CHAPTER 12
SECTION 3.1

TRICARE - PHARMACY BENEFITS

Issue Date: July 8, 1998
Authority: 32 CFR 199.17

I. POLICY

A. The Managed Care Support (MCS) Contractor shall provide an integrated retail prescription service through a common pharmacy patient profile system in each TRICARE region to all Military Health System (MHS) TRICARE/CHAMPUS-eligible beneficiaries. Medicare eligible beneficiaries affected by Base Realignment and Closure (BRAC) may also use the retail pharmacy services (see Chapter 8, Section 26.1). As part of the Supplemental Program and the TRICARE Prime Remote program, active duty service members may use the contractor's retail pharmacy network under the same contract requirements as other MHS eligible beneficiaries, except that active duty service members will have no deductibles and copayments or cost-shares. (OPM Part Three, Chapters 8, 9, 10)

B. TRICARE retail network pharmacies shall dispense authorized medications and other supplies in accordance with 32 CFR 199.4(d)(3)(vi), "Prescription Drugs and Medicines," and Chapter 7, Section 7.1, of this manual.

C. A TRICARE retail network pharmacy is required to substitute generic drugs listed with an "A" rating in the current Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) published by the FDA and generic equivalents of grandfather or Drug Efficacy Study Implementation (DESI) category drugs for brand named drugs.

NOTE: A TRICARE retail network pharmacies may dispense a brand named drug having a generic equivalent only if the prescribing physician substantiates the medical necessity of the brand named drug in lieu of the generic equivalent.

D. When TRICARE Prime enrollees use pharmacies other than the TRICARE retail network pharmacies, contractors will process the claims under Point of Service provisions unless the enrollee is out-of-area and has an authorization from the Health Care Finder.

E. Prescription quantities shall not exceed a 90-day supply. The original prescription and the number of authorized refills shall not result in more than a 12-month supply.

F. Prescriptions for controlled substances (Schedule III, IV, V) shall not exceed a 30-day supply with a maximum of 5 refills in a 6 month period with the exception of controlled substances used for seizure control which may be dispensed in up to 90-day quantities with one refill.

G. Schedule II controlled substance prescriptions shall not exceed a 30-day non-refillable supply with the exception of drugs used for treating Attention Deficit Disorder which may be dispensed in up to 90-day quantities.

H. All medications shall have at least 90 days remaining until expiration unless medications are reconstituted, in which case, the reconstituted expiration date will be displayed on the bottle.

I. No prescription may be refilled until 75 percent of the prior prescription is expended unless the patient or the prescriber provides an explanation, which shall be recorded in the patient data base.

1. Early refills. A patient may request one (1) early refill per prescription; the patient must explain the circumstances, pay another co-pay, and have a refill decremented. Subsequent early refills will be at the patient's expense; i.e., DoD will not pay claims for more than one (1) early refill. The contractor shall track early refill requests.

2. Changed doses. If the patient requests an early refill because the physician increased the dosage without providing a new prescription, the refill shall be processed according to paragraph I.I.1., above. The pharmacy shall telephone the physician to verify the dosage change and request a faxed or mailed new prescription showing the new dosage. The new prescription will cancel out the old prescription for the same drug.

J. Pharmacies shall not charge the government (submit a claim) for any new or refilled prescription not picked up by, on behalf of, or delivered to, the patient.

K. Outpatient deductible amounts do not apply to TRICARE Extra or Medicare BRAC prescription claims.

L. Compounding will be done at the same dispensing fee.

II. POLICY CONSIDERATIONS

A. TRICARE Retail Network Pharmacy Services

1. The TRICARE retail network pharmacy shall have the capacity to process telephonic refill requests.

2. A TRICARE retail network pharmacy shall charge a co-payment for each 30-day supply of medication dispensed even if the pharmacy dispenses more than a 30-day supply at one time. Active duty family members enrolled in TRICARE Prime shall pay a $5.00 co-payment for each 30-day supply of medication dispensed at one time; e.g., $10.00 for a 60-day supply of a medication. All other beneficiaries enrolled in TRICARE Prime shall pay a $9.00 co-payment per 30-day supply; e.g., $18.00 for a 60-day supply. Non-enrolled active duty family members requesting prescriptions under TRICARE Extra pay a cost-share of 15% of the allowable charge. All other non-enrolled beneficiaries pay 20% of the allowable charge.

