PARTNERSHIP HEALTHPLAN OF CALIFORNIA

PHARMACY PROCEDURE MANUAL

4665 BUSINESS CENTER DRIVE
FAIRFIELD, CA 94534

Pharmacy Department: (707) 863-4414
PHC Main Telephone: (800) 863-4155

FAX Lines:
(707) 419-7900 (Providers using ONLINE/POS billing ONLY)

(707) 863-4330 (Providers using PAPER CLAIMS/HAND billing ONLY)

www.partnershiphp.org

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INTRODUCTION

Partnership HealthPlan of California (PHC) is pleased to provide you with this Pharmacy Manual. This manual is intended for use by Pharmacy Providers who bill for PHC's prescription benefit through MedImpact. Although PHC is responsible for Pharmacy Management policy and overall program administration, PHC has contracted with a Pharmacy Benefit Manager (PBM), MEDIMPACT, to assist in the administration of its Pharmacy Management Program. PHC oversees MEDIMPACT'S role in assisting the pharmacy network with claims processing and day-to-day operations and has thus developed this manual for the following purpose:

1. Assist you in providing optimum pharmaceutical services to PHC members consistent with PHC policies and procedures.
2. Provide you with administrative guidelines and detail procedures to be followed to assure that your PHC customers receive pharmaceutical services consistent with their PHC scope of benefits.
3. Provide you with pertinent information which is necessary to achieve our mutual goal of providing quality pharmaceutical services to your PHC customers.

This manual is not intended to detail how pharmacy should be practiced nor how prescriptions should be filled.

The PHC Pharmacy Manual contains useful information on the following topics:

- Member Eligibility
- Covered Services
- Coordination of Benefits (COB)
- Claims Submission
- Drug Formulary
- Treatment Authorization Requests (TARs)
- Appeals Process

This information pertains to PHC members receiving pharmacy benefit under the Medi-Cal program. It does not pertain to members receiving Medicare benefits under the Partnership*Advantage* (P*A*) program.

The PHC Pharmacy Manual has been prepared to provide you with complete, easy to use information; therefore, reducing the need to contact PHC or MEDIMPACT for clarification, minimizing any delay with the prescription filling process. However, PHC realizes that improvements can always be made and that excellence can only be achieved through continuous quality improvement. PHC welcomes any suggestions related to this manual. Communication related to suggestions for improvement should be directed to the PHC Health Services Department at (800) 863-4144 or (707) 863-4133.

GENERAL INFORMATION

Participating Pharmacy Network

All participating pharmacies that provide pharmacy services for eligible members of PHC are contracted with PHC's Pharmacy Benefit Manager, MEDIMPACT. Pharmacy providers located in PHC's State contracted counties are referred to as "in-network" pharmacy providers and all other PHC pharmacy providers are referred to as "out-of-network" pharmacy providers. All PHC members are provided with an updated list of "in-network" pharmacy providers at the time of their enrollment.

Pharmacy Reimbursement

Participating pharmacies receive reimbursement from MedImpact for pharmacy services provided as specified for a covered medication and/or reimbursable service as identified in the MedImpact Pharmacy Network Agreement Plan Sheet. MedImpact reimbursement is based on the lower of: Average Wholesale Price (AWP) less the contracted discount plus the contracted dispensing fee; Maximum Allowable Cost (MAC) plus the contracted dispensing fee; or Usual & Customary (U&C); whichever is lowest. Reimbursements are paid on a bimonthly reimbursement cycle in a 30-day average time frame from MedImpact receipt of a reimbursable claim.

Pharmacy & Therapeutics (P&T) Committee

The Pharmacy & Therapeutics Committee meets four times per year and is responsible for making recommendations to the Physician Advisory Committee regarding the content of the PHC Drug Formulary, including new drug evaluations, therapeutic class reviews, development of Prior Authorization Criteria, Code 1 Restrictions and other matters regarding the PHC drug benefit. The committee's membership is comprised of the PHC Chief Medical Officer (CMO), the Associate Medical Director, the Health Services Director, the PHC Director of Pharmacy, the PHC Clinical Pharmacist and practicing physicians and pharmacists from the community. Community practitioners interested in becoming a P&T member may contact the PHC CMO or Pharmacy Director.

Scope of Drug Coverage

With very few exceptions, the scope of drug coverage for PHC members potentially includes all Food and Drug Administration (FDA) approved drugs as part of the drug benefit. Those FDA approved **drugs not on the PHC Drug Formulary are covered benefits with an approved Treatment Authorization Request (TAR).** It is misrepresentation of the PHC drug benefit by pharmacy providers to attempt to collect cash payment from a PHC member and inform them that their prescriptions are "not covered". PHC is concerned that such responses misrepresent the scope of PHC drug coverage and result in members not receiving needed medications. Those pharmacies identified as misrepresenting the PHC scope of coverage will be subject to corrective action by PHC and MedImpact.

Care Coordination Programs

- **Growing Together Perinatal Program**

PHC offers clinical support services to pregnant individuals in collaboration with prenatal care providers and other case managers. Provider support and consultation services are available on difficult cases. The PHC staff is an excellent resource to community based services. Member Education is distributed assisting pregnant members to enter care within the first trimester with the use of incentives for attending prenatal visits. Additional assistance is given on an as needed basis for transportation to prenatal and postpartum visits, focused health education, access to childbirth education classes and assistance with breastfeeding.

- **Health Promotion and Prevention Services**

PHC offers clinical support services to all members in collaboration with physicians and other case managers that have been identified at risk due to high emergency room utilization, noncompliance issues and difficulty with access to care and or medication compliance. PHC will work with providers on strategies for managing challenging clients and is resourceful for community based services. Member Health Education is available in the form of referrals to health education classes and programs. These are published on a regular basis and mailed to the member's home address. To assist the provider with education a PHC Member Newsletter is also published on a regular basis.

- **Medical Case Management**

PHC offers individual case management in collaboration with physicians and other case managers for members that have been identified with moderate to severe asthma, high risk diabetes and chronic kidney disease.

PHC is the liaison to California Children's Services (CCS), a medical program for treating California residents under age 21 with physically handicapping conditions who meet medical and financial eligibility. Conditions such as, but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer and traumatic injuries are covered by CCS.

PHC administers EPSDT Supplemental Services for our members. These are medical, dental and or mental health services needed for a person under age 21 that exceeds the scope of benefits available to the general Medi-Cal population.

The PHC Care Coordination Program Department may be contacted at (707) 863-4276 or (800) 809-1350.

TELEPHONE SUPPORT NUMBERS

Contact	Subject	Telephone Number
MedImpact Customer Service Customer Service hours are 24/7 x 365 days.	**Support / Help Desk** **On-Line Claims Assistance**	**(800) 788-2949**
Partnership HealthPlan of California (PHC) Hours: M-F 8:00AM-5:00PM Sat./Sun.: Closed	General HealthPlan Information	(800) 863-4144 (707) 863-4100
PHC Pharmacy Dept.	**Pharmacy / Drug Formulary / TAR Inquiries**	**Phone:** – **(707) 863-4414** **Fax Numbers:** – **Online Billing (707) 419-7900** – **Paper Billing (707) 863-4330**
PHC Member Services	Member Related Assistance / Eligibility Inquiries	(800) 863-4155 (707) 863-4120 (707) 863-4415 - Fax
PHC Claims Dept.	Claims / Billing Inquiries (for claims billed directly to PHC)	(707) 863-4130 (707) 863-4119 - Fax *Note: please do not fax claims*
PHC Provider Relations	General Provider Inquiries	(707) 863-4100 (707) 207-0436 - Fax
PHC Care Coordination	Individual Case Management Service for Members	(800) 809-1350 (707) 863-4276
Linguistic Services	Language/Interpretation Services for Pharmacy Providers	(866) 425-0217 (access code: 798094)
AEVS (Automated Eligibility Verification System)	Eligibility Verification Share of Cost Transactions	(800) 456-2387 (800) 866-2387
PHC Automated Eligibility System	Eligibility Verification	(800) 557-5471 (707) 863-4140
State Medi-Cal	State Medi-Cal Help Desk	(800) 541-5555
CCS (California Children Services) – Del Norte County	CCS Assistance	(707) 464-3191 (707) 465-1783 - Fax
CCS – Humboldt County	CCS Assistance	(707) 445-6212 (707) 441-5686 - Fax
CCS – Lake County	CCS Assistance	(707) 263-1090 (707) 263-5872 - Fax
CCS – Lassen County	CCS Assistance	(530) 251-8183 (530) 251-2668 - Fax
CCS – Marin County	CCS Assistance	(415) 473-6877 (415) 473-6396 - Fax

