Parkland
Community Health Plan

PHARMACY FAQs

Q. What is a drug formulary?
A. This is a list of medications that the health plan will cover. It includes medications from each category of drugs so that medically necessary medications are available when ordered by your provider. A formulary may not include every drug in each category; it may include generic drugs when they are available. The development of a formulary ensures that health plan members have access to effective, safe, and cost-effective drugs.

Q. What is step therapy?
A. A drug formulary may include step therapy in which certain drugs must be tried and found to be insufficient or unsuccessful before other drugs will be covered.

Q. Are OTC drugs covered by the formulary?
A. Most drug formularies do not include drugs available over the counter even with a prescription from your provider.

Q. What if the drug you prescribed or preferred is not on the formulary?
A. There may be other drugs on the formulary in the same category as the drug you need. It is up to your provider to determine which formulary drugs may be equivalent to treat your condition. In addition, your provider can seek an exception to the formulary.

Q. Why do health plans use formularies?
A. Plans use formularies because there are often many safe and effective drugs used to treat the same conditions and some cost more than others. Health plans usually only cover drugs (brand and generic) that are on this "preferred" list.

Q. What is a formulary exception?
A. An exception may be requested if the formulary drug is not working or causes an allergic reaction, has an adverse interaction with another medication, or can demonstrate that the non-formulary drug will provide the maximum medical benefit. Members, care takers and providers have the right to appeal a formulary exception request that is denied by your Health Plan. The Non-formulary drug coverage request form can be found here.

Q. What is the process for obtaining a formulary exception?
A. Each health plan has an established formulary exception process. Providers should become familiar with the process and typically file the formulary exception request for their members/patients.

Q. Does a drug formulary list change over time?
A. Yes. Health and Human Services Commission (HHSC) determines what drugs are added to the formulary. Each Health Plan is mandated to keep its formulary current by adding and removing specific medications based on the mandate from HHSC.

Q. What is the difference between brand name and generic name medication?
A. There is no difference in the active ingredients between a brand name drug and its generic equivalent. A generic name drug may look different from the brand name drug and may be produced by a different manufacturer. The inactive ingredients will differ. Generic name drugs usually cost less than brand name drugs. There typically is a higher copay for brand name drugs vs. generic name drugs for applicable lines of business.

Q. What are Specialty Drugs?
A. Specialty drugs as typically high-cost drugs used to treat complex and chronic medical conditions that are progressive, debilitating, or fatal if left untreated or under-treated. The delivery method may be an oral, injectable, inhalable, or infusible drug product. They often require special storage or shipment requirements and can be self-administered in the home or administered by a health care provider in the home or practitioner's office. Specialty drugs require patient education, monitoring and clinical support. Many times, these drugs are only available through specialty pharmacy networks.

Q. What is the difference between Medical Benefit vs. Pharmacy Benefit?
A. ***Medical Benefit*****:** As it pertains to drugs, is when the provider buys the drugs from a manufacturer or pharmacy and bills the members insurance for the drugs as part of a procedure code such as a J-code.
Pharmacy Benefit: The pharmacy benefit is when the member has a prescription filled at a pharmacy and the pharmacy directly bills the member's insurance for the drug.

Q. What if a drug is not listed on PCHP's formulary?
A. Drugs that are not listed on PCHP's formulary may be non-formulary or covered as a medical benefit. Nonformulary drugs may be covered if the provider or member requests coverage.

Q. What is the process for requesting non-formulary drug coverage?
A. Most If your prescription drug is not listed on the formulary, you should first contact Member Service at the number on your identification card to be sure it is not covered. If Member Service confirms that we do not cover your drug, you have options:
- You can ask your doctor if you can switch to another drug that is covered by PCHP.

- Your doctor can request coverage of a non-formulary drug by completing the embedded form.

Coverage of a
Non-Formulary Drug

To process this request, documentation that all formulary alternatives would not be as effective or would have adverse effects is required. Please provide clinical information or other evidence supporting the medical necessity of the non-formulary drug, including previous formulary drugs attempted for the member's condition. You will be notified if the formulary exception is approved.

Q. How is a formulary developed or changed?
A. Health and Human Service Commission (HHSC) Vendor Drug Program (VDP) is responsible for developing and changing the formulary for PCHP. In this case, the DUR (Drug Utilization Review) Committee; made up of pharmacists and physicians from various medical specialties will review new and existing medications then select drugs to be on the State's formulary based on safety and how well they work. The committee then selects the most cost-effective drugs in each drug class.

Q. What is a drug class?
A. A drug class is a group of drugs that treat a specific health condition or that work in a certain way.

Q. Are there any drug classes or types of drugs that are not covered?
A. There are some types of drugs that are not covered. Some examples are drugs used for hair loss, sexual dysfunction or for cosmetic purposes. Even though these drugs are not usually covered, PCHP has processes in place to review requests for these drugs. See process on requesting non-formulary drug coverage.

Q. What is step therapy?
A. Step therapy is when a member is required to try one or more lower cost drugs in the same drug class or in a proven clinical alternative drug class before coverage can be provided for the requested drug.

Q. What is prior authorization (PA)?
A. When a drug requires prior authorization, it means that the health care provider must ask for approval before the drug can be covered. Drugs may require prior authorization because there is an equally effective low-cost alternative, there are safety concerns and/or a potential for inappropriate use.