3. Prescriptions for controlled substances written by providers who do not have individually assigned DEA numbers shall not be accepted.

4. The contractor shall implement formulary control based on the most current CHAMPUS formulary with a mechanism to ensure dispensing compliance.

NOTE: Currently, TRICARE/CHAMPUS has an open formulary. If the provider will not accept a formulary item, the beneficiary will be notified (by telephone for mail order prescriptions), and the unfilled prescription and co-payment shall be returned in two working days.

B. BRAC Pharmacy Benefit

1. In BRAC sites, the contractor shall make the TRICARE retail network pharmacy services available to Medicare eligible MHS individuals.

2. To use the TRICARE retail network pharmacy, the Medicare eligible beneficiary must be enrolled in DEERS. See Chapter 8, Section 26.1, for information on establishing eligibility for retail network pharmacy services for Medicare eligibles in BRAC sites.

3. The contractor is required to submit separate monthly cycle time and monthly workload reports by state on these claims. (Refer to OPM Part One, Chapter 3.)

4. Medicare beneficiaries who obtain their prescriptions from a TRICARE network retail pharmacy pay a cost-share of twenty percent (20%) of the negotiated rate. There is no deductible for prescriptions and none of the Medicare beneficiary's cost-shares/co-payments are credited to the family's catastrophic cap.

C. Other program requirements

1. Facility Requirements.

a. TRICARE retail network pharmacy operations, facilities, equipment, and staff required to fill authorized prescriptions shall conform to federal and state regulations.

b. The contractor shall adhere to the requirements of Section 4401 of the Omnibus Budget Reconciliation Act of 1990 regarding prospective and retrospective drug use review, counseling of individual beneficiaries, data collection and maintenance, application of standards, and educational programs.

c. All participating pharmacies shall be licensed in the states in which the retail pharmacies are located and they shall be TRICARE/CHAMPUS-authorized pharmacists.

2. Utilization Management/Quality Management/Quality Control

The contractor's quality assurance/improvement program shall include a system of standard operating procedures routinely updated; technical personnel training; quality control records for compounded or prepackaged medications; medication order verification prior to packaging for shipping; an error prevention program with error documentation and reporting; drug product defect reporting; proper management of drug recalls; problem reporting to the contracting officer's representative, the Lead Agent, and appropriate agencies; and maintenance of minutes of QA/QM meetings.

3. Reports

a. The contractor shall establish and maintain a database system that contains patient profiles, medication histories, patient/provider special requests, allergy screens, interaction information and prescription tracking information, and the capability to extract ad hoc reports.

b. The contractor shall provide to the Contracting Officer and the Lead Agent quarterly pharmacy report(s). The report(s) shall be submitted on disk in dBASE format no later than 10 calendar days following the end of each calendar quarter. The information/format required on the report(s) shall either be as mutually agreed upon between the contractor, the Lead Agent and the Contracting Officer or shall report the following information:

(1) Prescriptions per individual patient,

(2) Intervention reports,

(3) Average days between prescription refills,

(4) Dispensing errors,

(5) Monthly inventory/formulary compliance reports,

(6) Medication dispensed by ZIP code of beneficiaries,

(7) Total dollars of co-payments received,

(8) Total dollars of dispensing fees,

(9) Prescription Ingredient Cost [price paid for pharmaceuticals sorted by National Drug Code (NDC)],

(10) Medications not received by beneficiary (mail order services), and

(11) Average prescription cost for all prescriptions for a specific medication or for the American Hospital Formulary Service's therapeutic category.

c. The contractor shall install and maintain a toll-free line with standard modem access for MTF pharmacy personnel to gain read-only access to patient profiles.

d. The contractor's computer system that performs the pharmacy reporting must be in conformance with the National Council of Prescription Drug Programs (NCPDP) Telecommunication Standards Manual (Version 3.2).

4. Marketing

The contractor shall develop, publish, and distribute publications and/or marketing materials to inform beneficiaries and providers about the program. Publications and marketing materials must be submitted through the Lead Agent to the Contracting

Officer for approval.

NOTE: This policy issuance does not apply to the National Mail Order Pharmacy (NMOP) program. For information on the NMOP, see:

http://www.dscp.dla.mil/medical/pharm/nmop.htm

- END -