



Pharmacy and Therapeutics Committee Policies and Procedures

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Charter

Mission

The mission of HealthPartners Pharmacy and Therapeutics (P&T) Committee is to promote the appropriate use of high quality and cost-effective pharmaceuticals for HealthPartners members.

Goals & Objectives

- ◆ Promote the appropriate use of high quality and cost-effective pharmaceuticals for HealthPartners members.
- ◆ Ensure compliance with appropriate standards and state and federal regulations.

Functions

The Pharmacy and Therapeutics Committee is responsible for the following major functions:

- ◆ Maintain the Drug Formulary to promote safety, effectiveness, and affordability according to the Formulary Principles.
- ◆ Oversight consists of the Commercial Drug Formulary (PreferredRx and GenericsPlusRx), the Medicare Formulary, and the Medicaid Formulary (Minnesota Health Care Programs).
- ◆ Maintain pharmacy-related medical policies that promote the safety, effectiveness, and affordability of medications used in clinic settings.
- ◆ Maintain Formulary Principles that guide the management of the Drug Formulary.
- ◆ Review new drugs, drug classes, new clinical indications, therapeutic advantages, new chemical entities, and new safety information.
- ◆ Review the Drug Formulary and therapeutic classes at least annually.
- ◆ Review and update Pharmaceutical Management Policies and Procedures at least annually and as new pharmaceutical information becomes available. Policies are shared regularly with providers in a plan newsletter.

Structure & Membership

The Pharmacy and Therapeutics Committee reports to the Pharmacy Quality and Utilization Committee, which reports to the Quality Council. Membership consists of broad primary care and specialty representation, a majority of which are practicing physicians and pharmacists from both HealthPartners Medical Group and from Contracted Care providers. Membership includes at least one practicing physician and one practicing pharmacist who are experts in the care of the elderly or disabled persons. At least one practicing physician and pharmacist will be free of conflicts of interest from HealthPartners and from pharmaceutical manufacturers. Members and a Committee Chair are appointed annually by a HealthPartners Medical Director. Membership changes are reported to CMS during the contract year.

Members complete a “Conflict of Interest” disclosure form and a “Non-Disclosure” Agreement annually.

Meetings

The Pharmacy and Therapeutics Committee meets at least quarterly. Minutes reflect the members in attendance, items discussed, decisions reached, lead accountability assigned for action undertaken and subsequent reporting, as well as follow-up data for these activities. Minutes are forwarded to the Pharmacy Quality and Utilization Committee and to the Benefits Committee, and are maintained for at least 10 years in Pharmacy Administration.

Formulary Principles

The HealthPartners Pharmacy and Therapeutics Committee develops and maintains its formulary based on these guiding principles. These principles reflect the 6 AIMS (safe, timely, effective, equitable, efficient and patient centered). These principles are prioritized in descending order (i.e. effectiveness is weighted most heavily, followed by safety issues, and then by cost). Formulary decisions are made following a careful review of these often-competing principles.

1. Proven effectiveness documented in the medical literature.

The primary consideration will be the degree to which a medication produces clinically desirable effects. Beneficial effects are assessed on the strength of scientific evidence including peer-reviewed medical literature, pharmacoeconomic studies, and outcomes research, and standards of practice including treatment protocols and evidence-based practice guidelines such as Institute for Clinical Systems Improvement (ICSI). Randomized, controlled trials are weighted most heavily, followed by non-randomized trials, case reports, and medical opinion.

2. Maximizing safety and minimizing the potential for errors.

The safety risk / benefit of a product will be compared with other treatments.

We will minimize the potential for errors caused by product characteristics such as name, dosage form, and packaging that pose threats to patient safety or increase the potential for errors in the health care system.

3. Optimizing pharmacoeconomics.

The overall value of a drug or therapy will be compared with existing treatments to assess pharmacy costs in relation to medical outcomes. We will consider direct and indirect pharmacy and medical costs. We will take into consideration and give preference to those agents that optimize the use of financial and service resources over the largest potential population.

4. Emphasis on products essential to health.

5. Significant improvements in patient convenience, adherence, and satisfaction.

We will review more favorably products that have significant improvements in patient convenience, adherence, and satisfaction. Examples include variables such as dosing convenience, variety of dosage forms, taste, ability to crush or divide doses, and storage requirements (refrigeration).

6. The formulary will support ICSI protocols and other locally adopted treatment algorithms.

7. Long term stability of formulary decisions.

Changes to the formulary will be minimized for member care continuity.

