PRESBYTERIAN

Presbyterian Health Plan Pharmacy Services Guide

Greetings from the Presbyterian Pharmacy Services Team!

Our team works within the Health Plan to manage prescription drug benefits for members with Presbyterian prescription drug coverage.

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Pharmacy Benefit Assistance

Getting answers for pharmacy benefit related questions is easier than ever.

Call the number on the back of your member ID card
Monday through Friday from 8 a.m. to 5 p.m.

Understanding Pharmacy Benefits

The **Pharmacy benefit** is the part of the health insurance that helps to pay the cost of certain prescription medications. The terms of coverage for these drugs are determined by a committee of doctors, pharmacists, and health care professionals who use clinical knowledge, government regulations and FDA guidelines to recommend the most beneficial products based on the efficacy, safety, and overall value. The list of these drugs is managed by a member's health plan and is called a **formulary**. Medications that are not on that list are classified as **non-formulary**.

Although drugs on a formulary are considered preferred by your health plan over other, similar drugs on the market; *additional terms and restrictions may still apply.*

Safety limits, Prior Authorization criteria requirements, and Step Therapy programs are used by the health plan to ensure that medications are used effectively and safely, as intended by the professionals who manage the drug list. Formularies are revised periodically throughout the year to ensure that our members are receiving the highest quality care at the lowest possible cost.

How Does the Formulary Work?

Formulary (Drug List):

A list of pharmacy products a health plan covers based on the recommendations of a committee of healthcare professionals. This list is updated based on various factors such as evidence-based practice guidelines, state and federal regulations, and changes in cost. **Drugs on the preferred drug list may still have additional requirements and restrictions.** Example:

terbinafine hcl oral tablet 250 mg	**Tier 1**	Quantity Limit applies (90 EA per 365 days)

Tier Status:

Some plans group drug coverage in levels ranging from preferred generics to Specialty medications. **Different tiers may follow different co-payment and coinsurance rules.**

T1 Tier 1	**Tier 1 Preferred Generic**	T3 Tier 3	**Tier 3 Non-Preferred Drug**

Prior Authorization:

Clinical evaluation process to determine service is:

- medically necessary
- a covered benefit
- delivered in appropriate setting

Submitted documentation must confirm all clinical requirements are met **before** your doctor can provide the service or medication.

Step Therapy:

Promotes use of equally effective but lower-cost Formulary drugs first.

"Prerequisite" drugs must be used prior to the Step Therapy drug.

Documentation may be required if indicated steps have been tried and failed or can't be tolerated.

Additional Limits:

Certain drugs on your formulary may have restrictions, such as:

- Quantity limits
- Age limits
- Dispensing sites requirements

Prior Authorization and Coverage Requests

When is a Coverage Request needed?

A request for coverage must be submitted to the health plan when a prescription is written for a product that requires a Prior Authorization (PA) or if you need an exception to be made to your formulary or its coverage rules. The criteria for drugs requiring a PA is publicly available. Providers requesting exceptions for their patients should submit documentation indicating the product is medically necessary over other preferred products listed on the formulary. This can include clinical notes showing the exhaustion of formulary alternatives or the inability to take these alternatives.

How does the coverage request process begin?

A request for coverage must be submitted to the health plan when a prescription is written for a product that requires a Prior Authorization (PA) or if you need an exception to be made to your formulary or its coverage rules. The criteria for drugs requiring a PA is publicly available. Providers requesting exceptions for their patients should submit documentation indicating the product is medically necessary over other preferred products listed on the formulary. This can include clinical notes showing the exhaustion of formulary alternatives or the inability to take these alternatives.

Review and Determination Completion Times

Once the Pharmacy Services team receives a request, a clinical pharmacy review specialist will determine whether a standard or urgent review is being requested. Presbyterian must follow strict guidelines outlining how long we can take to either approve or deny any request. Some requests may qualify for a time extension. If you feel you are experiencing excessive delays, please contact the number on the back of your member ID card or access the member portal via myPRES to view the status of your request.

When all necessary information is provided with the drug PA request, **standard requests** are processed as expeditiously as the member's health requires. In most cases **72 hours** is an appropriate turnaround time and allows for Pharmacy Services to reach out for missing paperwork.

When a member or their provider believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in jeopardy, an **urgent/expedited request** can be made. These requests are processed within **24 hours** after the request is received.

Line of Business	Standard Request	Urgent/Expedited Request
Medicaid	24 hours	24 hours
Commercial/Exchange	72 hours	24 hours
Medicare	72 hours	24 hours

Clinical Review of Coverage Requests

What happens during a review?

To determine medical necessity, a registered pharmacist performs a clinical review. The pharmacist confirms the member meets PA criteria or that an exception to the formulary or its coverage rules must be made. When necessary, a medical director performs a secondary review. In rare instances you may qualify for an extension.

Request is APPROVED

An authorization is entered into the system and the authorization details are sent to the requesting entity, the affected member, and the dispensing pharmacy (if available). To ensure members continue to receive appropriate and efficient care, please note:

- Authorizations typically expire and will need to be renewed.
- Start and end dates are outlined in the approval notices
- The Pharmacy Services team sends reminders to members when approvals for medications used regularly to treat chronic or ongoing health conditions are about to expire
- Members can also view the status of their Prior Authorization requests on the member portal

Request is DENIED

The request may be denied for a variety of reasons ranging from criteria to missing documentation.

A denial notice is sent within three business days to the requesting entity, the affected member, and the dispensing pharmacy (if available). Reasons for the denial and available alternatives are provided. The notice includes information on member appeal rights.

If the provider disagrees with the denial, documentation addressing each of the denial reasons may be submitted for review. The provider may also call to request a verbal review with a pharmacist or medical director within 10 days of the denial. If the denial is still upheld additional steps will be mailed directly to the member. Both the member and provider can contact the health plan to initiate an appeal.

Pharmacy Tools and Resources

Pharmacy Resources on the Presbyterian Website

Presbyterian's formularies and drug coverage rules are posted publicly at phs.org.

On the Prescription Drug Coverage page, members can access their printable and online formularies, find pharmacies near them and learn about home delivery.

Visit https://www.phs.org/tools-resources/member/pharmacy to learn more.

myPRES Member Portal

As a Presbyterian member, you also have access to personalized tools to help customize your care plan to meet your needs!

myPRES allows patients, members, and providers to access information and tools designed specifically for them.

Login to myPRES

You can view the status of your Prior Authorization in real time, access your claims history, and search for best drug pricing from the comfort of your home using My Rx! My Rx is available through the myPRES application.