First Script Prescription Benefit News
for Workers' Compensation

January 2016

COVENTRY

2015 Accomplishments and Opportunities

As we head into 2016, we at First Script would like to thank our clients for another successful year of growth and partnership. Last year, pharmacy benefit management (PBM) within workers' compensation evolved in relation to ongoing industry experience. We continue to look for new and innovative ways to solve for the industry's toughest challenges.

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FIRST SCRIPT®

For questions or comments, contact First Script at

FirstScriptNews @cvty.us.com

Changing Industry Experience

In response to increases in non-traditional dispensing channels (billers for physician-dispensed medications, occupational-medicine clinics, third-party billers, external mail houses, and compounding prescription sources), First Script broke new ground by publishing a fully transparent view into 100% of its pharmacy transactions in its annual Drugs Trends Report.

First Script remains resolute that a PBM must offer its clients full transparency into their total pharmacy experience and that true transparency is only possible when the PBM incorporates data on all managed (in-network) and unmanaged (out-of-network) prescriptions.

Developing Real-World Solutions

Our call to action for total drug utilization and spend transparency provided a sound foundation for delivery of two significant First Script innovations: Smart Prior-Authorizations (SmartPA) and Urine Drug Monitoring (UDM).

SmartPA is our next-generation medication authorization process. Fusing outcomes-based clinical knowledge with total pharmacy data in a user-friendly delivery model has allowed our clients to operate more effectively and efficiently. As SmartPA becomes the norm for First Script's PBM service delivery, we look forward to helping our clients better understand how SmartPA can be further enabled to provide new efficiencies and opportunities for better clinical outcomes.

UDM similarly took an industry-based need and elevated it to a best-in-class program through the use of fully integrated pharmacy and medical data. While addressing the need to ensure compliance to medication therapy, our UDM program is setting the new standard for comprehensive drug monitoring by incorporating not only responsible, cost-efficient testing, but by providing post-testing services that promote future compliance and reduced waste.

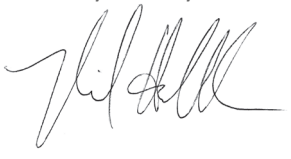
Valuing Our Partners

Challenging the industry to see pharmacy management through the correct lens, First Script also took an introspective look into how we support our partners in managing total pharmacy. In doing so, we recognized an opportunity to redesign and re-launch our client-facing web tool, Coventry Connect.

The result was a new, streamlined, user-friendly portal focused on delivering simplified decision-making support, as well as a deeper understanding of what you need from us to be successful in managing the pharmacy portion of your workers' compensation business. We look forward to continued development of user-focused solutions beginning with a new mobile application to be released in 2016. Recognizing the increasing need for people to work remotely, this app will empower our clients to further execute on claims management in the manner they see most fit.

While we are very pleased with the strides we have taken in 2015, we look forward to continuing improvement on our responsiveness, service delivery, and our innovation in 2016.

Thank you for your continued partnership,



Michael Halbach
Vice President, First Script PBM

Drug of the Month

Generic Pennsaid® 1.5% (diclofenac sodium 1.5% topical solution)

The Food and Drug Administration (FDA) recently approved a generic version of Pennsaid® 1.5% (diclofenac sodium 1.5% topical solution) made by Novel Laboratories. Pennsaid® 1.5% (Nuvo Research® Inc.) is FDA-approved for the treatment of pain from osteoarthritis in the knee(s). It should be noted that use was not evaluated in any other joints. The dosing of Pennsaid® 1.5% is 40 drops to be applied to each affected knee four times daily as 10 drops at a time, either directly on the knee or first into the hand and then onto the knee. The 10 drops should be spread evenly over the front, back, and sides of the knee and repeated until the knee is completely covered with the full dose.

The manufacturer recommends application on clean, dry, uncompromised skin (free of any cuts, rashes, or infection). Further recommendations include allowing the area to dry completely before touching (the area may be covered with clothing until dry) or application of other topical products (such as sunscreen, insect repellent, lotion, etc.). Showers or baths should also be avoided for at least 30 minutes following application. The area of application should be protected from the sun by avoiding exposure to both natural sunlight as well as tanning beds or sunlamps. Additionally, the treated area should never be covered with heating pads or bandages.

