2012 Clinical Quality Assurance Program: Drug Utilization Review and Utilization Management

Medi-Pak Rx (PDP), Medi-Pak Advantage (PFFS), and Medi-Pak Advantage (PPO)
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OVERVIEW

The Clinical Quality Assurance (QA) Program is designed to encourage safe and effective drug utilization, enhance beneficiaries’ health outcomes, and promote cost-effective, drug benefit plan designs. This Program is built upon the requirements of the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (d.b.a. American Accreditation Healthcare Commission) (URAC), Centers for Medicare & Medicaid Services (CMS) and other applicable regulatory organizations.

Coordination of the Clinical Quality Assurance (QA) program involves communication among practitioners, pharmacists, beneficiaries, the Plan and various other internal departments, including, but not limited to:

- Clinical Affairs
- Clinical Services
- Clinical Program Development
- Clinical Services Operations
- Clinical Account Management
- Formulary Administration Services
- Operations Excellence
- Compliance and Integrity

PROGRAM GOALS

The goal of the Clinical Quality Assurance Program is to help ensure beneficiaries receive access to high quality prescription drug coverage and quality service and to reduce the risk of fraud, waste and abuse within the Part D prescription benefit. The goal is accomplished through the following:

- Provide therapeutically appropriate drug intervention and formulary management recommendations
- Support beneficiaries’ timely access to the drugs prescribed by their practitioners
- Promote targeted prescriber communication identifying clinically based, cost effective therapy options for their patients covered by Medicare Part D that improves safety, adherence and healthcare outcomes
- Promote the regular review of data related to complaints/grievances, drug utilization review (cDUR, rDUR), Medication Error Identification and Reduction (MEIR) processes, UM/STM program, formulary processes and Fraud, Waste and Abuse program in order to identify opportunities to meet or exceed industry or regulatory benchmarks for Medicare Part D
- Monitor the effectiveness of QA practices intended to respond to opportunities identified by the review of various quality metrics to improve member safety, improve timely and appropriate access to covered medications, maintain regulatory compliance for formulary processes and reduce unnecessary cost/waste/abuse of the Part D prescription benefit
- Identify opportunities to work more directly with beneficiaries (on on one) regarding their medication therapy
- Help ensure that QA, DUR, and UM activities meet accreditation and regulatory requirements
- Maintain beneficiary, practitioner and client confidentiality in compliance with the Health Insurance Portability and Accountability Act (HIPAA)

**SCOPE**

The scope of the Clinical Quality Assurance Program includes all of the clinical programs and processes designed to ensure that Part D services beneficiaries receive access to high quality prescription drug coverage and quality service. Aspects of this may include, but not limited to, formulary management, cDUR, rDUR, clinical programs related to drug management, clinical complaints, prior authorization criteria development, appeals process, medication safety and MEIR.

**PROGRAM STRUCTURE**

The Clinical Quality Assurance Program Description is reviewed, revised and approved annually by the Medicare Part D Clinical Quality committee and Medicare Part D Services Medical Director. The effectiveness of the Program is measured throughout the year by review of metrics and related activities.

**CLINICAL QUALITY OVERSIGHT**

**Medicare Part D Clinical Quality Committee**

This committee provides clinical oversight to the Medicare Part D clinical program. The committee provides oversight of applicable policies and procedures to help ensure compliance to regulations while working with the business areas to close any identified gaps. The committee tracks performance measures related to Medicare Part D clinical programs.

The committee membership is a multidisciplinary group representing various departments that are responsible for providing services supporting Medicare Part D. The committee meets at least ten times per year, maintains written records of these meetings and reports to the Medicare Quality Improvement Committee (QIC). The Medicare Clinical Quality committee is chaired by the Medicare Part D Services Medical Director.

**PERFORMANCE MEASURES**

Tracking specific performance measures helps ensure the beneficiaries are receiving the highest quality prescription coverage and services. Performance measures are tracked by the various
business areas and through appropriate committees. If goals are not met and/or rates are trending negatively, actions are taken to improve performance.