Contact	Subject	Telephone Number
CCS – Mendocino County	CCS Assistance	(707) 472-2600 (707) 472-2735 - Fax
CCS – Modoc County	CCS Assistance	(530) 233-6311 (530) 233-5754 - Fax
CCS – Napa County	CCS Assistance	(707) 253-4391 (707) 299-2123 - Fax
CCS – Shasta County	CCS Assistance	(530) 225-5760 (530) 225-5355 - Fax
CCS – Siskiyou County	CCS Assistance	(530) 841-2132 (530) 841-4075 - Fax
CCS – Solano County	CCS Assistance	(707) 784-8650 (707) 421-7484 - Fax
CCS – Sonoma County	CCS Assistance	(707) 565-4500 (707) 565-4520 - Fax
CCS – Trinity County	CCS Assistance	(530) 623-1358 (530) 623-1297 - Fax
CCS – Yolo County	CCS Assistance	(530) 666-8333 (530) 666-1283 - Fax
Medicare – Palmetto GBA	Medicare Part B Billing	(866) 931-3901
Kaiser	Member Services for Kaiser Capitated Members	(800) 464-4000
Molina Healthcare – West Sacramento	Member Services for Molina Capitated Members	(916) 373-1495
Molina Healthcare- Woodland	Member Services for Molina Capitated Members	(530) 668-9293
Rx America	Support / Help Desk for Molina Pharmacy Claims	(800) 770-8014

MEMBER ELIGIBILITY

The local County Health and Human Services Agency and the County's Social Security Agency determine member eligibility for Medi-Cal benefits. PHC's role is to administer the Medi-Cal benefits for those persons deemed eligible in Napa, Solano, Yolo, Sonoma, Marin and Mendocino Counties. Effective September 1, 2013 Del Norte, Humboldt, Lassen, Lake, Modoc, Shasta, Siskiyou and Trinity will be added to PHC's Medi-Cal managed care counties. PHC **DOES NOT** determine a person's eligibility for Medi-Cal benefits. PHC electronically receives Medi-Cal eligibility from the State of California's Department of Health Care Services (DHCS) on a daily, weekly and monthly basis. After PHC receives the eligibility file and the membership records are updated in PHC's Amisys System. An eligibility file is created and forwarded to MedImpact for inclusion into their on-line eligibility system, MedAccess.

Eligibility Verification

Each PHC member should present a PHC Identification (ID) card at the time they have a prescription filled. The ID card contains the member's name, birth date and PHC ID number. The MedImpact system accepts the PHC ID number, the first 10 digits of the member's Medi-Cal ID Card (also known as the BIC card) or the SSN number that is to be used when submitting claims to MedImpact. If a prescription claim is rejected by MedImpact for "Non-Matched Cardholder ID", eligibility may be verified by the following procedure:

1) Call the State Automated Eligibility Verification System (AEVS) at (800) 456-2387. The AEVS eligibility file is updated throughout the day with the file being sent to PHC each evening. Thus a member may be eligible as verified through AEVS, but the updated file may not have been transferred yet to PHC and MedImpact.
2) If AEVS confirms that the member is eligible through PHC, then the pharmacy can complete an eligibility form (Attachment A) and fax it to PHC Member Services at (707) 863-4415 or call into the PHC Member Services at (707) 863-4120 or (800) 863-4155 and request the eligibility file to be updated as soon as possible.
3) Pharmacy providers may also contact the PHC Automated Eligibility System at (707) 863-4140 or (800) 557-5471 to inquire about member eligibility.

During the interim while the member's eligibility status is being researched, pharmacies should exercise appropriate clinical judgment when determining whether to dispense medications pending eligibility verification.

Retroactive Eligibility

Some PHC members become retroactively eligible for PHC after the month in which services were rendered. To verify retroactive eligibility, pharmacy providers may access AEVS at (800) 456-2387 or the PHC Automated Eligibility System at (707) 863-4140 or (800) 557-5471. For further additional information pharmacy providers may call PHC Member Services at (707) 863-4120 or (800) 863-4155. Refer to the Claims Submission section of this manual for timeliness billing of retroactive claims.

Capitated Members – Kaiser

"Capitated Members" are those members who are eligible through PHC and have chosen a Primary Care Physician (PCP) who is affiliated with a contracted Medical Group provider that is responsible for all of the member's medical care, including outpatient prescriptions. In Solano Napa, Yolo, Sonoma and Marin Counties, members who are assigned to Kaiser Medical Group for their PCP are "Kaiser Capitated Members" and must receive their prescriptions through a Kaiser facility. Prescription claims for these "Capitated Members" will be denied on-line by MedImpact with a message informing the pharmacy that that the claim must be billed according to the member's capitated arrangement. Pharmacy providers may verify "Capitated Member" status by calling the PHC Automated Eligibility System at (707) 863-4140 or (800) 557-5471. For further additional information pharmacy providers may call PHC Member Services at (707) 863-4120 or (800) 863-4155.

Newborns

Newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother's eligibility. Refer to the Claims Submission section of this manual for billing instructions.

Share of Cost (SOC)

Some PHC members must meet a specified Share of Cost (SOC) for medical expenses, including prescriptions, before they can be eligible to receive Medi-Cal benefits within a given month. SOC dollar amounts can be verified through the Medi-Cal Automated Eligibility Verification System (AEVS). All health services including medical services, devices and prescription drugs, whether Medi-Cal covered or not, can be used to meet SOC. Pharmacies must clear SOC transactions through AEVS at the time services are rendered. Once the member has met his/her SOC obligation for a given month, all future prescriptions for that month may be billed to MedImpact.

Restricted Status

A PHC member may be placed on a restricted status for receiving prescription medications prescribed in an outpatient setting based on determination by the PHC CMO that such services may have been used inappropriately by the member. Members found to be possibly misappropriately using prescription medications may be subjected to the following types of restricted status:

- Prior Authorization (TAR) required for specific medications
- Prior Authorization (TAR) required for all controlled medications
- Allowed to use only one pharmacy, chosen by the member

Providers may request a PHC member to be reviewed for potential restricted status by contacting the PHC Health Services Department at (800) 863-4144 or (707) 863-4133.

California Children Services (CCS)

California Children Services (CCS) is a program of physical habilitation or rehabilitation for children 21 years of age and under with specific handicapping conditions. These children need specialist care, but their families are unable, wholly or partially, to pay for these services on a private basis. The program goal is to obtain for handicapped children the medical and allied services necessary to achieve maximum physical and social function.

Services for PHC members with CCS eligibility are paid by PHC. The CCS program will continue to approve members for eligibility for CCS services and for diagnosis and notify the Primary Care Provider and member. All prescription claims for CCS members with eligibility in Napa, Solano, Yolo and Marin Counties should be submitted to MedImpact for payment. Refer to the Claims Submission section of this manual for CCS billing procedures.

Services for other PHC designated counties CCS services are carved out. Pharmacies should bill CCS directly for those drugs associated with the CCS eligible condition.

Genetically Handicapped Persons Program (GHPP)

The Genetically Handicapped Persons Program (GHPP) is a State funded program which coordinates care of persons over age 21 years with certain medical conditions. All prescription claims for PHC members with GHPP eligibility are paid for by PHC and should be submitted to MedImpact. Providers with questions regarding GHPP may contact the Department of Health Services at (916) 654-0503.

Other Health Coverage (OHC)

Other Health Coverage (OHC) is any private health insurance plan or policy under which the recipient is entitled to receive health care services. OHC includes benefits through commercial insurance companies, prepaid health plans (PHPs), Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups, employer-employee benefit plans, including self-insured and self-funded plans.

Eligibility under Medicare is not considered OHC; however, Medicare supplement policies are considered OHC. Refer to the Coordination of Benefits (COB) section of this manual for instructions on billing for members with OHC and Medicare covered drugs and supplies.

Medi-Cal insurance coverage under PHC is always the payer of last resort. All pharmacy providers are required to bill OHC, and Medicare, before billing PHC. Effective 4/1/09 pharmacy providers may bill on line for Coordination of Benefits (COB)

Currently because the Point of Service (POS) network is not equipped to accept or adjudicate claims when there is a denial or partial payment from the OHC, providers must continue to hardcopy bill for these services. Under the authority of Title 22 of the

California Code of Regulations providers may not refuse treatment of PHC members because either a member may also have insurance coverage in addition to PHC or the provider may be required to hardcopy bill.

Claims submitted electronically to MedImpact for members who have OHC with pharmacy benefits will reject with the message: "Bill Primary Carrier First". Refer to the Coordination of Benefits (COB) section of this manual under Commercial COB for billing instructions of secondary coverage.

Medicare

Medicare's outpatient prescription coverage is currently limited to selected drugs for cancer and organ transplant. **When a member is eligible for both Medicare Part B and PHC Medi-Cal, the pharmacy provider must bill Medicare as the primary insurer and PHC as the secondary insurer.** Refer to the Coordination of Benefits (COB) section in this manual under Medicare COB for billing instructions and a list of covered Medicare drugs and supplies.

Presumptive Eligibility (PE)

Presumptive Eligibility (PE) recipients are issued a paper Medi-Cal Presumptive Eligibility Identification Card (PREMEDCARD) to use until their Medi-Cal eligibility is determined or their PE period ends. Recipients are eligible for all Medi-Cal approved drugs prescribed for pregnancy-related services that are dispensed within the recipient's PE period time. Questions about the PE card should be directed to the provider who issued it.