Topical diclofenac solution (e.g., Pennsaid®) should not be used concomitantly with oral Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) due to an increased risk of adverse effects. Therefore, combination therapy with topical diclofenac solution and oral NSAIDs should be avoided unless the benefit of use outweighs the risk, and periodic monitoring is conducted through creatinine, urea, and hemoglobin laboratory tests. Patients should also be monitored for signs or symptoms of gastrointestinal bleeding with long-term treatment through periodic evaluations of the Complete Blood Count (CBC) and a chemistry profile. In controlled clinical trials with Pennsaid®, the most commonly reported adverse events were application site reactions.

The Official Disability Guidelines does not consider Pennsaid® to be first-line treatment. Instead, topical diclofenac is recommended as an option following failure of an oral NSAID or in patients who are unable to take oral NSAIDs.

References:http://www.accessdata.fda.gov/scripts/cder/drugsatfda/
www.odg-twc.com

Ask The Pharmacist

To suggest a topic, send an email to:
AskThePharmacist@cvty.us.com

During the holidays, many people traveled. Are there any rules or recommendations for traveling with a controlled substance?

It is a good idea to always keep medications for an injury or chronic condition on hand when traveling. However, one should only bring as much medication as will be required for the time period away from home. For example, if a patient has a prescription for Vicodin® (a Schedule II controlled substance) that is intended to be taken as one tablet twice a day with a bottle of 60 tablets (a 30-day supply), it would be wise to bring only 14 of the 60 tablets on a seven-day trip (with perhaps a few extra tablets just in case). This way, if the medication is lost or stolen, the owner will not be left without any medication for the remainder of the month and may potentially have less of an issue getting a replacement or early refill. Controlled substances, unlike non-controlled medications, have tighter restrictions for the prescriber and often will not be dispensed by the pharmacy again prior to the time period they should run out according to the prescription.

If a patient is traveling with a controlled substance prescription medication, it is best to keep the medication in the original prescription bottle or to put the reduced amount into a separate bottle with the same labeling. A second empty bottle with a duplicate prescription label can usually be requested at the pharmacy for this purpose. Alternatively, a copy of the prescription or a note from the prescriber may also be a good idea and may be required in certain situations. If traveling by plane, the Transportation Security Administration (TSA) does not currently require that medications be in a prescription bottle; however, states have different laws regarding the labeling of medications that the patient should be aware of before traveling. The TSA screens medication, and asks that meds be separated from other belongings for this purpose, thus, it would be a good practice to ensure that both the patient and the medication are clearly identifiable on the container to avoid confusion. Ideally, medication should be kept with the owner at all times if possible, or alternatively, in a locked or secure location such as a hotel room safe. If the patient is traveling out of the country, the patient should consider that medications may have different approvals and indications in different countries. This is true in the states as well. For example, medical marijuana laws vary greatly state to state, and medical marijuana is not recognized federally as a legal substance. The traveler should familiarize himself or herself with the laws applicable to the area to which he or she is traveling. The TSA and Customs and Border Protection (CBP) have additional information regarding medications and travel that may be found online by visiting their websites (see reference section below).

In the event that a patient finds that his or her prescription medication is misplaced or stolen, it is important to report this immediately to the prescriber, especially if the prescription is for a controlled substance. Depending on the situation, it may also be appropriate to notify law enforcement as theft of a controlled substance is a punishable offense.

References:
http://blog.tsa.gov/2013/09/tsa-travel-tips-tuesday-traveling-with.html
http://www.cbp.gov/travel

Regulatory Roundup

2016 Regulatory & Legislative Projections

Hot on the heels of a very active and influential year for workers' compensation pharmacy regulatory and legislative reform, 2016 projects to be another year of substantial change for workers' compensation pharmacy regulation. Along with the typical fee schedule modifications, First Script is closely tracking the following topics:

Closed Formularies

2015 seemed to be the year of the closed formulary. With formulary regulation proposed, debated, and (in some cases) adopted in California, North Carolina, Tennessee, and Louisiana, the topic was certainly at the forefront of the workers' compensation pharmacy agenda.