8. The formulary will serve as a guideline for the vast majority of patients.

- a. Utilization management programs such as prior authorization, step-edits, MD-edits, quantity limits, and age limits will be applied to promote appropriate utilization.
- b. A "Formulary Exception" process will be readily available, easy to use, and timely.
- c. A "Transition of Care" policy will be available to assist members transitioning to HealthPartners.

Drug Review Process

When are medications reviewed?

HealthPartners monitors for FDA New Drug Approvals and new clinical indications. HealthPartners also monitors guidelines, clinical studies, and safety information, and initiates reviews as needed.

Providers and members can also request reviews of new drugs and changes in current coverage criteria. Requests should include advantages over existing formulary options, references to supporting literature, and a conflict-of-interest disclosure statement.

A request form is available on our internet site

(https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_063736.pdf).

A reasonable effort is made to review new chemical entities within 90 days of their availability, and reviews and decisions are made within 180 days unless clinically justified. New anticonvulsants, antipsychotics, antidepressants, chemotherapies, HIV medications, and immunosuppressants receive expedited reviews, with decisions within 90 days of their availability.

Reviews and decisions of new clinical indications are made within 180 days of their availability.

New indications for anticonvulsants, antipsychotics, antidepressants, chemotherapy, HIV medications, and immunosuppressants receive expedited reviews, with decisions within 90 days of their availability.

The Pharmacy and Therapeutics Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products at least annually in accordance with CMS requirements.

How are medications reviewed?

Formulary requests are first reviewed by Clinical Pharmacists within HealthPartners Pharmacy Services. Preparation includes a literature review, a review of the FDA-approved prescribing information, a review of guidelines and drug compendia, a comparison with current formulary products, and a pharmaco-economic comparison.

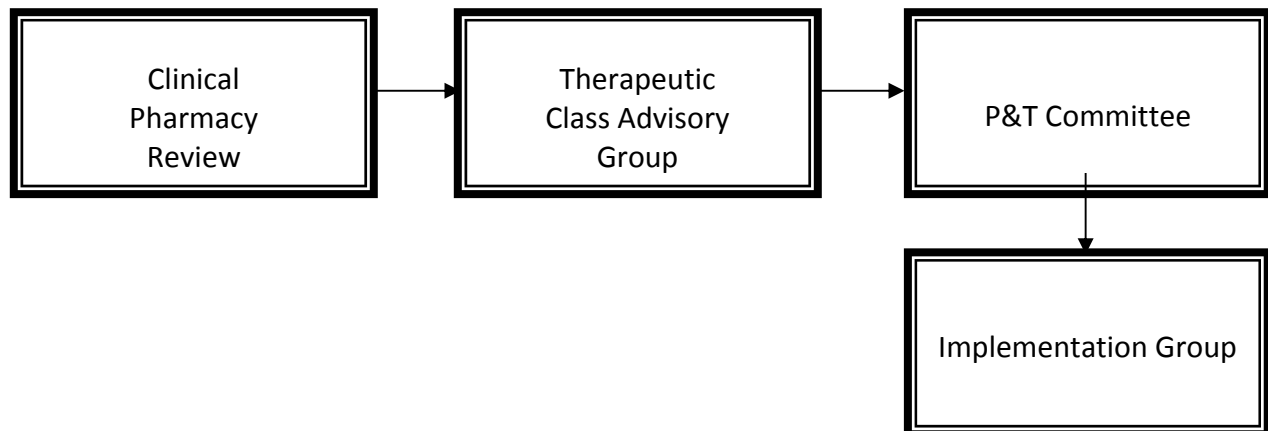
Medications are then reviewed by a therapeutic-specific advisory group that includes specialists and primary care providers. This advisory group forwards recommendations to the P&T Committee.

The P&T Committee considers the advisory group recommendation and also considers more closely the cost implications and member service issues to HealthPartners resulting from any formulary changes.

Decisions are made following a careful review of these often-competing principles.

Following P&T Committee decisions, an implementation group meets to finalize decisions per several considerations:

- Review P&T decisions for compliance with CMS requirements, employer benefits, and manufacturer contracts
- Determine specific position on formulary tiers or in medical policies, consistent with P&T committee recommendation for coverage
- Forward recommendations for in-clinic drugs to the Medical Director Committee for a final decision.
- Communicate specific formulary positions to providers, members, and business partners.