Examples of areas of performance measures that fall under the scope of the Medicare Part D Clinical Quality Committee include:

- Clinical complaints
- Coverage determination outcomes (prior authorization/appeals, formulary requests, etc.)
- Medication Error Rates
- Medication Therapy Management encounters
- Patterns of potentially inappropriate or unnecessary medication use (DUR reports, FWA program, etc)
- Prescriber and beneficiary satisfaction with clinical programs
- Timeliness of new drug to market – Medicare Part D
- Other clinical measures related to the Medicare Part D population (e.g. STAR rating/metrics)

CLINICAL COMPLAINTS

Grievances related to quality of care issues, regardless of how the grievance is filed, are responded to in writing. The response will include a description of the beneficiary’s right to file a written complaint with the Quality Improvement Organization (QIO) in the beneficiary’s state of residence.

MEDICATION ERROR IDENTIFICATION AND REDUCTION (MEIR)

Per CMS, a medication error is a preventable medication dispensing event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. A Medication Error Identification and Reduction (MEIR) system is in place to identify and require reporting of such errors. The system utilizes internal control systems and regular monitoring programs to reduce opportunities for medication errors.

For dispensing pharmacies, such events are classified, recorded and tracked as either Level One Dispensing Errors or Quality Related Events (QREs). Categories of errors tracked and trended include errors involving:

- Incorrect Drug
- Incorrect Patient or Patient Name
- Incorrect Instructions/Directions
- Incorrect Strength
- Inappropriate Override of Drug Utilization Review (DUR) Alert
The quality measures associated with MEIR are reported to the appropriate business area and/or quality oversight committee. Opportunities for improvement are identified and resources made available to work on these initiatives.

**COVERAGE DETERMINATION**

A Coverage Determination is any determination made by or on behalf of the Plan with respect to providing or paying for a Medicare Part D drug. This includes the decision to not pay because the drug is not on the Plan’s formulary; because the drug is determined not to be requested for a Medicare Part D eligible use; because the drug is furnished by an out-of-network pharmacy; or because the Plan determines that the drug is otherwise excluded as a non-Part D drug. This includes decisions concerning formulary and tiering exceptions, cost sharing for a drug and whether an enrollee has satisfied the PA or other UM requirements.

Some initial coverage determinations may be identified as requiring a medical necessity decision or determination. Such decisions, if they involve adverse determinations or denials, are made by a physician reviewer meeting the CMS requirements for such decisions.

Standard turnaround times for coverage determinations are consistent with the regulations as provided by CMS and are reviewed by Clinical Services and reported as required.

- Expedited coverage determinations – within 24 hours after the Plan receives the request for an expedited coverage determination
- Standard coverage determinations – within 72 hours after the Plan receives the request for a standard coverage determination

If notice of a coverage determination is not provided within the required timeframe, the complete case file must be forwarded to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication time frame unless a decision to approve the request will be rendered on the case within the next 24 hours.

A review of the Medicare Part D beneficiary’s coverage determination is completed and decisions are either approved or denied. If an override is required, it is entered into the system within 24 hours for an expedited coverage determination and 72 hours for standard requests. (This is calculated from the time of receipt of the request and the prescribing practitioner’s supporting documentation.) The override will be effective at least through the end of the plan year if authorized by the prescriber and will not require another exception for refills. In addition, beneficiaries and their prescribing practitioner will be notified of the outcome of the coverage determination within 24 hours of receipt of the request and the prescribing practitioner’s supporting statement for expedited requests and 72 hours for standard requests.
REDETERMINATION

A redetermination is a review of an adverse coverage determination; the evidence and findings, upon which it is based; and any other evidence the requestor submits. A Medicare Part D beneficiary may request a redetermination of an adverse coverage determination by submitting a request within 60 days of receiving notice of an adverse determination. If the 60-day period has expired, the beneficiary may request a redetermination and extension of timeframe in writing stating why the request was not filed on time. If the beneficiary can show there was good cause for the delay, the extension may be granted. The requestor may withdraw a request in writing.

Redeterminations are accepted in writing, by fax or orally in the case of an expedited request. Expedited requests are completed within 72 hours of receipt of the request. Standard requests are completed within seven (7) calendar days of receipt of the request. Beneficiaries and prescribing practitioners will be notified in writing of the determination outcome.

