Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual - Pharmacy

Important note:

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

In this Section

The following topics are covered in this section.

Blue Choice PPO and BlueHPN Provider Manual - Pharmacy

Introduction

The following applies to members who have a Blue Cross and Blue Shield of Texas (BCBSTX) Prescription (RX) Drug Rider. Depending on the member's individual contract, pharmacy services may or may not be provided through the BCBSTX pharmacy plan. Some plans may be "carved out" to other Pharmacy Benefit Managers (PBMs). BCBSTX's PBM name is listed on the front of the member's identification card. Prime Therapeutics is the PBM that provides drug benefits through BCBSTX.

Pharmacy Network

BCBSTX members with a "pharmacy card" prescription (RX) drug benefit must use a pharmacy on the approved list of participating pharmacies to maximize their benefits. This pharmacy network can include retail for up to a 30-day or 90-day supply, home delivery for up to a 90-day supply or specialty pharmacy for up to a 30-day supply. Some members' pharmacy benefit plans may include an additional preferred pharmacy network, which offers reduced out-of-pocket expenses to the member if they use one of these pharmacies instead. Pharmacy networks and supply limits are dependent upon the member's benefit plan. Please encourage your patients to use one pharmacy for all their prescriptions to better monitor drug therapy and avoid potential drug-related problems.

BCBSTX contracts for home-delivery pharmacy services to augment our retail pharmacy network. Members of our plans may receive up to a 90-day supply of maintenance medication (e.g., drugs for arthritis, depression or diabetes) through the home-delivery program. If you believe that a member of one of our plans will continue the same drug and dose for an indefinite time, please consider writing the prescription for a 90-day supply with three refills. If the patient is starting a new medication for the first time, you should write two prescriptions, one for up to a 90-day supply with three refills and a starter supply for up to 30 days that the patient can fill right away at the local retail pharmacy.

Specialty drugs that are U.S. Food and Drug Administration (FDA) approved for patient self-administration typically must be acquired through a specialty pharmacy provider. The patient may also bill these drugs under their pharmacy benefit to receive maximum coverage.

Prescription Drug List Evaluation

BCBSTX uses the Prime Therapeutics National Pharmacy and Therapeutics (P&T) Committee, which is responsible for drug evaluation. The P&T committee consists of independent-practicing physicians and pharmacists from throughout the country who are not employees or agents of Prime Therapeutics. BCBSTX will have one voting member on the committee. The P&T Committee meets quarterly to review new drugs and updates drug information based on the currently available literature.

Prescription Drug List Evaluation, cont.

BCBSTX delegates RX utilization management services to Prime Therapeutics for prior authorizations, quantity exceptions, and/or step therapy for members who have a BCBSTX Prescription Drug Rider. To submit a request, visit the Prior Authorization and Step Therapy Programs webpage. BCBSTX committees determine the addition of brand-name drug products to the Prescription Drug List.

Prescription Drug Benefits

BCBSTX members can have a pharmacy benefit of up to six-tiers. Listed drugs on the member's drug listmay be covered at generic, brand and specialty tier levels. Depending on the member's benefit plan, drug tiers may be split between preferred and non-preferred and members may pay a lower member share (out-of-pocket expense) for prescription drugs in the lower tiers.

For some members, the BCBSTX Prescription Drug List may only list generics and lower cost brand drugs. For other members, BCBSTX Prescription Drug List may reference all covered prescription drugs while not listing the uncovered drugs. If the prescription drug is not covered, you may be able to submit a coverage exception for consideration (based on the member's benefit plan). Refer to the member's certificate of coverage for more details, including benefits, limitations and exclusions.

Prescription Drug List Updates

The BCBSTX Prescription Drug List helps providers select cost-effective drug therapy. The drug list also describes how drugs are selected, coverage considerations and dispensing limits. As a reminder, drugs that have not received FDA approval are not covered under the member's pharmacy benefit for safety concerns. Please refer to the drug list when prescribing for our members.

BCBSTX notifies physicians of Prescription Drug List additions and changes through newsletters, the provider News and Updates webpage and the Prescription Drug List.