What types of decisions are made by the P&T Committee?	Formulary status options for the P&T Committee are: - F on Formulary, no restrictions - PA on formulary with Prior Authorization criteria - ST on formulary with Step-Therapy criteria - QL on formulary with a specific quantity limit - AGE on formulary, reserved for specific age groups - NF not on formulary - NF-PA, Non-Formulary, with Prior Authorization criteria The P&T Committee can also table decisions pending additional data and review. The P&T Committee can also recommend specific educational programs regarding appropriate use, and can request specific monitoring of utilization.
Communication of Formulary changes	The HealthPartners Quarterly Drug Formulary Update is distributed as a provider newsletter. The HealthPartners internet site contains recent Drug Formulary Updates (www.healthpartners.com). This information is updated quarterly, and is mailed upon request. HealthPartners provides written notice to affected members* at least 30 days prior to any negative formulary changes. Changes may be made more quickly for significant safety issues with a retrospective notice sent to affected members. * For Medicare Part D, written notice is provided at least 60 days prior to any negative formulary change to affected members, all providers, all pharmacies, CMS, State Pharmaceutical Assistance Programs, and “entities providing other prescription drug coverage.”
Formulary listing	The HealthPartners internet site contains the Drug Formularies, our Pharmaceutical Management Policies and Procedures, and several commonly used forms (www.healthpartners.com/Provider, Pharmacy Services). This information is updated quarterly, and is mailed upon request. Formulary information is made available to new providers. Updates are provided at least annually.

Line extensions	New formulations of drugs currently on formulary will be added to the Drug Formulary by Pharmacy Administration if they are cost-neutral. New formulations that are expected to have a significant cost impact are brought to the P&T Committee for consideration. An example is a new product formulation introduced just before a patent expiration.
Classes of Concern	All or almost all classes of clinical concern are covered. Classes of clinical concern are anticonvulsants, antipsychotics, antidepressants, chemotherapies and antineoplastic medications, HIV medications including antiretroviral medications, and immunosuppressants. Newly approved medications in these classes receive expedited reviews. These new medications are generally added administratively to the Part D formulary with a prior authorization status in order to meet CMS requirements, and then receive a clinical review at the following P&T Committee meeting. Coverage criteria are updated following the clinical review by the P&T Committee.

Drug Utilization Management

HealthPartners uses various tools to ensure cost-effective drug utilization and prevent over and under utilization. The following utilization management tools are used:

