Pharmacy Benefits Manager

CVS Caremark, is MVP's pharmacy benefit manager (PBM) for all retail and mail order prescriptions. This applies to all MVP products that offer prescription drug coverage. The CVS Mail Order Pharmacy, part of the CVS Caremark family of pharmacies, is the mail order pharmacy vendor MVP uses to fill prescriptions for maintenance medications for MVP products that have a mail order benefit.

Prescription Drug Benefits

MVP offers multiple different prescription drug benefit options. The CVS Caremark claims system is configured to adjudicate these different benefits as well as program-mandated prescription drug coverage. Most drug plans have prior authorization, step therapy, or quantity limit requirements on select medications. Refer to the MVP formularies on the website for a complete list of drugs that are subject to pharmacy management programs.

Pharmacy and Therapeutics (P&T) Committee

MVP's P&T Committee is comprised of physicians from multiple specialties and primary care, practicing pharmacists, and MVP staff. The committee uses utilization, pharmacoeconomic, and clinical information to develop drug inclusion/exclusion criteria. Each new drug* requires prior authorization for at least six months. For the Medicare Part D formulary, new drugs may be excluded until the next benefit year. The P&T Committee evaluates the value of adding or excluding a new drug to the formulary based upon whether or not the new drug offers significant clinical and therapeutic advantages over current formulary drugs. The committee also designates in which coverage tier a specific drug is placed and reviews all policies and drug classes at least annually.

Commercial Prescription Drug Formulary

The MVP Commercial formulary applies to members with employer-sponsored large group or select self-funded [ASO] prescription drug coverage, and children covered under the Child Health Plus plan (CHP).

The formulary is a guide to use when prescribing medications for members. The drugs listed on the formulary are intended to provide sufficient therapeutic options for most situations. The formulary is available in several formats:

- The most current printed version is available on the MVP website at **www.mvphealthcare.com**.
- Periodic updates are published in the *Healthy Practices* newsletter and/or sent to provider offices via FastFax. Updates also can be found on the MVP website.

The formulary is divided into three tiers:

- Tier 1 generally includes preferred generic drugs.
- Tier 2 includes covered brand name drugs chosen for their overall value.
- Tier 3 includes all other covered prescription drugs and all new drugs* that are under review.
    - Tier 3 is non-formulary for CHP and requires prior authorization for coverage.

The Federal Employee Health Benefits (FEHB) Program is divided into four tiers:

- Tier 1 includes most generic drugs
- Tier 2 includes preferred brand name drugs, select high cost generic drugs and preferred specialty drugs
- Tier 3 includes non-preferred brand name drugs
- Tier 4 includes non-preferred specialty drugs

*A "new drug" is defined as a new molecular entity or biosimilar; a new route of administration; a new dosage form, formulation, or delivery system; a combination of currently approved drugs; a drug with potential safety and/or efficacy issues; and a drug that has the potential for inappropriate utilization.

MVP Marketplace Prescription Drug Formulary

The MVP Marketplace formulary applies to members with employer-sponsored small group or individual-purchased through MVP or the state Exchange, or Essential Health Plan prescription drug coverage.

The formulary is a guide to use when prescribing medications for members. The drugs listed on the formulary are intended to provide sufficient therapeutic options for most situations. The formulary is available in several formats:

- The most current printed version is available at **mvphealthcare.com**.
- Periodic updates are published in the *Healthy Practices* newsletter and/or sent to provider offices via FastFax. Updates also can be found on the MVP website.

The formulary is divided into three tiers:

- Tier 1 generally includes preferred generic drugs.
- Tier 2 includes covered non-preferred generics and brand name drugs chosen for their overall value.
- Tier 3 includes all other covered prescription drugs and all new drugs* that are under review.

Members in select Essential Health Plan pharmacy benefits may have coverage of some over-the-counter medications.

*A "new drug" is defined as a new molecular entity or biosimilar; a new route of administration; a new dosage form, formulation, or delivery system; a combination of currently approved drugs; a drug with potential safety and/or efficacy issues; and a drug that has the potential for inappropriate utilization.

MVP Medicaid Prescription Drug Formulary

This Formulary is a guide to use when prescribing medications for MVP Medicaid members. This formulary promotes the use of generic medications. The formulary is available in several formats:

- The printed version is available on the MVP website **www.mvphealthcare.com/ provider/pharmacy.html**.
- Periodic updates are published in the *Healthy Practices* newsletter and/or sent to provider offices via FastFax. These updates also can be found on the website.

