

11/01/10

Bulletin No.10-11

5450

5450 Coverage

Beneficiaries who are entitled to Medicare benefits under Part A or enrolled in Medicare Part B, and who live in the service area of a Part D plan, are defined under Medicare rules at 42 CFR §423.30 as eligible for Part D. Vermont is included in the service area for several Part D plans. According to 42 CFR §423.906, Medicare is the primary payer for covered drugs for Part D eligible individuals. VPharm does not cover drugs in classes included in the Part D benefit. VPharm provides secondary pharmacy coverage as described below for those eligible for Medicare and VPharm.

~~VPharm provides secondary pharmacy coverage, as described below for those eligible for Medicare and VPharm, limited to drugs dispensed by participating pharmacies from manufacturers that, as a condition of participation in the program, have signed a rebate or price discount agreement with the Office Department of Vermont Health Access. These rebate or price discount agreements must be at least as favorable as the rebate or price discount paid in connection with the Medicaid program.~~

Part D is administered either through a prescription drug plan (PDP) or as a component of Part C, Medicare managed care, in a Medicare Advantage – Prescription Drug benefit (MA-PD).

VPharm will provide supplemental coverage for the following categories of drugs if they are not covered by the PDP/MA-PD:

- A. drugs for anorexia, weight loss, or weight gain (7502.3);
- B. prescription vitamins or minerals if the conditions described in 7502.4 are met;
- C. over-the-counter prescriptions if the conditions described in 7502.5 are met;
- D. barbiturates; and
- E. benzodiazepines.

Payment for the covered pharmaceuticals described above shall be based upon current Medicaid payment and dispensing policies.

For those beneficiaries whose household income is not greater than 150 percent of the federal poverty level (FPL), the drugs in the above categories are covered as they are covered under Medicaid. In addition, benefits are provided for one comprehensive visual analysis (including a refraction) and one interim eye exam (including a refraction) within a two-year period, and diagnostic visits and tests related to vision.

For those beneficiaries whose household income is greater than 150 percent FPL and no greater than 225 percent FPL, VPharm covers the drugs in the above categories only if they are maintenance drugs.

"Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer and includes insulin, an insulin syringe and an insulin needle. It may not be dispensed unless prescribed by a licensed physician.

~~For those beneficiaries whose household income is greater than 175 percent but no greater than 225 percent of the poverty level, coverage in the classes listed above is limited to drugs dispensed by participating pharmacies from manufacturers that, as a condition of participation in the program, have signed a rebate agreement with the Office Department of Vermont Health Access.~~

In addition, VPharm covers beneficiary cost-sharing after any federal limited-income subsidy (LIS) is applied. This may include basic beneficiary premiums for the PDP up to the low-income premium subsidy amount (as determined by the Centers for Medicare and Medicaid Services), Part D deductible, co-payments, coinsurance, the Part D coverage gap, and catastrophic co-payments according to Medicare Part D rules. Beneficiaries have co-payments as described in 3505.1.

For those beneficiaries whose household income is greater than 175 percent but no greater than 225 percent of the poverty level, cost-sharing coverage is limited to maintenance drugs. On a case-by-case basis, OVHA DVHA may pay or subsidize a higher premium for a Medicare Part D prescription drug plan offering expanded benefits if it is cost-effective to do so.

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5450 Coverage (Continued)

In the case of the statin lipotropic and proton pump inhibitor drug classes, VPharm requires the use of a select OTC and/or a generic drug in order to receive coverage of the Medicare Part D cost-sharing, or of the prescription when the drug would be paid for entirely by VPharm, except that:

- (A) a beneficiary who is taking a brand name drug on June 30, 2009, under a prior authorization through a Medicare Part D plan, may continue to receive coverage under VPharm for that drug; and
- (B) a prescriber may override the substitution of an OTC or generic drug by requesting an exception override from ~~DVHA~~~~OVHA~~. The override will be based on the same criteria provided for ~~in~~~~under~~ section 4606 of Title 18 (generic substitutions). The prescriber must provide a detailed explanation regarding:
 - (1) the OTC or generic drug or drugs that have been previously tried by the beneficiary and:
 - (a) were ineffective; or
 - (b) resulted in the adverse or harmful side effects to the beneficiary; or
 - (2) the reasons why the provider expects that the OTC or generic drug(s) may be ineffective or result in adverse or harmful side effects to the beneficiary if they have not previously tried the drug(s).