Members may be notified of changes by direct mailings. Members who are identified as taking a medication(s) that has been deleted from the BCBSTX prescription drug list are sent a letter detailing the change at least 60 days before the effective, deletion date. Medications deleted from the BCBSTX prescription drug list may still be available to members at a higher copayment, or the medication may not be covered, and the member is charged for the full cost of the drug. BCBSTX and Prime Therapeutics also provide pharmaceutical-safety notifications to dispensing providers and members regarding point-of-sale drug-drug interaction and FDA drug recalls.

Call the number on the back of your patient's member ID card for assistance in determining the correct Prescription Drug List, if needed.

Prescription Drug List Updates, cont.

Note: The BCBSTX Prescription Drug List is a tool to help members maximize their benefits. The final decision about what medications should be prescribed is between the health care provider and the patient

Generic Drugs

The FDA has a process to assign equivalency ratings to generic drugs. An "A" rating from the FDA means that the drug manufacturer has submitted documentation demonstrating the equivalence of its generic product compared to the brand name product.

BCBSTX supports the FDA process for determining the equivalency and encourages its contracted providers to prescribe drugs that have generic alternatives available and not to add "dispense as written" to prescriptions unless medically necessary, and if clinically appropriate, coverage criteria that prevent use of a generic for a particular patient has been met. Most plans may require members to pay the difference between the brand-name drug and generic drug plus the generic copayment.

If you determine that your patient cannot tolerate the available generic equivalent, some member's plans may allow you to submit documentation for consideration to waive any cost share penalties that may be applied to the member otherwise. If approved, the member would only be responsible for their applicable cost share for the brand drug. Call the number on the back of your patient's member ID card for assistance in completing this process.

Drug Utilization Review (DUR) Overview

BCBSTX and Prime Therapeutics conducts concurrent and retrospective drug utilization reviews to ensure the most appropriate and cost-effective drugs are used safely.

Concurrent DUR occurs at the point of sale (i.e., at the dispensing pharmacy). Pharmacies are electronically linked to Prime Therapeutics' claims adjudication system. This system contains various edits that check for drug interactions, overutilization (i.e., early refill attempts), and therapeutic duplications. The system also alerts the pharmacist when the prescribed drug may have an adverse effect if used by elderly or pregnant members. The pharmacist can use his or her professional judgment and call the prescribing provider if a potential adverse event may occur.

Safety checks on prescription opioids address permissible quantity and medication dose, as recommended by the Centers for Disease Control and Prevention (CDC) and other nationally recognized guidelines. The pharmacist will receive alerts advising if authorization may be required before the full quantity of opioids as prescribed may be dispensed at the point of sale.

Drug Utilization Review (DUR) Overview, cont.

Retrospective DUR uses historical prescription and/or medical claims data to identify potential prescribing and dispensing issues after the prescription is filled. Examples of retrospective DUR include appropriate use of controlled substances, a polypharmacy, adherence and generic utilization programs. These programs aim to promote safety, reduce overutilization and close gaps in care.

Retrospective DUR programs are developed based on widely accepted national practice guidelines. Individual letters may be mailed to providers identifying potential drug therapy concerns, together with a profile listing the member's prescription medications filled during the study period, references to national practice guidelines and/or a link to an on-line survey to be completed.

Covered Pharmacy Services

The following is a list of typically* covered pharmacy services:

- Glucagon and anaphylactic kits
- Insulin, syringes, lancets, and test strips
- Any prescription drug, unless specifically excluded (e.g., obesity, infertility) provided that the drug is ordered by the member's Primary Care Physician (PCP) or a physician to whom the member has been referred.
- The member's applicable prescription copayment will apply for each prescription or refill for 30 days.
- Oral Contraceptives
- Diaphragms
- Preventive vaccinations (e.g., influenza, Tdap, shingles etc.)
- One applicable copay will apply to most "packaged" item (e.g., inhalers)
- Medications that are approved by the U.S. Food and Drug Administration (FDA) for self-administration.