Prior Authorization (PA)	Prior authorization helps assure the appropriate use of medications. Prior authorization criteria are listed in the Drug Formulary. <u>Requests from providers</u> can be submitted via fax (preferred), phone, or mail to HealthPartners Pharmacy Customer Service using the “Prior Authorization / Exception” forms (available at www.healthpartners.com/public/pharmacy/forms/). HealthPartners Pharmacy Customer Service is available from 8:00 AM - 6:00 PM Central Standard Time, Monday – Friday. Requests are reviewed and responded in compliance with applicable regulations, not to exceed 14 calendar days. Expedited requests will be reviewed within applicable regulation, typically within 24 hours. All requests not meeting criteria are reviewed by a medical director. Approval Process: If requests meet the prior authorization criteria, an authorization is entered into the pharmacy billing system to allow any contracted network pharmacy to process the prescription for the enrollee’s appropriate benefit tier. Approvals will be entered for a sufficient time period to ensure continued therapy under the enrollee’s appropriate benefit tier. The requesting individual is notified of this approval. Denial Process: If denied, both the requesting provider and the enrollee are notified of the denial by mail or fax, the reason for the denial, and the process for appealing this decision. A “Formulary Exception” process is available for unique situations not meeting prior authorization criteria. HealthPartners call center is available to providers (physicians, pharmacies, and pharmacists 365 days per year and 24 hours per day. HealthPartners Pharmacy Prior Authorization Provider help line at 952-883-5813 or 1-800-492-7259 is available from 8 AM - 6 PM Central Time, Monday through Friday. After these hours, the telephone line is routed to our Pharmacy Benefit Manager (PBM). Our PBM is available 365 days per year and 24 hours per day. The Pharmacy Prior Authorization Provider help line will answer inquiries regarding claims processing; benefit coverage, claims submission and payment, and prior authorization. This help line is staffed by trained Pharmacy Customer Service Assistants and clinical pharmacists. The “Prior Authorization / Exception” forms are available on our internet site at www.healthpartners.com/public/pharmacy/forms/. Forms can be faxed to HealthPartners Pharmacy Services at 952-853-8700 or 1-888-883-5434. Questions and requests for forms can be directed to HealthPartners Pharmacy Services at 952-883-5813 or 1-800-492-7259. <u>Requests by enrollees and enrollee’s authorized representatives</u> can be submitted to HealthPartners Member Services via phone, fax, mail, or initiated on-line at HealthPartners.com. In most cases, the prescriber will need to submit specific information to document whether criteria are met.
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Step-Therapy (ST)	Step-Therapy helps assure the appropriate use of medications and can simplify the request process. A specific medication must be tried prior to using step-therapy medications. The formulary lists specific step-therapy criteria. If a claim for the required medication is in our pharmacy database (a previous prescription claim from HealthPartners), then the step-therapy medication will be processed (there is no need for approval from HealthPartners Pharmacy Customer Service). If a record of the required medication is not available, then the prior authorization process should be followed (a request form needs to be submitted to HealthPartners Pharmacy Services). A “Formulary Exception” process is available for unique situations not meeting step-therapy criteria. Requests are reviewed and responded in compliance with applicable regulations, not to exceed 14 calendar days. Expedited requests will be reviewed within applicable regulation, typically within 24 hours. All requests not meeting criteria are reviewed by a medical director.
Quantity Limits (QL)	Quantity limits help ensure the appropriate use of medications, and are specified in the formulary. Quantity limits are often applied for safety reasons (e.g. limiting products containing acetaminophen to maximum safe limits). A “Formulary Exception” process is available for unique situations requiring greater quantities. Requests are reviewed and responded in compliance with applicable regulations, not to exceed 14 calendar days. Expedited requests will be reviewed within applicable regulation, typically within 24 hours. All requests not meeting criteria are reviewed by a medical director.
Age-Edit (AGE)	Age-Edits help assure the appropriate use of medications and can simplify the request process for some medications. Age-edit medications are available without restrictions for patients within specific age groups. Age criteria are listed in the Drug Formulary. Patients outside of the specified age group need to meet specific criteria before the medication is approved, and need to use the prior authorization process to submit this information. A “Formulary Exception” process is available for unique situations not meeting age-edit criteria. Requests are reviewed and responded in compliance with applicable regulations, not to exceed 14 calendar days. Expedited requests will be reviewed within applicable regulation, typically within 24 hours. All requests not meeting criteria are reviewed by a medical director.

Formulary
Exceptions

A “Formulary Exception” process is available for non-formulary medications, continued coverage of drugs removed from formulary, exceptions to prior authorization criteria, exceptions to step therapy criteria, exceptions to dose limitations, medications newly approved by the FDA, and for new enrollees transitioning from other prescription drug coverages.

Requests from providers can be submitted via fax (preferred), phone, or mail to HealthPartners Pharmacy Customer Service using the “Prior Authorization / Exception” form. HealthPartners Pharmacy Customer Service is available from 8:00 AM - 6:00 PM Central Standard Time, Monday – Friday. Faxes after business hours are reviewed on the next business day.

All requests are reviewed by HealthPartners Clinical Pharmacists. Requests are reviewed and responded in compliance with applicable regulations, not to exceed 14 calendar days. Expedited requests will be reviewed within applicable regulation, typically within 24 hours. All requests not meeting criteria are reviewed by a medical director. Required information includes diagnosis and the results of previous therapy.

Reviews are based on diagnosis, formulary product(s) previously tried, evidence of efficacy, and medical necessity. Requests are generally approved if enrollees have tried and failed formulary products due to either an inadequate response or a medical contraindication to their use, and for enrollees who are previously stable on certain medications such as anticonvulsants, antipsychotics, antidepressants, chemotherapy, HIV medications, immunosuppressants, and medications determined to be medically necessary.

HealthPartners will review coverage of non-formulary drugs for the treatment of mental illness and emotional disturbances for coverage at the formulary benefit level pursuant to Minnesota Statute 62Q.527. This applies to antipsychotic drugs if the provider certifies that all equivalent drugs have been considered. When a formulary changes, enrollees may continue to receive the prescribed drug if previously stable for up to one year without special payment requirements.

Approval Process: If requests meet the prior authorization criteria, an authorization is entered into the pharmacy billing system to allow any contracted network pharmacy to process the prescription for the enrollee’s appropriate benefit tier. Approvals will be entered for a sufficient time period to ensure continued therapy under the enrollee’s appropriate benefit tier. The requesting individual is notified of this approval. Members are notified following regulatory protocol.

Denial Process: If denied, both the requesting provider and the enrollee are notified of the denial by mail or fax, the reason for the denial, and the process for appealing this decision.

The “Prior Authorization / Formulary Exception” forms are available on our internet site at www.healthpartners.com/public/pharmacy/forms/.

Requests by enrollees and enrollee’s authorized representatives can be submitted to HealthPartners Member Services via phone, fax, or mail or initiated on-line at HealthPartners.com. In most cases, the prescriber will need to submit specific information to document whether criteria are met.

Hours of Operation	Pharmacy Customer Service is available to providers (physicians and pharmacies) from 8AM - 6PM CST, Monday through Friday and 8AM – 4PM CST, on Saturday. After hours calls are answered by our Pharmacy Benefit Manager, available 365 days per year and 24 hours per day. If a provider is calling with an urgent prior authorization or coverage determination request, they may press option 2 and leave a message for a staff member to return the call. • Fax 952-853-8700 or 1-888-883-5434 • Telephone 952-883-5813 or 1-800-492-7259 • Mail - HealthPartners Pharmacy Services, 8170 33rd Avenue S, PO Box 1309, Mpls, MN 55440. Pharmacy Customer Service answers inquiries regarding claims processing, benefit coverage, claims submission and payment, and prior authorization. This help line is staffed by trained Pharmacy Customer Service Assistants and clinical pharmacists.
Appeals Process	Appeals by enrollees and physicians should be directed to HealthPartners Member Services. Decisions on Medicare Part D enrollee appeals will be communicated by Member Rights and Benefits pursuant to CMS policy and procedures. Appeal response timeframes follow guidelines and include: • Standard Redetermination involving requests for covered drug benefits = 7 calendar days. • Expedited Redetermination = within 72 hours of receiving request. • HealthPartners will forward the enrollee’s request to IRE within 24 hours of the expiration of the appropriate adjudication timeframe if a decision could not be made. Decisions on Non-Part D enrollee appeals will be communicated by Member Rights and Benefits pursuant to regulatory rules. Appeal response timeframes follow guidelines and include: • Standard Appeals involving requests for covered drug benefits = 30 calendar days. • Expedited Appeals = within 72 hours of receiving request. In addition, if enrollees would like to review the status or discuss the request with the decision maker, enrollees may contact HealthPartners. A temporary override will be extended to new enrollees processing through a grievance and appeal.

Generic Substitution Policy	HealthPartners requires the use of a generic product when available, unless specifically noted. Providers can request brand name products if medically necessary by submitting a prior authorization request and writing “Dispense as Written” on the prescription. The prior authorization request should include the problem caused with the generic, or rationale why the generic can’t be tried. Members are then responsible for their co-payment.
Egregious Medications	HealthPartners Pharmacy Administration may take administrative action to limit a medication that is considered to be egregiously priced. Considerations include high-price and the availability of low-cost alternatives. Medications will be limited by changing the formulary status to non-formulary or prior authorization. Members currently using these products will be given at least 60-days notice. Any actions will be brought to the next P&T Committee meeting.
OTC Medications	Over-the-counter products can be purchased without a prescription and are not covered under HealthPartners’ benefit plans or the benefit plans of its Related Organizations unless otherwise noted.
Herbal Medications	Herbal products can be purchased without a prescription and are not covered under HealthPartners’ benefit plans or the benefit plans of its Related Organizations unless otherwise noted.
Compounded Medications	Compounded prescriptions are a combination of a prescription medication with one or more other products, prepared by individual pharmacies, usually because a commercially-available product is not available. Compounded prescriptions may be covered at the member’s in-network benefit when submitted on-line by a contracted network pharmacy. Coverage of compounded prescriptions follows these principles: • High-cost compounded prescriptions (over \$200) will be reviewed for medical necessity. Required information includes the diagnosis, products previously tried, evidence of efficacy, and medical necessity. Prior authorization is required for specific compounding ingredients, including diclofenac, flurbiprofen, ketoprofen, meloxicam, fluticasone, gabapentin, ketamine, and cyclobenzaprine. This policy is available in coverage policies, www.healthpartners.com/public/coverage-criteria/compounded-medications.htm. Required information for review includes the diagnosis, products previously tried, and evidence of efficacy.

Specialty Drugs	In order to provide our members with quality health care and use premium dollars responsibly, HealthPartners has made arrangements with select vendors for specialty medications. Commercial and State Public Programs are required to use these specialty vendors. Medicare products are encouraged but not required to use these specialty vendors. This program applies only to specialty medications, and members can continue to obtain all other non-specialty prescription medications through retail or mail order pharmacy. This program doesn't apply to in-clinic administration of medications. Specialty Medications are noted as SP in the Drug Formulary and in the Specialty Drug List. A "Formulary Exception" process is available for unique situations that require dispensing from other pharmacy providers.
Transition of Care Policy	A transition process is available to new enrollees who are transitioning from other prescription drug coverages, enrollees whose current drug therapies may not be included in the HealthPartners formulary, and unplanned transitions as individuals change treatment settings due to changes in level of care. Certain medications are usually authorized to allow continued therapy. These medications include anticonvulsants, antipsychotics, antidepressants, chemotherapy, HIV medications, and immunosuppressants, and medications determined to be medically necessary. Patients who have been treated with a drug to treat a mental illness or emotional disturbance for 90 days may continue to receive the prescribed drug for up to one year without the imposition of special co-payment requirements. HealthPartners offers temporary coverage for other medications for new and transitioning enrollees. This is designed to accommodate the immediate needs of enrollees for a limited period of time.
Long Term Care Exception Process	Enrollees residing in a LTC facility will receive special consideration based upon their enrollment and transition to a LTC facility. Overrides will be in place until an appropriate liaison between the facility, the attending physician, and the plan's LTC pharmacy can be achieved. The overrides will be effective for a minimum of 90 days to accomplish appropriate communication.

Therapeutic Interchange	Member-specific requests may be sent to providers requesting changes to preferred formulary products. If approved by the provider and returned, members receive an explanation letter, and pharmacies receive a new prescription. Examples include: preferred product changes, and generic and less-costly alternatives.
Member Cost Sharing	Member benefits are applied to all pharmaceuticals and are collected at the point of service. Member benefits vary with specific benefit designs. Tiered cost-sharing is available to encourage cost-effective utilization. Member payments are usually lowest for generic formulary products, followed by formulary brands, and then non-formulary products (highest co-pay).
The Pharmacy Network	The HealthPartners pharmacy network is maintained by our pharmacy benefit manager. The network is required to comply with standards for pharmacy practice as established by State Boards of Pharmacy.

Quality Assurance Programs

These quality assurance tools are used to help reduce medication errors and adverse drug reactions, and to improve appropriate medication use.

Concurrent Drug Utilization Reviews	Point-of-dispensing screening edits are routinely applied by our pharmacy benefit manager to each prescription claim. These edits are designed to check the member's prescription history for possible conflicts. Edits applied before dispensing include screening for drug interactions, allergies (if data available), early refills, duplicate prescriptions, over utilization/ refill too soon, under utilization, pediatric warnings, geriatric warnings, acute/ maintenance dosing, therapeutic duplication, drug-inferred health state, drugs exceeding maximum daily dosage and drugs below minimum daily dosage. Drug interactions are screened based on the First Data Bank drug interaction severity rating system. There are four severity types: • Major: Interactions have the potential of serious adverse outcomes (potentially life-threatening). • Moderate: Interactions are less likely than major interactions to cause harm to the member. • Minor: Interactions pose a limited or unclear risk to the member. • None: No known interactions When concurrent DUR warnings occur, pharmacists are expected to use their professional judgment in dispensing a product after consultation with the physician and/or patient as necessary.
Retrospective Drug Utilization Reviews	Retrospective drug reviews using claims data are performed to identify patterns of inappropriate or medically unnecessary care.
Medication Therapy Management	HealthPartners has developed a network of Medication Therapy Management (MTM) pharmacists. The goal of the program is to ensure optimum therapeutic outcomes through improved medication use.
Adherence Programs	Adherence programs are available to help educate patients and support appropriate medication duration.

Drug Recalls,
Withdrawals,
and Safety
Advisories

Communications are sent to providers and members for significant drug recalls, product withdrawals, and safety advisories.

Follow-up by HealthPartners is determined by the Medical Director with input from Clinical Pharmacy and from practicing providers. Issues considered in determining follow-up by HealthPartners include the degree of health risk, the extent of distribution, the extent of media coverage, and recommendations by local providers.

Issues are identified using the FDA MedWatch e-list, the FDA Recall e-list, notifications by manufacturers, and press releases. Drug utilization reviews by HealthPartners are also used to identify issues.

Communication options include notifications to providers and/ or patients by either HealthPartners or its business partners (e.g. our pharmacy benefit manager, our specialty pharmacy provider(s), and the pharmacy network). Communications may be sent via US mail, fax, and by e-mail.

Drug Safety Alerts are categorized into three classes, according to the level of hazard involved:

Class I Recalls: Dangerous or defective products that predictably could cause serious health problems or death. Members and providers are notified in an expedited manner, within 14 days.

Class II Recalls: Products that might cause a temporary health problem, or pose only a slight threat of a serious nature. Members and providers are notified within 30 days for Class II recalls with the potential for significant negative effects.

Class III Recalls, Unclassified Recalls, Product Withdrawals, and Safety Advisories: Members and providers are notified within 30 days for issues with the potential for significant negative effects.

Communication options include notifications to providers and/ or patients by either HealthPartners or its business partners (e.g. our pharmacy benefit manager, our specialty pharmacy provider(s), and the pharmacy network). Communications may be sent via US mail, fax, and by e-mail.

A log of issues and follow-up is kept in Pharmacy Administration.

HealthPartners supports and promotes reporting serious medication-related adverse reactions to the MedWatch Reporting System.

Pharmacy Fraud,
Waste, and
Abuse Program

HealthPartners Pharmacy Fraud, Waste & Abuse Program employs retrospective claim review across all products to identify patterns of inappropriate and/or medically unnecessary medication use, prescribing, or distribution.

Multifaceted member-, provider, and pharmacy-level clinical assessments of claims are conducted quarterly by pharmacists in conjunction with a multidisciplinary team including physicians, nurses, and/or quality review professionals.

Clinical criteria are used to identify outlier members, providers, and pharmacies with high or duplicative utilization, prescribing, or distribution of controlled substances, costly medications, and/or medications of concern over a sustained period of time.

Formal communication between HealthPartners clinical staff and providers is used to ascertain medical necessity in concerning cases. Case review findings and results are documented by Pharmacy Administration. Formal communication is used to convey case review findings to providers as needed.

When necessary following clinical review, outlier members, providers, and/or pharmacies are referred to appropriate entities for further action. HealthPartners may also utilize beneficiary-level point-of-sale edits for Medicare Part D members; providers and beneficiaries are formally notified of edits prior to implementation.

Sampling Policy

A primary concern is patient safety. In addition, the use of samples leads to prescribing and use which may not be most effective or efficient for our members. Clinics should eliminate sampling of all prescription pharmaceutical products supplied by manufacturers and dispensed by clinic providers and staff directly to patients.

Clinics choosing to continue to stock and dispense sample medications must follow safe medication practices, consistent with those identified by JCAHO. These requirements include but are not limited to:

- Develop procedures for sample storage and disposal (e.g. must be locked and have controlled access and checked for outdates that are appropriately disposed of).
- Develop procedures for proper dispensing (labeling, patient education, documentation in the medical record, review for allergies and drug interactions).
- Keep a log of all samples dispensed which includes: date, patient, medication name, dose, expiration date and prescriber.
- Designate a person or persons to be responsible for the sampling program at the clinic and ensuring compliance with policies and procedures.
- Develop an approved list of samples with care taken to evaluate efficacy, safety and value compared to other alternatives.

Contact Information

Contact Information HealthPartners Pharmacy Services
8170 33rd Ave S, P.O. Box 1309, Minneapolis, MN 55440
Fax 952-853-8700 or 1-888-883-5434
Telephone 952-883-5813 or 1-800-492-7259

HealthPartners call center is available to providers (physicians, pharmacies, and pharmacists) 365 days per year and 24 hours per day. HealthPartners Pharmacy Prior Authorization Provider help line at 952-883-5813 or 1-800-492-7259 is available from 8 AM - 6 PM Central Time, Monday through Friday, and 8 AM – 4 PM Saturday. After these hours, the telephone line is routed to our Pharmacy Benefit Manager. Our PBM is available 365 days per year and 24 hours per day. Pharmacy Customer Service answers inquiries regarding claims processing, benefit coverage, claims submission and payment, and prior authorization. This help line is staffed by trained Pharmacy Customer Service Assistants and clinical pharmacists.