The redetermination process includes the following:

- A review of the beneficiary’s coverage determination
- Collecting eligibility data, beneficiary demographics and pertinent clinical information
- Reviewing additional evidence that may have been submitted by the beneficiary and/or the prescribing practitioner
- Review process conducted by a person not involved in the original coverage determination
- Redeterminations are reviewed by a physician with expertise in the field of medicine appropriate for the services under review and meeting required CMS regulations for licensing. Such redeterminations include but are not limited to formulary/tiering exceptions which were denied at the initial coverage determination level and reviews of PA denials
- Following review, the decision is either an approval or denial
- If approved, overrides are entered into the adjudication system within 72 hours for expedited and seven (7) calendar days for standard requests

Notification for expedited requests will be completed as expeditiously as the beneficiary’s health condition requires but no later than 72 hours of the receipt of the request. Notification for standard requests will be completed as expeditiously as the beneficiary’s health condition requires but no later than seven (7) calendar days of the receipt of the request.

If notice of a redetermination is not provided within the required timeframe, the complete case file must be forwarded to the IRO within 24 hours of the expiration of the adjudication timeframe.
UM CRITERIA DEVELOPMENT AND MAINTENANCE

Drug utilization management (UM) services include the development, maintenance and application of Prior Authorization (PA), Quantity Limits and Step Therapy programs. Standard Medicare Part D PA, Quantity Limits and Step Therapy programs utilize objective clinical criteria to ensure safe, evidence-based, clinically appropriate drug use and are reviewed and approved by the CVS Caremark National P&T committee before submission or implementation.

The UM criteria are based on current principles and processes of pharmacotherapy, such as those included in drug labeling approved by the U.S. Food and Drug Administration (FDA) and those published in CMS-recognized compendia. The criteria for each drug are updated, reviewed and approved annually by Medical Affairs and the Clinical Services Operations Department and undergo external clinical review by appropriate, actively practicing external physicians and pharmacist with current knowledge relevant to the criteria. After annual review and approval by the CVS Caremark National P&T committee, Medicare Part D UM criteria are submitted annually to CMS for approval before implementation.

PRIOR AUTHORIZATION

Prior authorization criteria are designed to determine whether medication requests for certain highly utilized medications are intended for use in Medicare Part D approved indications. They are also intended to promote the safe use of medications for beneficiaries based on the medications’ labeling. PA may also be implemented in conjunction with Quantity Limits or Step Therapy protocols. Claims for drugs subject to PA are screened at the point-of-service, and the dispensing pharmacy is advised to have the prescribing practitioner contact the PA Department. The PA Department obtains the relevant information from the practitioner necessary to determine whether the beneficiary meets the established criteria for the requested drug. If the request is approved, an override is entered into the claims payment system. If the request is denied, the following information is provided to the prescribing practitioner (via fax) and the beneficiary orally (by IVR) and in writing:

- The principal reason(s) for denial, in easily understandable language
- A reference to the benefit provision on which the denial decision is based
- A statement that the beneficiary and/or practitioner may request a copy of the actual criteria on which the denial decision was based and any other information relevant to the denial decision
- Information regarding the right to appoint a representative to file a redetermination on the enrollee’s behalf
- For coverage denials, a description of both the standard and expedited re-determination processes and time frames, including conditions for obtaining an expedited reconsideration, and the rest of the appeals process; and
- For payment denials, a description of the standard redetermination process and time frames, and the rest of the appeals process
Prescribing practitioners are provided with the opportunity to discuss any UM denial decision with a physician or pharmacist reviewer by contacting the PA Department. Prescribers or beneficiaries may request exceptions to coverage determinations utilizing PA, step therapy or quantity limits. Such requests, when requested based on medical necessity, are reviewed by physician reviewers meeting current CMS requirements for such reviewers.

QUANTITY LIMITS

Quantity Limits establish a maximum quantity of certain medications that will be covered over a specified time period. The limit is expressed in terms of a quantity dispensed over a period of time. When a beneficiary’s claim exceeds the established limit for the drug, the claim will be rejected by the claims adjudication system. Messaging is provided to the dispensing pharmacy advising that the quantity limit has been exceeded or that PA is required for coverage of additional medication quantities.

