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DENNIS G. TRAINOR
Assistant to the Vice President

TO: **Verizon NY & NE Local Presidents**

FROM: **Dennis G. Trainor, Assistant to the Vice President**

Date: **February 26, 2013**

RE: **Request for Coverage Review - Brand/generic copay difference due to clinical reasons**

As per the 2012 MOU, if a member purchases a brand name drug when a generic is available, our member will pay an amount equal to the Discounted Network Price "DNP" up to a maximum of $8 in 2013 and $9 in 2015 plus 100% of the cost difference between the brand name and the generic drug. If the member or one of their dependents treating physician certifies that they are medically unable to take the generic medication and **such exception is approved by the TPA's procedures for approval of treatment or services then the single source and multi-source coverage will apply.**

Our Members and their dependents who are medically unable to take a generic drug will need to have their physician file the proper paperwork.

Our members or their physician will need to contact Express Scripts Call Center with a Coverage Review for the brand/generic copay difference due to clinical reasons. Express Scripts will advise that this can be done through one of two ways:

- the prescriber (physician) faxing the required information to 888-235-8551 (Express Script's preferred method), or
- the prescriber (physician) calling 800-946-3979.

The request will be directed to Express Script's Benefit Coverage Review team. This is a specialist unit within the Coverage Review Department handling administrative cases.

If a member calls with this request, the Benefit Coverage Review team will build a case and then fax the prescriber a form. The form will be pre-populated with the member's

information and case number captured as a barcode so that when it is returned it is automatically attached to the case and routed to the Benefit Coverage Review team for review.

If a prescriber (physician) calls, the Benefit Coverage Review Team will try to complete the case while on the call. If the prescriber (physician) asks for a form, they will be sent the form pre-populated with the member's information and any information gathered during the call together with the case number as the barcode.

If the prescriber (physician) faxes Express Scripts directly without receiving the pre-populated form, the team will try to complete the case with the supplied information. If the prescriber has not provided sufficient information for Express Scripts to render a decision, a specialist will fax the doctor the form pre-populated with the member's information and any information gathered from the initial fax that was received.

Again, members should be directed to call Express Scripts to ask for a **Coverage Review for the brand/generic copay difference**. The form sent out by the Benefit Coverage Review team to the prescriber (physician) will have the variable fields completed and the fax bar-coded with the case reference. The barcode ensures the fax ends up in the right group (Coverage Review Department) and attached to the right case.

The member will be notified of an approval of the review process via outbound call or, if Express Scripts is unable to contact the member by phone, approval notification will be sent via mail. Denial decisions are sent in writing and include instructions on how to appeal. Prescribers (physicians) are notified of decisions via fax.

A member will only have to do this review once for each prescribed drug. Once it is approved then going forward the single source and Multi-source coverage will apply.

If you should have any questions, please do not hesitate to call