In 2016 the debate and discussion around closed formularies appears to be no less pervasive, but perhaps will be more measured. With a significant period of time passing since the adoption of the Texas and Oklahoma ODG-centric formularies, payors and their advocates are able to present more advanced data that demonstrates both the intended benefits of these closed formularies coming to fruition (for example, a reduction in opioids) and the unintended detriments created by the same formularies (a rise in compounded medications and a rise in medications not related to work comp injuries). As has been discussed previously in First Script's formulary webinar, the devil does appear to be in the details of the formulary-enabling/supportive rules and laws, as opposed to the formularies themselves.

Concepts such as the continued need for prospective and retrospective utilization review, or allowing PBMs to continue to utilize more restrictive, injury-specific clinical tools, are the subject of debate in ongoing formulary rule-making in both Tennessee and California. Perhaps because of this, states that are also considering the adoption of a pharmacy formulary are taking a wait-and-see or exhaustive research approach to the subject matter before moving forward with rule-making proposals. However, given the fiscal benefits that are projected to accompany a state-based formulary, it is unlikely that this topic will lose any momentum in 2016.

Medical Treatment Guidelines

Operating as almost a corollary to the closed formulary adoptions of 2015, medical treatment guidelines specifically aimed at pharmacy treatments were more prevalent in 2015 and will continue to be so on 2016. As both California[1] and Arizona[2] finalize treatment guidelines that will shape how their respective work comp systems manage the topic of opioids, other states are looking to either refine existing treatment guidelines or adopt first versions of treatment guidelines aimed specifically at pharmacy-centric topics like opioids and chronic pain.

On a related note, medical marijuana, as an accepted form of medical treatment for workers' compensation, will continue to undergo national discussion. With the validation of medical marijuana in New Mexico in 2015, and pending lawsuits in a number of states over the validity of medical marijuana as a treatment for workers' compensation injury,[3] the issue of whether payors will have to reimburse (and how they will reimburse) for marijuana will continue to be hashed out in 2016.

Direction of Pharmacy Care

After years of debating a litany of ancillary pharmacy regulatory issues (prescriber dispensing, pricing/utility of compounds, etc.), PBMs have finally begun to gain more traction with regulators and legislators regarding the specific value of allowing work comp payors/PBMs to direct where an injured worker must receive their medications. Similarly to the once hotly debated topic of generic medications vs. brand medications, it has taken a substantial period of time and evidence for regulators to be responsive to payor advocates (like First Script). Unfortunately, with increasingly nuanced issues like selective medication pricing (aka, up-charging by dispensers and manufacturers who utilize boutique national drug codes to artificially inflate the average wholesale price of medications) and subversive medication selection to avoid regulations (witness the increase of medications with no ODG Appendix A indicator in Texas), it has become more transparent to regulators that the most effective and most efficient way to deter bad actors in the workers' comp pharmacy space is to allow payors and their agents (PBMs) to direct injured workers to only fill prescriptions through payor contracted pharmacies.

Making the concept more palatable, even to workers' rights groups, is the increasingly expansive nature of pharmacy benefits networks. As entities like First Script continue to expand their networks to include more diverse and convenient dispensers (including clinics, mail order pharmacies, and doctors' offices), the argument against payor control limiting injured worker access to care has significantly diminished. However, the independent pharmacy lobby continues to be vocal in opposition to the concept of payor direction of pharmacy care. Even New York, which has long upheld the payors' right to direct care for pharmacy, looked to amend the law to allow injured workers the right to select any pharmacy for the dispensing of their workers' compensation medications (A.4642[4] [Simotas]). It is noteworthy that A.4642, which has not passed, is sponsored not by pro-labor or pro-injured worker supporters, but by independent pharmacies whose sole argument is that they are not allowed to capitalize on filling injured worker prescriptions at state fee schedule maximum rates because they have not wanted to become part of pharmacy benefits networks.