STEP THERAPY

The Step Therapy protocols may require that alternative drugs must be tried first and for certain durations before the prescribed drug will be covered. A “post-step” PA/Exceptions process is available when the established step requirement is not satisfied, to allow such requests to be reviewed for medication necessity.

TIERING AND FORMULARY EXCEPTIONS

The tiering and formulary exception process is for Medicare Part D beneficiaries seeking to obtain coverage of non-formulary drugs or formulary drugs at a different tier.

- A Tiering Exception is a coverage determination decision made that will allow for coverage of a non-preferred drug at the preferred price whenever the drug is determined to be medically necessary, consistent with the Medicare Part D beneficiary’s physician’s statement.
- A Formulary Exception is a coverage determination decision that allows for coverage of a non-formulary drug at the formulary price whenever the drug is determined to be medically necessary, consistent with the Medicare Part D beneficiary’s physician’s statement.

Exceptions will not be made for drugs that do not meet the definition of a Medicare Part D drug. Exceptions for Part D eligible drugs based on medical necessity are reviewed by physician reviewers meeting current CMS requirements for such reviewers.
INDEPENDENT REVIEW ORGANIZATION

Redeterminations are performed at a beneficiary’s request to re-review coverage denials resulting from PA or Formulary or Tiering determinations in which adverse determinations have been made.

All redeterminations are performed by a physician reviewer meeting CMS requirements who follows/adheres to the CMS definition of a Medicare Part D covered drug. A prescription drug is a Medicare Part D drug only if it is prescribed for medically accepted indications defined as uses which are approved by the FDA or supported by a citation included in one of the three compendia listed below. These are:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia Drug Information
- DRUGDEX Information System

For oncology drugs, off-label or unapproved uses may be based on listings in NCCN or supported by citations in specific CMS approved oncology journals.

A random sample of reviews conducted by the IRO is evaluated for turnaround time adherence each month and reported quarterly to the Clinical Quality Committee. In addition, periodical teleconferences occur with the IRO to review the results of the redetermination process. The review includes:

- Turnaround times (TAT) – Clinical redeterminations will be returned by the fifth calendar day after receipt by the IRO if non urgent and within 36 hours if urgent appeal. TATs are measured from the date/time the review is stamped received by the IRO until date/time the review is stamped by CVS Caremark.
- IRE overturns – Review rates of appeal denial overturns by the federal reviewer Maximus and specific examples of denial disagreements between the IRO and IRE.
- Miscellaneous case reviews as identified by the appeals team or Part D Services Medical Director

A request may be made for the IRO to submit a written corrective action plan, as needed.

ADDITIONAL LEVELS OF REVIEW

Reconsideration by the Independent Review Entity (IRE)
In cases where a beneficiary has filed a reconsideration request with the IRE, the IRE requests a copy of the case file and all of its contents by fax and it is provided to the IRE by fax within 24 hours for expedited requests or 48 hours for standard requests. The case file will contain all of the information required under Chapter 18 of the Prescription Drug Benefit Manual section 70.30. The IRE notifies the Plan of their decision and if approved an override is entered for the timeframe as indicated by the IRE.
Administrative Law Judge (ALJ) and Medicare Appeals Council (MAC) Review
In cases where the amount in controversy meets the appropriate threshold requirement, a beneficiary who is dissatisfied with the IRE’s reconsideration decision has a right to a hearing before an ALJ. A beneficiary who is dissatisfied with an ALJ hearing decision may request a MAC review. Upon notification of an ALJ hearing or MAC review, the Appeals Department will review the entire appeal history and determine whether there is a need to file additional materials or attend the hearing. The Plan, according to 42 CFR § 423.612 (a), is not considered a party to the ALJ hearing, but may participate in the hearing at the discretion of the ALJ.

The Appeals Department will send a notification to the ALJ hearing officer/MAC representative regarding the decision to file documents, appear or take no further action. The ALJ or MAC notifies the Plan of their decision and if favorable, an override is entered in the system within the applicable timeframe.