PE information is unavailable through the Automated Eligibility Verification System (AEVS) and until further notice a PE card (PREMEDCARD) is considered acceptable proof of eligibility for PE services. The PREMEDCARD indicates an initial eligibility date with eligibility expiring on the last day of the month following the month in which PE is determined.

Pharmacy claims for these recipients ARE NOT a benefit of Partnership HealthPlan of California (PHC) and must be billed on the pharmacy claim form 30-1 and mailed to EDS. For more information regarding Presumptive Eligibility (PE) please refer to the EDS Pharmacy Instruction Manual pages 100-24-12 and 300-33-5 or call EDS at 800-257-6900.

ATTACHMENT A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Pharmacy Eligibility Update Form

Fax to (707) 863-4415

Instructions:

Complete this form to report PHC eligibility or to report a status change to primary coverage. A printout from the primary carrier reflecting the change, i.e. termination of coverage, no pharmacy coverage, must be submitted with this form.

____**Add Eligibility Information** _____**Remove Pharmacy Coverage from Primary Carrier**

1) Last Name_____ First Name_____

SSN:_____DOB_____ Aid Code_____ Sex_____

State Eligibility Confirmation #(not required for removal of pharmacy coverage correction)_____

Date(s) of Service:_____

Comments:_____

**********Internal Use Only**********

Eligibility Confirmed: ____Amisys _____AEVS Confirmation #: _____ MR Initial: _____

****

2) Last Name_____ First Name_____

SSN:_____DOB_____ Aid Code_____ Sex_____

State Eligibility Confirmation #(not required for removal of primary coverage)_____

Date(s) of Service:_____

Comments:_____

**********Internal Use Only**********

Eligibility Confirmed: ____Amisys: _____AEVS Confirmation #: _____ MR Initial: _____

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Pharmacy Name:_____ Phone #:_____

Contact Name:_____ Date:_____

Form #23

COVERED SERVICES

This section of the PHC Pharmacy Manual contains an overview of prescription benefits provided to PHC members, as well as specific guidelines for the pharmacy provider when providing prescription services to PHC members. Information regarding claim submission through MedImpact's on-line prescription claims processing system or for claims billed directly to PHC is provided in the Claims Submission section of this manual.

PHC's formulary requires mandatory generic substitution when an equivalent generic product is available.

Prescription Drugs

PHC's prescription drug formulary contains selected Federal Legend Drugs from all the major therapeutic drug classes. The drugs are listed in the drug formulary by the brand name. Refer to the Formulary section of this manual for further information regarding covered prescription drugs.

Injectable Drugs

Injectable drugs that are covered can be billed on-line to MedImpact when dispensed in the original container. Covered injectable drugs are listed in the formulary under a separate "Injectable Drug" section. This section does not list all covered injectable drugs "for physician office, clinic or outpatient facility use." Non-pharmacy providers may contact the PHC Claims Department for information regarding other covered injectable drugs.

Compound Drugs For IV Infusion

Home Infusion Therapy is a covered benefit for PHC members. Claims for compounded IV infusion drugs do not require a TAR if the drug is listed in the formulary under "Injectable Drugs Formulary (Medi-Cal Only)". All drugs compounded for IV infusion and related administration supplies must be billed directly to the PHC Claims Department. Pharmacy claims for drug dispensed in the original container should be billed on-line to PHC's Pharmacy Benefit Manager.

Compound Drugs For Non-Parenteral Use

Extemporaneously compounded prescriptions for non-parenteral use are covered without a TAR if all of the ingredients is on the PHC Formulary, and the total billed cost is less than $50.00. See the Claims Submission section for billing instructions.

Over-the-Counter (OTC) Drug

Over-the-counter (OTC) drugs, as with all drugs prescribed for PHC members, require a prescription from the prescribing physician to be covered. OTC drugs are listed in the formulary under a separate "Over-The-Counter" sec **Medical Supplies / Durable Medical**

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Medical Supplies / Durable Medical Equipment (DME)

Medical Supplies and Durable Medical Equipment (DME), including diabetic supplies, ostomy supplies, incontinence supplies and disposable gloves are covered benefits for PHC members. Covered items are listed in the formulary under "Medical Supplies / Durable Medical Equipment". See Billing Limitations under this section for billing limits.

Nutritional Supplements (Oral / Enteral)

Nutritional supplements for oral and enteral administration are a covered benefit for PHC members with an approved TAR. See the Claims Submission section for billing instructions.

Carve-Out Drugs

Certain HIV/AIDS drugs, certain psychotherapeutic drugs, and certain alcohol, heroin detoxification and dependency treatment drugs have been eliminated from PHC's scope of service and are referred to as "carve-out drugs". For Sonoma, Mendocino, Lake, Humboldt, Lassen, Del Norte, Modoc, Shasta, Siskiyou, and Trinity County members with California Children Services (CCS) eligible conditions, the drugs for the eligible conditions are carved out. These drugs continue to be a benefit for eligible PHC members but PHC is not financially responsible and the pharmacy provider must bill claims for these drugs to State Medi-Cal. These drugs are listed in the formulary and have a "carve-out" footnote (♠ or ✔) stating that the pharmacy provider must bill State Medi-Cal PHC will notify providers of new drugs added to the Carve-out lists in the Quarterly Pharmacy Update.

CARVE-OUT ALCOHOL, HEROIN DETOXIFICATION AND DEPENDENCY TREATMENT DRUGS

GENERIC NAME	TRADE NAME
Acamprosate Calcium	Campral
Buprenorphine HCL	Suboxone
Buprenorphine/Naloxone HCL	Suboxone Sublingual
Buprenorphine Transdermal Patch	Butrans
Naloxone HCL	Narcan/Nalone/Evzio/Narcanti
Naltrexone (oral and injectable)	ReVia/Depade/Vivitrol
Naltrexone Microsphere Injectable Suspension	Vivitrol Kit

CARVE-OUT HIV/AIDS DRUGS

GENERIC NAME	TRADE NAME
Abacavir sulfate	Ziagen
Abacavir, lamivudine,	Epzicom
Amprenavir	Agenerase
Atazanavir Sulfate	Reyataz
Atazanavir/Cobicistat	Evotaz
Cobicistat	Tybost
Darunavir Ethanolate	Prezista
Darunavir/Cobicistat	Prezcobix
Delavirdine Mesylate	Rescriptor
Dolutegravir	Tivicay
Efavirenz	Sustiva
Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate	Atripla
Elvitegravir	Vitekta
Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Disoproxil Fumarate	Stribild
Emtricitabine/Rilpivirine/ Tenofovir Disoproxil Fumarate	Complera
Emtricitabine	Emtriva
Enfuvirtide	Fuzeon
Etravirine	Intelence
Fosamprenavir Calcium	Lexiva
Indinavir sulfate	Crixivan
Lamivudine	Epivir
Lopinavir/Ritonavir	Kaletra
Maraviroc	Selzentry
Nelfinavir Mesylate	Viracept
Nevirapine	Viramune
Raltegravir Potassium	Isentress
Rilpivirine Hydrochloride	Edurant
Ritonavir	Norvir
Saquinavir	Fortovase
Saquinavir mesylate	Invirase
Stavudine	Zerit
Tenofovir disoproxil/Emtricitabine	Truvada
Tipranavir	Aptivus
Tenofovir disoproxil fumarate	Viread
Zidovudine/Lamivudine	Combivir
Zidovudine/Lamivudine/ Abacavir Sulfate	Trizivir

CARVE-OUT PSYCHOTHERAPEUTIC DRUGS

GENERIC NAME	TRADE NAME
Amantadine HCL	Symmetrel
Aripiprazole	Abilify
Asenapine	Saphris
Benztropine mesylate	Cogentin
Biperiden HCL	Akineton
Biperiden Lactate	Akineton injection
Chlorpromazine HCL	Thorazine
Clozapine	Clozaril
Fluphenazine Decanoate	Prolixin
Fluphenazine Enanthate	Prolixin
Fluphenazine HCL	Prolixin
Haloperidol	Haldol
Haloperidol Decanoate	Haldol
Haloperidol Lactate	Haldol
Iloperidone	Fanapt
Isocarboxazid	Marplan
Lithium Carbonate	Various
Lithium Citrate	Various
Loxapine HCL	Loxitane
Loxapine Succinate	Loxitane
Lurasidone Hydrochloride	Latuda
Mesoridazine Mesylate	Serentil
Molindone HCL	Moban
Olanzapine	Zyprexa
Olanzapine/Fluoxetine HCL	Symbyax
Olanzapine Pamoate Monohydrate	Zyprexa Relprevv
Paliperidone	Invega
Paliperidone Palmitate	Invega Sustenna
Perphenazine	Trilafon
Phenelzine sulfate	Nardil
Pimozide	Orap
Procyclidine HCL	Kemadrin
Quetiapine fumarate	Seroquel

Risperidone	Risperdal
Risperidone microspheres	Risperdal Consta
Selegiline (transdermal only)	Emsam
Thioridazine HCL	Mellaril
Thiothixene	Navane
Thiothixene HCL	Navane
Tranylcypromine sulfate	Parnate
Trifluprom azine HCL	Vesprin
Trihexyphenidyl	Artane
Ziprasidone HCL	Geodon
Ziprasidone mesylate	Geodon

