

**Customized CalPERS High Performance Generic Step Therapy (HPGST)  
Proposal: Provider and Member Communications, and Member Experience,  
with Grandfathered and Non-Grandfathered Drug Classes**

CVS/Caremark and CalPERS, June 2014

**Pre-Implementation General Communications**

Member mailing, top prescriber mailing, website update, and newsletter article will be completed 3-6 months prior to implementation. These communications will inform all members and prescribers of the upcoming changes, where to direct questions, and how to access the HPGST drug list.

**Grandfathered Drug Classes: Provider and Member Communications**

1. Customized mailing 3-6 months prior to implementation to members taking targeted brand drugs and their prescribers. This will state that member has a prescription for a targeted brand drug, and that the member may continue refilling the prescription after January 1, 2015; however, any changes to the dose of the targeted brand, or a change to another targeted brand for the same condition, will cause the member to be subject to HPGST.
2. Post-implementation customized mailing in January 2015 to members taking targeted brand drugs and their prescribers. The message will be the same as for the customized mailing 3-6 months prior to implementation.

**Grandfathered Drug Classes: Member Experience**

If a member in a CalPERS health plan serviced by CVS/Caremark has a targeted brand prescription filled between October 1, 2014, and December 31, 2014, that prescription (i.e., any refills) will not be subject to HPGST. A new prescription for the targeted brand with a different dose (e.g., 40 mg to 60 mg) and any new prescription for a different targeted brand (e.g., brand X to brand Y) will be subject to HPGST.

**Non-Grandfathered Drug Classes: Provider and Member Communications**

1. Customized mailing 3-6 months prior to implementation to members taking targeted brand drugs and their prescribers. This will state the upcoming changes and allow time for member to obtain prescription for generic alternative or to work with prescriber to request medical necessity clinical exception review.
2. Post-implementation targeted communication for new targeted brand and previously targeted users and prescribers – additional customized impacted member and prescriber mailing after implementation to inform the changes and remind member and prescriber of the change, the alternatives, and options available.

3. Retrospective post-rejection communications - if no generic claim is processed within 72 hours of the brand claim rejection, a communication will be sent to the member by mail and the prescriber by fax informing them of the change, the alternatives and options available.

### **Non-Grandfathered Drug Classes: Member Experience**

At a retail pharmacy, when a prescription for a targeted single-source brand is transmitted to CVS/caremark, the CVS/caremark claims adjudication system will check for previous generic(s) use.<sup>1</sup>

- If the history shows generic(s) use, the single source brand claim will be paid.
- If the patient's record shows no history of a generic(s) trial, the claim is rejected and the retail pharmacist receives an electronic message with the generic-first criteria and a toll-free Prior Authorization number for the prescriber to call for more information.

Similarly at CVS/caremark Mail Service, the rejected claim for a patient with no generic history triggers a fax to the prescriber explaining the alternative first-line medication requirement and requesting a new prescription for a generic alternative, along with a toll-free Prior Authorization telephone number.

In the event the prescriber determines that a generic alternative is not right for the member (for example, member has a documented generic trial history older than the look back period), the prescriber can call the toll-free Prior Authorization Department to request a medical necessity clinical exception review for the targeted brand coverage at the applicable brand copay.

- The maximum Prior Authorization turnaround time for a standard request is 72 hours and for an urgent request is 24 hours. In 2013, CVS/caremark processed 99% of CalPERS Prior Authorizations in less than 1 day.
- If the Prior Authorization is approved, it is typically valid for 2 years. A targeted letter is also sent to prescriber prior to the 2 year approval expiration for re-authorization or a trial of generic alternative. The re-authorization process is important due to constant changes in medical knowledge and member's clinical conditions.

The targeted brand will not be covered if the patient does not have a history of generic use or a medical necessity clinical exception. A one-time transition fill with a 30 day supply of the targeted brand will be provided in the event member has not switched to a generic alternative and does not have a medical necessity clinical exception approval. This occurs at the time member arrives at the pharmacy or submits prescription to mail order for their refill.

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<sup>1</sup> CVS/caremark has claim history data for CalPERS PPO members dating back to January 1, 2012. The claim look back period is 180 to 365 days depending on the drug class.