MEDICATION THERAPY MANAGEMENT PROGRAM

Medication Therapy Management Program (MTMP) monitors for appropriate medication usage. The MTMP is designed to optimize therapeutic outcomes for targeted Medicare Part D beneficiaries by improving medication use and reducing adverse drug events. The MTMP identifies Medicare Part D beneficiaries at risk for adverse medical events per CMS criteria and works collaboratively with prescribing practitioners and case managers to reduce that risk and avoid potential medical costs. The program encourages compliance with national evidence-based clinical guidelines. The MTMP identifies eligible beneficiaries using CMS targeting criteria, suggests prescribing practitioner interventions, provides Medicare Part D beneficiary education and includes CMS reporting requirements.

The MTMP is targeted at Medicare Part D beneficiaries taking more than eight (8) chronic Medicare Part D covered medications, who have three (3) or more targeted chronic health conditions and who are likely to spend more than $3,000 on covered Medicare Part D medications in identified years. The targeted chronic health conditions include the following:

- Alzheimer’s Disease
- Asthma
- Behavioral Health (including depression, bipolar disorder and schizophrenia)
- Diabetes
- Cardiovascular Disease (including dyslipidemia, dysrrhythmias, ischemic heart disease and hypertension)
- Heart Failure
- Osteoporosis

CORE MEDICATION SAFETY AND MONITORING (SMS)

The Safety and Monitoring Solution focuses on utilization of high-risk drug classes, such as controlled substances (CSs), by using indicators that suggest inappropriate use or misuse of
CSs such as poly-pharmacy, “provider shopping” and high total controlled substance claims volume. Algorithms with a graduated risk score identify highest-risk beneficiaries and profiles are generated. On a quarterly basis, clinical pharmacists evaluate controlled substances claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. After analyzing the generated profiles, clinical pharmacists may contact prescribing practitioners to obtain more clinical data regarding the beneficiary’s prescription use. If it is observed that there are potential misuse or safety concerns, letters are sent to the prescribing practitioner(s) noting the observation and requesting verification of drugs prescribed along with medical diagnosis codes.

An “enhanced” safety and monitoring program utilizes a multidisciplinary team approach to working with beneficiaries and prescribers to reduce inappropriate medication use in high risk classes like controlled substances. This program works closely with regional MEDICs to report potential fraud, waste, and abuse of medications.

**ENHANCED SAFETY AND MONITORING SOLUTION**

The Enhanced Safety and Monitoring Solution provides a more extensive range of interventions for those cases that continue to show evidence of inappropriate or unexplained utilization despite interventions applied in the Core Safety program. Cases are referred to the Enhanced Safety and Monitoring Solution (ESMS) – FWA program for SSIC or Clinical Operations for the Plan – for further review by the ESMS Committee. This review includes a secondary level of analysis and risk stratification that can culminate in one of the following two outcomes:

- Inclusion of the beneficiary in the beneficiary/practitioner lettering campaign. This is a three-letter campaign designed to promote awareness of the medication history to both the beneficiary and each practitioner who has written a prescription with the overall goal to change beneficiary behavior in line with current pain management guidelines;
- Referral of the case to one of the CMS Medicare Drug Integrity Contractors (MEDICs) for further investigation or to client for their reporting if deemed appropriate.

**ACCESS TO COVERAGE DETERMINATION SERVICES**

The following communication services are available to beneficiaries and practitioners:

- Access to staff at least eight (8) hours a day during normal business hours for inbound calls regarding UM issues
- Staff that can receive inbound communications regarding UM issues after business hours
- Staff that can send outbound communications regarding UM inquiries during normal business hours, unless otherwise agreed upon
- Staff members that identify themselves by name, title and organization name when initiating or returning calls regarding UM issues
- A toll-free number with staff who accept collect calls regarding UM issues
- Access to staff for callers with questions about the UM process.

For urgent requests, the answering service relays contact information for the prescribing practitioner to an on-call pharmacist. The pharmacist will attempt to contact the practitioner within 24 hours to process the urgent request. For non-urgent requests, the prescribing practitioner may leave a voicemail that will be returned the next business day.

