ACO Pharmacy Program
Frequently Asked Questions

Please refer to the Fallon Health pharmacy website for the latest updates here:
https://fallonhealth.org/en/providers/pharmacy

How is a full uniform formulary going to differ from the current Fallon Health ACO formulary?
Prior to 4/1/23, Fallon Health followed a partial unified formulary with MassHealth covering roughly 33 therapeutic drug classes. As of 4/1/23, Fallon Health, along with all other Managed Care Organizations (MCO), is required to follow the MassHealth formulary in its entirety.

Does this change impact Medical benefit drugs (i.e., buy and bill) and Pharmacy benefit drugs?
Some drugs may be offered on both benefits, we will align with MassHealth for these drugs. Certain drugs only available on Medical benefit may have different coverage requirements than Pharmacy benefit requirements under MassHealth.

How do I access the MassHealth fully unified formulary?
Please visit Fallon Health's pharmacy website for latest updates. Our website will include a direct link to the MassHealth website--https://mhdl.pharmacy.services.conduent.com/MHDL/pubsearch.do?index=Z--for formulary listing, corresponding prior authorization criteria, and prior authorization forms. The formulary listing will also include drug notes such as, quantity limits or restrictions, age limits or restrictions, gender restrictions, dose restrictions, and/or polypharmacy restrictions, etc. Please note that Fallon Health's ACO formulary will no longer be published on our website after 4/1/23.

How often is the MassHealth fully unified formulary updated?
The formulary can be updated at any time and is dependent on instructions and requirements from MassHealth. Notification will be sent to our ACO partners as quickly as possible, including when the changes will occur, and if there is potential impact.

Who is Fallon Health's current pharmacy benefit manager?
Fallon Health collaborates with OptumRx (our pharmacy benefit manager) for drugs obtained at a pharmacy.

How do I request a prior authorization for a drug obtained at a pharmacy?
While the MassHealth fully unified formulary and PA forms are posted on the MassHealth website https://mhdl.pharmacy.services.conduent.com/MHDL/pubpa.do. OptumRx reviews pharmacy benefit drugs (drugs obtained at a pharmacy) for Fallon Health ACO members. All pharmacy benefit PA requests for Fallon Health ACO members must be submitted to OptumRx. Our process offers you multiple ways to submit a prior authorization request for patient self-administered drugs:

- Electronic prior authorization tools (ePA)
    - https://professionals.optumrx.com/prior-authorization.html
    - ePAs can be submitted through EMR systems that support Cover-My-Meds and SureScripts
- Call (1-844-720-0033) or fax (1-844-403-1029)

Once a prior authorization is submitted to OptumRx, how long does OptumRx have to make a determination?
Urgent requests and non-urgent requests will be completed within 24 hours of receiving all the necessary information to complete the request.

How do I verify if a pharmacy is in network?
For a detailed list of pharmacies and locations, go to the Pharmacy Finder Tool on our website and choose your plan, state, and pharmacy name:
https://fchp.org/Pharmacyfinder/

How do I find a compounding pharmacy in network?
For a detailed list of compounding pharmacies, go to Optum's website:
https://professionals.optumrx.com/content/dam/optum3/professional-optumrx/resources/PharmacyLocatorGuide.pdf

Where do I access the specialty drug list?
For a listing of specialty drugs, please visit our website:
https://fallonhealth.org/en/providers/pharmacy/specialty-pharmacy.

Are MassHealth ACO members allowed to receive a specialty drug at any in-network pharmacy before switching to a specialty pharmacy?
MassHealth ACO members are allowed one grace fill per drug at any in-network retail pharmacy. After the member obtains their one fill at any network retail pharmacy, they will receive a letter notifying them that they must switch to an in-network specialty pharmacy.

How do MassHealth ACO members get set up at a specialty pharmacy?
MassHealth ACO members can set up their accounts and providers can send in prescriptions to an in-network specialty pharmacy.

