Chapter 5: Getting your outpatient prescription drugs through the plan

Table of Contents

Introduction

This chapter explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid.

CareSource MyCare Ohio also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4, Section D, *The Benefits Chart*.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider in our network write your prescription. This person often is your primary care provider (PCP). It could also be another network provider. A *network provider* is a provider who works with the health plan.

   - The plan will cover prescriptions from out-of-network providers *only* in the following cases:
     - » If the prescriptions are connected with emergency care that the plan pays for
     - » If the prescriptions are connected with urgently needed care that the plan pays for when you cannot get to a network provider
     - » If the prescriptions are connected with a Federally Qualified Health Center, Rural Health Clinic, qualified family planning provider, certified nurse practitioner, or certified nurse midwife.

   In other cases, you must first get approval from the plan if you want the plan to pay for a prescription from an out-of-network provider.

2. You must use a network pharmacy to fill your prescription.

3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.

   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See Section D, *Why your drug might not be covered*, to learn about asking for an exception.

4. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

➔ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

Show your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

You should **always** show the pharmacy your plan ID card when you fill a prescription to avoid any problems. If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

➔ If you need help getting a prescription filled, you can contact Member Services, or CareSource24 or your care manager.

What if you want to change a prescription to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

➔ If you need help finding a network pharmacy, you can contact Member Services or your care manager.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

➔ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy.* Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home. Usually, long-term care facilities have their own pharmacies. Residents may get prescription drugs through a facility's pharmacy as long as it is part of our network. If your long-term care facility's pharmacy is not in our network, please contact Member Services.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

➔ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs that are not available through the plan's mail-order service are marked with NM (non-mail-order) or * (non-Part D drugs) in our Drug List.

Our plan's mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply. A 90-day supply has the same co-pay as a one-month supply.

To get order forms and information about filling your prescriptions by mail, contact Member Services. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually, a mail-order prescription will get to you within 7-10 days. However, sometimes your mail order may be delayed. If delivery of your medication does not arrive within 10 days, please call Member Services to check on the status of your prescription. If your medication requires a prior authorization, our mail-order pharmacy will contact your doctor. If the prescription is rejected or the medication is out of stock, our mail-order pharmacy will contact you and make arrangements for a two-week supply of your medication through a local retail pharmacy. For more information about mail order, visit our website at **CareSource.com/MyCare** or call our Member Services Department.

Our plan's mail-order service previously provided members with mail-order drugs using an "automatic refill" service. If you used our "automatic refill" service in the past, we automatically sent you a refill of your drugs when our records indicated that you were about to run out. However, we now need to get your permission before we can send you a refill by mail. We will not need to get your permission to send your drugs by mail when you ask us for

the refill or ask us for a new prescription.

This may be a change for you if you have always used mail order in the past and have not needed to tell us to send a refill of your prescription. But this change helps us to make sure you only get drugs you really need.

So that we can make sure that you want a refill, please tell us the best way to reach you. Please call Member Services at **1-855-475-3163**, Monday – Friday, 8 a.m. – 8 p.m. TTY users should call 1-800-750-0750 or 711. If we don't know the best way to reach you, you might miss the chance to tell us whether you want a refill and you could run out of your prescription drugs. Remember, your drugs will not be automatically shipped unless you confirm you still want to receive the order. This policy won't affect refill reminder programs in which you go in person to pick up the prescription and it won't apply to long–term care pharmacies that give out and deliver prescription drugs.

Can you get a long-term supply of drugs?

You can get a long-term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same co-pay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above, *Can you use mail-order services to get your drugs?*, to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- We have network pharmacies outside of our service area where you can get prescriptions filled. However, you may not be able to use a network pharmacy due to special circumstances such as an emergency or an illness or injury while traveling outside of our service area where there are no network pharmacies. Day supply and step therapy requirements still apply at out-of network pharmacies.

➔ In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

If you use an out-of-network pharmacy, you may have to pay the full cost when you get your prescription.

➔ If you were unable to use a network pharmacy and had to pay for your prescription, see Chapter 7, Section A, *When you can ask us to pay for your services or drugs*.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription drugs covered under your Medicaid benefits.

The Drug List includes both brand-name and *generic* drugs. Generic drugs have the same ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it.)
- Visit the plan's website at **CareSource.com/MyCare**. The Drug List on the website is always the most current one.

- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

CareSource MyCare Ohio will *not* pay for the drugs listed in this section. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9.)

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are tiers?

Every drug on the plan's Drug List is in one of five tiers.

- **Tier 1** includes generic drugs. This is the lowest tier.
- **Tier 2** includes brand drugs.
- **Tier 3** includes non-Part D generic drugs covered under the Medicaid benefit.

- **Tier 4** includes non-Part D brand drugs covered under the Medicaid benefit.
- **Tier 5** includes over-the-counter (OTC) drugs covered under the Medicaid benefit.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

➔ Chapter 6, *What you pay for your Medicare and Medicaid prescription drugs*, tells the amount you pay for drugs in each tier.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

➔ To learn more about asking for exceptions, see Chapter 9.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. If there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us the medical reason that the generic drug will not work for you or has written "No substitutions" on your prescription for a brand-name drug or has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from CareSource MyCare Ohio before you fill your prescription. If you don't get approval, CareSource MyCare Ohio may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, the plan might limit:

- how many refills you can get, ***or***
- how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at **CareSource.com/MyCare**.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above, *What kinds of rules are there?*, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:

- is no longer on the plan's Drug List, ***or***
- was never on the plan's Drug List, ***or***
- is now limited in some way.

2. You must be in one of these situations:

- **You are new to the plan and do not live in a long-term care facility.**

  We will cover a supply of your drug **one time only during the first 90 days of your membership** in the plan. This supply will be for up to 30 days, or less if your prescription is written for fewer days. You must fill the prescription at a network pharmacy.

- **You are new to the plan and live in a long-term care facility.**

  We will cover a supply of your drug **during the first 90 days of your membership** in the plan, until we have given you at least a 91-day supply and may be up to a 98-day supply consistent with the dispensing increment, or less if your prescription is written for fewer days.

- **You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.**

  We will cover one 31-day supply, or less if your prescription is written for fewer days.

- Long-term care facility members receive up to a 31-day supply, unless the member presents a prescription written for less than 31 days, and they are entitled to refills (up to a 98-day supply), as necessary, during the transition period (first 90 days on the plan, beginning on the member's effective date of coverage or when admitted into a qualified long-term care facility). Additionally, institutionalized members are allowed a 31-day supply, when a qualifying level-of-care change has occurred, which affects the member's ability to obtain a Part D non-formulary drug, for example, when a member's Part A coverage expires. CareSource MyCare Ohio's pharmacy benefit manager will verify the level-of-care change by confirming admission date of the member and the type of facility in which the member will reside. Assisted living facilities, retirement homes or other non-skilled group homes are not deemed by CMS to be an approved institutional setting and thereby do not qualify for the long-term care transition protocols.

➔ To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- **You can ask for an exception.**

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception. We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year. We will answer your request for an exception within 72 hours after we receive your request (or your prescriber's supporting statement).

➔ To learn more about asking for an exception, see Chapter 9.

➔ If you need help asking for an exception, you can contact Member Services or your care manager.

E.Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
  - » The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - » You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - » You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9.
- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - » Your provider will also know about this change. He or she can work with you to find another drug for your condition.

➔ If there is a change to coverage for a drug you are taking, **the plan will send you a notice.** Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a co-pay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership, until we have given you at least a 91-day supply and may be up to a 98-day supply. The first supply will be for up to a 31-day supply, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and you need a drug that is not on our Drug List, we will cover one 31-day supply. We will also cover one 31-day supply if the plan has a limit on the drug's coverage. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

➔ To learn more about asking for exceptions, see Chapter 9.

G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

Programs to help members manage their drugs

We have programs for people who meet certain requirements for how much their total covered drug costs are, which medical conditions they have, and how many different drugs they take. These are called medication therapy management (MTM) programs.

A team of pharmacists and doctors developed the medication therapy management programs for us. The programs can help make sure our members are using the drugs that work best to treat their medical conditions. The programs also help members avoid potential drug-related problems.

Medication therapy management programs are voluntary and free to members. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

➔ If you have any questions about these programs, please contact Member Services or your care manager.