References:
1. http://www.dir.ca.gov/DIRNews/2015/2015-112.pdf
2. http://www.ica.state.az.us/MRO/MRO_EBM_ReportToDirector.pdf
3. https://www.workcompcentral.com/news/story/id/1a9f5f384100574b0c7d2640017d25781ce73eae
4. http://www.nysenate.gov/legislation/bills/2015/a4642

Fee schedules for current pricing, compounding rules and physician dispensing rules

State	Brand Rate & Dispensing Fee	Generic Rate & Dispensing Fee	Compound Rate & Dispensing Fee	Physician/Repackager Rate & Dispensing Fee
Alabama	AWP + 5% + $8.92	AWP + 5% + $11.58	None	Pricing is based on the lesser of the repackaged/ relabeled NDC and the original manufacturer's NDC. Dispensing fee applies only to pharmacies.
Alaska	AWP + $5	AWP+ $10	Reimbursement for compounded drugs shall be limited to medical necessity and reimbursed at the manufacturer's AWP for each drug included in the compound (listed separately by NDC) plus a $10 compounding fee.	Fee schedule applies to physician dispensed medications.
Arizona	AWP-5% + $7	AWP-15% + $7	AWP determined by the "underlying drug product"; payer may select AWP if "original labeler" information cannot be determined.	AWP determined by the "underlying drug product"; payer may select AWP if "original labeler" information cannot be determined.
Arkansas	AWP + $5.13	AWP + $5.13	None	Same as retail pharmacy rates, but physician is not entitled to dispensing fee.
California	AWP-17% + $7.25	AWP-17% + $7.25	Sum of all ingredients with an NDC, plus a compounding fee which includes the dispensing fee.	AWP determined by use of the NDC of the underlying drug product from the original labeler, plus the retail dispensing fee.
Colorado	AWP + $4	AWP + $4	All prescriptions shall be billed using the DoWC Z code. Consult rules for specifics.	For prescriptions, except topical compounds, written after 30 days from the date of injury, reimbursement shall be AWP + $4.00. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.
Connecticut	AWP + $5	AWP + $8	None	None
DC	Follows CMS Guidelines	Follows CMS Guidelines	None	None
Delaware	AWP-12% + $4	AWP-20% + $5	Compound drugs shall be billed by listing each drug included in the compound and separately calculating the charge for each drug, using NDC. When compounding, a single compounding fee of $10 per prescription shall be added to the calculated total.	If a prescription drug or medicine has been repackaged, the AWP used to determine the maximum reimbursement in controverted and uncontroverted cases shall be the AWP for the underlying drug product, as identified by its NDC, from the original labeler.
Florida	AWP + $4.18	AWP + $4.18	Provider and insurer must agree to pricing prior to compounding.	AWP+12.5% +$8, utilizing original manufacturer pricing
Georgia	AWP + $4.26	AWP + $6.38	The maximum allowable reimbursement for the compound shall be the sum of the AWP for each active ingredient minus 50 percent, plus a single compounding fee of $20. If the NDC for the compound ingredient is a repackaged drug, the maximum allowable reimbursement for the repackaged drug shall be determined based on the AWP of the NDC of the original manufacturer.	Requires biller to provide original manufacturer's NDC.
Hawaii	AWP + 40%	AWP + 40%	AWP + 40% of each underlying drug, with AWP determined by the original manufacturer's AWP.	All pharmaceutical claims submitted for repackaged,relabeled, or compounded prescription drugs shall include the NDC of the original manufacturer.
Idaho	AWP + $5	AWP + $8	Sum of all medications only, plus a $5 dispensing fee and a $2 compounding fee. See rules for further comments.	Reimbursement based on original manufacturer's NDC, as supplied by the provider . See rules for further comments.