Are new MassHealth ACO members currently on drugs that require prior authorization or other UM management allowed a transition fill or continuity of care fill?
During a new MassHealth ACO member's initial 90 days of enrollment, Fallon Health will allow a temporary "transition fill" for a member's pre-existing medications that require prior authorization, quantity limit, or step therapy requirements. This allows the member to work with their provider to change to a drug on our formulary or to request a prior authorization. Members will receive a letter explaining the "transition fill" and actions they need to take.

Are new MassHealth ACO members allowed to use Out-of-Network pharmacies?
No, but during the initial 90 days of enrollment, Fallon Health allows a temporary transition fill if a member uses an out-of-network pharmacy. This allows the member to contact Customer Service using the phone number listed on the back of their member ID card to locate a pharmacy near them that is in our network and to have the prescription transferred. The member will receive a letter explaining the temporary transition fill and actions they need to take.

How much will prescriptions cost?
Most MassHealth ACO members must pay the following pharmacy copayments:

- $1 for certain covered generic drugs mainly used for diabetes, high blood pressure, and high cholesterol. These drugs are called antihyperglycemics (such as metformin), antihypertensives (such as lisinopril), and antihyperlipidemic (such as simvastatin)
- $3.65 for certain over-the-counter (OTC) drugs for which there is a prescription from the doctor
- $3.65 for both first-time prescriptions and refills for certain covered generic and OTC drugs
- $3.65 for both first-time prescriptions and refills of covered brand-name drugs

Are there preventive prescriptions covered at no cost?
Yes, the following categories are considered preventive and are $0 copayment:

- Aspirin preventive medication: cardiovascular risk & Preeclampsia prevention
- Breast cancer preventive medication
- Colorectal cancer screening
- Folic acid supplementation
- HIV prevention
- Statin preventive medication
- Substance abuse disorder
- Tobacco use counseling and interventions: nonpregnant adults
- Vaccines

Drugs that fall into these categories will be represented as preventive on drug list and will designated $0 copayment.

What is the Brand Name Preferred Over Generic Drug List?
It is a list of brand name drugs that MassHealth and Fallon Health prefer over their generic equivalents. In general, MassHealth and Fallon Health require a trial of the preferred brand drug or clinical rationale for prescribing the non-preferred drug generic equivalent. Brand Preferred Drugs are available on the MassHealth website.
https://mhdl.pharmacy.services.conduent.com/MHDL/The MassHealth drug list uses “BP” to identify brand preferred products.

What is the Over-the-Counter Drug List?
It is a list of the only over-the-counter drugs that are covered. (*Note, the OTC list does not include insulins*). This list can be found on MassHealth’s website, https://mhdl.pharmacy.services.conduent.com/MHDL/.

What is the Non-Drug Product List?
It is a list of non-drug products that are covered through a MassHealth ACO member’s pharmacy benefit at an in-network pharmacy. This list can be found on MassHealth’s website, https://mhdl.pharmacy.services.conduent.com/MHDL/.

What is the 90-day Supply Medication Initiative?
The 90-Day Supply Medication Initiative includes mandatory and allowable dispensing of certain medications. Effective 4/1/23, certain generic drugs and other low-net-cost drugs, designated with M90 on the formulary, will be mandated to a 90-day supply after an initial fill of medication. Medications designated with M90 are typically maintenance medications. Mandatory dispensing in a 90-day supply may not apply to all formulations of a drug, and certain other restrictions including but not limited to Prior Authorization (PA) requirements and quantity limits may apply.

In general, generic formulation will be required unless a particular form of the drug (for example, specific strength or formulation) does not have a generic equivalent, or the drug is listed on the Brand Name Preferred Over Generic Drug List, in which case the brand name drug may be dispensed. Where applicable, due to package size, allowances may be made for dispensing greater or less than exactly a 90-day supply of medication. The 90-Day Supply mandate may apply to medications not listed on the MassHealth Drug List. This requirement does not apply to drugs dispensed to members in certain long term care facilities, hospices, and group homes, or as specified by law or regulation.

