Medicare Part D

November 2015

CHANGES TO HMSA'S MEDICARE FORMULARY

As part of HMSA's ongoing efforts to provide our members with a sustainable and affordable health plan option, it's necessary to make adjustments to the HMSA Medicare Part D formulary. The changes, which are effective January 1, 2016, are designed to encourage you and your patients to consider lower-cost alternative medications that are equally effective. The changes are also being made to address quality and safety concerns that are associated with high-risk medications.

New Preauthorization Medications — Table 1

These medications will require preauthorization (PA) for HMSA Medicare Part D members.

Table 1: Medicare Formulary – New preauthorizations – Effective January 1, 2016

Drug Name	Drug Class	Rationale/Criteria
guanfacine ER	ADHD	FDA approved indications/high-risk medication
testosterone cypionate inj	Androgens	FDA approved indications/appropriate use
testosterone enanthate inj	Androgens	FDA approved indications/appropriate use

Non-formulary Medications — Table 2

These medications will be removed from the Medicare Part D formulary because equally effective, safe, and lower-cost alternatives are available. This isn't a comprehensive list of all the drugs being removed; our members are using these drugs, so they may have the most impact on patient care.

Table 2: Medicare Formulary – Non-formulary medications – Effective January 1, 2016

Drug Name	Drug Class	Alternative Formulary Drug(s)
Abilify tablets	Antipsychotics	Use generic
Adcirca	Pulmonary Arterial Hypertension	sildenafil
amcinonide	Corticosteroid	betamethasone dipropionate, desoximetasone, diflorasone, fluocinonide, mometasone
Asmanex	Steroid Inhalant	Flovent, Pulmicort, Arnuity Ellipta
Combipatch	Endocrine	Jinteli, norethindrone/ethinyl estradiol
Copaxone Inj 20mg	Multiple Sclerosis	Glatopa
cyclobenzaprine	Musculoskeletal Agents	baclofen, tizanidine
Dulera	Steroid/Beta-agonist Combinations	Advair, Breo Ellipta, Symbicort
Edecrin	Diuretics	bumetanide, furosemide, torsemide

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Non-formulary Medications — Table 2 (continued)

Table 2: Medicare Formulary – Non-formulary medications – Effective January 1, 2016 (continued)

Drug Name	Drug Class	Alternative Formulary Drug(s)
Foradil	Beta-agonists	Serevent
Lanoxin	Digitalis Glycosides	Use generic
Lialda	Inflammatory Bowel Disease	Apriso, balsalazide, sulfasalazine
Nevanac	Anti-inflammatories	Bromfenac, Ilevro
Nitrolingual pump spray	Nitrates	Nitrostat tabs
Patanol	Antiallergics	azelastine, Pataday, Pazeo
Pentasa	Inflammatory Bowel Disease	Apriso, balsalazide, sulfasalazine
Premarin vag cream	Estrogens	Estrace vag cream, Vagifem
ProAir HFA	Beta-agonists	Ventolin HFA, Xopenex HFA
QVAR	Steroid Inhalants	Flovent, Pulmicort, Arnuity Ellipta
Spiriva	Anticholinergics	Incruse Ellipta
Testim gel	Androgens	Axiron, Androderm
Tudorza	Anticholinergics	Incruse Ellipta

New Quantity Limits — Table 3

These medications will require a preauthorization for HMSA Medicare Part D members when the prescribed amounts exceed the quantity limit listed. Quantity limits are based on FDA prescribing maximum limits for safe and effective use. Patients using these medications in amounts lower than the amount listed won't need a PA. This isn't a comprehensive list of all the drugs with new quantity limits; these are drugs with new quantity limits that may have the most impact on patient care.

Please review the therapies of your patients whose current medications exceed the listed quantity limits to determine if their prescription strengths are appropriate.

Table 3: Medicare Formulary – New quantity limits – Effective January 1, 2016

Drug Name	Strength	Rationale/New Limit	Drug Class
clonazepam ODT	0.125 mg 0.25 mg 0.5 mg 1 mg	Amount: 960.0, Days: 30 Amount: 480.0, Days: 30 Amount: 240.0, Days: 30 Amount: 120.0, Days: 30	Anticonvulsants
clonazepam tablet	0.5 mg 1.0 mg	Amount: 240.0, Days: 30 Amount: 120.0, Days: 30	Anticonvulsants

Tier Changes — Table 4

Patients who take these medications will pay a higher amount in 2016. Consider moving your patients to a lower-cost and equally effective alternative on the HMSA Medicare Part D formulary. This isn't a comprehensive list of all the drugs that are changing tiers; these are drugs that are being used by our members, so they may have the most impact on patient care.