The MVP Medicaid formulary is divided into two tiers:

- Tier 1 includes all generic medications.
- Tier 2 includes formulary brand medications selected for their overall value.

Non-formulary drugs require prior authorization from MVP. Some drug classes such as erectile dysfunction drugs, weight loss drugs, drugs used to treat infertility, cough and cold products, cosmetic, marked "sample" or "not for sale", DESI drugs, non-FDA approved drugs (NDA/ANDA/BLA), used for radiological testing, packaged in unit dose when bulk packaging is available, regularly supplied to public free of charge, and viscosupplementation products are excluded from coverage. Drugs (legend and OTC) and supplies which are not covered under the NYS Medicaid Formulary are not covered.

- Atypical antipsychotics, antidepressants, anti-rejection, anti-retroviral, select endocrine (including but not limited to growth hormone, diabetic drugs and insulin and pancreatic enzymes), hematological, multiple sclerosis and anti-seizure agents will be subject to Prescriber Prevails provisions. This enables the prescriber's reasonable professional judgment to prevail in the prior authorization process for atypical antipsychotics. When the plan is unable to complete a prior authorization due to missing information or because the prescriber's reasonable professional judgment has not been adequately demonstrated, either by consistency with FDA approved labeling or use supported in at least one of the Official Compendia as defined in federal law under the Social Security Act section 1927 (g)(1)(B)(i), the plan will issue a Notice of Action to the provider and member.

The MVP Medicaid benefit includes coverage for select over-the-counter medications, diabetic supplies, enteral products and some medical supplies. Coverage is limited to a 30-day supply of medications at a participating retail pharmacy. Mail order is not a covered benefit. Specialty medications may be obtained from CVS Specialty Pharmacy, MVP's specialty pharmacy vendor, or a contracted specialty retail pharmacy.

The formulary exception and prior authorization process are the same as for Commercial, Marketplace, and Medicaid members. Prescribing practitioners should use existing MVP prior authorization forms found on our website.

All prior authorization and formulary exception requests for MVP Medicaid members can also be submitted on the Medicaid standardized prior authorization form. This form can be found on our website at https://www.mvphealthcare.com/providers/forms

Formulary Indicators^

- **Mail** – Those medications listed with an asterisk (*) are available via mail order.
- **Step Therapy (st)** – Certain drugs requiring prior authorization have a step therapy edit in place to systematically allow a claim to process if certain criteria are met. These edits are supported by MVP benefit interpretations that are available in the MVP's Provider Portal. Prior authorization is required if step therapy edits are not met. Step therapy clinical reviews will use recognized evidenced-based and peer-reviewed clinical review criteria that is appropriate for the medical condition.
- **Prior authorization (#)** – Requests for drugs requiring a prior authorization must be submitted through the Pharmacy Department using the Medication Prior Authorization Request form and faxing it to **1-800-376-6373** for commercial, Marketplace and Medicaid members. Benefit interpretations containing applicable prior authorization criteria are available from MVP and are available in the MVP Provider Portal.

- **Quantity Limit (q)** – Certain drugs have quantity limitations or durations. Benefit interpretations containing the applicable prior authorization criteria are available from MVP.
- **Specialty Medications (+)** – Certain drugs must be obtained from the MVP specialty pharmacy vendor or contracted specialty pharmacy
- **Medical (M)** – A prescription drug rider is not required for coverage. If provider does not buy and bill, drug must be obtained from CVS Specialty or other contracted Specialty provider.
- **Excluded Drug (EX)** – Excluded drug; medical exception approval required

^ The above indicators are common across multiple formularies. Each formulary may also contain additional indicators. Please refer to the descriptions noted within the formulary for additional information.

Prescription Drug Formulary – Medicare Part D

There are two MVP Medicare Part D formularies which apply to all members with Part D prescription drug coverage. There is a formulary for Medicare Advantage plans with coverage through a former employer and a formulary for Individual Medicare Advantage Plans (plans purchased directly by the member). The Part D formularies are a guide to use when prescribing medications for members. The drugs listed in the formularies are intended to provide sufficient therapeutic options for most situations. The formularies are available in several formats:

- The printed version is available at **mvphealthcare.com/medicare**.
- Periodic updates are published in the *Healthy Practices* newsletter and/or sent to provider offices via FastFax. These updates also can be found on the website.