Illinois	U & C	U & C	None	AWP + $4.18 reimbursement based on original manufacturer's NDC, as supplied by the provider.
Indiana	U & C	U & C	None	Senate Bill 294 was signed into law on March 25, 2014: a medical service provider may not be reimbursed for more than one office visit for each repackaged legend drug prescribed; and the maximum period during which a medical service provider that is not a retail or mail order pharmacy may receive reimbursement for a repackaged legend drug begins on the date of the injury or disablement and ends at the beginning of the eighth day after the date of the injury or disablement.
Iowa	U & C	U & C	None	None
Kansas	AWP-10% + $3	AWP-15% + $5	Compound drugs and physician dispensed medications shall be reimbursed the same as pharmacies based on the original manufacturer NDC and shall only be dispensed on prior approval of the employer/carrier.	Physician dispensed E21 medications shall be reimbursed at the same schedule as pharmacies, and only using the original manufacturer's NDC. Also, they may only be dispensed with prior approval of the employer/carrier.
Kentucky	AWP + $5	AWP + $5	None	For repackaged medications dispensed by a physician, AWP is determined by the NDC of the original manufacturer. No dispensing fee for physicians.
Louisiana	AWP+10% + $10.51	AWP+40% + $10.51	Compounded prescriptions will be paid utilizing the same reimbursement formula as generic drugs.	Physicians may only dispense controlled substances or drugs of concern if registered as a dispensing physician and only up to a single 48-hour supply.
Maine	AWP	AWP	None	Applies to physician dispensed medications.
Maryland	U & C	U & C	None	None
Mass.	AWP-16% + $3	AWP-16%+ $3	Compounded drugs receive a $3 dispensing fee, plus additional compounding fees.	AWP determined by using the "most frequently purchased packaged size" of a medication. Physician dispensing permitted only when necessary for immediate and proper treatment until possible for patient to have prescription filled by pharmacy (General Laws Part I Title XV Ch 94C Sec 9(b)).
Michigan	AWP-10% + $3.50	AWP-10%+ $5.50	Effective 6/1/15 - Reimbursement for custom compounded topical medications significantly limited by R 418.101009. Sets a cap of $600 per topical compound, sets a compounding fee of $12.50 for non-sterile topicals. Requires use of WC-UCF, which requires ingredient level adjudication. There is no stated compound fee for sterile compounds. Pre-auth required, medical necessity must be demonstrated.	All pharmaceutical bills submitted for repackaged products shall include the original manufacturer or distributer stock package NDC number.
Minnesota	Paper=AWP + $5.14; Electronic claims= AWP-12%+ $5.14	Paper=AWP +$5.14; Electronic claims= AWP-12% + $5.14	None	Physician dispensing allowable when not for profit.
Mississippi	AWP + $5	AWP + $5	Compounded drugs should be calculated by the total of each ingredient, plus a $5 dispensing fee. Compound pricing for ingredients to be based on original manufacturer pricing.	No dispensing fee for physician prescribed. If the NDC for the drug product as dispensed is a repackaged drug, the maximum allowable fee shall be the lesser of AWP using a) the NDC for the underlying drug product from the original labeler.
Missouri	U & C	U & C	None	None
Montana	AWP-10% + $3	AWP-25% + $3	None	None
Nebraska	U & C	U & C	None	None