**MEDICATION SAFETY**

Several programs operate to ensure safe medication use for Medicare Part D beneficiaries. Mechanisms are in place to respond on an urgent basis to FDA safety alerts and other situations that could pose an immediate threat to the health and safety of beneficiaries.

**Drug Safety Alert**

Key safety information is provided to beneficiaries and prescribing practitioners in the event there is a black box warning, recall or voluntary drug recall from the market, consistent with FDA, NCQA and URAC requirements. FDA defines the following categories:

Class I recall as a situation in which there is a reasonable probability that the use of or exposure to a product will cause serious adverse health consequences or death.

Class II recall as a situation in which use of, or exposure to a product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Class III recall as a situation in which use of, or exposure to a product is not likely to cause adverse health consequences.

Market withdrawal as a firm’s removal or correction of a distributed product that involves a minor violation which would not be subject to legal action by the FDA.

**DRUG UTILIZATION REVIEW (DUR)**

Multiple drug utilization review processes are in place to evaluate prescriptions received by Medicare Part D beneficiaries for safe, appropriate use. Some reviews are performed before a beneficiary received a medication (UM, cDUR, plan design/formulary edits) and others retrospectively (rDUR). Each process has unique attributes to contribute to safe and effective medication therapy while reducing unnecessary cost and mediation waste.

**Concurrent Drug Utilization Review (cDUR)**

Point-of-Service DUR (cDUR) is a concurrent online editing system that electronically screens drug claims for several types of potential adverse drug interactions before each prescription is
dispensed to a beneficiary. Such edits are particularly useful to detect duplicate therapy or potential adverse drug interactions. Edits applied through cDUR process include screening for:

- Excessive doses
- Therapeutic appropriateness
- Generic use
- Duplicate therapy
- Drug-drug or drug-allergy interactions
- Drug dosage
- Duration of treatment
- Clinical abuse or misuse
- Drug-disease contraindications
- Over and under utilization
- Drug-age precautions
- Drug-gender interactions
- Benefit design
- Regulatory limitations

When potential safety issues are triggered, warning messages are transmitted to the dispensing pharmacy to provide an opportunity for the pharmacist to evaluate the issues and determine the need for intervention.

Each point of service processed prescription that receives a cDUR warning based on information stored in First DataBank® or Medi-Span® allows review by a pharmacist to make certain that the prescribed medication(s) is/are being properly administered to the beneficiary.

The cDUR process enables the pharmacist to review the prescription, evaluate the warning for clinical relevance and significance and determine the next course of action. The following actions are available:

- The pharmacist determines that the cDUR warning is not clinically significant and requires no further intervention. The pharmacist documents any comments that are necessary in the prescription record and overrides the cDUR warning.
- The pharmacist determines that the cDUR warning is clinically significant and therefore requires a prescribing practitioner contact. The pharmacist routes the prescription to the appropriate area with question(s)/concern(s) documented in the prescription record.

When determined to be appropriate to resolve the edit, the prescribing practitioner may be consulted to verify if he/she is aware of the cDUR warning and the pharmacist is required to document one of the following outcomes:

- Prescriber agrees that the warning/interaction is clinically significant and requests that the prescription in question is cancelled.
- Prescriber agrees that the warning/interaction is clinically significant and prescribes an alternate medication or dosing.
- Prescriber is aware of the warning/interaction, but believes that the benefit outweighs the risks and still wants the prescription filled. The discussion with the prescriber will be documented in the prescription record and the cDUR will be overridden.
- Prescriber is aware of the warning/interaction, but believes that the benefit outweighs the risks. However, the pharmacist disagrees and informs the prescriber that the prescription will not be filled. The pharmacist documents the discussion with the prescriber in the prescription record and the prescription is returned to the beneficiary with the appropriate general communication as to why the prescription was not filled.

Retrospective Drug Utilization Review (rDUR)
Retrospective Drug Utilization Review (rDUR) provides a focused beneficiary-specific review of a particular drug, therapeutic drug class or issue. The review identifies potential opportunities for improvements in beneficiaries’ therapies or practitioners’ prescribing practices within the therapeutic class. Written communications are provided to prescribing practitioners that offer potential alternative therapies.

