Guidelines on Prior Authorization, Step Therapy, Quantity Limits, and Exceptions

How to find out if a drug requires Prior Authorization, Step Therapy or Quantity Limits
Some drugs in the formulary may require Prior Authorization, may have Step Therapy requirements or Quantity Limitations. You can find out if your drug has any additional requirements or limits by looking in the formulary or visiting our website at www.CarePlusHealthPlans.com. You may also call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Prior Authorization (PA)

What is Prior Authorization?

Some prescription drugs require prior authorization (PA) to be covered by CarePlus. If your prescription drug requires prior authorization, you, your appointed representative, or your prescribing physician or other prescriber will need to request and receive approval in advance from CarePlus before you fill your prescription. If you don't get approval, CarePlus may not cover the drug.

Why is Prior Authorization required?

The prior authorization process helps ensure you make the best use of your benefits and receive the most appropriate treatment. For example, if you have diabetes, and your doctor wants you to try a new medication, we may need to authorize this drug before you fill the prescription. We want to make sure the medication won't interfere with others you take or add to your costs unnecessarily.

Step Therapy (ST)

What is Step Therapy?

With Step Therapy drugs, CarePlus requests that you first try certain drugs to treat your medical condition before we cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, CarePlus may not cover Drug B unless you try Drug A first. If Drug A does not work for you, CarePlus may then cover Drug B.

If your drug has a step therapy requirement, your prescribing physician or other prescriber will need to provide a supporting statement to CarePlus if you are prescribed Drug B or wish to try Drug B first, without trying Drug A. CarePlus' approval must be received before you fill your prescription for Drug B. If you don't get approval, CarePlus may not cover Drug B.

Why is Step Therapy required?

Step Therapy promotes the safe and cost-effective use of medication. CarePlus requests that you try medications that are considered first-line medications before a medication that is considered a second-line medication is covered. First-line medications are widely recognized as safe and effective. Second-line medications are either preferred or non-preferred brand-name drugs and are potentially more costly.

Quantity Limits (QL)

What are Quantity Limits?

For certain drugs, CarePlus limits the amount of the drug that will be covered per prescription or for a defined period of time. If you require additional quantities over the limit, your physician will need to provide a supporting statement to CarePlus. CarePlus' approval must be received before you fill your prescription for the additional quantity, otherwise the additional quantity may not be covered.

Why are Quantity Limits required?

Quantity limits are based on manufacturer dosing guidelines and current medical recommendations. Quantity limits help avoid the potential misuse and abuse of medications. Prescriptions written for quantities above the established limits will require authorization before the prescription can be filled.

Coverage Determination

What is a Coverage Determination?

A coverage determination is a decision made by CarePlus as a Medicare Part D sponsor regarding the payment or benefit to which you believe you are entitled to. It may involve a decision regarding whether CarePlus will cover a drug, the portion of the drug cost you may be responsible for, quantity limits, step therapy, or prior authorization requirements.

How to request a coverage determination

You, your appointed representative, your prescribing physician or other prescriber may file a coverage determination request with CarePlus.

For your PHYSICIAN or other prescriber to submit a Coverage Determination request, he/she must contact the Pharmacy Coverage Determination Review team at CarePlus in one of the following ways:

- Calling the **Pharmacy Coverage Determination Review Team** at 1-866-315-7587, from 8 am to 8 pm EST; Monday through Friday; OR

- Faxing a coverage determination request along with any applicable supporting documentation to 1-800-310-9071. For your physician's convenience, he/she may obtain a copy of the **Request for Medicare Prescription Drug Coverage Determination Form** through the following links: English / Spanish. You may also print this form and take it with you to your physician's office; OR

- Submitting the request electronically along with any applicable supporting documentation. Your physician may fill out the **Request for Medicare Prescription Drug Coverage Determination Form** online through the following links: English / Spanish; and send it to us electronically; OR

- Mailing a written request to:

  CarePlus Health Plans
  Attention: Pharmacy Coverage Determination Review Team
  11430 NW 20th Street, Suite 300
  Miami, FL 33172

If you would like to make the coverage determination request YOURSELF, you or your appointed representative must contact us in one of the following ways:

- Calling Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays, and we will return your call within 1 business day; OR

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- Submitting the request online along with any applicable supporting documentation provided by your physician. You may fill out the **Request for Medicare Prescription Drug Coverage Determination Form** online from the following links: English / Spanish; and send it to us electronically; OR

- Mailing a written request to:

  CarePlus Health Plans, Inc.
  Attention: Pharmacy Coverage Determination Review Team
  11430 NW 20th Street, Suite 300
  Miami, FL 33172

Once the coverage determination request is submitted, we must notify you of our decision no later than 24 hours (expedited) or 72 hours (standard) from the date and time the request is received. Your request will be expedited if we determine, or your doctor informs us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

If you have any questions regarding your request, please call Member Services at 1-800-794-5907. TTY users should call 711.

Exceptions

You may request an exception to our coverage requirements, including prior authorization, quantity limit, and step therapy.

How to request an exception

You, your appointed representative, or your prescribing physician or other prescriber may ask us to make an exception to our Part D Coverage rules in a number of situations:

- You may ask us to cover your Part D drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to waive coverage restrictions or limits on your drug (e.g. step therapy or quantity limits). For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you will pay for your drug. For example, if your drug is usually considered a non-preferred drug, you can ask us to cover it as preferred drug instead.

Please note, if we grant your request to cover a Part D drug that is not on our formulary, you cannot ask us to provide a tiering exception for the non-formulary drug approved under the formulary exception process. Also, you cannot ask us to provide a higher level of coverage for Part D drugs that are in the “Tier 5 – Specialty” tier.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the plan formulary or the Part D drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

For all exception requests, your physician or other prescriber must provide a statement supporting the request. CarePlus must receive this supporting statement before the review of your request can begin. You may help us accelerate the determination review by including the supporting medical information provided by a physician at the time you send the exception request to CarePlus; or by asking your physician to send the request and supporting statement to CarePlus directly.

Once the physician's statement is submitted, we must notify you of our decision no later than 24 hours (expedited) or 72 hours (standard) from the date and time the physician statement is received. Your request will be expedited if we determine, or your doctor informs us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

Your PHYSICIAN or other prescriber may submit the exception request on your behalf along with a supporting statement by:

- Calling the **Pharmacy Coverage Determination Review Team** at 1-866-315-7587 between the hours of 8 am to 8 pm EST; Monday through Friday; OR

- Faxing the request to 1-800-310-9071. For your convenience, you may obtain a copy of the **Request for Medicare Prescription Drug Coverage Determination Form** through the following links: English / Spanish. You may also print this form and take it with you to your physician's office; OR

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and attach your physician's supporting statement online through the following links: English / Spanish; and send it to us electronically; OR

- Mailing a written request including your physician's supporting statement to:

  CarePlus Health Plans
  Attention: Pharmacy Coverage Determination Review Team
  11430 NW 20th Street, Suite 300
  Miami, FL 33172

If you have any questions regarding your request, please call Member Services at 1-800-794-5907. TTY users should call 711.

CarePlus Health Plans, Inc. complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. Any inquiries regarding CarePlus' non-discrimination policies and/or to file a complaint, also known as a grievance, please contact Member Services at 1-800-794-5907 (TTY: 711).

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.