Nevada	AWP + $10.25	AWP + $10.25	None	Prohibits medical providers from dispensing more than an initial 15-day supply of a Schedule II or Schedule III controlled substances. Also requires the use of original manufacturer NDC.
New Hamp.	U & C	U & C	None	None
New Jersey	U & C	U & C	None	Physician dispensing limited to a 7 day supply only, unless IW is greater than 10 mi. from a pharmacy.
New Mexico	AWP-10% + $5.00	AWP-10% + $5.00	Compounded medications shall be reimbursed at the ingredient level, with each ingredient identified using the applicable NDC registered with the FDA, of the drug product and the corresponding quantity. All bills submitted for compounded products must include the NDC number of the original manufacturer registered with the FDA or its authorized distributor's stock package used in the compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the ingredient(s), calculated on a per unit basis, as of the date of dispensing. A repackaged drug NDC number shall not be used and shall not be considered the original manufacturer's NDC number. If the original manufacturer's NDC number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically-equivalent drug, calculated on a per unit basis. Ingredients with no NDC number shall not be separately reimbursable. Payment shall be based upon the sum of the allowable fee for each ingredient plus a single dispensing fee per compound. Compounded medications not dispensed by a licensed pharmacy: - Shall not exceed a ten-day supply for a new prescription only - Shall not exceed the cost of a generic equivalent [see NAMC 11.4.7.9.C.(6)]	AWP-10%, no dispensing fee for physicians
New York	AWP-12% + $4	AWP-20% + $5	Reimbursement based on sum of all line-item listed ingredients, plus a single dispensing fee.	Reimbursement based on original manufacturer's NDC, as supplied by the provider.
North Carol.	AWP-5%	AWP-5%	None	Reimbursement of all medications, including those dispensed by a physician may not exceed 95% of the AWP of the original manufacturer's AWP, as determined by the original manufacturer's NDC number.
North Dakota	WAC+8% + $4	Lesser of MAC + 5% or WAC + 8% + $5	Compounds reimbursed by WSI at AWP-72%.	None
Ohio	State Fund = AWP-9% + $3.50 Self-Insured A = AWP-9% + $3.50	State Fund = AWP-9% + $3.50 Self-Insured A = AWP-9% + $3.50	Maximum reimbursement for compounds is $600, plus a $12.50 compounding fee.	For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.
Oklahoma	AWP-10% + $5	AWP-10% + $5	Reimbursement based on sum of all line-item listed ingredients, plus a single compounding fee.	Reimbursement based on original manufacturer's NDC, as supplied by the provider. At AWP-10%.
Oregon	AWP-16.5% + $2	AWP-16.5% + $2	None	Maximum 10 day supply for physician dispensed medications.
Pennsylvania	AWP+10%	AWP+10%	None	Outpatient providers, other than pharmacies, may not seek reimbursement for: C-II > 1 initial 7-day supply (15-day supply exception for medical procedure), any other Rx drug > 1 initial 30-day supply or an OTC.

Rhode Island	AWP-10%	AWP-10%	Compounds with repackaged NDCs must price according to the underlying original manufacturer's NDC/AWP.	Only reimbursable if medication dispensed by physician is an injectable.
South Carolina	AWP + $5	AWP + $5	Payment shall be based on the sum of the fee for each ingredient, plus a single dispensing fee of $5. If the NDC for any compounded ingredient is a repackaged medication NDC, reimbursement for the repackaged ingredient(s) is based on the original manufacturer's NDC.	Reimbursement for a drug that has been repackaged or relabeled shall be calculated by multiplying the number of units dispensed times the per-unit AWP set by the original manufacturer for the underlying drug, plus a $5 dispensing fee, except where the carrier has contracted for a different amount.
South Dakota	U & C	U & C	None	None
Tennessee	AWP + $5.10	AWP +$5.10	$25 limit on compounding fee.	Reimbursement based on original manufacturer's NDC, as supplied by the provider.
Texas	AWP+9% + $4	AWP+25% + $4	A single compound fee of $15 may be added to the retail reimbursement formulas.	Physician dispensing not permitted except in limited (rural) circumstances.
Utah	U & C	U & C	None	Physician dispensing not permitted.
Vermont	AWP + $3.15	AWP + $3.15	None	None
Virginia	No FS	No FS	None	None
Washington	Brand = AWP-10% + $4.50 Brand w/generic equivalent (DAW) = AWP-10% + $4.50	AWP-50%+ $4.50	Allowed cost of ingredients (+) $4.50 professional fee (+) $4 compounding time fee (per 15 minutes).	Effective 9/1/2012, the department will not pay for repackaged drugs.
West Virginia	U & C	U & C	None	None
Wisconsin	AWP + $3	AWP + $3	None	Dispensing fee applies only to pharmacists.
Wyoming	AWP-10% + $5	AWP-10% + $5	Limited dispensing of compounds (see rules for criteria).	Physicians billing for compounded drugs must provide the pharmacy invoice. The Division shall pay 130% of the supplier's/ manufacturer's invoice price.
Federal (OWCP)	AWP-15% + $4	AWP-30% + $4.00	None	None