CARVE-OUT BLOOD FACTORS; COAGULATION FACTORS

GENERIC NAME	TRADE NAME
Antihemophilic factor VIII/von Willebrand factor complex (human)	Wilate
Factor VIIa (antihemophilic factor, recombinant)	NovoSeven RT
Factor XIII (antihemophilic factor, human)	Corifact
Factor VIII (antihemophilic factor, recombinant)	Xyntha
Factor VIII (antihemophilic factor, recombinant)	Novoeight
Factor VIII (antihemophilic factor, human)	Refacto
Factor IX (antihemophilic factor, purified, nonrecombinant)	Mononine
Factor IX complex	Konyne
Factor IX (antihemophilic factor, recombinant)	Rixubis
Factor XIII A-Subunit (recombinant)	Tretten
Hemophilia clotting factor, not otherwise classified	Alprolix
Injection, Factor VIII, Fc fusion protein (recombinant)	Wilate
Injection, Factor IX fusion protein (recombinant)	Benefix

Von Willebrand factor complex (human), Wilate	Wilate
Von Willebrand factor complex (Humate-P)	Humate-P

Billing Limitations

- **Mandatory Generic Substitution**
  PHC requires generic substitution when an equivalent generic product is available. However, clinicians may prescribe a brand name drug with a "do not substitute" order when there is clinical justification for doing so, but submission of a Treatment Authorization Request (TAR) is necessary. If a formulary drug is a single-source product (i.e., no generic has been FDA approved), then the brand is covered without a TAR.

- **Code 1 Restricted Drugs**
  Code 1 Restricted Drugs are drugs covered with a restriction that limit the use of a drug based on diagnosis, failure or intolerant to 1st line therapy, specific use of the drug, member's place of residence (i.e. Skilled Nursing Facility), or specialty of the prescriber. A list of Code 1 Restricted Drugs is contained in the Formulary section of this manual. Code 1 Restricted Drugs are also designated in the formulary with a symbol © and the Code 1 restriction is listed next to the drug. Any other use of the drug is considered non-formulary and requires a TAR. See the Claims Submission section for billing instructions of Code 1 Restricted Drugs.

  Although Code 1 Restricted Drugs do not require a TAR, the dispensing pharmacist is expected to contact the prescriber's office to document the Code 1 restriction when necessary. It is NOT sufficient for the prescription simply to have a "Code 1" on its face, even if it is apparently designated by the prescriber. Information as to the name of the person verifying compliance of the restriction with the prescriber, the date and time of the call and the full signature of the pharmacist receiving such information should be kept with the prescription.

- **Step Therapy Edit**
  A Step Therapy Edit (STE) allows a drug to be filled without a TAR if the member has had a 1st line drug filled within the last 120-365 days depending on the drug and/or if the member meets other specified criteria. A list of drugs with a Step Therapy Edit is contained in the Formulary section of this manual. Drugs requiring a STE are designated in the formulary with **STE** with a 1st line or drug or specific criteria listed.

- **Formulary Dispensing Limits**
  Selected formulary drugs have a dispensing limit that limits the drug to a specified quantity, duration of use or member age. A list of drugs that have dispensing limits is contained in the Formulary section of this manual. Drugs with a dispensing limit are also designated in the formulary by the symbol Ψ with the dispensing limit listed next to the drug.

- **Days Supply**
  PHC allows prescribed drugs to be dispensed in quantities up to a maximum of a ninety (90) day supply for generic maintenance drugs and 30 days for Brand Name (Single Source) drugs. For patients stable on maintenance Brand Name drugs, a TAR may be submitted for up to a 90 day supply.

- **$500 Limit**
  Any single prescription that exceeds $500, and not designated with a #$500 exempt footnote, requires a TAR, even if it is a formulary item.

- **Medical Supplies**
  Incontinence Supplies: A TAR is required if the monthly accumulative cost for all related supplies exceeds $50.00. Washes and creams will only be authorized if the prescriber indicates medical necessity such as skin breakdown.
  Disposable Gloves: Maximum dispensing is 100 gloves per month.
  Ostomy Supplies: A TAR is required if the monthly cumulative cost for all related supplies exceeds $150.00.
  Diabetic Supplies: Blood Glucose Strips and lancets are limited to a maximum of 100 per 25 days for members on insulin, and 50 per 25 days for members not on insulin. Supplies are limited to those for the Freestyle System, all others require a TAR.

  All other prescriptions for members exceeding these limits require a TAR submitted with medical justification.

CLAIMS SUBMISSION

MedImpact Healthcare Systems, Inc. is the Pharmacy Benefit Manager (PBM) contracted with PHC to process pharmacy claims for all of PHC's eligible members. **All prescription claims for PHC members must be submitted through MedImpact. ALL PRESCRIPTION CLAIMS SUBMITTED DIRECTLY TO PHC WILL BE RETURNED TO THE PROVIDER FOR SUBMISSION TO MEDIMPACT. All inquiries regarding claims submission, rejected claims, plan limitations, or PHC's pharmacy benefit should be directed to MedImpact Pharmacy Help Desk at (800) 788-2949.** Customer Service Open 24/7, 365 days of year.

Electronic Claims Submission (ECS)

MedImpact's prescription claims processing is accomplished in a real-time point-of-sale mode through the MedImpact on-line claims adjudication system. Pharmacies must use the NCPDP (National Council of Prescription Drug Programs) Telecommunication Standard Version 3.2A or higher to comply with MedImpact's standard for on-line claims submission. The BIN Number or "Electronic Address" for MedImpact is **003585**.

Line of Business	BIN	PCN and Group Number	
Medi-Cal (SPH01)	003585	36200	
PartnershipAdvantage (SPH02) EFFECTIVE 1/1/2012	015574	PCN ASPROD1	Group# SPH02
PartnershipAdvantage (SPH02) (DOS PRIOR TO 1/1/2012)	003585	PCN 56260	Group# 56260
Healthy Kids (SPH04)	003585		
Healthy Families (SPH03)	003585	36250	

Member information required for submitting on-line claims:

- First and last name
- Date of birth
- ID number
- Relationship to cardholder "1"

On-Line Drug Utilization Review (DUR)

The On-Line Drug Utilization Review (DUR) process assists pharmacists in providing quality care by identifying potential therapeutic conflicts. As claims are sent to MedImpact, the DUR process assesses the prescription against the claims history of the member. An on-line message is sent to the pharmacy when a potential problem exists. **If assistance is required regarding a DUR message contact MedImpact Pharmacy Help Desk at (800) 788-2949.**

Universal Claim Form (UCF) Billing

Electronic Claims Submission (ECS) is the preferred method to submit claims to MedImpact. All claims not submitted by ECS **MUST** be submitted on a Universal Claims Form (UCF). Other forms cannot be accepted. MedImpact reserves the right to assess a processing fee for claims submitted on UCFs. Refer to the Coordination of Benefits section, under Commercial COB, for instructions on completion of the UCF.

Timeliness of Submitted Claims

Pharmacies have up to 30 days from the date of service to submit claims on-line. The exceptions to this policy are:

- If a member was not eligible with PHC at the time service was rendered and was subsequently granted retroactive eligibility; a 120-day billing limit is calculated from the date retroactive eligibility was established.

- If a member has other primary insurance and claims are processed by the primary insurance carrier, a 120-day billing limit is calculated from the time the other insurance carrier rendered a payment determination. This does not by-pass PHC's fifteen-day timeliness submission for TARs.

DAW (Dispense as Written)

MedImpact's on-line adjudication system **ONLY ACCEPTS DAW = 0** for all claims submitted by Electronic Claims Submission. PHC requires generic substitution when an equivalent generic product is available.
However, prescribers may order other brand name drugs with a "do not substitute" when there is clinical justification for doing so. In this case, submission of a Treatment Authorization Request (TAR) by the pharmacy is necessary, along with a completed FDA MedWatch Form indicating the adverse reaction/problem associated with use of specific generic products (Attachment B)
, with medical justification for brand included on the TAR. Those pharmacy providers who have difficulty submitting on-line claims with a DAW = 0 due to software limitations should contact the MedImpact Pharmacy Help Desk at (800) 788-2949 for claims submission assistance.

Return to Stock / Claim Reversal

Prescriptions filled and submitted for payment, but not picked up by the member within a reasonable time frame must be reversed on-line. The requirement applies to unused reusable stock in all types of pharmacies, including Long Term Care pharmacies. Pharmacies are advised to maintain documentation of all reversals to demonstrate compliance with this requirement.

Refill Too Soon

Prescriptions refilled at a "too frequent" interval, based on day's supply reported with the claim will be rejected with a "Refill Too Soon" edit. A prescription is considered to be filled "too frequent" if less than 75% of the days supply submitted with the last fill has not elapsed.

To avoid a "Refill Too Soon" claim denial when the prescriber has increased the amount of drug to be taken by a member, the pharmacy should enter a therapy change code of "05" in the Denial Override field and the claim will be approved. If the claim does not approve, MedImpact Pharmacy Help desk at (800) 788-2949 should be contacted for assistance. The therapy change code will not allow early refills for those medications that exceed the monthly dispensing limit as indicated in the formulary.