See our complete Medicare formulary at hmsa.com/portal/provider/zav_dr.02.02.htm.

Table 4: Medicare Formulary – Tier changes – Effective January 1, 2016

Drug Name	Drug Class	2015 Tier	2016 Tier	Lower Tier Alternatives
atenolol/ chlorthalidone	Beta-blocker/ Diuretic combinations	1	2	bisoprolol/HCTZ
Avodart	Benign Prostatic Hyperplasia	3	4	finasteride
baclofen	Musculoskeletal Agents	1	2	
bumetanide	Diuretics	1	2	furosemide, torsemide
Canasa	Inflammatory Bowel Disease	4	5	mesalamine enema
carbamazepine 100mg chew, 200mg	Anticonvulsants	1	2	
cefuroxime	Cephalosporins	1	2	
chlorthalidone	Diuretics	1	2	hydrochlorothiazide
diphenoxylate/ atropine	Gastrointestinal	1	2	loperamide
fluoxetine tablets	Antidepressants	1	2	fluoxetine capsules
hydroxychloroquine	DMARDS	1	2	
Jalyn	Benign Prostatic Hyperplasia	3	4	finasteride with tamsulosin
ofloxacin ophthalmic	Anti-infectives	1	2	
Onfi 20mg, susp	Anticonvulsants	4	5	clonazepam, lamotrigine, topiramate
prazosin	Alpha Blockers	1	2	terazosin
Renvela	Phosphate Binder Agents	3	5	calcium acetate
spironolactone/ hydrochlorothiazide	Diuretics	1	2	amiloride/HCTZ, triamterene/HCTZ
theophylline ER	Xanthines	1	2	
Vimpat 100mg, 150mg, 200mg	Anticonvulsants	4	5	carbamazepine, lamotrigine, levetiracetam, oxcarbazepine

We understand that some cases may medically warrant the continued use of certain medications. In these situations, you may request an exception. We encourage you to discuss formulary options with your patients; some of them may benefit from switching to an alternative medication. If needed, your patients can get one 30-day transition supply during the first 90 days of 2016 for new PA medications, non-formulary medications, and medications with new quantity limits.

Medicare Formulary Preauthorization and Exception Requests

To request a PA or an exception, please call or fax CVS/caremark, HMSA's pharmacy benefits manager.

Call	1 (855) 479-3659 toll-free
TTY	711
Electronic PAs	caremark.com/epa
Fax	1 (855) 633-7673 toll-free
Hours of operation	24 hours a day, seven days a week
Mail	Medicare Coverage Determination and Appeals MC 109 P.O. Box 52000 Phoenix, AZ 85072-2000

General Information about HMSA Akamai Advantage Part D (Drug)

In CY2016, HMSA Akamai Advantage (AA) plans will use a five-tier standard drug formulary.

- Tier 1: Preferred generic.
- Tier 2: Generic.
- Tier 3: Preferred brand.
- Tier 4: Non-preferred brand.
- Tier 5: Specialty.

Retail (30-day supply)	Complete	Complete Plus	Standard	Standard Plus
Tier 1	$4.50	$4.00	$5.00	$4.00
Tier 2	$12.00	$11.00	$20.00	$11.00
Tier 3	$47.00	$45.00	$47.00	$45.00
Tier 4	$100.00	$95.00	$100.00	$95.00
Tier 5	25%	33%	25%	33%

Mail Order (90-day supply)	Complete	Complete Plus	Standard	Standard Plus
Tier 1	$4.50	$4.00	$5.00	$4.00
Tier 2	$24.00	$22.00	$40.00	$22.00
Tier 3	$94.00	$90.00	$94.00	$90.00
Tier 4	$200.00	$190.00	$200.00	$190.00
Tier 5	25%	33%	25%	33%

The HMSA Akamai Advantage prescription drug benefit has four stages.

