Pharmacy Newsletter
Q1 2023

How to Manage Your Patient's Drug Formulary Restrictions

Providers send multiple coverage determinations and appeal requests daily to their patients' Medicare Part D (drug coverage) plan sponsors to obtain coverage for a drug. At [Plan Name], we understand that this process can become tedious and overwhelming. Therefore, we wanted to offer our providers some helpful tips as well as answers to frequently asked questions (FAQs) about Medicare Part D coverage determinations and provide more insight as to what you can do to ease some of the apprehension surrounding this process.

Coverage Determination Headaches?

Helpful Hints and FAQs to ease the pain of coverage determination and appeals requests.

What are coverage determination requests and what are the types of requests?

A **coverage determination (also called prior authorization)** is defined as the receipt of, or payment for, a prescription drug that a beneficiary/patient believes may be covered under the Medicare Part D drug plan. There are many types of coverage determinations that a beneficiary/provider, or beneficiary's appointed representative can request, which are as follows:

- **Formulary Exception** – A request that applies to medications which are not on the plan's formulary.
- **Tiering Exception** – A request to have a medication pay at a lower cost share.
- **Quantity Limit Exception** – A request that asks for a larger quantity of medication than the limits set forth by the health plan.
- **Step Therapy** – A request to forgo trying a first line agent.
- **Drug with Prior Authorization Criteria.**

What are the timeframes for coverage determination requests?

Under Medicare Part D law, coverage determinations need to be reviewed within a specific timeframe to provide patients with the best possible care so that there is no interruption in therapy. For **urgent** coverage determination requests, the managed care organization must issue a decision, whether it's an approval or denial, within **24 hours** from the time that the request was received. For **standard** coverage determination requests, the managed care organization must issue a decision, whether it's an approval or denial, within 72 hours from the time that the request was received. **It is worth noting that the time allotted for these requests is continuous and does not pause for weekends and holidays.**

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How do I find out what supportive information I need to provide to my patient's Medicare Part D plan for a medication coverage determination request?

All Medicare Part D plans have online formularies that inform the patient and the provider about what criteria must be met to satisfy prior authorization requirements for a medication. However, some medications are non-formulary, and in this case the patient must try **all** formulary alternatives before receiving the non-formulary medication, **or**, you must submit a supporting statement that includes information as to why the formulary alternatives would not be appropriate for the patient. You can check your patient's Medicare Part D plan website to obtain this information.

What if I do not submit adequate medical information or supportive evidence that meets the criteria for the drug that is being requested for review within the allotted CMS timeframes for coverage determinations?

When the Medicare Part D health plan reviews the request, if there is not enough supportive medical information to either approve or deny a coverage determination request for a medication, the health plan will fax a Request for Information (RFI) request to you, the provider. The RFI provides specific details to you about the missing information that is needed to appropriately review the requested medication to either approve or deny the request. **It is important for you to respond to RFIs in a timely manner; otherwise, a denial may be issued, which may delay patient therapy. To be timely with an "RFI" response, you would have to provide any supportive information to the health plan within 24 or 72 hours of the date of you receive the RFI depending on whether the request is urgent or standard, respectively.**

What if I provide the information needed for an approval of the coverage determination request to the health plan after the allotted timeframe?

If the health plan denied the coverage determination because the supporting information was not received in a timely manner, the beneficiary/provider, or beneficiary's appointed representative may file an appeal with the patient's Medicare Part D plan. An appeal must be filed within 60 days of the coverage determination denial date. If more than 60 days has passed since the denial decision date, the beneficiary/provider, or beneficiary's appointed representative will need to re-submit the request as a new coverage determination request.

Turnaround times for Part D appeals are different than coverage determination timeframes. An **urgent** appeal must be reviewed within 72 hours, and a **standard** appeal must be reviewed within seven days. Please note that RFIs will also be sent to you for appeals if there is not enough supporting information to make a decision for the appeal request.

Amerihealth Caritas VIP Care is here to help!

If you have any questions about how to submit a coverage determination or about an RFI sent to your office, please reach out to our Pharmacy Benefits Manager, PerformRx, at **866-543-2657** to reach their Provider Services Team for more information!

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