Certain generic drugs and other low-net-cost drugs, designated with A90 on the formulary, may be allowed to be dispensed in up to a 90-day supply. Allowed dispensing in a 90-day supply may not apply to all formulations of a drug, and certain other restrictions including but not limited to PA requirements and quantity limits may apply. In general, the generic formulation will be required unless the drug is listed on the Brand Name Preferred Over Generic Drug List, in which case the brand name drug may be allowed.

In addition, medications not designated with A90 or M90 will be excluded from dispensing in a 90-day supply. Examples of medications and medication formulations that are excluded from dispensing in a 90-day supply include, but are not limited to, health care professional administered drugs, hospital outpatient administered drugs, injectable formulations, and Prescription Monitoring Program (PMP) designated agents. Medication status denoted as mandatory 90-day dispensing, allowed 90-day dispensing, or excluded from 90-day dispensing may be updated often and is subject to change at any time.

What is the Pediatric Behavioral Health Medication Initiative?
The Pediatric Behavioral Health Medication Initiative was created to ensure safe and effective prescribing of behavioral health medications for members who are less than 18 years of age. As part of the initiative, the following situations will require a prior authorization:

1. **Behavioral health medication polypharmacy:** pharmacy claims for any combination of four or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotic agents, and mood stabilizers) within a 60-day period for members less than 18 years of age.
2. **Antipsychotic polypharmacy:** overlapping pharmacy claims for two or more antipsychotics for at least 60 days within a 90-day period for members less than 18 years of age.
3. **Antidepressant polypharmacy:** overlapping pharmacy claims for two or more antidepressants for at least 60 days within a 90-day period for members less than 18 years of age.
4. **Cerebral stimulant polypharmacy:** overlapping pharmacy claims for two or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for at least 60 days within a 90-day period for members less than 18 years of age.
5. **Benzodiazepine polypharmacy:** overlapping pharmacy claims for two or more benzodiazepines for at least 60 days within a 90-day period for members less than 18 years of age.
6. **Mood stabilizer polypharmacy:** overlapping pharmacy claims for three or more mood stabilizers for at least 60 days within a 90-day period for members less than 18 years of age.

7. Any pharmacy claims for an antidepressant, antipsychotic, atomoxetine, benzodiazepine, buspirone, hypnotic or hypnotic benzodiazepine, or mood stabilizer for members less than six years of age.
8. Any pharmacy claims for an alpha2 agonist or cerebral stimulant for members less than three years of age.

What is a Silent Auth rule?
A clinical rule that permits the drug to be considered payable at the pharmacy, if a MassHealth ACO member meets clinical rule, the prescription can be filled without the prescriber needing to submit a prior authorization request.

Where can providers access additional news and announcements from Fallon Health?
Fallon Health has a news and announcement page on our provider website. This page includes our Connections newsletter and includes a section for updates specific to pharmacy. https://fallonhealth.org/providers/announcements.aspx

Where can pharmacists access MassHealth's Pharmacy Facts?
Pharmacists can access current and recent information about the MassHealth Pharmacy Program on MassHealth's pharmacy facts website. https://www.mass.gov/lists/masshealth-pharmacy-facts-2016-current

Fallon Health Medical Drug Program

Fallon Health collaborates with MagellanRx to manage our outpatient medical drug prior authorizations and post service claim editing (PSCE).

Where do providers access the Medical Benefit Formulary?
Fallon Health's Medical Benefit Formulary is listed on our website at https://fallonhealth.org/providers/pharmacy/online-drug-formulary. When choosing a formulary from the drop-down menu, select "**Medical Benefit Formulary"**. Our medical benefit formulary also displays drugs which require prior authorization criteria or drugs subject to PSCE. The list of medications included in the Medical Pharmacy Program is updated at least annually and as new drugs come to market.