- The first stage is the annual deductible.
  - AA Complete and AA Standard have an annual deductible of $360, except for tier 1 drugs.
  - AA Complete Plus and AA Standard Plus have no deductible. The first dollar the member spends goes toward the cost of the member's prescription drugs.

- The second stage is the initial coverage.
  - The member stays in the initial coverage stage until the total drug costs (what the plan, the member, and others pay for the drugs) reach $3,310.
- The third stage is the coverage gap.
  - The member stays in the coverage gap stage until their annual out-of-pocket drug costs reach $4,850.

Complete	Complete Plus	Standard	Standard Plus
No additional coverage gap	Additional gap coverage for tier 1 drugs: $4.00	No additional coverage gap	Additional gap coverage for tier 1 drugs: $4.00
Member has to pay 45 percent of the drug cost for brand-name drugs. Member has to pay 58 percent of the drug costs for generic drugs.			

- The fourth stage is the catastrophic stage.
  - The member moves to this stage after the yearly out-of-pocket drug costs reach $4,850.

	All HMSA Akamai Advantage Plans
Retail (30-day supply)	The greater of 5 percent or $2.95 for generic drugs (including brand-name drugs treated as generic) and $7.40 for all other drugs.

Example:

Stage 1 *Yearly Deductible Stage*	Stage 2 *Initial Coverage Stage*	Stage 3 *Coverage Gap Stage*	Stage 4 *Catastrophic Coverage Stages*
You begin in this payment stage when you fill your first prescription of the year. During this stage, **you pay the full cost** of your Tier 2, Tier 3, Tier 4, and Tier 5 drugs. You stay in this stage until you have paid $360 for your drugs ($360 is the amount of your deductible).	During this stage, the plan pays its share of the cost of your Tier 1 drugs and **you pay your share of the cost.** After you (or others on your behalf) have met your Tier 2, Tier 3, Tier 4, and Tier 5 deductible, the plans pay their share of the costs of your Tier 2, Tier 3, Tier 4, and Tier 5 drugs and you pay your share. You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) reach $3,310.	During this stage, you pay 45 percent of the price for brand-name drugs (plus a portion of the dispensing fee) and 58 percent of the price for generic drugs. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach $4,850. This amount and rules for counting costs toward this amount have been set by Medicare.	During this stage, **the plan will pay most of the costs** of your drugs for the rest of the calendar year (through December 31, 2016).

Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when HMSA pays for them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective way. These rules also help control overall drug costs and keep members' drug plans more affordable.

In general, these rules encourage members to get a drug that works for their medical condition and is safe and effective. Examples of rules include:

- Restricting brand-name drugs when a generic version is available.
- Getting the plan's approval in advance.
- Trying a different drug first.
- Quantity limits.

Why does HMSA restrict brand-name drugs when a generic version is available?

Generally, a generic drug works the same as a brand-name drug and usually costs less. When a generic version of a brand-name drug is available, HMSA usually won't cover the brand-name drug; network pharmacies will provide the generic version.

Why does HMSA require getting plan approval (preauthorization) in advance for certain drugs?

This requirement helps guide appropriate use of certain drugs. You or the member need to get approval from the plan before HMSA will agree to pay for certain drugs. This is called "preauthorization." If approval isn't obtained, HMSA might not pay for the drug.

Why does HMSA require trying a different drug (step therapy) first?

This requirement encourages members to try less costly but just as effective drugs before HMSA pays for another drug. For example, if drug A and drug B treat the same medical condition, the plan may require the member to try drug A first. If drug A doesn't work, the plan will then pay for drug B. This requirement to try a different drug first is called "step therapy."

Why does HMSA require quantity limits?

HMSA limits the amount of certain drugs that members can have. For example, the plan might limit the number of refills or how much of a drug can be dispensed at one time. If it's normally considered safe to take only one pill per day of a certain drug, for example, HMSA may limit coverage to no more than one pill per day.

What is HMSA's mail-order drug program?

- Generally, the drugs available through mail order are drugs that are taken on a regular basis for a chronic or long-term medical condition.
- The drugs available through HMSA's mail-order service are marked as "mail-order" (M) drugs on our formulary.
- HMSA's mail-order service saves patients money when they order a 90-day supply.
- To get order forms and information about filling prescriptions by mail, members can call our mail-order pharmacy at 1 (855) 479-3659 toll-free. This number is available 24 hours a day, seven days a week. TTY users, call 711.
- If your patient uses a mail-order pharmacy that's not in the plan's network, the plan won't pay for it.