Non-Covered Pharmacy Services

The following is a list of typically* non-covered pharmacy services:

- Any charge for most therapeutic devices or appliances (e.g., support garments and other non-medical substances), regardless of their intended use
- Investigational use of medication
- Medications specifically excluded from benefit (e.g., drugs used for cosmetic purposes)
- Any drug that, as required under the Federal Food, Drug and Cosmetic Act, does not bear the phrase: "Caution: Federal law prohibits dispensing without a prescription," even if prescribed by a physician/provider (over the counter)
- Drugs that have not received approval from the FDA Nutritional Supplements (coverage requires prior authorization)
- Compounded medications are not a covered benefit under most plans
- Prescriptions obtained at an out-of-network pharmacy unless in an emergency

* Note: Not all BCBSTX plans include pharmacy benefits. BCBSTX highly recommends checking member's benefits before prescribing mediciation.

Drugs Requiring Prior Authorization

Drugs with high potential for experimental or off-label use may require prior authorization (PA), also known as preauthorization. For drugs that require a prior authorization, step therapy or quantity limits, view the Pharmacy Program section of our provider website for detailed information including links to forms and program criteria summaries.

You can submit the TX Standard Prescription Drugs Prior Authorization Form request electronically via CoverMyMeds® site by attaching the form during the request process. Other physcian/ provider fax forms are also available.

Changes to prior authorization or step therapy requirements are also published in our provider newsletter, Blue Review. If you have additional questions, please call Prime Therapeutics at **1-800-289-1525**.

BCBSTX allows for certain off-label uses of drugs when the off-label uses to meet the requirements of the BCBSTX policy.

For information about PA criteria, please review our Medical Policies.

Drugs Requiring Prior Authorization, cont.

If you are prescribing and/or administering select infusion drugs, you may need to submit a prior authorization request prior to administration of the drug. These infusion drugs are administered by health care professionals and typically covered under the member's medical benefit. For a list of the infusion drugs, please visit our Utilization Management page to review the prior authorization lists the **Prior Authorizations Lists** for designated groups of infusion drugs. Benefits can be determined by calling the number on your patient's member ID card.

Prior Authorization Exemptions

Under Texas House Bill 3459, providers may qualify for an exemption from submitting prior authorization requests for particular health care service(s) for all fully insured and certain Administrative Services Only (ASO) groups. Prior authorization exemption status may be granted to providers meeting the legislation requirements for applicable members. PA exemption status does not supersede benefits, eligibility or referral requirements.

Where a PA exemption has been granted, requests for prior authorization for the exempted service(s) are not required for applicable members or groups after the date of notice. PA requests for non-exempt services are still required as applicable. Re-evaluation may occur every six months to determine eligibility.

View the Prior Authorizations Exemptions page for additional information. For a list of services that require prior authorization, review the Utilization Management requirements.

*Prior authorization exemption status for any prior authorization managed by a Pharmacy Benefit Manager (PBM) other than Prime Therapeutics will be conveyed by the PBM.

Specialty Pharmacy Program and Specialty Pharmacy Network

Specialty medications are used to treat serious or chronic conditions, such as immune deficiency, multiple sclerosis and rheumatoid arthritis. Due to the unique storage and shipment requirements, some specialty medications may not be available at retail pharmacies. The Specialty Pharmacy Program helps deliver these medications directly to providers, and sometimes directly to the member.

Specialty medication coverage is based on the member's benefit. Prior Authorization or Recommended Clinical Review approval may still apply to specific specialty medications.

Some members may be required to use a specific preferred contracted specialty pharmacy, or be subject to a split fill program, in order for pharmacy benefits to apply.

Specialty Pharmacy Program and Specialty Pharmacy Network, cont.

Most specialty medications will require prior authorization.You can submit the TX Standard Prescription Drugs Prior Authorization Form electronically through CoverMyMeds. For more information about medical criteria, please refer to the Medical Policies.

BCBSTX members may be required to use contracted, specialty network pharmacies only to fill their prescription for coverage consideration, per their benefit plan. The pharmacists, nurses, and care coordinators in our specialty network pharmacies are experts in supplying medications and services to patients with complex health conditions.