The Part D formulary is divided into five tiers:

- Tier 1 includes select generic drugs for diabetes, blood pressure control, bone health, heartburn, and ulcers. The drugs in Tier 1 are provided at little to no cost.
- Tier 2 includes non-preferred generic drugs.
- Tier 3 includes non-preferred generics and preferred brand drugs that have the lowest cost share for brand name drugs.
- Tier 4 includes non-preferred brand name and non-preferred generic drugs. In addition, Part D drugs excluded from the formulary must go through an exception process in order for MVP to cover them. If they are approved, they will be covered in Tier 4.
- Tier 5 (Specialty tier) includes most drugs (brand name and generic) that cost $670 or more for a 30-day supply. All drugs in this tier are restricted to a 30-day supply at retail and are excluded from the mail order program.

The Medicare Part D formularies exclude most new drugs and most drugs with a generic equivalent (as determined by the FDA). These drugs may be obtained through the Formulary Exception Procedure (see below). Medicare regulations also require that certain drug classes not be covered: DESI drugs, unapproved drugs (approved NDA/ANDA/BLA), drugs used to treat sexual dysfunction (including erectile dysfunction), and drugs used to promote weight gain or loss. Brand name drugs manufactured by companies that did not sign the Medicare Coverage Gap agreement are not eligible to participate in the Medicare Part D program. Some enhanced Part D riders may include coverage of Medicare Part D

excluded drugs, including drugs for weight loss or weight gain, or erectile dysfunction medications. Prior authorization criteria and quantity limits for these medications follow the Commercial pharmacy policies.

Members and providers may view MVP's Medicare Part D Pharmacy Management programs on the MVP website at https://content.mvphealthcare.com/medicare/index.html. Requests for Prior Authorization and Formulary Exceptions should be submitted using the MVP Prior Authorization form or the Medicare Part D Coverage Determination form and faxing the completed form, including the physician supporting statements, to 800-401-0915.

Formulary (Medicare Part D) Indicators

- **Prior Authorization (PA)** – MVP requires prior authorization for certain drugs.
- **Quantity Limits (QL)** – For certain drugs, MVP limits the amount of the drug that we will cover. For example, MVP covers one tablet per day for Linzess®. This limit may be applied to a standard one-month or three-month supply.
- **Step Therapy (ST)** – In some cases, MVP requires certain drugs to treat a medical condition to be tried before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, MVP may not cover drug B unless Drug A is tried first. If Drug A does not work, MVP will then cover Drug B.
- **Dispensing Limits (DL)** – Certain drugs are limited to a 30-day supply through a retail pharmacy and are not available through the mail order pharmacy.
- **Limited Availability (LA)** – Some medications are available only through a designated Specialty Pharmacy because of manufacturer limited distribution.
- **Part B versus Part D drug coverage (B/D)** – Some drugs could be covered under the Part B or Part D benefit, depending on the specific member situation. This means that a request must be submitted to MVP to determine, based on Medicare guidelines, if the drug will be covered as Part B or Part D.
- **Not available at mail-order (NM)** – Certain drugs are not available through the mail order pharmacy.

Medicare Medical Injectables and Vaccines

Most injectable medications, including all vaccines (**except Part D vaccines for Medicare members), administered in a providers office must be obtained by the provider and billed to MVP on the appropriate billing code (i.e. J-code), unless otherwise specified. Office-administered injectable medications should not be purchased at the retail pharmacy by the member and transported back to the office these medications are not covered under the member's prescription drug benefit when obtained at a retail pharmacy. Physician-administered injectables may be covered under the member's Medicare Part B benefit and applicable coinsurance. Review the Medicare Part D formulary at **www.mvphealthcare.com** which includes injectable medications that may be covered under the Medicare Part D benefit. Most home infusion medications are covered under the Medicare Part D benefit and billed to the PBM.

****For Medicare members**: All commercially-available vaccines will be covered under the Part D pharmacy benefit only (unless excluded as a Part B benefit, such as pneumococcal and influenza vaccines). This also includes the administration fees associated with the vaccinations. **All Part D vaccines and vaccine administration fees must be billed through CVS Caremark.** Since physician offices may not be able to bill CVS Caremark directly, Medicare members with a Part D rider may need to pay the provider for the vaccine and administration fee and then submit a reimbursement claim directly to CVS Caremark. Members will be reimbursed the negotiated rate minus their applicable copayment for these vaccines. Reimbursement forms are available at **www.mvphealthcare.com**. Providers now have an online option for processing Medicare Part D vaccine claims electronically. **TransactRx Part D Vaccine Manager**, a product of Dispensing Solutions Inc., provides physicians with real time claims processing for in-office administered vaccines. This new online resource helps to reduce the current challenges in providing Medicare Part D vaccines and vaccine administration reimbursement to our members. Enrollment in TransactRx is available at no cost to providers. Simply complete the one- time online enrollment process at https://www.mytransactrx.com/ws_enroll/

For questions related to enrollment or claims processing, contact Vaccine Manager Support at **1-866-522-3386**.