The drug utilization review (DUR) board shall determine the list of OTC and generic drugs that shall be available for coverage in each class and shall ensure that the list of generic drugs includes drugs available on the formularies of 90 percent of the Medicare Part D prescription drug plans available in Vermont. In designing the list, the DUR board shall maximize access to a variety of OTC and generic drugs for beneficiaries.

When a beneficiary appeals a denial of coverage of a drug under a Part D or Part C plan, and has exhausted the plan's appeal process through the Independent Review Entity (IRE) decision level, or the plan's transition processes as approved by the Centers for Medicare and Medicaid Services (CMS), the beneficiary may apply to the ~~Office-Department~~ of Vermont Health Access (~~OVHA~~~~DVHA~~) for coverage of the drug if it would have been included in the corresponding Vermont pharmacy benefit (Medicaid or maintenance level of coverage) if the beneficiary were not covered by Part D. If the beneficiary's prescriber documents medical necessity in a manner established by the director of the ~~OVHA~~~~DVHA~~, and the process for documentation conforms with the pharmacy best practice and cost control program established under subchapter 5 of chapter 19 of Title 33, the drug shall be covered.

At the beginning of coverage under Medicare Part D, when a beneficiary has applied for and has attempted to enroll in a Part D plan and has not yet received coverage due to an operational problem with Medicare, or has otherwise not received coverage for the needed pharmaceutical, the necessary drugs will be covered, if ~~OVHA~~~~DVHA~~ finds that good cause and a hardship exist, until such time as the operational problem, good cause and hardship ends. The beneficiary must have made every reasonable effort with CMS and the PDP, given the beneficiary's circumstances, to obtain coverage. The intent of the good cause and hardship exception is remedial in nature and shall be interpreted accordingly. In general "good cause" shall include instances where the lack of coverage can not reasonably be considered the fault of the beneficiary, and "hardship" shall include circumstances where alternative means for the coverage at issue are not reasonably available or will likely result in irreparable loss or serious harm to the beneficiary. ~~OVHA~~~~DVHA~~ will make determinations of whether or not operational problems, good cause, or hardship exists for purposes of coverage.

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5450 Coverage (continued)5450.1 Rebate or Price Discount

VPharm provides secondary pharmacy coverage as described in section 5450 for those eligible for Medicare and VPharm. Manufacturers shall pay to the DVHA a rebate on all pharmaceuticals paid by the State for VPharm beneficiaries in an amount at least as favorable as the rebate or price discount paid in connection with the Medicaid program.

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5641 Maintenance Drugs

"Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle. It may not be dispensed unless prescribed by a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid.

Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances.

Select drugs used for maintenance treatment must be prescribed and dispensed in 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Office Department of Vermont Health Access.

Up to five refills are permitted if allowed by federal or state pharmacy law.

Physicians and pharmacists are required to conform to Act 127 (18 -VSA- Chapter 91), otherwise known as the Generic Drug Bill. In those cases where the Generic Drug Bill permits substitution, only the lowest-priced equivalent shall be considered medically necessary. If, in accordance with Act 127, the beneficiary does not wish to accept substitution, VScript will not pay for the prescription.

Lists of covered drugs classes are maintained and periodically updated by the Office Department of Vermont Health Access and available upon request.

For beneficiaries whose VScript group income is greater than 175 percent but no greater than 225 percent of the federal poverty level coverage is limited to drugs dispensed by participating pharmacies from manufacturers who pay to the DVHA a rebate on all pharmaceuticals paid by the State for VScript beneficiaries in an amount at least as favorable as the rebate or price discount paid in connection with the Medicaid program, that as a condition of participation in the program, have signed a rebate agreement with the Office of Vermont Health Access.