For those medications that are approved by the FDA for self-administration, BCBSTX members may be required to use their pharmacy benefit and acquire self-administered drugs (oral, topical and injectable) through the appropriate contracted pharmacy provider and not through the physician's office. Self-administered drugs must billed under the member's pharmacy benefit for your patients to receive coverage. View specialty medications on the Specialty Drug Program page.

If services are submitted on professional/ancillary electronic (ANSI 837P) or paper (CMS-1500), claims for drugs that are FDA-approved for self-administration and covered under the member's prescription drug benefit, BCBSTX will notify the provider that these claims need to be re-filed through the member's pharmacy benefit. In this situation, the following message will be returned on the electronic payment summary or provider claim summary: "Self-administered drugs submitted by a medical professional provider are not within the member's medical benefits. These charges must be billed and submitted by a pharmacy provider."

If you have questions about the specialty program, a patient's benefit coverage and/or to ensure the correct benefit is applied for medication fulfillment, please call the Customer Service number on the back of your patient's member identification (ID) card.

Accredo is a preferred specialty pharmacy for most BCBSTX members. Please call the number on the back of the member's ID card to confirm the member's preferred specialty pharmacy provider.

To obtain specialty medications through Accredo, follow these steps:

1. Collect patient and insurance information.
2. Contact Accredo at **1-833-721-1619** or e-prescribe the patient's prescription to Accredo.
3. You can find referral forms by therapy and e-prescribing information at accredo.com/prescribers.
4. If your patient has an existing prescription for a covered specialty medication, you can call **1-833-721-1619** to transfer the prescription.

Specialty Pharmacy Program and Specialty Pharmacy Network, cont.

Accredo specialty pharmacy's team of pharmacists and benefit specialists will handle the details from checking eligibility to coordinating delivery. You also have access to varied support tools, such as physician concierge, ePA, interoperability with electronic health records (EHR) and visibility into the status of Accredo patients through a provider portal.

BCBSTX contracts with select specialty pharmacies to obtain specialty medications for physician administration to our members. These medications that must be administered to a patient by a health care provider are typically covered under the member's medical benefit. Providers should only bill for the administration of the specialty medication(s) when received from these specialty pharmacies. Providers may not bill for the specialty medication.

BCBSTX contracts with select in-network specialty pharmacies* to ensure the availability of specialty medications. For those members who have Prime Therapeutics (Prime) as their pharmacy benefit manager, acquiring self-administered specialty drugs through these specialty pharmacies will help to ensure maximum benefit coverage.

For a complete list of all in-network specialty pharmacies, including in-network specialty pharmacies for physician-administered medications that are typically covered under the medical benefit, please visit the Pharmacy Program/Specialty Drug Program.

*The relationship between BCBSTX and the specialty pharmacies is that of independent contractors.

Split Fill Program

Some BCBSTX members have the Split Fill Program as part of their benefit plan. This program applies to select medications that patients are often unable to tolerate. Under this program, members who are new to therapy (or have not had claims history within the past 120 days for the drug) are provided a partial fill, or"split" fill for up to the first three months of therapy, giving them the opportunity to try the drug at a prorated cost. This allows the member to make sure they can tolerate the medication and any potential side effects before continuing ongoing therapy.

The Split Fill Program applies to specific drugs known to have early discontinuation or dose modification. Each drug is evaluated using evidence-based criteria to determine the frequency and duration of a split fill. The Pharmacy Program page lists all the current drugs in this program. This list of drugs is subject to change at any time.

Split Fill Program, cont.

Members must use an in-network specialty pharmacy. This includes specialty pharmacies participating in our oral oncology network and Limited Distribution (LD) pharmacies. Members will pay an applicable prorated cost share for each fill received for the duration of the program. Once the member can tolerate the medication, the member will pay the applicable cost share amount for a full supply. All member cost share amounts are determined by the member's pharmacy benefit plan.

Billing for Compounded Drugs

Drug compounding is the process of mixing, combining or altering ingredients to create a customized medication. This is considered experimental, investigational and unproven in most cases according to the BCBSTX Medical Policy on Compounded Drugs.