When to Contact MVP's Pharmacy Department

The following are examples of when to contact the Pharmacy Department under either urgent or routine circumstances:

- Medications requiring prior authorization (including medical drugs listed on the formulary)
- Medications that are not on the formulary, on MVP's excluded drug list, or when requesting coverage of a non-formulary drug when the member has a two-tier prescription drug benefit*.
- Medications subject to step therapy when criteria are not systematically met.
- Medications that are subject to quantity limitations or durations.
- Member with an existing authorization and changes to a different MVP benefit will require a new authorization (e.g. Essential Health Plan to Medicaid, Commercial to Medicare, etc.)

*For members with a two-tier prescription drug benefit (MVP Medicaid or MVP Child Health Plus), a prior authorization for non-formulary agents will be considered in accordance with criteria listed in the Formulary Exception Policy and noted below. The form must be completed and the request approved before the member fills the prescription at the pharmacy. Medicare members requesting a formulary exception request for non-formulary drugs or drugs with a quantity limit will follow the Medicare Formulary Exception process.

Incomplete information on the request may result in a decision delay or denials. The provider must fax the completed form to the appropriate fax number listed on the form. Forms must include the signature of the prescriber or an attestation from the prescriber attesting that the information on the submitted form is complete, accurate, and available for review if requested. All urgent requests must be marked "Urgent" at the top of the form. The turn-around time for urgent requests is typically 1 business day from MVP's receipt of the request; and 3 business days for non-urgent requests. Medicaid retail pharmacy requests are reviewed within 24 hours of receipt of the request. See Coverage Determination for Medicare Members below for the applicable Medicare Part D timeframes. For NY Commercial, NY Marketplace: a Step Therapy protocol determination will be made within 24 hours (urgent) or 72 hours

(standard) of the receipt of a supporting rationale and documentation. Marketplace requests for non-formulary drugs: a determination will be made within 24 hours (urgent) or 72 hours (standard) of the receipt of a supporting rationale and documentation.

Only the prescriber responsible for the treatment and evaluation of the member, an authorized agent, member or member's authorized representative may initiate a prior authorization or coverage determination. An authorized agent is someone who is an employee of the prescribing practitioner and has access to the member's medical records (e.g. nurse, medical assistant, etc.). An authorized representative is someone who has been designated by the member to represent them for a specific healthcare decision via a Power of Attorney (POA) or Authorization of Representation (AOR) form. Pharmacists, pharmacies, third-party vendors, or other patient advocacy personnel are not eligible to initiate a prior authorization or coverage determination. Requests from these providers will not be accepted or acknowledged as received. Prescribers excluded by CMS, OIG, OMIG or other regulatory entity will be deemed "excluded" and prescriptions will reject at the PBM.

No payment will be made for prescriptions filled or services rendered prior to the approval of a Prior Authorization request. Members may be allowed a 72-hour emergency supply of medication while awaiting review for a Prior Authorization or Formulary Exception request.

For information on lost/stolen/damaged medications and vacation overrides, please refer to the Pharmacy Programs Management Policy.

Pharmacy Forms

All pharmacy-related prior authorization forms are available at **www.mvphealthcare.com** on the Provider page under Forms. Forms should be faxed to the phone number on the bottom of each form.

Formulary Exception Process

There may be occasions when a non-formulary medication is medically necessary. In such cases, the appropriate medication may be obtained through the MVP Formulary Exception Process as follows:

1. The provider completes the *Prior Authorization Request Form for Medication* before the member fills the prescription at the pharmacy.
2. The provider faxes the completed form and all necessary clinical documentation to support the medical necessity for the exception to the appropriate fax number listed on the form. A letter containing the decision to approve/deny the request is sent to the provider and the member, preceded by a phone call. Although circumstances may vary, reasons for approving an exception may include documented:
    - allergic/adverse reaction to all formulary agents
    - therapeutic failure of all clinically appropriate formulary agents
    - patient therapy stability issues where a formulary agent is contraindicated or a change in therapy is inadvisable
    - patient-specific contraindication or reason formulary agents are inappropriate
    - policy and/or benefit interpretation
    - member contract and/or prescription drug rider
3. "Sample" use alone does not satisfy criteria.

