BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health ℠ Provider Manual - Pharmacy

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health**. These specific requirements will be noted with the plan/ network name. If a plan/network name is not specifically listed or the "**Plan**" is referenced, the information will apply to **all** HMO products.

In this Section

The following topics are covered in this section:

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Introduction

The following applies to members who have a Blue Cross and Blue Shield of Texas (BCBSTX) Prescription 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 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 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 period of 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 must be acquired through a specialty pharmacy provider. The patient must also bill these drugs under their pharmacy benefit to receive maximum coverage.

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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.

BCBSTX delegates prescription (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 request a prior authorization, go to the *Prior Authorization and Step Therapy Programs* information on the BCBSTX provider website. We have established BCBSTX committees which determine the addition of brand-name drug products to the Prescription Drug List.

Prescription Drug List Updates

The BCBSTX Prescription Drug Lists are provided as a guide to help in the selection of cost-effective drug therapy. In addition to the list of approved drugs, the drug list 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.

BCBSTX members can have a pharmacy benefit of up to six-tiers. Listed drugs may be covered at generic, brand and specialty tier levels. Depending on the member's benefit plan, drugs may be split between preferred and non-preferred within these tiers. Based on the benefit plan, members may pay a lower member share (out of pocket expense) for prescription drugs in the lower tiers.
Some BCBSTX members' Prescription Drug List may only list generics and lower cost brand drugs. Some BCBSTX members' Prescription Drug List may reference all covered prescription drugs, and drugs not listed are not covered. If the drug is not covered, you may be able to submit a drug list coverage exception to BCBSTX 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, cont.

Please refer to the BCBSTX Prescription Drug List when prescribing for our members. Call the number on the back of your patient's member ID card for assistance in determining the correct Drug List, if needed.

BCBSTX provides notification to physicians of additions and changes made to the BCBSTX Prescription Drug List by newsletters and on the BCBSTX Provider website. Members may be notified of changes by direct mailings. Additions and updates to the Drug List can be found on the BCBSTX provider website under the Pharmacy Program tab.

Members who are identified as taking a medication 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. It is important to remember that a medication deleted from the BCBSTX Prescription Drug List may still be available to members yet at a higher copayment or the medication may not be covered and the member is charged for the full amount of the drug cost. BCBSTX and Prime Therapeutics also provide pharmaceutical safety notifications to dispensing providers and members regarding point-of-dispensing drug-drug interaction and FDA drug recalls.

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 the use of a generic for a particular patient have been met. Most plans require members to pay the difference between the brand-name drug and generic drug plus the generic copayment.

Generic Drugs, cont.

If you determine that your patient cannot tolerate the available generic equivalent, some members' 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 conduct 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.

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, 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 online survey to be completed.

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Covered Pharmacy Services

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

- Glucagon and anaphylactic kits
- Insulin, syringes, lancets and test strips
- Unless specifically excluded (e.g., obesity, infertility), any prescription drug, provided that the drug is ordered by the member's Primary Care Provider (PCP) or a physician/provider 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 limited to a 28-day or one-month supply
- 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 which, as required under the Federal Food, Drug and Cosmetic Act, does not bear the legend: "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)
- Compound 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. For BCBSTX plans with Pharmacy coverage, verifying member's benefits is highly recommended as each policy may have unique benefits

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Drugs Requiring Prior Authorization

Drugs with a high potential for experimental or off-label use may require prior authorization (PA) (also known as preauthorization. For drugs that require prior authorization, step therapy or quantity limits, go to the Pharmacy Program tab on the BCBSTX Provider website for detailed information, including links to forms and program criteria summaries. While physician/provider fax forms are available, you can also submit the request electronically via the CoverMyMeds® website. A link to this site can be found on the BCBSTX Provider website.

Changes to these requirements are published in our provider newsletter, Blue Review. If you have any 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 meet the requirements of the BCBSTX policy.

For information about the PA medical criteria, please review our Medical Policies in the Standards & Requirements section of our BCBSTX provider website.