What is a Post Service Claim Edit?
Fallon Health limits coverage of certain drugs to appropriate ICD-10 codes and other required information submitted on the claim. Drugs that have a post service claim edit will be flagged within our medical benefit formulary. There is also a link to our current Drugs and Biologicals Payment Policy; Payment Rules for Post-Service Claim Edit Drugs. For payment, providers must submit a covered ICD-10 code, NDC, and not exceed the dosage limits listed on the Biologicals Payment Policy.
https://fm.formularynavigator.com/FormularyNavigator/DocumentManager/Download?clientDocumentId=q0rFBp8AKkCU0tq0MP4Vhw

At which places of service (POS) does prior authorization apply?
Prior authorizations are required for medications administered at the following places of service:

- Physician Office (POS 11)
- Outpatient Facility (POS 19, 22)
- In Home (POS 12)

Prior authorization by Magellan Rx for the medications included in this program will not be required when those medications are administered during an inpatient stay, in an emergency room or in an observation room setting.

How do providers request a prior authorization or re-authorization of a Medical Benefit drug?
Fallon Health collaborates with MagellanRX for medical benefit prior authorizations. Authorizations can be sent through the MagellanRx Provider portal (**see below**), or requests can be made by calling Magellan Rx at 1-800-424-1740, Monday through Friday, 8 a.m. to 6 p.m. EST for all authorization requests, including urgent requests, or by faxing to 1-888-656-6671. If the provider is contracted directly with Fallon Health, non-urgent authorizations can also be done through Magellan Rx's secure website at mrxgateway.com. Click on the Providers and Physicians icon to access your provider account page.

To expedite prior authorizations, the provider should have the following information:

- Member name, date of birth and ID number
- Health plan name (Fallon Health)
- Member height and weight
- Ordering provider name, tax ID number, address, and office telephone and fax numbers

- Rendering provider name, tax ID number, address, and office telephone and fax numbers (if different from ordering provider)
- Requested drug name or HCPCS code
- Anticipated start date of treatment
- Dosing information and frequency
- Diagnosis (ICD-10 code)
- Any additional clinical information pertinent to the request
- If requested by Magellan Rx, you should be prepared to upload the following documents to the Magellan provider portal, or to fax the following documents to Magellan Rx's HIPAA-compliant fax:
- Clinical notes
- Pathology reports
- Relevant lab test results

Please note: It is the responsibility of the ordering provider to obtain prior authorization before services are provided. If the ordering provider and the rendering provider are different, the rendering provider is responsible for ensuring that the appropriate approval is on file prior to rendering services.

Magellan Rx online portal

How does a provider obtain a user ID and password for the Magellan Rx website?

Providers directly contracted with Fallon can have the practice administrator request a unique username and password for the Magellan Rx provider portal. To do so, visit Magellan Rx's website at ih.magellanrx.com and complete the following steps:

1. Click on the New Access Request – Provider link on the right side of the home page under Quick Links.
2. Select Contact Us and complete the required fields indicated with a red asterisk (*) and click Send.

Please have the following information ready:

- Requestor's name, email address and phone number
- Health plan name (Fallon Health)
- Provider, facility, or group name
- Provider, facility, or group service address
- Tax ID number
- Office administrator name (the person responsible for maintaining the list of staff authorized to access the Magellan Rx provider portal on behalf of the practice)

Please allow up to two business days for information regarding your user access to be sent to you by email. The practice administrator will then be able to set up a user name for each individual in the practice authorized to access the Magellan Rx website.

Whom do I contact if one of the providers in our practice is not listed on Magellan Rx's website?

- You can send a secure message to Magellan Rx through the provider portal if the provider is directly contracted with Fallon.
- If it is an urgent request, you can call Magellan Rx at 1-800-424-1740.

If all the providers in a practice share a tax ID number (TIN), is more than one user ID and password needed to manage each clinician separately?
No. MRx Provider Portal users linked to the practice TIN will be able to conduct transactions for every network provider linked to the practice TIN.

What if Magellan Rx does not have all the necessary information to make a determination on a prior authorization request?
If Magellan Rx does not have the necessary information to make a determination, the request will be pended for clinical review and the provider will be given a tracking number.