Step Therapy Program (NY Commercial, NY Exchange and NY Medicaid)

Prior authorization requests for drugs requiring Step Therapy will use recognized evidenced-based and peer-reviewed clinical review criteria that is appropriate for the medical condition of the member.

Supporting rationale and documentation: A step therapy protocol override prior authorization request will be granted when it includes supporting rationale and documentation from a requesting health care professional, demonstrating that:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the member;
- The required prescription drug is expected to be ineffective based on the member's known clinical history, condition, and prescription drug regimen;
- The member has tried the required prescription drug while covered by MVP, or under previous health insurance coverage, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- The member is stable on a prescription drug selected by the requesting health care professional for the medical condition, unless the required prescription drug is an AB-rated generic equivalent; or
- The required prescription drug is not in the member's best interest because it will likely cause a significant barrier to adherence to or compliance with the member's plan of care, will likely worsen a comorbid condition, or will likely decrease the member's ability to achieve or maintain reasonable functional ability in performing daily activities.

Coverage Determination Procedure for Medicare Members

Coverage determination requests may be submitted on one of the MVP Prior Authorization Request forms or by using the Medicare Part D Coverage Determination Request form and faxed to **1-800-401-0915** or submitted via the online Medicare Coverage Determination form. Coverage determinations are requests required for:

- drugs that require Prior authorization
- drugs subject to Step Therapy
- Part D drugs that are excluded from the formulary
- quantity limits that are in excess of the formulary allowed amount
- tier exceptions (requests to cover a drug at a lower tier copay then what is listed on the formulary)

Coverage determination requests for drugs that require prior authorization or step therapy will be reviewed and a decision made within 72 hours of the receipt of the request unless the request is marked "URGENT," in which case the request will be reviewed and a decision made within 24 hours. Coverage determination requests to cover an excluded Part D drug, a quantity that exceeds the allowed amount, or a request to cover a drug at a lower-tier copay must be accompanied by a supporting statement from the prescriber. Requests submitted without the supporting statement will be pended for

a decision until the information is received but no longer than 7 days from the receipt of the request. Supporting statements may include:

- Rationale why all other drugs included on the formulary have not been or would not be as effective, or would cause adverse effects compared to the non-formulary (higher tier) drug, formulary excluded drug, or drug requiring step therapy. (Tier exceptions to generics only cost share tier and drugs within the specialty tier to a lower cost share tier are excluded. Approved formulary exceptions are also exempt from tier exceptions.)

- The number of doses available has not been effective, would likely not be effective, or would adversely affect the drug's effectiveness.

Mail Order Pharmacy

MVP members (excluding MVP Medicaid, MVP Child Health Plus, some MVP Marketplace and Essential Health Plan, and some MVP Select Care [ASO] members) may use the mail service option when filling prescriptions. Mail service includes home delivery of medications. In most cases, there are member copayment savings by ordering a 90-day supply. When prescribing a drug eligible for the mail order program for the initial order, the MVP member may ask the provider to send two electronic prescriptions. One is for up to 30 days to be filled at a local pharmacy. The other can last up to 90 days, with refills for up to one year, and can be filled through the CVS Health Mail Order Pharmacy, part of the CVS Health family of pharmacies. MVP recommends that an order be placed two to three weeks before medications are needed to save on rush delivery charges and avoid possible problems if the shipment is delayed. Not all prescription drugs are eligible to be filled through the Mail Order Pharmacy. Please refer to the MVP formularies to determine if the drug is eligible to be filled through the Mail Order Pharmacy.

Brand/Generic Difference Program

When a health care provider writes a prescription for a brand name drug and indicates "dispense as written" and there is a Food and Drug Administration (FDA) approved generic equivalent, the member will be responsible for paying the generic copay plus the difference between the cost of the brand and generic drug. This Brand/Generic Difference program helps encourage the use of generic drugs over brand name drugs. This does not apply to all MVP prescription benefits. Please refer member to their prescription rider to determine if a copay penalty applies.