- Mail-order drugs usually arrive within 14 days. If the mail order is delayed, your patient may get a temporary 30-day supply of the drug from a retail pharmacy at no cost.

Did you know there are programs to help people pay for their drugs?

Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. Resources include savings and stocks, but not their home or car.

If members qualify, they can get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. Extra Help also counts toward out-of-pocket costs.

To see if they qualify for Extra Help, your patients can call:

- 1-800-MEDICARE (1 (800) 633-4227 toll-free). TTY users, call 1 (877) 486-2048 toll-free, 24 hours a day, seven days a week.
- The Social Security Office at 1 (800) 772-1213 toll-free, 7 a.m. to 7 p.m., Monday through Friday. TTY users, call 1 (800) 325-0778 toll-free.
- Med-QUEST (Hawaii's Medicaid program) at 587-3521 on Oahu or 1 (800) 316-8005 toll-free on the Neighbor Islands and U.S. Mainland. TTY users, call 692-7182 on Oahu or 1 (800) 603-1201 toll-free on the Neighbor Islands and U.S. Mainland.

What is a network pharmacy?

A network pharmacy has a contract with the plan to provide members with covered prescription drugs. "Covered drugs" means the Part D prescription drugs that are on HMSA's formulary.

To find a network pharmacy, refer to your Provider Directory, visit our website (hmsa.com/advantage), or call Customer Relations.

HMSA Akamai Advantage Dual Care (PPO SNP)

HMSA Akamai Advantage Dual Care is a dual-eligible Special Needs Plan (D-SNP) for patients eligible for both Medicare and Medicaid.

- Dual Care does **not** combine or integrate Medicare and Medicaid benefits into a single plan. Members enrolled in HMSA's D-SNP for their Medicare coverage may have QUEST Integration with HMSA or another plan for their Medicaid coverage.
- Medicaid "fills in the gaps" in Original Medicare by helping to pay premiums and cost sharing, and paying for benefits not offered under Medicare.
- CMS requires that D-SNPs have a model of care for care coordination.

The Dual Care formulary will have two tiers, but will use the same drug list, utilization management, and CVS/caremark clinical services as our individual HMSA Akamai Advantage plans.

HMSA's Medication Therapy Management Program

Some of your HMSA Akamai Advantage patients may be eligible for the Medication Therapy Management (MTM) program, which is a Medicare benefit that can help them manage and take their medications.

Eligibility is for a calendar year. Your patients qualify for the program if they meet all of the following criteria:

- Have three or more chronic diseases such as chronic heart failure, diabetes, dyslipidemia, ischemic heart disease, hypertension, asthma, osteoporosis, or depression.
- Are taking eight or more maintenance medications.
- Spend more than $876.75 per quarter on medications.

Medication therapy management services

Contracted pharmacists provide MTM services for one year at no cost to eligible members. The pharmacists work with patients to optimize medication use and avoid, prevent, or resolve medication-related problems, which can help your patients live happier, healthier, and more productive lives. MTM services include:

- Annual comprehensive medication review (CMR): A CMR is an interactive, person-to-person, or telehealth (i.e., over the phone) medication consultation. A pharmacist reviews all medications (including prescriptions and over-the-counter [OTC] medications), herbal therapies, and dietary supplements. CMRs identify and address medication issues (such as duplications in therapy, drug interactions, poor adherence, etc.) and optimize patient outcomes. A pharmacist may identify potential medication-related problems and contact you to ask about the therapeutic goals for your patients or alert you to any potential issues. CMRs are typically offered once a year.
- Targeted medication review (TMR): As a follow-up to the CMR, pharmacists continue to track the patient's medication use quarterly. They may identify situations related to unresolved medication issues, new drug therapy problems, and transition in care, which may warrant your attention. In these situations, the pharmacist will share this information with you via fax.

How can I refer my eligible patients to this service?

If your patients qualify for this program, encourage them to make an appointment with one of our MTM pharmacists by calling Mirixa Support at 1 (866) 208-1223 toll-free. The hearing impaired can call the National Relay Service at 711.