Refill Too Soon: Nursing Home/ Board and Care Home

MedImpact Pharmacy Help desk at (800) 788-2949 may approve a one-time override per medication within a one-year time frame for claims that reject for "refill to soon" if the member is being placed in a Nursing Home or Board and Care Home and is not allowed to take their medications into the Home with them. If a second request is made within the one year, a TAR must be submitted to PHC for authorization review.

Lost, Stolen, Spilled Medications

MedImpact may approve a one-time override per medication (non-controlled) within a one-year time frame for lost, stolen, or spilled medications. If a second request is made within the one year, a TAR must be submitted to PHC for authorization review.
Controlled medications are not applicable for this benefit.

Vacation Supply

Pharmacies may call MedImpact to request a one-time override per medication (Formulary Drugs only) within a one-year time frame for a vacation supply of up to 60 days. Subsequent requests for a second vacation supply within a one-year time frame on the same medication must be requested to PHC through the TAR process. Please inform members that PHC will not authorize vacation supplies beyond a 60 day supply as

eligibility for Med-Cal is questionable when the member is absent from the area for more than 2 months.

Newborns

Newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother's eligibility. Claims submissions for newborns should be under the mother's nine-digit I.D. number () and date of birth using the newborn's name and a cardholder relationship of "1". Claims submission after this time frame will require the newborn to be eligible under their own I.D. number.

Compounded Prescriptions

Claims for extemporaneously compounded prescriptions for non-parenteral use should be submitted as follows:

- Submit the National Drug Code (NDC) number of highest cost legend ingredient in the compounded prescription
- Submit the total quantity of the amount dispensed
- Enter a "2" in the compound field that the drug is a compound
- Calculate the ingredient cost of all the ingredients in the compound based on your pharmacies reimbursement rate as indicated on the Pharmacy Network Agreement Plan Sheet from MedImpact

If none of the ingredients used in the compound are on the PHC Formulary, or the total billed amount exceeds $50.00 a Treatment Authorization Request (TAR) is required along with a completed Compounding Worksheet (Attachment C).

National Provider Identifier (NPI) Number

All prescription transactions submitted to MedImpact must include the NPI. MedImpact will reject claims submitted without a valid identification number. PHC has asked MedImpact to minimize member disruption and temporarily allow both the NPI "01" qualifier and the DEA "12" qualifier to be used on a claim as a valid physician identifier. Prescriptions written by a Physician Assistant (PA), Nurse Midwife (NM), and Nurse Practitioner (NP) must meet state law and be submitted utilizing the supervising physician's DEA number.

MedImpact continually evaluates pharmacies' compliance with providing accurate prescriber identification numbers. The accuracy of these numbers impacts the effectiveness of PHC's Drug Utilization Reports (DURs) and member drug profiling reports that are furnished to the member's prescribing physician.

Code 1 Restricted Drugs

If a drug meets the "Code 1" restriction listed in the PHC Formulary the drug may be billed on-line to MedImpact by placing a "07" in your computer software's prescription Denial Override Field. This is the same designated override field used when submitting claims to EDS for State Medi-Cal. Please verify current Code 1 requirement in PHC formulary, as Code 1 requirements may change. PHC Code 1 requirements will be different from the State's Fee-for Service Medi-Cal Code 1 requirements.

Nutritional Supplements (Oral / Enteral)

A TAR is required for all nutritional supplements to be used on an out-patient basis. All requests must be accompanied by a completed Nutritional Supplement Form (Attachment D) documenting medical necessity. Claims submission to MedImpact for nutritional supplements require the quantity submitted to be in **milliliters (mls) or grams (gms), not number of boxes, cans or bottles.** Claims for administration supplies for enteral feedings are to be submitted to the PHC Claims Department. Supplements for members residing in an acute care hospital or Long Term Care (LTC) facility are included in the per diem rate or capitation paid to the facility.

Medical Supplies / Durable Medical Equipment (DME)

Claims submissions for medical supply and DME items not listed in the PHC Formulary require an approved TAR for payment. Claims for formulary medical supplies, DME items and non-formulary items approved by a TAR (excluding incontinence supplies, disposable gloves, and ostomy supplies) with a National Drug Code (NDC) number must be submitted to MedImpact. **Items without an NDC number, all incontinence supplies, disposable gloves, and ostomy supplies must be submitted directly to the PHC Claims Department.**

PHC Claims Department will accept HCFA 1500 Forms and the State Medi-Cal Pharmacy Claim Form 30-1C. Providers with questions regarding claims submitted to the PHC Claims Department may contact that department directly at (707) 863-4130.

CCS Claims Submission Procedure

For Del Norte, Humboldt, Trinity, Siskiyou, Shasta, Lake, Modoc, Lassen, Sonoma and Mendocino County members with a CCS eligible condition, CCS is carved out. Bill CCS directly for medications and supplies for the CCS eligible condition and PHC for medications not related to the CCS eligible condition.

Services for PHC members in Solano, Napa, Yolo and Marin Counties with CCS eligibility are paid by PHC. The CCS program approves members for eligibility for CCS services and issues Service Authorization Request (SAR). ***Prescription claims***

from retail pharmacies for CCS members should be billed on-line to MedImpact for payment.

If a Healthy Kids member or a Healthy Families member have an approved CCS covered condition, pharmacy should bill CCS directly.

The following claims submission procedure is for PHC members who also have California Children Services (CCS) eligibility. All pharmacy claims for these members should be billed on-line to MedImpact using the following procedure:

- **PHC Formulary Medications**: No TAR required. Pharmacy submits claim on-line to MedImpact.

- **PHC Non-Formulary Medications:** TAR required.

  1) With CCS/GHPP Authorization:

  a) Pharmacy faxes TAR to PHC with CCS Authorization attached. In lieu of completing the Diagnosis and Medical Justification pharmacy writes "CCS Authorization Attached". Remainder of TAR is completed as usual.
  b) PHC enters TAR into the MedImpact System and faxes back to pharmacy.
  c) Pharmacy submits claim on-line to MedImpact.

  2) With CCS Denial:

  a) Pharmacy faxes completed TAR to PHC with CCS Denial attached
  b) Remainder of TAR is completed as usual

  3) Without CCS Authorization or Denial:

  a) Pharmacy faxes completed TAR to PHC, inclusive of diagnosis and medical justification

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4100
FAX (707) 863-4330

ATTACHMENT B

NUTRITIONAL SUPPLEMENT MEDICAL JUSTIFICATION

Member Name: _____ Date: _____

Member ID #: _____ TAR# _____

⋆ Required Patient Information:

1. Does this patient reside in a Skilled Nursing Facility (SNF)? YES____NO____

2. How many cans/bottles/packets will this patient require per day/week/month?_____Per____

3. Please explain why this patient is UNABLE to maintain adequate nutrition with ordinary foodstuffs and describe alternative nutrition programs that have been tried or considered (e.g.: changed food consistency such as pureed, assistance with menu alternatives and feeding etc.

   _____

   _____

4. What is the patient's current height and weight with date of last weight?
   Height:_____Weight:_____Date:_____

5. Describe the patient's pertinent medical and weight history, such as how much weight loss over what period of time, medical risk factors for malnutrition, etc._____

   _____

6. Why did you select this particular formula and what are the nutritional goals for this patient (weight goal, intake goal)? _____

   _____

7. How will you evaluate the patient's progress towards goal (monthly weights, albumin levels, etc.)?_____

8. Is this requested item to be used as a ____ temporary or a ____ long-term supplement to a regular diet, or as a ____ complete dietary replacement program? (check one). If the supplement is temporary, how long do you estimate the patient will require it? ____(Months)

9. If there is a question about this TAR request, who should be contacted? _____

   _____

If this patient would benefit from an appointment with a Registered Dietitian, please FAX a RAF to the SCHSS Clinical Nutrition Program @ FAX # (707) 435-2217, or send an E-RAF. Questions? Call(707) 435-2216

COORDINATION OF BENEFITS (COB)

Some PHC members have prescription coverage through other payment sources. Examples of other coverage include Medicare Part B, Medicare HMO, or private health insurance, under which a member is entitled to receive prescription benefits.
All PHC pharmacy providers are required to bill other health coverage before billing PHC Medi-Cal. This is referred to as Coordination of Benefits (COB).

MedImpact's Point of Sale (POS) network is equipped to accept and adjudicate electronic claims when there is a denial or partial payment from the other health coverage. This is called electronic Coordination of Benefits (eCOB). MedImpact provides pharmacies with specific instructions to accept and process eCOB claims for PHC members. The process and instructions are compliant with NCPDP standards. If the pharmacy is unable to process eCOB claims due to software limitations, a Universal Claim Form (UCF) may be submitted to MedImpact.

Providers may not refuse service to PHC members who have other insurance coverage in addition to PHC Medi-Cal. PHC also prohibits pharmacy providers from billing members for the copay amount or for a prescription that is a primary insurance plan exclusion.