How are urgent requests handled?
Urgent requests will be addressed as a top priority and completed within 24 hours of receiving all the necessary information to complete the request. Magellan Rx's website cannot be used for urgent or retrospective approval requests. Therefore, these requests must be processed directly through the Magellan Rx call center at 1-800-424-1740. The review and determination process may take longer if member or provider eligibility verification is required, or if the request requires additional clinical review.

How are routine (non-urgent) requests handled?
Non-urgent requests will be completed within 24 hours of receiving all the necessary information to complete the request. In most cases, Magellan Rx can review and determine prior authorizations during the initial request if all the information needed to process a request is provided. Contracted providers should utilize the Magellan Rx's secure website at mrxgateway.com to submit standard requests The review and determination process may take longer if member or provider eligibility verification is required, or if the request requires additional clinical review.

Once prior authorization is given, can a request be made to change the dose or frequency before the approval duration has expired?
After an approval is generated, a change in dose and/or frequency may be requested via phone at 1-800-424-1740. The clinical staff will review the request and render a decision.

Can the length of the prior authorization be negotiated or is it predetermined?
The approval duration or validity period of a prior authorization is dependent on the medication and is not negotiable. Because existing conditions, such as lab values and chemotherapy regimens, can change more frequently, the validity period for supportive medications will be shorter, depending on the class of medications.

Can one prior authorization include multiple medications? Or will the provider have to obtain a prior authorization for each medication?
There is one prior authorization number per medication. However, Magellan Rx can process multiple requests during the same web session or telephone call.

Fallon Health Member Appeals and Grievance Information

What is an appeal?
An **appeal** is a request to change an adverse determination made by Fallon Health. An adverse determination means that Fallon Health has made a decision, based on the review of information provided to us that denies, reduces, modifies or terminates coverage for health care services. This includes--but is not limited to--cases where the treatment does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

What is a grievance?
A **grievance** is the type of complaint you make if you have any other type of problem with the plan or one of our plan providers. You would file a grievance if you have a problem with things such as the quality of the care or service you received.

How can I file an appeal or grievance?

- Write:
  - Fallon Health Member Appeals and Grievances Department
    10 Chestnut St.
    Worcester, MA 01608
- Call:
  - 1-800-333-2535, ext 69950 (TRS 711).
  - Monday through Friday, 8 a.m. to 5 p.m.
- Email:
  - grievance@fallonhealth.org
- Fax:
  - 1-508-755-7393
- In Person:
  - Fallon Health. Member Appeals and Grievances Department
    10 Chestnut St.
    Worcester, MA 01608

Who can file a member appeal or grievance?
You may file the appeal or grievance yourself, or with the completion of the personal representative authorization form or other legal document, you may have someone else (such as a family member, friend, physician/practitioner) do this for you. The personal representative authorization form is available online at fallonhealth.org, or by calling our Customer Service Department at the number below. You must file your appeal/grievance within 180 calendar days of initial notification of the denial.

For more information about your appeal and grievance rights, see your *Member Handbook/Evidence of Coverage*, or call us at 1-800-868-5200 (TRS 711), Monday, Tuesday, Thursday and Friday from 8 a.m. to 6 p.m. and Wednesday from 10 a.m. to 6 p.m.
Para obtener asistencia en Español, llame al 1-800-868-5200.

Fallon Health Provider Appeals Information

How do providers appeal a claim?
If you do not agree with a determination made by Fallon Health, you may have the right to appeal. All requests for appeals related to late submission, lack of medical necessity or preauthorization issues must be submitted within 120 days from the original date of the Remittance Advice Summary of initial denial. All requests must be submitted in writing using the Request for Claim Review form and include all pertinent information to substantiate your request. The form and supporting information may be faxed to the provider appeals coordinator at 1-508-368-9890 or mailed to:

Fallon Health
Attn: Request for Claim Review/Provider Appeals
PO Box 211308
Eagan, MN 55121-2908

All appeal determinations will be final and binding in keeping with the provisions of your contract with Fallon Health or PHCS.