Q. What us the process to submit a prior authorization (PA)?
A. The process for submitting prior authorization requests may be found by accessing the provider portal of our website; and can also be done by phone, fax or electronically. In all cases, providers will need to provide their rationale for covering the drug.

Q. How long does the prior authorization (PA) process take?
A. The length of the PA process can vary depending on whether the request meets the expedited or standard PCHP requirements. PCHP pharmacy must receive all required information for evaluation and execution of a decision. If all required information is not received, the decision may be delayed. See our website for more information PA process and time frames.

Q. Who do I call if I have questions regarding pharmacy coverage?
A. You can call us toll free at HEALTH*first* Medicaid **STAR** - 1-888-672-2277 or KIDS*first* **CHIP** - 1-888-814-2352. Our representatives can answer provider and member questions regarding pharmacy benefit information or limitations, assist in providing formulary alternatives, if the drug you are calling about requires a PA. If a customer service representative is unable to assist you, then you can ask to speak to a supervisor or a health care professional, such as a pharmacist.

Q. Where can I find the prior authorization (PA) forms?
A. The Texas standardized PA form can be found here or on our website.

Q. What do I do if the dose of a drug has changed and the prior authorization (PA) that was previously obtained for that drug has not yet expired?
A. If a new PA is required, submission of a new standardized PA form is helpful. It will address issues relating to dose titration and dose adjustments.

Q. What is a notice of action or letter of determination?
A. A notice of action is a letter sent to both the provider and member which explains why a drug is not covered or is not medically necessary. The notice may also be called an Initial Adverse Determination. The notice explains what rights the member has to appeal the decision and the member's right to a State fair hearing. If the denial was based on medical necessity, the notice explains the member's right to an independent external appeal.

Q. Could you explain the 72-hour procedure?
A. If a Prior Authorization is required and not on file, a rejection message will be returned to the pharmacy indicating that the prescriber should contact PCHP's PBM - Navitus. If the prescribing provider cannot be reached, or is unable to request a prior authorization, the pharmacy should move forward with submitting an emergency 72-hour prescription claim.

Pharmacies are required to dispense a 72-hour emergency supply of prescription drugs for all drugs not on the preferred drug list if the denial is solely due to lack of prior authorization.

If the medication is a dosage form that prevents a three-day supply from being dispensed (e.g., an inhaler, eye or ear drops, or creams) it is permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed.

The requirement that the Member be given at least a 72-hour supply for a new medication does not apply when the dispensing pharmacist determines that the taking of the prescribed medication would jeopardize the health or safety of the Member (e.g. if a potential adverse event may occur - high dose for a child, severe drug-drug interaction). In such event, expects the pharmacist to make good faith efforts to contact the prescriber.

The 72-hour supply applies to drugs on the Texas HHSC Vendor Drug formulary and requires PA approval because it is considered: (1) a "NON-preferred" drug and/or (2) require a clinical edit PA. If a drug is NOT on the Texas HHSC Vendor Drug formulary, it is NOT a covered item; and therefore, the 72-hr supply does not apply.

This procedure should not be used for routine and continuous overrides.

Q. What is an appeal?
A. An appeal is a process in which the member may ask to have the plan review a denied request again. The member will have at least 60 business days to file an appeal from the date of the notice of action. The appeal may be expedited if a delay will cause harm to the member's health. The health plan must make its decision within a specified time. See the health plan's member handbooks here for more information about the health plan's appeal process.

Q. Can a provider appeal?
A. A provider may appeal a health plan's decision on behalf of a member by following the health plan's process for internal appeals. Go to the health plan's website for information on the Provider appeals process.

Q. What is an independent review such as an external appeal?
A. An independent external appeal is a review of the drug request by health professionals that do not work for the health plan or the State. When a health plan denies a medication as not medically necessary, the member has a right to external appeal. A provider may act as the member's designee. A provider also has their own right to an external appeal in certain situations. See the health plan's website for more information about when an external appeal may be filed.

Q. What is a State fair hearing?
A. A fair hearing is a review of the member's request for coverage by an Administrative Law Judge. PCHP's members have a right to a fair hearing from Texas when PCHP decides to deny, reduce, or end their health care or does not decide in a reasonable amount of time. The decision the member receives from the fair hearing officer will be final. If a member asks for an external appeal

and a fair hearing, the decision of the fair hearing officer will be the one that counts. For more information about member rights and how to ask for a fair hearing, see our health plan's website or the Texas State Office of Administrative Hearings website.

Q. Where can I find the Medicaid Managed Care Model Contract?
A. The Medicaid Managed Care Model Contract can be found here.

Q. What to do if I have complaints?
A. We encourage you to let us know right away if you have any questions, concerns or problems related to your prescription drug coverage. A grievance is any complaint other than one that involves a coverage determination. You will file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug.

For example, you will file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy. If you have a grievance, we encourage you to first call the Member Services at HEALTH*first* Medicaid **STAR** - 1-888-672-2277 or KIDS*first* **CHIP** - 1-888-814-2352. You can also submit a request through the **member** portal or **providers** portal. We will try to resolve any complaint that you might have over the phone.

If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. You should send your written grievance to:

A&G
PO Box 560307
Dallas, TX 75356