The Drug Savings Review program is an rDUR program that evaluates the appropriateness of therapy from a variety of perspectives, with a primary focus on ensuring safety and efficacy and a secondary focus on reducing unnecessary cost. Clinical pharmacists review flagged profiles based on product selection, dosage, quantity and duration. Pharmacists review the clinical appropriateness of proposed interventions and avoid unnecessary communications with prescribing practitioners. All proposed changes are carefully researched. These letters contain specific clinical references from established medical literature and include supporting material. Prescribing practitioner responses to the alert letters are encouraged, but not required, and tracked when received. No changes are made to a prescription without the permission of the prescribing practitioner. By providing prescribing practitioners with specific and detailed clinical information, and specific suggested adjustments, prescribing practitioners can make informed, clinically-sound decisions with the health and well-being of the beneficiary in mind. The result is lower drug spending and appropriate utilization. All Drug Savings Review interventions are updated at least annually and are reviewed by independent external practicing physicians.

FORMULARY MANAGEMENT SERVICES

The Medicare formulary template is developed and maintained according to the guidelines for formularies as published by CMS. The formularies developed are based on current, accepted standards of medical practice and pharmacotherapy. The formularies are reviewed and approved by the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee and are submitted to CMS for approval.

Sources used to develop formularies may include:

- Drug labeling approved by the FDA
- Published peer-reviewed journals
- Recognized compendia
- Accepted practice guidelines
- National Institutes of Health (NIH)
- Agency for Healthcare Research and Quality (AHRQ)
- Relevant government agencies, medical associations and national commissions

Formulary Review Committee
The Formulary Review Committee (FRC) provides recommendations for formulary management including requests for drug list additions and deletions. The FRC also provides recommendations for services that include the preparation and maintenance of formulary templates and tiered copay templates. The recommendations for drug list changes (i.e., additions and deletions) by FRC are reviewed and approved by the P&T Committee prior to implementation.

Pharmacy and Therapeutics Committee
The P&T Committee helps ensure integrity by impartially evaluating the clinical information regarding drugs presented for consideration for inclusion on the drug list. The Plan utilizes the services of an independent P&T Committee to approve safe and clinically effective drug therapies. The P&T Committee consists of external clinical experts from a variety of medical specialties including high volume specialty physicians, pharmacists and other health care professionals. A majority of the P&T Committee members are actively practicing pharmacists and physicians. At least one P&T Committee practicing pharmacist and one practicing physician is an expert in care of the elderly or disabled persons. Voting members of the P&T Committee may not be employees of CVS Caremark and must attest that they are free of any significant financial relationship or conflicts of interest with any pharmaceutical manufacturers or other conflicts of interest. Members of the P&T committee may not be “excluded providers” for Medicare Part D Services.

Medicare Part D Drug Formulary
The P&T Committee reviews and approves a Medicare Part D Formulary. The Medicare Part D Formulary is a comprehensive list of prescription drugs across multiple therapeutic categories, which have been reviewed and approved by the P&T Committee based on their safety, efficacy and CMS requirements. Additions and deletions to the Medicare Part D Formulary must be reviewed and approved by the P&T Committee for clinical appropriateness. For example, such changes are made as new drugs are developed and subsequently approved by the FDA, as FDA approved indications are modified, as new clinical data becomes available or as new generic drugs become available in the marketplace. In addition, the P&T Committee reviews drugs within 90 days post launch and makes a decision on formulary status 180 days post launch. Reviews and decisions for drugs in classes of clinical concern are completed within 90 days of new drug approval.