Compounded drugs should be filed under the appropriate "Not Otherwise Classified" procedure code with the Modifier KD. You can review the Compound Drug Schedule through the **secure content** section of the General Reimbursement Information page.

Pain Pump and Progesterone Therapy
The properties of certain drugs may be altered and combined by a compounding pharmacy to create a customized medication for the use in a pain pump or for progesterone therapy as a technique to reduce pre-term delivery in high-risk pregnancies.

BCBSTX has adopted the same methodology as the Centers for Medicare and Medicaid Services (CMS) to more effectively and consistently price those drugs approved under these medical policies for Progesterone Therapy and Implantable Infusion Pumps. Review the following BCBSTX Medical Policies related to **Progesterone Therapy (RX501.062)** and **Implantable Infusion Pumps (SUR707.008)**. (**Note:** you will have to agree to the policy disclaimer before accessing the policies page, then select "Active Policies" and choose the policy you wish to reference.)

If you have any further questions, please contact Provider Customer Service at **1-800-451-0287** to speak with a Customer Advocate.

Billing Unlisted Drug Codes

More than 50% of National Drug Code (NDC) numbers billed have either an assigned Current Procedural Terminology (CPT®) code or an assigned Healthcare Common Procedure Coding System (HCPCS) code?

CPT codes are referred to as Level I codes and are maintained by the American Medical Association (AMA). Level I codes are comprised of five (5) characters in length (e.g., 99211, 30520, etc.). HCPCS codes are referred to as Level II codes and are governed by the American Hospital Association (AHA) and CMS. Level II codes are five (5) characters in length and are comprised of one (1) letter and four (4) numbers (e.g., J1950, J9217, etc.).

In most instances, NDC numbers billed are compared to a list of specific CPT or HCPCS drug codes. It is important that claims be submitted with the CPT/HCPCS code with the most specific description when billing for medications that are used during a patient's visit. BCBSTX checks the NDC numbers and NDC units submitted with an unlisted drug code to ensure these codes are being billed correctly.

What does this mean for our providers?

- If a claim is submitted using an unlisted drug code (e.g., J3490) and a valid CPT/HCPCS code exists for the drug being administered, BCBSTX will deny the service line and request the provider to resubmit the service using the more accurate CPT/ HCPCS code.
- If a claim is submitted with an unlisted drug code (e.g., J3490) and there is not a more specific CPT/HCPCS code for the drug being administered, the provider will need to provide the necessary information on the claim for BCBSTX to properly adjudicate the service line. Otherwise, the claim may be denied and returned with a request to resubmit the service and include the necessary information.

Avoiding a claim rejection

To avoid a claim rejection, include the following information when submitting valid, unlisted drug codes:

- NDC qualifier, N4
- NDC billing number
- NDC product package size unit of measure (e.g., UN, ML, GR, F2, etc.)
- NDC unit to reflect the quantity of drug product billed

Billing Unlisted Drug Codes, cont.

- NDC Number
- Drug Name
- Strength of drug administered (e.g., 25 mg/ml, 10 mg/10ml, etc.)
- Dosage administered (e.g., 5 mg, 10 mg, etc.)
- Include how the number of units being billed on the claim is being administered (e.g., 5 mg = 1 unit, 10 mg = 5 ml, etc.)
- Single dose vial or multi-dose vial

Note: An NDC number will be reimbursed for a maximum of two (2) years after it becomes inactive. After this timeframe, the NDC number is considered obsolete.

For more information, reference the **Unlisted/Not Otherwise Classified Coding Policy**, the **NDC Billing Guidelines** or the N**DC Billing Frequently Asked Questions**. You may also contact Provider Customer Service at 1-800-451-0287 and speak with a customer advocate.

Forms

All required forms can be downloaded from the Forms page under the Education & Reference page on the website.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are instructed to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the subscriber's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

BCSTX contracts with Prime Therapeutics LLC to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Accredo is a specialty pharmacy that is contracted to provide services to BCBSTX members. The relationship between Accredo and BCBSTX is that of independent contractors.