Commercial COB

PHC can indicate if a member has other primary insurance coverage by submitting a COB indicator of 2 on MedImpact's member eligibility file. The COB indicator of 2 indicates a member has other primary insurance coverage and will reject online prescription claims with a POS message, **"Bill Primary Carrier First"**. The pharmacy should use the following procedure when this message is received:

- **Confirmation of other insurance coverage:** Confirm other primary insurance coverage status by requesting the insurance information from the member, or by calling the Automated Eligibility Verification System (AEVS) at (800) 456-2387. AEVS will indicate if the member has other coverage, and the letter "P" under the scope of coverage to indicate pharmacy benefits under a commercial health plan. The letter "R" indicates that member has pharmacy benefits under a Part D plan. If you are still unable to determine primary pharmacy coverage status from either of these sources, the pharmacy may call PHC Member Services at (707) 863-4120 or (800) 863-4155 for additional assistance.

- **Claims submission when other insurance confirmed:** If the pharmacy determines that the member ***does*** have other pharmacy insurance coverage, the pharmacy bills the prescription claim online to the primary insurance carrier. The copay or deductible amount is then billed to MedImpact, the secondary insurance carrier, by populating the required COB fields.
  If the pharmacy is unable to bill the secondary insurance carrier online, then a UCF may be submitted to MedImpact for processing. The UCF must be accompanied by

documentation of the amount paid by the primary insurance carrier. Documentation may be either the primary insurance Explanation of Benefits (EOB), or a copy of the pharmacy's adjudication screen.

- **MedImpact will accept both online and hardcopy UCF copay billings for all prescriptions approved for payment by the primary insurance carrier. Online processing of all COB claims is recommended by PHC. Copays greater than $50.00 will require a TAR submitted to PHC along with a completed eCOB form** (Attachment C)

- **Claims submission for prescriptions not covered by primary insurance:** If the prescription is not on the primary insurance formulary, then the pharmacy must pursue normal procedures to obtain a prior authorization from the primary insurance carrier. If the prior authorization is denied and an alternative primary insurance formulary drug cannot be used, and the drug is on PHC's formulary, the pharmacy may then bill the prescription claim to MedImpact through the online COB process. If the prescription is denied by the primary insurance carrier and not on PHC's formulary, then the pharmacy must submit a TAR to PHC. An approved TAR is required for eCOB processing.

- **Claims submission for other insurance plan exclusions:** If the primary insurance carrier does not cover the prescription as a plan exclusion, and the drug is on PHC's formulary, the pharmacy may then bill the prescription claim to MedImpact using the online COB process. For example, many insurance carriers do not cover OTC or medical supply items, whereas PHC may cover these items. If the prescription is a primary insurance plan exclusion and not on PHC's formulary, then an approved TAR from PHC is required for processing.

- **Member does not have other primary insurance:** If the pharmacy determines that the member does not have other pharmacy insurance coverage or other pharmacy insurance benefits have been exhausted, then a completed Eligibility Update Form (Attachment A in the Member Eligibility section) attached by a copy of the adjudication screen showing a rejected claim due to "No coverage" should be faxed to PHC Member Services at (707) 863-4415. If the pharmacy is unable to produce a copy of the adjudication screen, they should have the member call PHC Member Services for assistance. Member Services will then research the primary insurance prescription coverage status and add the member to the MedImpact eligibility file if the member is found not to have primary pharmacy insurance coverage.

- **Billing Notes:**
  Transmittal Carrier Numbers The carrier number field, which indicates the type of COB claim, must be entered on the transmittal form or MedImpact will not pay the claim. Transmittal carrier numbers:

COB copay or deductible	**#36203**
Plan exclusion claims	**#36205**

Mailing Address for COB Claims:

MedImpact Healthcare Systems, Inc.
Operations Dept. Attn: COB Claims
10680 Treena St., 5th floor
San Diego, CA 92131

Medicare COB

Some PHC members have primary coverage for prescriptions through Medicare Part B. If the member has Medicare Part B coverage, the pharmacy must submit claims for Medicare-covered drugs/supplies to the Medicare carrier as the primary insurance. PHC requires that participating pharmacy providers accept assignment on all Medicare/PHC Medi-Cal claims billed on the member's behalf. The assignment acceptance is an agreement with Medicare that **the provider will not charge the member, including coinsurance and deductible amounts**, and will accept Medicare's determination of approved charges.

- **Drugs and supplies covered under Medicare Part B:** This partial list contains drugs and supplies which are currently covered under Medicare Part B. However, some coverage limitations may apply in accordance with specific Medicare regulations. Pharmacy providers are encouraged to verify coverage through other reference sources and/or by contacting the Medicare fiscal intermediary. Other drugs, medical supplies, biologicals, blood modifiers and nutritional therapies covered by Medicare are PHC non-formulary items and will be monitored for Medicare coverage through the TAR process. Please refer to your Medicare Supplier Manual for a detailed listing of these items.

CATEGORY	MEDICARE COVERED DRUGS / SUPPLIES
Diabetic Equipment and Supplies (1)	Blood Glucose Monitors Blood Glucose Testing Strips Lancets Lancet Auto Injectors Reagent Strips
Oral Anti-Cancer Drugs	Busulfan (Myleran) Capecitabine (Xeloda) Cyclophosphamide (Cytoxan) Etoposide (Vepesid) Melphalan (Alkeran) Temozolomide (Temodar)
Immunosuppressive Drugs (2) **(Covered after an organ transplant)**	Cyclosporin (Neoral, Sandimmune, Gengraf) Mycophenolate Mofetil (Cellcept) Sirolimus (Rapamune) Tacrolimus (Prograf)

(1) Not covered by Medicare if member is residing in a SNF
(2) Member must have enrolled in Medicare at the time of transplant

- **Medicare Provider Number:** Pharmacy providers must have a Medicare Provider Number to bill Medicare for covered drugs and supplies. To obtain a Medicare Provider Number, providers must contact the National Supplier Clearing House, P.O. Box 100142, Columbus, SC 29292-3142 or by phone at (866) 238-9652

- **Cigna Medicare Region D:** Provider may contact Medicare at (866) 243-7272 or access the web at www.cignamedicare.com for all questions pertaining to billing and coverage parameters. To order a Medicare Supplier Manual providers may call (202) 512-1629.

- **Claims submission procedure for Medicare covered drugs/supplies:**

  1) MedImpact's eligibility file will indicate when a member has Medicare Part B coverage and will reject on-line prescription claims for Medicare covered drugs and supplies with the edit message **"Must Bill Medicare"**.

  2) The pharmacy bills Medicare according to the billing instructions as provided by Medicare.

- **Medicare Part D**

PHC Medi-Cal is not responsible for Medicare Part D or the copays/deductibles for Medicare Part D drugs. PHC is only responsible as the payor for excluded Medicare Part D drugs.

Partnership*Advantage* is a MAPD plan to members that have Medicare and Medi-Cal. Enrollment into the Partnership*Advantage* plan is optional.

Partnership HealthPlan of California

Pharmacy Services Dept.
4665 Business Center Drive
Fairfield, CA 94534-4036
(707) 863-4414
(707) 419-7900 fax

eCOB TAR ATTACHMENT FORM FOR COPAYS >$50

Fax *CONFIDENTIALITY NOTICE: The materials sent with this transmission are private and confidential, protested by CA Evidence Code 1157. The information contained in the material is privileged and is intended only for the use of the individual(s) or entity(ies) named above. If you are not the intended recipient be advised that unauthorized use, disclosure, copying, distribution, or taking of any action in reliance on the contents of this telecopied information is strictly prohibited.*
If you have received this facsimile transmission in error, please immediately notify us by telephone to arrange for the return of the documents to us.

MEMBER NAME: _____ PHC ID#:_____

Drug/Rx# or PHC PA#: _____

● Comments: Please respond ASAP. THE FOLLOWING INFORMATION IS NECESSARY IN ORDER TO EVALUATE THE REQUEST FOR COPAYMENT REIMBURSEMENT:

PT's Primary Information: Ins. Company _____

ID#_____Group#_____ Phone #_____

REQUIRED: ☐3rd party Rx insurance as part of medical plan, or ☐ Discount plan only. If unknown, include front and back copy of card. NOTE: Discount plans are not considered primary and PHC cannot be billed as secondary to any discount plan/coupon—must bill PHC as primary.

COMPLETE THE FOLLOWING –OR—ATTACH COPY OF PRIMARY ADJUDICATION SCREEN (WITH DEDUCTIBLE INFO IF APPLICABLE):

Primary Claim Info (check all that apply): COPAY AMOUNT $_____

☐Non-Formulary/Non-Preferred [1] ☐Not a covered benefit (eg, OTCs) [2]

☐Member has unmet deductible [3] ☐ Member's primary eligibility has lapsed [2]

☐Covered benefit with primary, with majority of claim paid by primary but copay is over $50.

☐ Member's copay is for amount in full – please explain why, if not indicated in other checkboxes: _____

[1] If Non-Formulary/Non-preferred with primary, has prescriber applied for prior auth with the primary? ☐YES ☐No. If primary denied PA, submit copy of denial letter with TAR.