If you are prescribing 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 are typically covered under the member's medical benefit. For a list of the infusion drugs, please visit the Prior Authorizations Lists under the Utilization Management section of our BCBSTX provider website. Benefits can be determined by calling the number on your patient's member ID card.

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.

Most specialty medications will require prior authorization/ preauthorization. Links to forms and program criteria summaries can be found in the Prior Authorization/Step Therapy section of our BCBSTX provider website.

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 are 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 be billed under the member's pharmacy benefit for your patients to receive coverage. A list of medications that BCBSTX identifies as being a specialty medication is available on our Specialty Drug Program section of our BCBSTX provider website.

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."

Specialty Pharmacy Program and Specialty Pharmacy Network, cont.

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 ID card. For more information about medical criteria, please refer to the Medical Policies information located on the BCBSTX Provider website.

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

To obtain specialty medications through the 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.

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 electronica health records (EHR) and visibility into the status for all of your 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.

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

Specialty Pharmacy Network- and Specialty Pharmacy Network, cont.

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 Programs section of our provider website.

Specialty Pharmacy Network - Split Fill

Some BCBSTX members have the Split Fill program as part of their benefit plan. This program applies to select specialty 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, 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 a specific list of 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. You will be able to find the current list of drugs in this program from a link off our Pharmacy Program/Specialty Drug Programs section. Note: The list of drugs is subject to change at any time.

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 is able to 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.

Are You a Provider Billing Unlisted Drug Codes

Did you know more than 50% of National Drug Code (NDC) numbers 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 the Center for Medicare and Medicaid Services (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 are assigned to a specified CPT or HCPCS drug code. It is important that claims be submitted with the CPT/HCPCS code with the most accurate description when billing for injectable medications that are administered during a patient's visit.

In an effort to ensure providers are billing appropriately and are being reimbursed properly, BCBSTX checks the NDC numbers and the 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 using the more accurate CPT/HCPCS code.

If a claim is submitted with an unlisted drug code (e.g., J3490) and there is no other 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. If the claim is received without the necessary information, the service line may be denied and sent back to the provider with a request to resubmit the service along with the necessary information.

Are You a Provider Billing Unlisted Drug Codes, cont.

Necessary information needed to systematically process valid unlisted drug codes:

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

Necessary descriptive information needed to process valid unlisted drug codes

- NDC Number
- Drug Names
- Strength of drug administered (e.g., 25 mg/ml, 10 mg/ml, etc.)
- The 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
  - Single dose vial or multi dose vial

Please 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.
If you have questions , please contact Provider Customer Service:

Blue Essentials: 1-877-299-2377

Blue Advantage HMO: 1-800-451-0287

Blue Premier: 1-800-876-2583

MyBlue Health: 1-800-451-0287

Are You a Provider Billing for Compound 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 Blue Cross and Blue Shield of Texas (BCBSTX) Medical Policy on Compounded Drugs.

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. Please review the following BCBSTX Medical Policies related to Progesterone Therapy (RX501.062 and Implantable Infusion Pumps (SUR707.008 by going to Standards & Requirements on the provider website.

Are You a Provider Billing for Compound Drugs?, cont.

Compound drugs should be filed under the appropriate "Not Otherwise Classified" procedure code with the Modifier KD.

In an effort to more effectively and consistently price those drugs approved under these medical policies for progesterone therapy and implantable infusion pumps, BCBSTX has adopted the same methodology as the Centers for Medicare and Medicaid Services (CMS).

Under the Standards & Requirements tab, please visit our General Reimbursement Information area on our provider website. You will be directed to enter the password and agree to our Policies Disclaimer notice. Select the Compound Drug Schedules located under Reimbursement Schedules & Related Information section.

If you have any questions, please contact the **Plan's** Provider Customer Service:

Blue Essentials – 1-877-299-2377

Blue Advantage HMO – 1-800-451-0287

Blue Premier – 1-800-876-2583

MyBlue Health – 1-800-451-0287

Forms

All required forms can be downloaded from the **Forms** section under **Education & Reference** on the BCBSTX provider 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 member'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.

BCBSTX 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.

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