15.7 Coverage Determinations for Part D Prescription Drugs – Medicare

Most Healthfirst Medicare plans offer Medicare prescription drug coverage (Part D). Generally, the members must share costs for their prescription drugs. Drugs on the formulary are grouped into four (4) tiers *with the lowest cost share being Tier 1 and the highest being Tier 4*:

- **Tier 1**: Generic
- **Tier 2**: Preferred Brand
- **Tier 3**: Non-Preferred Brand
- **Tier 4**: Specialty

Healthfirst 65 Plus Plan however is designed to be the preferred plan for Medicare beneficiaries who do not qualify for "Extra Help," either in the form of Low Income Subsidy (LIS) for Part D or Medicare Savings Programs (MSP) for Medical benefits. As such, this plan offers a comprehensive benefit package, including additional benefits not covered by Original Medicare, but at a $0 monthly premium, making it a high-value yet affordable choice. Healthfirst 65 Plus Plan has a 5 tier prescription drug formulary.

Tier 1: Generic
Tier 1: Non-Preferred Generic Drugs
Tier 3: Preferred Brand Drugs
Tier 4: Non-Preferred Brand Drugs
Tier 5: Specialty Tier Drugs

Coverage determinations include exception requests. An exception request is the way a member can exercise his or her right to ask for an "exception" to the formulary. In other words, to request lower cost-sharing. An exception request must be accompanied by a supporting statement from the prescribing provider.

Healthfirst strongly encourages and recommends that a prescribing provider review the current Medicare Part D formulary to identify the drugs that are covered for Healthfirst members. The formulary can help a provider identify the therapy or therapies that will be least expensive for the member. In general, the lower the drug tier, the lower the cost of the drug. The formulary can also help a provider identify the drugs and therapies that are preferred by Healthfirst. The formulary was developed by a Pharmaceutical and Therapeutics (P&T) Committee comprising a national panel of clinicians. The formulary can help providers understand the Healthfirst strategy for managing the pharmacy benefit. Healthfirst recognizes that sometimes this strategy may not align with a provider's treatment criteria.

Prior Authorization (PA)

Healthfirst Medicare Plan requires a member or his or her provider to request prior authorization for certain drugs. This means the member must obtain prior approval for a prescription from Healthfirst Medicare Plan before the prescription is filled. If you do not obtain approval, Healthfirst Medicare Plan may not cover the drug.

- **Quantity Limit (QL):** For certain drugs, Healthfirst Medicare Plan limits the amount of the drug that Healthfirst Medicare Plan will cover.
- **Step Therapy (ST):** In some cases, Healthfirst Medicare Plan requires the member first try certain drugs to treat their medical condition before we will cover another drug for that condition.

Healthfirst's Medicare formulary, as well as Prior Authorization (PA), Step Therapy (ST), and Quantity Limit (QL) criteria listings, can be found on Healthfirst's public website:www.healthfirst.org/formulary.html.

To initiate a coverage determination request, including a request for a Part D drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department, 7:00am to 5:30pm MST, Monday–Friday, in one of the following ways:

- **CALL** CVS Caremark at 1-855-344-0930, 7:00am to 5:30pm MST, Monday–Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7:00am to 5:30pm MST, Monday–Friday
- **WRITE** CVS Caremark

CVS Caremark Part D Services

Attention: Prior Authorization – Part D

MC109

PO Box 52000

Phoenix, AZ 85072-2000

Medicare Part D Appeals

A member's appointed representative or his or her prescribing provider may request that a coverage determination be expedited. Time frames begin after receipt of the request. A member may appeal an adverse coverage determination; however, if an exception request for a non-formulary drug is approved, the member cannot request an exception to the copayment they are required to pay for the drug.

A member has a right to appeal if he or she believes that Healthfirst/CVS Caremark, Inc. did any of the following:

- Decided not to cover a drug, vaccine, or other Part D benefit,
- Decided not to reimburse a member for a part D drug that he/she paid for,
- Asked for payment or provided reimbursement with which a member disagrees,
- Denied the member's exception request,
- Made a coverage determination with which the member disagrees.

Appeals for Part D Prescription Drugs

- **CALL** CVS Caremark at 1-855-344-0930, 7:00am to 5:30pm MST, Monday–Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7:00am to 5:30pm MST, Monday–Friday
- **TTY** Number: 1-866-236-1069
- **WRITE** CVS Caremark

CVS Caremark Part D Services

Attention: Prior Authorization – Part D

MC109

PO Box 52000

Phoenix, AZ 85072-2000

Complaints About Part D Prescription Drugs

WRITE TO:

CVS Caremark
Attn: Grievance Department
MC 121
P.O. Box 53991
Phoenix, AZ 85072-3991

If CVS Caremark fails to meet coverage determination or redetermination time frames, it must automatically forward the member's request(s) to the Independent Review Entity (IRE) contracted by CMS.

If the IRE upholds the Healthfirst adverse coverage determination, the IRE will notify the member in writing and explain further appeal options that may be available to the member.

Time Frames for Coverage Determinations and Appeals

CVS Caremark is required to make coverage determinations and to process appeals as expeditiously as the member's health status requires but no later than is indicated in the following chart:

Medicare Prescription Drug (Part D) Time Frames for Appeals

	STANDARD*	EXPEDITED*
Pharmacy Coverage Determinations (Initial Decision)	72-hour time limit†	24-hour time limit†
APPEAL PROCESSES		
FIRST LEVEL OF APPEAL (Internal)	**MAPD/PDP** **Standard Redetermination** 7-day time limit	**MAPD/PDP** **Expedited Redetermination** 72-hour time limit
SECOND LEVEL OF APPEAL (Independent Review Entity – IRE)	**Independent Review Entity** **Standard Redetermination** 7-day time limit	**Independent Review Entity** **Expedited Redetermination** 72-hour time limit
THIRD LEVEL OF APPEAL (Office of Medicaid Hearings and Appeals) For amounts in controversy ≥ $150.00‡	**Administrative Law Judge** **Standard Decision** 90-day time limit	**Administrative Law Judge** **Expedited Decision** 10-day time limit
FOURTH LEVEL OF APPEAL (Medicare Appeals Council – MAC)	**Standard Decision** 90-day time limit	**Standard Decision** 10-day time limit
FINAL LEVEL OF APPEAL – JUDICIAL REVIEW (Federal District Court)	**Federal District Court**	

Note: Each appeal level requires member or member's representative to file the appeal within 60 days of previous determination.

* A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the member, by the member's appointed representative, or by the member's provider or other prescriber.

† The adjudication time frames generally begin when the request is received by CVS Caremark/Healthfirst. However, if the request involves an exception request, the adjudication time frame begins when CVS Caremark/Healthfirst receives the provider's supporting statement.

‡ The amount in controversy requirement for an Administrative Law Judge hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2015.