[2] Submit copy of claim rejection/adjudication response

[3] Annual Deductible _____ Amount Remaining _____

Note that all formulary & limitation issues should be resolved with the primary before submitting eCOB claims to PHC for secondary coverage. Rx's should be reduced to the primary's day supply limit if exceeded. With the exception of deductibles & eligibility issues, the provider should seek prior authorization for rejected claims with the primary before submitting a TAR to PHC.

FORMULARY OVERVIEW

The PHC Formulary is updated and distributed to all PHC providers on a yearly basis. The Pharmacy & Therapeutics Committee, contingent upon approval from the Physician Advisory Committee, continually updates and revises the formulary based on sound clinical evidence, efficacy, safety and pharmacoeconomic considerations. Suggested formulary modifications may be requested by PHC prescribers, pharmacists or PHC staff. All suggested formulary modifications should be directed to the PHC Pharmacy Director or Chief Medical Officer. Please refer to the Provider Formulary Addition Request Form at the end of this section (Attachment D) **PHC would like to emphasize to all providers that with very few exceptions, all formulary medications are FDA approved. Those drugs not listed in the formulary will be considered with a submitted Treatment Authorization Request (TAR)**. Providers may request a current copy of the Formulary by contacting the PHC Pharmacy Department at (707) 863-4414. The Formulary is also available on PHC's website at www.partnershiphp.org.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4414
FAX (707) 863-4330

ATTACHMENT D

PROVIDER FORMULARY ADDITION/CHANGE REQUEST FORM

Drug Name	
Dosage Forms and Strengths	
FDA Approved Indications	
Rationale for Request (superior efficacy/safety profile, unique indications, comparative cost-effectiveness): *Please also attach any relevant articles supporting this request*	
Requested By (print)	
Phone Fax Email	
Please include or attach any supporting documents and send to: **PHC Pharmacy Director** **4665 Business Center Drive** **Fairfield, CA 94534** **(707) 863-7906** **FAX: (707) 863-4330** **Email: glouie@partnershiphp.org**	
Signature **X**	Date

To be considered for review all sections of form must be completed & form must be received by PHC 30 days prior to the quarterly Pharmacy & Therapeutics (P&T) Committee meeting.

FORMULARY UPDATES

The PHC Pharmacy & Therapeutics (P&T) Committee meets on a quarterly basis and is responsible for additions, changes and deletions to the drug formulary. Providers are then notified with a Formulary Update listing all changes that have been approved by the P&T Committee. These changes are then incorporated into the Drug Formulary which is printed and distributed in January of each year. The Formulary and Formulary Updates are also available on the PHC website at www.partnershiphp.org

Please insert quarterly Formulary Updates into this section.

MAXIMUM ALLOWABLE COST (MAC) LIST

PHC requires generic substitution when an equivalent generic product is available. Maximum Allowable Cost (MAC) pricing is a reimbursement schedule developed by MedImpact that determines the ingredient cost used to calculate reimbursement for generic pharmaceutical products. If a formulary drug is not listed on the Maximum Allowable Cost (MAC) list, then the brand name of that drug is covered without a TAR.

MedImpact distributes an updated MAC List to pharmacy providers every two weeks with the EOB.

You may use this section to file updated lists that you will receive from MedImpact.

TREATMENT AUTHORIZATION REQUEST (TAR)

Although PHC has contracted MedImpact to assist in the administration of the Pharmacy Management Program, all prior authorization requests are submitted directly to PHC through the Treatment Authorization Request (TAR) process. Every effort is made to approve or deny each TAR upon the initial submission. Pharmacists should make reasonable efforts to obtain Diagnosis and medical justification information, including conferring with the prescriber to facilitate the evaluation of a TAR. Prescriptions for the following require a TAR:

- All non-formulary medications
- Brand name drugs when an equivalent generic is available
- Drugs not meeting the Code 1 restriction criteria
- Drugs not meeting the Step Therapy Edit (STE) criteria
- Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits
- Any prescription that costs $500 or more and not designated with a #$500 exempt footnote
- Compounded prescriptions if some of the ingredients used in the compound are not on the PHC Formulary, or the total billed amount exceeds $50.00
- Selected Electronic COB claims that are rejected. (see Coordination of Benefits Section 5 for specifics)

Each submitted TAR is reviewed by a clinical pharmacist or PHC authorized Pharmacy Technician who will approve or defer the request for more information. All TARs that lack medical justification for the intended use of the drug will be denied by the PHC's Chief Medical Officer, Regional Medical Director or Associate Medical Director.

TAR Submission

PHC does not accept verbal prior authorization requests by telephone. Additionally, manually faxed TARs sent for medications billed online will no longer be accepted. **All eligible providers must submit prior authorization requests through PHC's online pharmacy TAR system, PARx (Prior Auth. Rx):**

- **PARx website: https://parx.partnershiphp.org/**
- **Please note the user guide and training video are located on the 'Help' page of the website.**

TAR Forms

Manually faxed TARs will only be accepted for medications billed via paper claims or under emergency conditions where providers are unable to access the PARx system. PHC does not supply TAR forms to providers. TAR forms are available on

PHC's website, www.partnershiphp.org, under Pharmacy/Formularies, Faxed Pharmacy TAR. PHC accepts only one request per TAR form.

If the situation is appropriate, fax the completed TAR form to PHC at:

- **Providers using ONLINE/POS billing – (707) 419-7900**
- **Providers using PAPER CLAIMS/billing PHC Claims Department – (707) 863-4330**

Timeliness Submission of TARs

All TAR's must be received by PHC no more than fifteen (15) business days after the requested start date of service. TARs received by PHC that do not adhere to the timeframes defined for timely submissions are denied.

Retroactive TARs

Retroactive TARs received after fifteen (15) business days of requested date of service may be considered for review only under the following conditions:

- When certification of the Medi-Cal beneficiary's eligibility by the county welfare department was delayed.
- When a member does not identify himself/herself to the provider as a Medi-Cal member by deliberate concealment or because of physical or mental incapacity to identify himself/herself. TAR must be received by PHC within 60 calendar days from the requested date of service.
- When Medicare Part B denied payment of a claim for services on explanation of benefits. TAR must be received by PHC within 60 calendar days from the date of denial from other health insurance.
- When a member has obtained retroactive eligibility. The TAR must be received by PHC within 60 calendar days of the date retroactive Medi-Cal eligibility was established.

Provider Notification of TAR Action

Notification of action on a TAR (Approved, Modified, Deferred, Denied) will be made to the submitting provider by PHC within one (1) business day of receiving a completed TAR. Inquiries regarding status of a TAR may be directed to the PHC Pharmacy Department @ (707) 863-4414.

- **Approved TARs**

PHC enters the approved TAR into the MedImpact system and faxes the TAR back to the requesting provider. The approved TAR is entered directly into the member's prescription file and the billing provider is not required to enter the TAR Control Sequence Number when submitting the claim to MedImpact.

- **Modified TARs**

A modified TAR is a TAR that is approved with a quantity that differs from the requested quantity submitted by the provider. The modified TAR is entered into the MedImpact system and faxed back to the requesting provider. Members are provided written notification of modified TARs.

- **Deferred TARs**

Incomplete TARs or TARs that require additional information will be deferred back to the provider by PHC. If the provider does not respond to the request for additional information within 14 business days (Mon-Fri) days, the TAR will be denied.

- **Denied TARs**

Written notification of a denied TAR that lacks medical justification for the intended use of the drug or a deferred TAR past 14 days will be sent to the member, the requesting pharmacy provider and the prescribing physician. The denied TAR will include the reason for the denial and information about the appeals process.

Emergency After Hour Authorizations

Emergency authorizations for TAR's outside of PHC's normal business hours (M-F 8am to 5pm), including weekends and holidays may be requested from MedImpact at (800) 788-2949. MedImpact may authorize up to a 5 day supply of medication, pending further authorization by PHC. In an emergency situation, when both PHC and MedImpact are unavailable, PHC will authorize a retroactive TAR allowing the pharmacy to dispense up to a 5 days supply of a non-formulary drug.

TAR Form Completion

Highlights of the PHC TAR form follows: PHC allows only **ONE** drug per TAR form to be submitted.

Check all that apply: Indicate the type of request applicable. If medically urgent TAR request check the Boxed section above the **Requested By** section.

Requested By: enter name, Address with phone and FAX number

Member Information: Member ID# is (Medi-Cal ID: 10 digit CIN #). Indicate Gender: Use "M" for male, or "F" for female. Enter age of member. Indicate place member is residing.

Diagnosis Description: Enter the description of the diagnosis. Include all relevant diagnoses for review purposes

Medical Justification: Provide sufficient documentation of appropriate clinical information that supports the medical necessity of the requested item. Documentation of other drugs tried previously and the clinical outcomes are also required.

Prescription Information: Provide drug name, NDC, quantity per fill, strength, form, # refills on Rx and directions for use. If retroactive, please indicate in the Check all that Apply section. ***PHC REQUIRES ONLY ONE REQUESTED ITEM PER TAR FORM.***

Prescriber Information: Name, Phone, DEA/NPI #, FAX #, Specialty and practice group if known.

