle Lite® Test Strips; and Precision Xtra® Test Strips.

AGE AND GENDER LIMITS

The FDA has established specific procedures that govern prescribing practices. These rules are designed to prevent potential harm to patients and ensure that the medication is prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals age 14 and older, such as ciprofloxacin, or prescribed only for females, such as prenatal vitamins.

The pharmacist's computer provides up-to-date information about FDA rules. If the plan member's prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request preapproval of restricted medications when medically necessary.

The approval criteria for this review were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing physicians and pharmacists. The plan member should contact the prescribing physician to request that he or she initiate the preapproval process. To determine if a covered prescription drug prescribed for you has an age or gender limit, call FutureScripts at 1-888-678-7013.

If the request is approved	If the request is denied
<ul style="list-style-type: none"> ▪ FutureScripts notifies the prescribing physician by fax or telephone and enters the approval in the claims processing system. ▪ The plan member may call FutureScripts Customer Service at 1-888-678-7013 to determine if the prescription is approved. 	<ul style="list-style-type: none"> ▪ FutureScripts notifies the prescribing physician by letter, fax, or telephone. ▪ FutureScripts also notifies the plan member by letter. ▪ The denial letters sent to the plan member and physician explain the appeals process.

APPEALING A DECISION

If a request for prior authorization/preapproval or override results in a denial, the plan member or physician, on the plan member's behalf, may file an appeal. Both the plan member and the physician will receive written notification of a denial, which will include the telephone number and address to which they can direct an appeal. In all cases, the physician must be involved in the appeals process to provide the required medical information for the basis of the appeal.

QUANTITY LEVEL LIMITS

Quantity level limits are designed to allow a sufficient supply of medication based on FDA-approved maximum daily doses and length of therapy of a particular drug.

30-day supply. The first type of quantity limit is based on a 30-day supply of a medication per fill. Examples include: Avonex[®] (1 kit, 4 injections); Betaseron[®] (15 vials); Copaxone[®] (32 vials); Fosamax Plus DTM (5 tablets); and Rebif[®] (12 injections); sedative hypnotic drugs such as Sonata[®] (14 capsules) and Ambien[®] (14 tablets); and oral narcotic drugs such as OxyContin[®] (90 units), Percocet[®] (180 units), and Percodan[®] (180 units).

If the plan member's prescription exceeds the quantity limit, the pharmacist will fill it for the 30-day supply, and the plan member must follow up with his or her physician regarding future prescriptions. The physician may request a quantity limit override if the plan member's therapy requires a larger daily dose of medication. The plan member should ask the prescribing physician to initiate the preapproval request for an override.

Rolling 30-day period. Another type of quantity limit is based on FDA dosing guidelines over a rolling 30-day period. Examples of quantity level limits per rolling 30-day period include: Emend[®] [four 125mg capsules + eight 80mg capsules or four trifold packs (one 125mg capsule + two 80mg capsules)]; Boniva[®] (two 150mg tablets); and also migraine drugs such as: Amerge[®] (nine 2.5mg tablets); Imitrex[®] (36 50mg tablets); Maxalt[®] (12 10mg tablets); Migranal[®] (eight 4mg nasal spray units); Stadol NS[®] (four 10mg units); and Zomig[®] (nine 5mg tablets).

For example, if a plan member goes to the pharmacy on October 1 for one of these medications, the computer system looks back 30 days to September 1 to see how much medication was dispensed. If the quantity exceeds the FDA recommendations, the plan member's physician must submit information to explain why the increased quantity is needed. The plan member would need to contact the prescribing physician to initiate the preapproval request for an override. These limits are intended to ensure that these drugs are used properly and to guard against overuse or stockpiling.

Refill too soon. This ensures that the medication is being taken in accordance with the prescribed dose and frequency of administration. If a plan member has used less than 75 percent of the total day supply dispensed, the claim will be rejected at the pharmacy.

If a physician determines that a plan member needs a medication therapy that exceeds any of the quantity level limits described above, the physician must request a quantity limit override. The plan member must contact the physician to initiate a preapproval request for an override. To determine if a covered prescription drug prescribed for you has a quantity level limit, call FutureScripts at 1-888-678-7013.

THERAPEUTIC DRUG CLASS

This quantity level limit applies to some classes of drugs, such as narcotics (that is, short-acting and long-acting). If a plan member uses more than one drug within the same class, he or she may be unsafely duplicating medications and would be affected by the total quantity limits for a therapeutic drug class. Plan members will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic class each month.

96-HOUR TEMPORARY SUPPLY PROGRAM

The 96-hour Temporary Supply Program applies to the following covered medications:

- Most medications that require prior authorization;
- Medications that are subject to age limits (preapproval required for ages outside of recommended ranges);
- Migraine medications with quantity level limits, such as Amerge[®], Imitrex[®], Maxalt[®], Migranal[®], Stadol NS[®], and Zomig[®]. Preapproval of quantity override is required for amounts over the quantity level limits.

Under the 96-hour Temporary Supply Program, if a plan member's physician writes a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity limit for a medication, and the physician has not obtained prior authorization/pre-approval, the following steps occur:

1. The participating retail pharmacy is instructed to release a 96-hour supply of the drug to the plan member with no cost sharing at that time.
2. The plan member's physician submits the necessary documentation of medical necessity or medical appropriateness for review.
3. Once FutureScripts receives the completed medical documentation, they complete the review and approve or deny the request.
4. **If approved**, the pharmacy fills the remainder of the prescription order and the plan member will pay the appropriate prescription drug cost sharing.
5. **If denied**, FutureScripts will notify the physician and the plan member.

Obtaining a 96-hour temporary supply does not guarantee approval of the prior authorization/ preapproval request.

Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations. These drugs include but are not limited to: Retin-A® (tube); Enbrel® (2-week injection kit); medroxyprogesterone acetate (monthly injectable); and erectile dysfunction drugs. Additionally, certain drugs to treat hemophilia (antihemophilic factors) are not usually purchased at the pharmacy and must be special-ordered; therefore, they are not eligible for the 96-hour temporary supply.

HOW TO REQUEST A PRIOR AUTHORIZATION/PREAPPROVAL OR OVERRIDE

- The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and faxes it to FutureScripts at 215-241-3073 or 1-888-671-5285. Or the physician may request the form by calling 1-888-678-7013. Plan members may request the form through Customer Service on their physician's behalf, but the physician must complete and submit it.
- FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review it.
- A decision is made regarding the request.