Note: Copayment reduction for medical necessity for commercial and Marketplace members may be submitted for medications subject to the brand/generic penalty only. Criteria must meet that listed in the MVP Copayment Adjustments for Medical Necessity policy. Requests should be submitted on the *Medication Prior Authorization form* and specifically marked "Copayment Adjustment."

CVS Specialty Pharmacy

CVS is MVP's specialty pharmacy provider for select self-injectable and oral medications. Many specialty medications require prior authorization, which is obtained directly from MVP through the process described above. Prescription orders may be placed with CVS Specialty via fax, phone, or mail. Use CVS Specialty's toll-free fax at **1-800-323-2445** or call **1-866-444-5883**. Refer to the MVP Formularies to

determine if a medication must be obtained from CVS Specialty. Once the order is placed, CVS Specialty will contact the member to set up an account and arrange for delivery. Free delivery is available to the member's home or provider's office. CVS Specialty also offers educational support, compliance monitoring, adherence counseling, and coordinated care with the provider's office regarding these medications. Ancillary supplies, such as syringes and needles, may be provided to members at no additional charge.

Compounded Prescriptions

For all lines of business except Medicare Part D, compounded prescriptions more than $100 require prior authorization from MVP. Compound medications containing bulk powders and non-covered medications are not covered. In addition, these prescriptions are non-formulary and tier 3 (Commercial and Marketplace members). Bulk powders and non-covered drugs (OTC, excluded, etc.) are not covered. Refer to the MVP Compounded Medication BIM for additional information.

Onco360

For those unique situations where a physician is administering an oncology drug in the office setting and is not able to obtain the medication through their supplier, MVP has contracted with Onco360 to provide a select list of oncology medications. More information on Onco360 and the medications they can deliver can be obtained from your Professional Relations representative.

Benefit Coverage (Commercial, Exchange and Medicaid unless otherwise noted)

Most contracts and prescription drug riders allow for coverage of legend (prescription required), FDA-approved medications (FDA approved via NDA/ANDA/BLA) that are reasonably self-administered. The PBM system is configured to process these medications at the pharmacy point-of-service and for the claim to take the appropriate copay, coinsurance, deductible etc. Some contracts and/or riders prohibit coverage for certain drugs classes (i.e.: cosmetic agents, drugs used to treat erectile dysfunction). The PBM system is also configured to deny coverage for these drugs as appropriate.

1. OTC Equivalent Program

   Legend drug products that have an over-the-counter (OTC) equivalent are not a covered pharmacy benefit unless medically necessary. Examples of drugs that are subject to this program include but are not limited to: ammonium lactate topical, benzoyl peroxide, diphendydramine, meclizine, butenafine topical, ketotifen fumarate, fluticasone nasal spray, and polyethylene glycol 3350.
2. Physician Administered Medications
   a. Generally, it is the physician's responsibility to "buy-and-bill" medications that are administered in the office or another similar place-of-service unless other specified. The CVS Caremark system is not configured to allow physician administered medications to process at a pharmacy. This includes chemotherapy drugs and vaccines (except for Medicare Part D vaccines, see Medicare Part D section). In rare circumstances when a physician is unable to obtain a drug, he/she should contact the Plan for a case-by-case determination and applicable override. The Plan reserves the right to determine whether a medication is usually physician administered and

reimbursable under the medical benefit. Physician administered medications that are mandated to the Plan's Specialty Pharmacy vendor should be billed on-line to CVS Caremark directly by the Specialty Pharmacy.

b. Generally, when a physician gives a patient pills or other oral medication, these drugs are excluded from coverage since the form of the drug is self-administered. Similarly, if a physician gives a patient an injection that is usually self-injected this drug is excluded from coverage, unless administered to the patient in an emergency situation.

3. Diabetic Drugs and Supplies

These drugs (including oral and injectable hypoglycemics and insulin) and supplies (including test strips, lancets and insulin pump supplies) are generally covered under the Commercial member's medical plan per applicable state mandates. The PBM system is configured to process these drugs and supplies and therefore claims should be billed online to CVS Caremark. The applicable diabetic copayment(s) will apply.

Preferred diabetic insulins, meters and test strips may apply. Refer to the applicable formulary for a list of preferred products.

Pharmacy Network

An extensive network, including thousands of pharmacies throughout the United States, is available to members. Covered drugs filled at a participating pharmacy are subject to the member's applicable copay(s) as defined by his/her pharmacy benefit. For information on Plan participating pharmacies refer to **www.mvphealthcare.com** or **www.mvphealthcare.com/Medicare**.