The P&T Committee thoroughly reviews each individual drug for safety and clinical efficacy before adding the drug to the Medicare Part D Formulary. Clinical decisions are based on scientific evidence, standards of practice, peer reviewed medical literature, accepted clinical practice guidelines, as well as other sources of appropriate information, such as pharmacoeconomic studies. A drug must be FDA-approved (or exempt from FDA approval) to
be considered for inclusion. The P&T Committee does not consider the specific cost of a drug in determining the composition of the Medicare Part D Formulary. The P&T Committee also does not have access to, nor does it take into consideration, any information regarding rebates or negotiated discounts with pharmaceutical manufacturers, or the net cost of the drug after application of all discounts in deciding whether a drug is included or excluded from the Medicare Part D Formulary or any drug lists. However, the P&T Committee does consider drug utilization information for certain formulary decisions in order to evaluate potential beneficiary disruption.

**Oversight of Clinical Programs**
Several clinical programs are designed to help improve clinical outcomes and/or reduce overall drug or total health care spend.

The P&T Committee provides clinical oversight, guidance and approval for clinical programs and formulary decisions before they are implemented.

All criteria for the above utilization management programs must be approved by the CVS Caremark P&T Committee before submission to CMS.

**DELEGATION**

Various functions may be delegated to CVS Caremark Part D Services which are mutually agreed upon and outlined in formal delegation agreements and/or incorporated into contracts. Written delegation agreements outline the responsibilities of CVS Caremark Part D Services and the Plan with respect to performance expectations and actions in the event of performance deficiencies. The delegation agreements delineate the reporting schedules and oversight expectations. CVS Caremark Part D Services works with the Plan to provide information that may include, but is not limited to, applicable policies and procedures and reports. CVS Caremark Part D Services may accept delegation for applicable NCQA and/or URAC standards related to UM, Member Connections and/or Disease Management.

In some situations, the organization enters into a sub-delegation relationship. In these situations, a signed delegation agreement exists between the sub-delegated entity(s) and CVS Caremark Part D Services. This agreement calls for adherence by the sub-delegated entity to CVS Caremark Part D Services’ standards of performance, CMS requirements for downstream entities and outlines sanctions if those standards are not met. CVS Caremark Part D Services receives performance reports at predetermined intervals and monitors these at the quality committee level and internal operations. CVS Caremark Part D Services maintains ultimate responsibility for any activities that have been sub-delegated in accordance with client contracts and/or delegation agreements.
CONFIDENTIALITY, PRIVACY AND SECURITY PROCEDURES

Privacy policies and procedures have been developed and implemented to help ensure compliance with the HIPAA rules (Privacy, Security and Transactions Rules). These policies and procedures help ensure that protected health information (PHI) is used and disclosed only in accordance with applicable law, and is appropriately safeguarded and protected from unauthorized access and disclosure. These policies and procedures specify that PHI may be used and disclosed only for the purposes of providing health care services, including treatment, payment and health care operations (e.g., UM, health management and case management), and as otherwise permitted by the Privacy Rule and other applicable law.

All Medicare Part D employees are required to take annual HIPAA, privacy and security training. The training reviews all privacy and security policies, including the review of the sanctions policy and procedure for disciplining those workforce members who violate the established policies and procedures or applicable law. The level of sanction depends on the seriousness of the offense but may extend to termination and/or criminal prosecution for the most serious violations.

UTILIZATION MANAGEMENT STAFF RESPONSIBILITIES

Staffing requirements are reviewed at least annually in order to maintain business objectives and customer service goals. Staffing requirements take into consideration regulatory standards and productivity levels that will support both customer service needs as well as the cost-effective use of personnel resources. Staff licensure is verified upon hire by the Human Resources Department and licensure for the Prior Authorization staff is tracked for expiration yearly in the Prior Authorization Department database. A copy of applicable licensure or certification is kept on file. Physicians on staff are credentialed through an ongoing process utilizing an external credentialing vendor.

Job descriptions are developed for each staff position that clearly identifies the scope of individual responsibility and authority. Also included in the job descriptions are the essential tasks, education, skill and experience requirements, and reporting relationships.

A designated medical director serves as the senior physician officer for the Clinical Quality Assurance Program. The designated medical director provides clinical oversight and leadership in the development and implementation of clinical programs, products and interventions and chairs or is a member of various clinical committees.

Only licensed pharmacists or pharmacy technicians (who are certified if required by the state in which they work) in good standing conduct prior authorization reviews. Non-certifications (denials) are rendered only by a pharmacist or designated internal medical director.