FORMULARY AND BENEFIT IMPLEMENTATION RECOMMENDATIONS

This document provides implementation recommendations for complying with requirements when transmitting NCPDP Formulary And Benefit transactions. This document also contains editorial corrections, clarifications to the NCPDP Formulary And Benefit Standard Implementation Guide documents.

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Formulary And Benefit Implementation Recommendations

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1. PURPOSE

The recommendations in this document are expected to be followed by the industry for consistent and complete prescription transactions of the NCPDP ***Formulary And Benefit Standard Implementation Guide***. As the electronic prescribing industry has matured, more robust requirements have been added to the transaction standards. These recommendations will be brought forward and it is anticipated that they will be reflected in future versions of the ***Formulary And Benefit Standard Implementation Guide***. These recommendations provide a bridge to the future versions.

This document also contains editorial corrections, clarifications to the NCPDP ***Formulary And Benefit Standard Implementation Guide*** documents.

The ***Formulary And Benefit Standard Implementation Guide*** and all NCPDP standards are available with membership at www.ncpdp.org.

2. BUSINESS JUSTIFICATIONS

2.1 BUSINESS JUSTIFICATIONS FOR SENDING PRIOR AUTHORIZATION INFORMATION

The prior authorization workflow is improved and more efficient for most stakeholders if the prescriber knows that prior authorization is required at the time of prescribing. Most prescribers are writing prescriptions electronically via an electronic health record (EHR) or stand-alone ePrescribing solution. Since most of these software solutions consume and ultimately display formulary and benefit information using the NCPDP ***Formulary And Benefit Standard Implementation Guide***, this standardized flat file serves as a proactive means of indicating to EHR and ePrescribing solution users that prior authorization is likely required for a specific medication.

The ***Formulary And Benefit Standard Implementation Guide*** includes prior authorization in the optional Coverage Information Detail file. Since the Coverage Information Detail file is the prescriber vendor's primary means for knowing whether a medication requires prior authorization, payers should ensure that they are sending it.

By supporting prior authorization information in the Coverage Information Detail file, the payer can alert the prescriber that there may be an extra step required for coverage approval. This may also facilitate a dialogue between the prescriber and patient that could lead to an informed discussion about whether the chosen medication represents the best option for the patient.

Prescribers will be able to make an informed decision, reducing inefficient, post-visit phone calls and faxes in the current prior authorization workflow. Patients will experience fewer issues at the pharmacy related to prior authorization. Pharmacists will receive a prescription for a medication that has received the appropriate prior authorization, rather than trying to obtain, sometimes without the necessary detail, the information necessary for the authorization. Payers will provide efficiencies to their clients in prior authorization processes and receive fewer calls from prescribers, pharmacists and members.

As the industry moves toward electronic prior authorization, the population of this file will serve as a first step toward the prescriber requesting prior authorization for the therapy he or she determines to be the most effective and appropriate for the patient.

3. RECOMMENDATIONS FORMULARY

This section intentionally left blank.

4. RECOMMENDATIONS ALTERNATIVES

4.1 ALTERNATIVES DISPLAY LOGIC USING FORMULARY AND BENEFIT STANDARD IMPLEMENTATION GUIDE VERSION 1.0-5.1

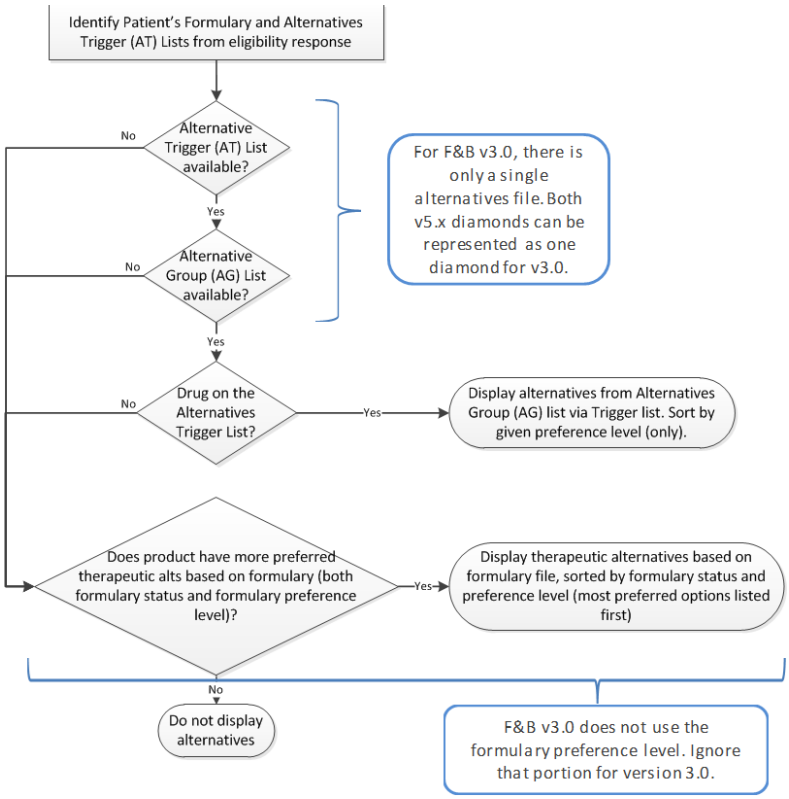
Question: What are the payers' expectations around how vendors should display alternatives based on the F&B alternative file(s) received?

Answer: Payers generate alternative lists for business and/or clinical reasons. When a trigger product is selected, the following should happen:

Trigger File	Alts Group File	Vendor Alts	Alternative List Source
Y	Y	N	Payer
Y	N	N	None
N	N	Y	Vendor

1. If a payer provides a trigger file and alternative group file (v5.0+) or an alternatives file (v1.0-4.4), then display the provided alternative products in the order specified. Other potential F&B information (e.g. formulary status, copay, etc.) should not be considered when processing payer provided alternative lists.
2. If a payer provides a trigger file and no alternatives in the alternative group file (v5.0+) or provides an alternatives file with the NDC as a trigger drug but no valid/empty alternative NDCs (v1.0 – 4.4) then do not display any alternatives. The payer is requesting that the vendor not display any alternatives.
3. If the product is not in the trigger file or no alternative trigger file is provided, then the vendor should create its own alternative list. The vendor generated alternatives use formulary status (all versions) and formulary preference level (version 5 and above) to filter and sort. Unknown, non-reimbursable, and non-formulary products should not be returned on the vendor generated alternatives. A vendor should show more preferred alternatives than the selected product by formulary status (v1.1 – 5.0+) and formulary preference level (e.g. alternatives should have a "better than" formulary status and formulary preference level than the selected product) (v5.0+). In the event of multiple products with the same formulary status and preference level, then sort by alpha then form then strength.

The following flow chart outlines how a vendor should determine when and how to display alternatives.



5. RECOMMENDATIONS COPAY

5.1 COMMUNICATING A COPAY DOLLAR RANGE USING FORMULARY AND BENEFIT STANDARD IMPLEMENTATION GUIDE VERSION 1.0-4.2

Question: A Medicaid payer would like to convey dollar copay range amounts instead of using copay tier. The ***Formulary And Benefit Standard Implementation Guide Versions 1.0-4.2*** do not allow displaying a copay range since the Minimum and Maximum Copay amounts are tied to a Percent Copay. Flat Copay is not applicable. How should they populate the copay lists?

Answer: In the ***Formulary And Benefit Standard Implementation Guide Version 1.0-4.2***, 100% in Percent Copay Rate (954-HQ) is usually seen as the patient paying 100% of an amount. So a payer should populate the Percent Copay Rate (954-HQ) field with a value of 1 in order to convey that the patient copay is an amount within a range.

When only the copay rate range needs to be conveyed, the Percent Copay Rate should be populated with a value of 1. The anticipated copay range is then conveyed as minimum and maximum copay.

Example 1:
A patient has a co-pay range between $0 and $3.50. It would be displayed as:

Percent Copay Rate (954-HQ) = 1
Minimum Copay (945-GS) = 0
Maximum Copay (939-GK) = 3.50

Example 2:
A patient has a co-pay range between $5 and $9.00. It would be displayed as:

Percent Copay Rate (954-HQ) = 1
Minimum Copay (945-GS) = 5
Maximum Copay (939-GK) = 9

Note that a future solution is available in NCPDP ***Formulary And Benefit Standard Implementation Guide Version 4.3***.

5.2 USING PERCENT COPAY AND THE MIN/MAX COPAY AMOUNTS

Question: If a payer chooses to use percent copay, are the minimum and maximum copay amounts required? If not, can a payer choose to use just the minimum or the maximum copay amounts instead of both?

Answer: There is not a requirement for the Minimum Copay (945-GS) and Maximum Copay (939-GK) fields to be used if there is percent copay. They may not be used when a Flat Copay Amount (925-ES) is present.

If a payer uses either Minimum Copay Amount or Maximum Copay but not both fields:

Minimum case: The value of "0" does not present any value to the prescriber and patient. If a "0" or null/blank is sent, do not display any verbiage about the minimum copay amount on the user interface.

Maximum case: If there is not a Maximum Copay, it is not recommended to send "9,999,999.99".

This approach allows payers to send smaller files and allows vendors to provide more succinct user interfaces to prescribers.

This applies to both the summary and detail copay files.

6. RECOMMENDATIONS COVERAGE

6.1 SIMPLIFYING QUANTITY LIMITS

Question: How are the Quantity fields interpreted by prescribers specifically the Maximum Amount, Maximum Amount Qualifier, Maximum Amount Time Period and Maximum Amount Time Period Units? For example: How would we send a medication with a "quantity supply to" of "18" and "days supply to" of "30" in the Quantity List of the ***Formulary And Benefit Standard Implementation Guide Version 3.0*** guide? Our initial approach is to literally recreate the above logic:

QDT|A|COVTXIX|00006026718|3| | | |30|DS
Drug X is covered for a maximum of a 30 day supply

QDT|A|COVTXIX|00006026718|3| | | |18|QY|DY|30
Drug X has a maximum quantity limit of 18 units every 30 days

Answer: When possible, keep it simple. The more data that is sent, the larger the files, the more processing by e-prescribing vendors and, more information that must be read by providers. For the example below, everything may be conveyed in one line.

QDT|A|COVTXIX|00006026718|3| | | |18|QY|DY|30
Drug X has a maximum quantity limit of 18 units every 30 days

Note that multiple quantity limits may be sent for the same medication but whenever possible, try to reduce the information to one line.

7. RECOMMENDATIONS FOR PRIOR AUTHORIZATION

7.1 PROVIDING PRIOR AUTHORIZATION FOR A MEDICATION

Question: How should a payer provide information to a prescribing system that prior authorization is required for a certain medication?

Answer: The Prior Authorization Coverage List is a component of the available Coverage Information Detail file in the NCPDP ***Formulary And Benefit Standard Implementation Guide***. It is highly recommended that the payer implement the Prior Authorization Coverage List populated with the medications that require prior authorization as close to group/plan level as possible for accuracy. (Please refer to the ***Formulary And Benefit Standard Implementation Guide*** for specifics.) The electronic prescribing system can then present this information in the prescriber environment.

8. FREQUENTLY ASKED QUESTIONS

8.1 How is a supply defined in the context of prescription benefit design? For Example, in assembling formulary files (Listed NDCs, and Unlisted Supplies)?

Answer: Medical supplies are defined as medically-necessary items that may be ordered or prescribed and are expendable, disposable, or non-durable such as diabetic supplies, bandages or ostomy supplies.

8.2 Can the Specialty Products File in Formulary and Benefit Version 52 be used to flag specific NDCs as Specialty Products, or is the intention that the file only be used if the product can be tagged as covered by Medical or Prescription Drug Benefit?

Answer: The Specialty Products file can be used to designate NDCs as specialty products. Within the Specialty Products File, the Specialty Product Benefit Indicator (C42-9N) is an optional field. The simple presence of a product in this list indicates the product is a specialty product. If the PBM/Payer would like to provide additional information on whether the product is covered by the Medical or Prescription Drug benefit, they may utilize the Optional Specialty Product Benefit Indicator (C42-9N) field to do so.

9. EDITORIAL MODIFICATIONS TO IMPLEMENTATION GUIDE

An editorial correction was made to the diagram in section "*Transmission Level from the Sender to the Receiver*" to move "Coverage List ID (911-BZ) = BBBBB" from Coverage Information Trailer to Coverage Information Header where it belonged. This was corrected in the Formulary and Benefit Standard Implementation Guide Version 4.3 and above, but is applicable to all versions.

10. MODIFICATIONS TO THIS DOCUMENT

10.1 VERSION 1.1

Added Section: Recommendation Alternatives, causing all sections that follow to be renumbered.

10.2 VERSION 1.2

Added Section: Definition of a Supply, causing all sections that follow to be renumbered.

10.3 VERSION 1.3

Modified Section: Definition of Supply to Frequently Asked Questions
Added new FAQ: Can the Specialty Products File in Formulary and Benefit Version 52 be used to flag specific NCDs as Specialty Products, or is the intention that the file only be used if the product can be tagged as covered by Medical or Prescription Drug Benefit?