Signature of Physician or Provider: Form must be signed by the physician, pharmacist, pharmacy technician or authorized representative and dated.

MEDI-CAL
TREATMENT AUTHORIZATION REQUEST FORM (TAR)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield CA 94534
(707) 863-4414 or (800) 863-4155
FAX # (707) 863-4330
www.partnershiphp.org

(PLEASE TYPE) **(FOR PROVIDER USE)** **(PLEASE TYPE)**

REQUEST IS RETROACTIVE ? ☐ YES ☐ NO

PROVIDER PHONE NO. ( )

FAX # ( )

PROVIDER NPI#

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS:

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)

PATIENT IDENTIFICATION NO.

STREET ADDRESS

SEX AGE DATE OF BIRTH (M M D D Y Y)

CITY, STATE, ZIP CODE

☐ HOME ☐ BOARD & CARE ☐ SNF/ICF ☐ ACUTE HOSPITAL

PHONE NUMBER
AREA
( )

DIAGNOSIS DESCRIPTION: CURRENT ICD-9CM CODE

MEDICAL JUSTIFICATION:

FOR PHC USE ONLY

PROVIDER: YOUR REQUEST IS:

☐ APPROVED AS REQUETED ☐ DENIED ☐ DEFERRED

☐ APPROVED AS MODIFIED

BY: _____
PHC CONSULTANT'S NAME

DATE (M M D D Y Y)

REVIEW COMMENT INDICATOR ☐

COMMENTS / EXPLANATION

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1								
2								
3								
4								
5								
6								

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER | TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE (M M D D Y Y) TO DATE (M M D D Y Y)

TAR CONTROL NUMBER

OFFICE | SEQUENCE NUMBER | PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBLITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) TAR ATTACHMENT FORM:

COMPOUND INGREDIENT WORKSHEET

PHC reimbursement for compounds: PHC reimburses at AWP, MAC or Submitted Price, *whichever is less.* Brand name ingredients are priced at AWP minus 16%. Generic substitution required when available in marketplace. Generic ingredients are subject to MAC (Maximum Allowable Cost) pricing when agents are included in MedImpact's MAC price list. When MAC is applied, the 16% deduction is waived. A $12.50 compound fee and a $2.25 dispensing fee will be added. The TAR approval letter will include the approved total reimbursement price.

Claim Submission: The NDC of the most expensive RX ingredient should be listed first, both on the worksheet and in the drug info list of ingredients in the pharmacy's Rx software. The software file should correctly identify the product as a compound. Quantities should be submitted for the total metric quantity dispensed in grams or milliliters (both on the TAR and the electronic claim). The electronic claim's total price submitted must match the approved price in order for claim to adjudicate, which will most likely require a manual price adjustment on the submitted claim. If pharmacy provider staff is unable to adjust the submitted price manually, pharmacy provider staff should contact either the pharmacy's software vendor help desk or corporate help desk for assistance with price submission.

MEMBER NAME: _____ PHC ID# _____

INGREDIENT DESCRIPTION	**AWP and package size (eg, 30's, 100's, 480ml, 1000ml, 25x10ml, etc.)**	**Amount used in compound & unit of measure (# of tabs, # vials, grams, mls, etc)**
NDC _____ **Name** _____ **Strength, Dosage form** _____		
NDC _____ **Name** _____ **Strength, Dosage form** _____		
NDC _____ **Name** _____ **Strength, Dosage form** _____		
NDC _____ **Name** _____ **Strength, Dosage form** _____		
NDC _____ **Name** _____ **Strength, Dosage form** _____		

FINAL CONCENTRATION OF PRODUCT (AS ORDERED ON RX): _____

TOTAL DISPENSED WEIGHT OR VOLUME OF FINAL PRODUCT on requested DOS: _____

APPEALS PROCESS (Medi-Cal)

The PHC Medi-Cal Appeals Process offers providers dissatisfied with the processing or payment of a claim, resubmission of a claim, a claim inquiry, or denial of a TAR, a method for resolving problems.

Provider Appeal Process for Claims Payment or a Denied Claim

1. Pharmacy providers dissatisfied with the processing or payment of a claim, including a denied claim, may seek an adjustment by submitting a Claim Inquiry Form (CIF) to the PHC Health Services Pharmacy Department. The CIF should contain additional information/corrections necessary to allow claim payment within the PHC/Medi-Cal benefits and claims processing guidelines. Providers have six (6) months to CIF a claim from the original date of the claim on the MedImpact Explanation of Benefits (EOB). CIFs received after six (6) months are subject to automatic denial. PHC will acknowledge receipt of the CIF within 5 working days and will respond with a Claims Inquiry Response (CIR) Letter indicating the outcome of the CIF review within 45 working days. If the claim submitted with the initial CIF does not appear on the EOB or a CIR Letter has not been received, the provider may file an appeal. Include all copies of the Claims Inquiry Acknowledgments with the Appeal.

2. Upon receipt of the outcome of the CIF, providers have a one time window of 90 days from the date of the CIF denial to re-CIF their claim with additional corrections.

3. If the CIF is not approved and the claim status is maintained, the provider may submit a "claim appeal" within 90 days of the CIF denial. Failure to submit an appeal within the 90-day time period will result in the appeal being denied. A claim which is submitted on appeal has already been reviewed and denied two separate times once on the original claim submission and once as the result of a CIF submission and/or a re-CIF. PHC will acknowledge receipt of the Appeal within 5 working days and will and will respond with an Appeal Response Letter indicating the outcome of the Appeal review 45 days.

4. Providers who are still not satisfied with the outcome of a Claim Appeal may file a Grievance with the PHC Provider Relations Department. Provider Grievances must be submitted in writing within 30 days of receipt of the Appeal Response Letter.

Provider Appeal Process for a Denied TAR

Pharmacy providers may request an appeal of a Utilization Management decision for a denied TAR on behalf of a member by calling or writing the Health Services Department

within 30 days of the denial. The CMO refers the appeal to Associate Medical Director, to a member of the Quality / Utilization Advisory Peer Review Committee or a board certified specialist for further consideration. The Peer Review Committee member or certified specialist may then request further information from the provider if needed. PHC has 30 working days to make a decision after receiving the request or receiving the additional information requested. The decision is communicated to the provider and member within 5 working days. Providers who disagree with the decision of the appeal may then file an informal or formal Provider Grievance with PHC.

Prescribers wishing to discuss denials of medications for medical necessity may call the PHC Pharmacy Department at (707) 863-4414.

Expedited Appeals

Expedited Appeals may be initiated by the member or by the provider acting on behalf of the member. Expedited appeals are performed by PHC only when, in the judgment of PHC, a delay in decision making might seriously jeopardize the life or health of the member.

Providers needing more information on the Claims Inquiry process, the Appeals process or the Provider Grievance process may contact the PHC Provider Relations Department at (800) 863-4144 or (707) 863-4100.

Administrative Denial Appeals

TARs received by PHC that do not adhere to the timeframes defined for timely submissions are denied as administrative denial. Administrative denials are **NOT** subject to the provider appeals process.

PHARMACY AUDITS

MedImpact maintains an ongoing Pharmacy Audit Program to assure pharmacy, member, and prescriber compliance with PHC's program policies and procedures. The Pharmacy Network Agreement with MedImpact contains a provision allowing MedImpact during regular business hours and upon reasonable notice to have access to all information maintained by the pharmacy related to pharmaceutical services. It is understood that such audits may be made at any time during the term of the Agreement and within one year after its expiration. Should such audit determine that a claim or claims resulted in overpayment to the pharmacy, MedImpact shall have the right to recover the amount overpaid.

Audit Triggers

The MedImpact Audit Program is supported by continuous in-house analysis of statistical dispensing triggers. These triggers include, but are not limited to:

- Average claim amount
- Quantity dispensed versus days supply
- Ratio of usual & customary billing to amount calculated payments
- Claim reversals
- Total number of rejects
- Use of physician identifiers
- Control drug percent
- Generic percent
- Refill percent
- Average number of prescriptions per member

Audit Programs

MedImpact utilizes the following type of audit programs:

- **Onsite Audits**: The MedImpact auditor visits the pharmacy to perform a comprehensive review which includes claims analysis, a general overview and examination of the pharmacy's practices, procedures, patient counseling program, and an overall facility requirements analysis.
- **In-Depth Electronic Audits**: On-line claims from preselected quarters are automatically flagged utilizing **predetermined** criteria and subjected to audit procedures.
- **Monthly Bench/Desk Audits**: Each month MedImpact's audit department scores and ranks pharmacies in targeted categories using a Statistical Provider Audit report and reviews those pharmacies that don't comply to established parameters.

PHARMACY UPDATES

This section is reserved for pharmacy providers to insert PHC Medi-Cal Pharmacy Updates that will be distributed periodically to all PHC in-network pharmacy providers. The updates will contain valuable information regarding formulary changes and additions, plan parameter changes, billing procedures, prior authorization criteria, the Treatment Authorization Request (TAR) process and other necessary information.

Click Here for Current Pharmacy Updates: