



Fresenius Health Partners
PPO SNP
Accountable Kidney Care

Pharmacy Coverage Determinations

In order to make our coverage accessible and affordable, Fresenius Health Partners requires certain drugs to be authorized in advance by us. There are two types of Pharmacy Coverage Determinations. They include Prior Authorizations and Exceptions. There are also various types of Exceptions which include Quantity Limits (limits the quantities that may be routinely dispensed for some drugs), Step Therapies (for certain drugs asks doctors to prescribe less costly alternatives first, among drugs in the same category), and Non-formulary (the drug your doctor is prescribing is not included in Fresenius Health Partners' formulary) exceptions.

You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier (Tier 4), you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier (Tier 3) instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are on Tier 5. Generally, Fresenius Health Partners will only approve your request for an exception if the alternative drugs included on the plan's formulary or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

When you are requesting a tiering exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. For all expedited decisions, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

If your drug is not included in our formulary, you should first contact Customer Service and confirm that your drug is not covered. If you learn that Fresenius Health Partners' Formulary does not cover your drug, you have two options:

1. You can ask Customer Service for a list of similar drugs that are covered on the Formulary. Take your formulary and show it to your doctor and ask him or her to prescribe a similar drug that is covered on the Fresenius Health Partners Formulary.
2. You can ask Fresenius Health Partners to make an exception and cover your drug.

When you are requesting a formulary exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an



Fresenius Health Partners
PPO SNP
Accountable Kidney Care

expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. For all expedited decisions, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

During the period of time you are talking to your doctor to determine the right course of action, we may provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year. When you go to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply within the first 90 days you are eligible, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

To request an exception, or to request prior authorizations, please follow the Coverage Determination and Exception Process.

Please see Chapter 9, sections 6.1-6.4 in your EOC for additional information regarding the Part D Coverage Determination/Exception Process. You can find your EOC by going to "Find Your Plan," then choosing your state, county and plan. Your EOC is in the plan information section.

Click here to download and print the CMS [Medicare Part D Coverage Determination Request Form](#).

Pharmacy Coverage Determination and Exception Process

The processes outlined below are followed in making coverage determinations which include Prior Authorizations, Step Therapy, Quantity Limits, and amount of cost sharing for a drug or Tier Exceptions.

1. Call Fresenius Health Partners Pharmacy Department and request a coverage determination or exception (members call (866) 307-3625; physicians call (866) 715-7519). If a Coverage Determination form is not available, all information may be given orally. A physician may use the Model Medicare Part D Coverage Determination Form or the Fresenius Health Partners Coverage Determination Form. If requesting an exception to a PA or other UM requirement (quantity limit, step therapy or tiering exception) in



which a member would suffer adverse effects if he or she were required to satisfy the PA requirement, the prescribing physician must provide a written supporting statement or documentation to Fresenius Health Partners. Additionally, members may request tier and formulary exceptions, but they will not be processed until the member's prescribing physician submits a coverage determination form with a written supporting statement or documentation.

2. After receiving the required information, the Coverage Determination will be reviewed by Fresenius Health Partners. If the request meets the established clinical criteria that has been recommended by the Fresenius Health Partners Pharmacy and Therapeutics Committee, which is a committee consisting of community physicians, pharmacists and nurses, approval of payment will be granted by Fresenius Health Partners.

3. If the Coverage Determination or exception is approved, the medication approved, date and length of the approval, are faxed back to the prescriber and mailed to the member. An override is then entered into the pharmacy claims processing system or the medical claims processing system depending on the delivery of the medication.

4. If the Coverage Determination or exception is denied, after not meeting established clinical criteria that has been recommended by the Fresenius Health Partners Pharmacy and Therapeutics Committee, which is a committee consisting of community physicians, pharmacists and nurses, denial notification of payment will be mailed to the prescriber and member. The letter of non-coverage of the requested drug is generated and includes the following: the name of the denied medication, the specific clinical reasons that coverage was denied, a statement that the clinical criteria is available upon request and free of charge, the notice of the right to file an appeal, and whom to contact for more information. The appeals process is available for any denial.

5. Coverage Determinations will be processed per with the following timeframes:

TYPE OF COVERAGE DETERMINATION / TIERING EXCEPTION	TIMEFRAME
STANDARD coverage determinations and tiering exceptions	As expeditiously as the member's health condition requires, but no later than 72 HOURS after receipt of the request/supporting statement
EXPEDITED coverage determinations and tiering exceptions	As expeditiously as the member's health condition requires, but no later than 24 HOURS after receipt of the request/supporting statement

6. Fresenius Health Partners Part D Members have the following rights:



Fresenius Health Partners
PPO SNP
Accountable Kidney Care

- The right to a timely coverage determination.
- The right to request an expedited coverage determination.
- The right to receive information from a network pharmacist regarding the member's ability to obtain a detailed written notice from Fresenius Health Partners regarding the member's Part D Benefits.
- The right to a detailed written notice of Fresenius Health Partners' decision to deny a benefit in whole or in part, which includes the member's appeal rights.
- The right to receive notice when a coverage determination is forwarded to the Independent Review Entity (IRE).

7. If Fresenius Health Partners does not provide notice of its standard or expedited coverage determination within the required time frame, the complete case file will be forwarded to the Independent Review Entity (IRE) contracted by CMS within 24 hours of the expiration of the adjudication time frame. Fresenius Health Partners must have the prescribing physician written supporting statement before sending to the IRE.

Pharmacy Coverage Determination Contacts for Prescribers

By Telephone: (866) 307-3625, TTY (877) 736-2535

By Fax: (615) 782-7869

Hours: 8 a.m. – 8 p.m., 7 days a week in your local time zone

By mail:

Fresenius Health Partners
Attention: Pharmacy Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

Pharmacy Coverage Determination Contacts for Members

(866) 307-3625, TTY (877) 736-2535

Hours: 8 a.m. – 8 p.m., 7 days a week in your local time zone

By mail:

Fresenius Health Partners
Attention: Pharmacy Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor.