CARE COORDINATION PHARMACY WEBINAR

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March 30th, 2022

AGENDA

- Welcome
- Introductions
- How can care coordinator assist on pharmacy related items?
  - Connection with member
  - Connection with family
  - Connection with provider
  - Connection in community
- Today, we will review many of these opportunities, how, and where to find information

BlueCross BlueShield Minnesota

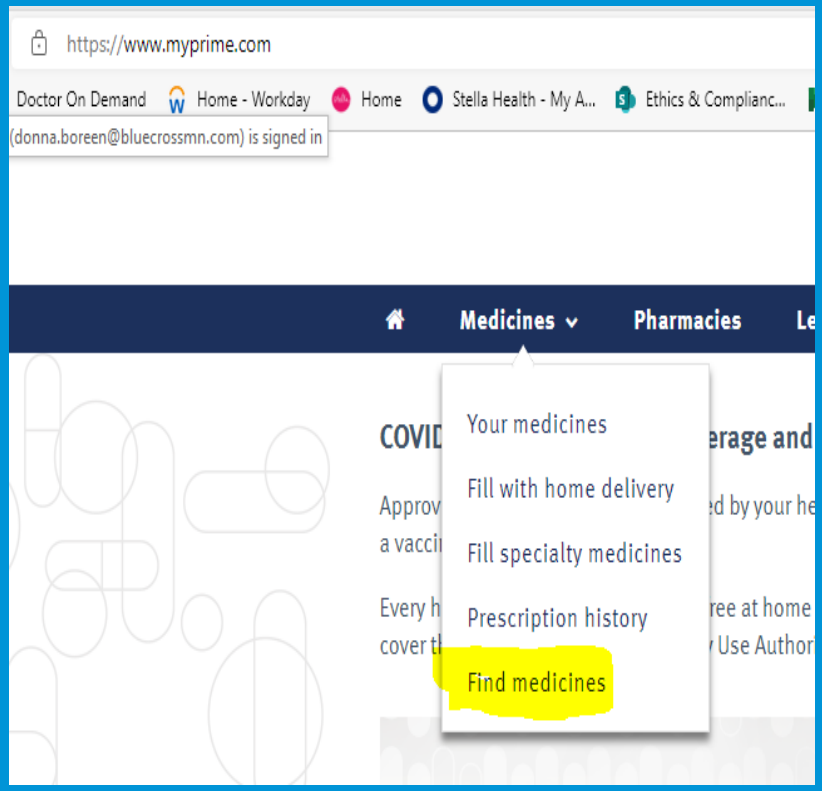
BCBSMN FORMULARY

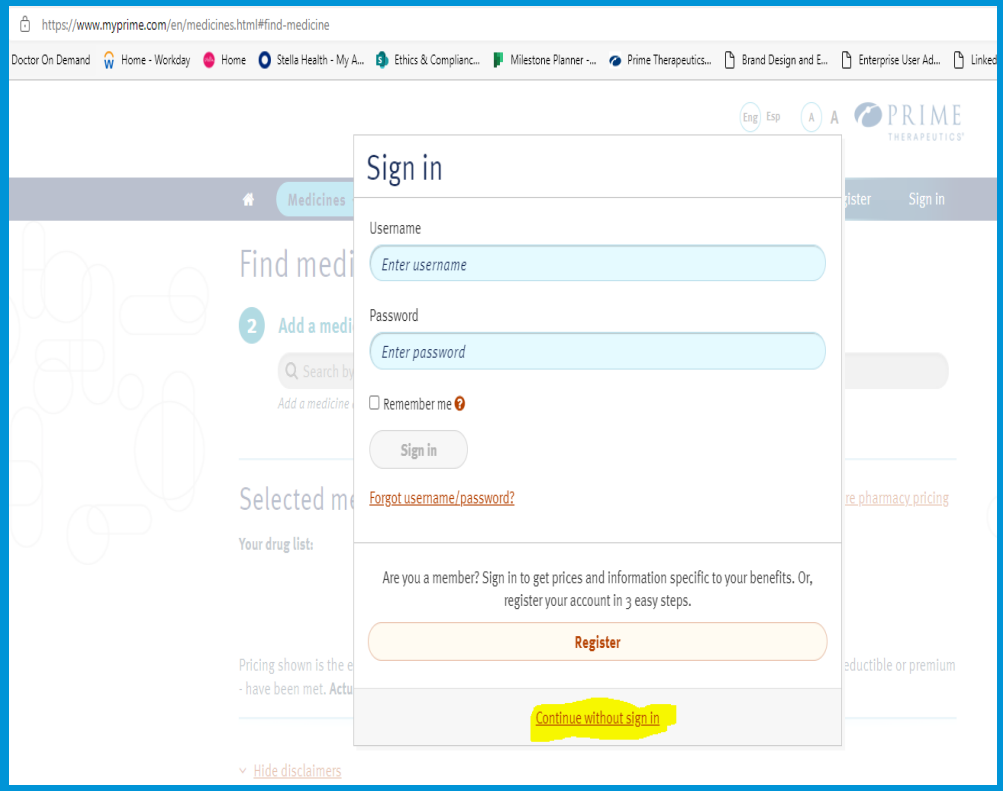
Where to find it and how to use it

BCBSMN SECUREBLUE FORMULARY

BlueCross BlueShield Minnesota

Home (myprime.com)





2022 SecureBlue Formulary pdf

BCBSMN SECUREBLUE FORMULARY

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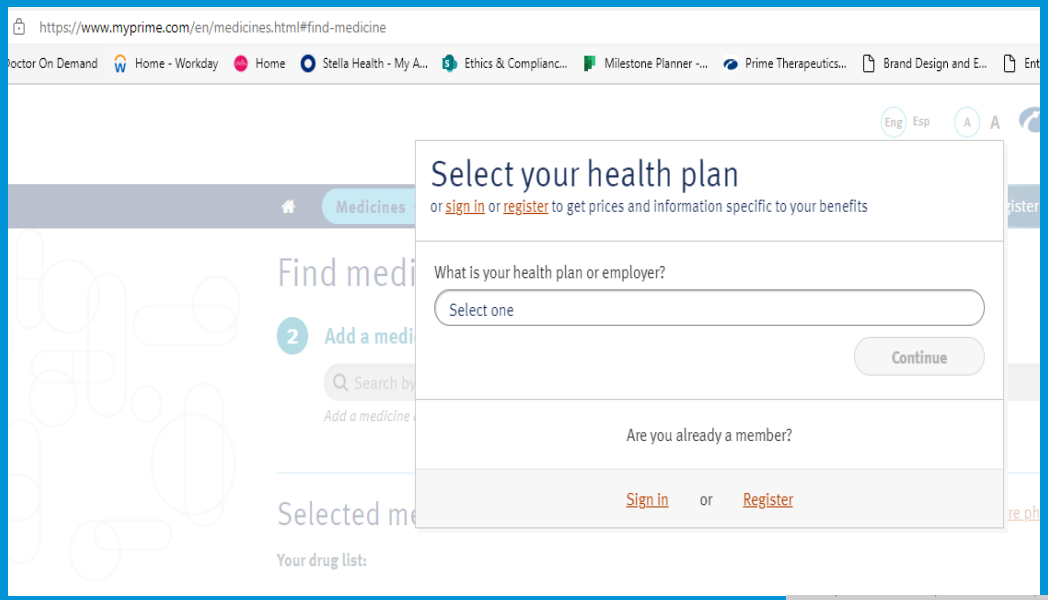
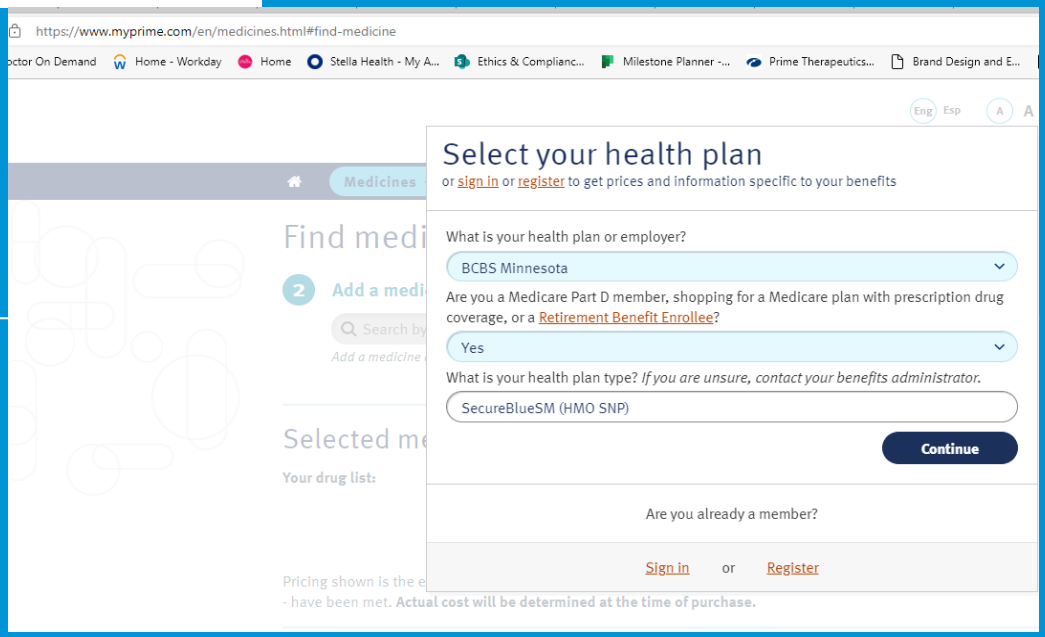
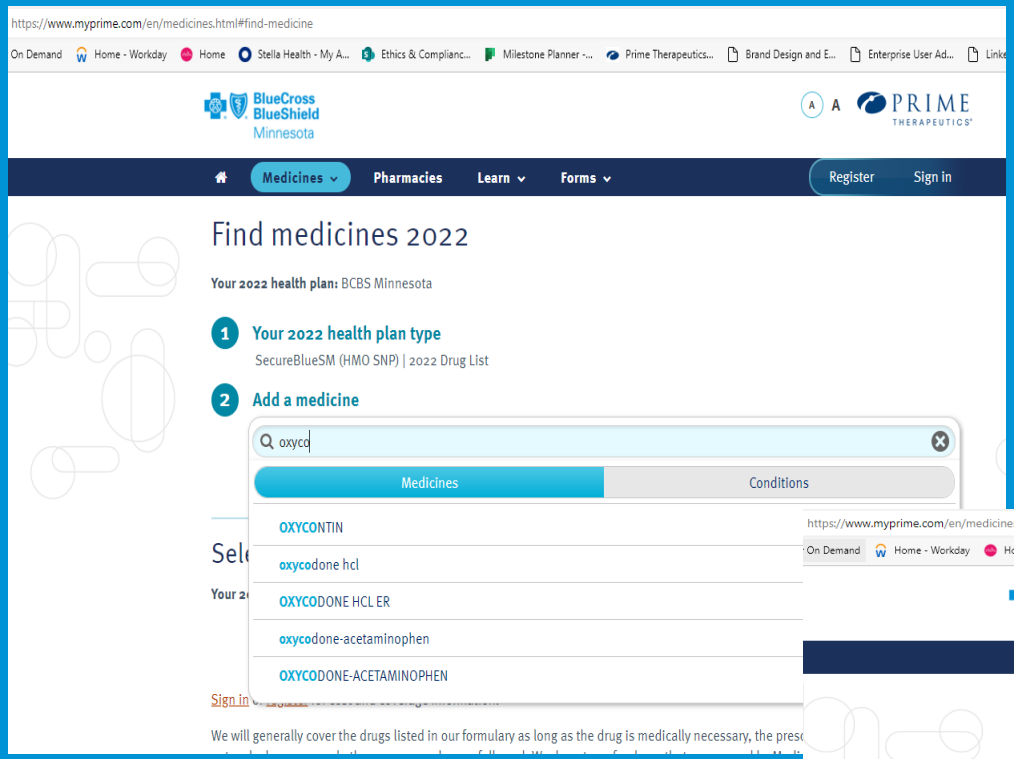
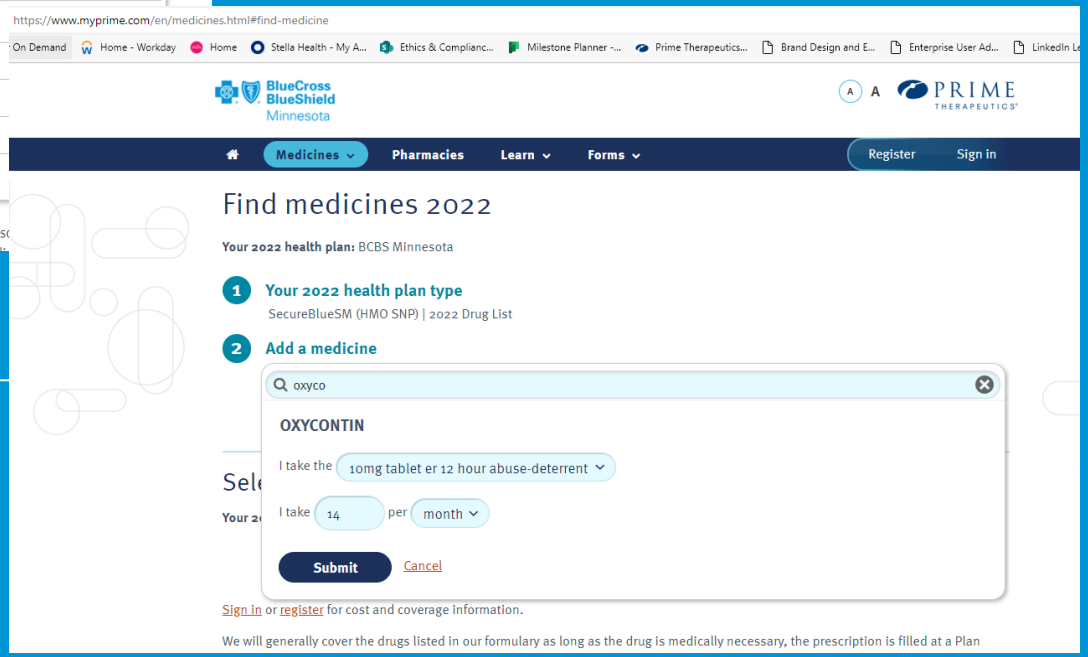




BCBSMN SECUREBLUE FORMULARY

BlueCross BlueShield Minnesota





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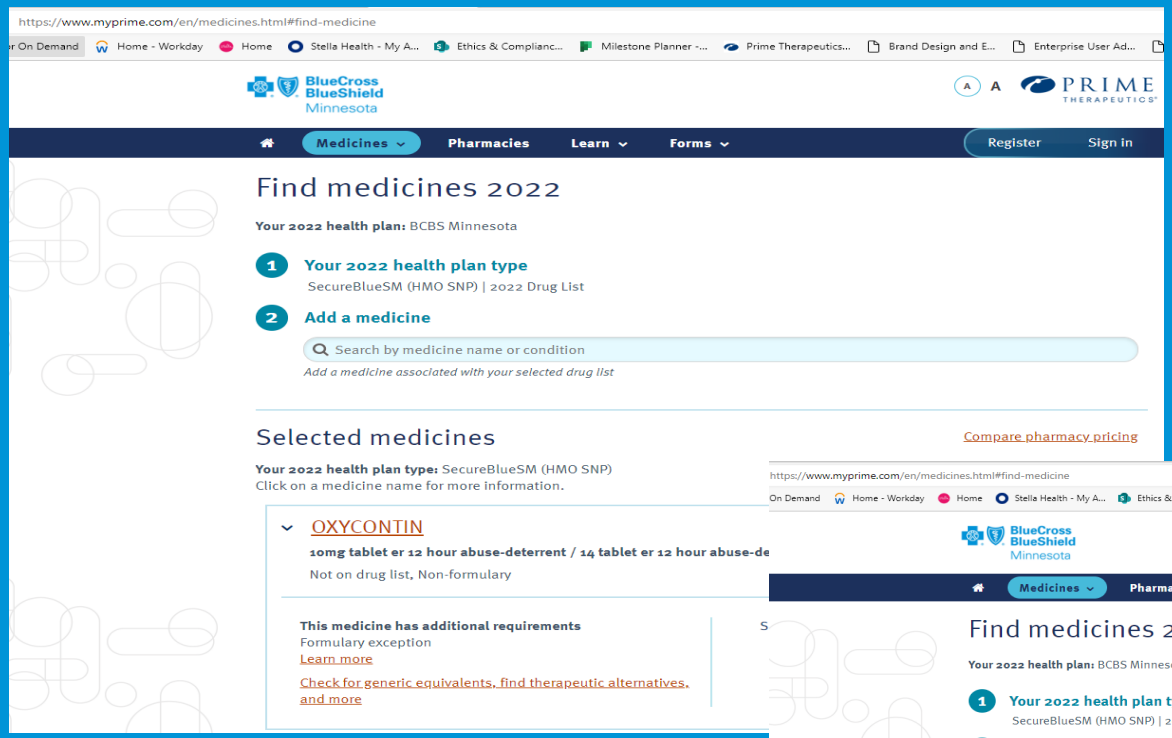
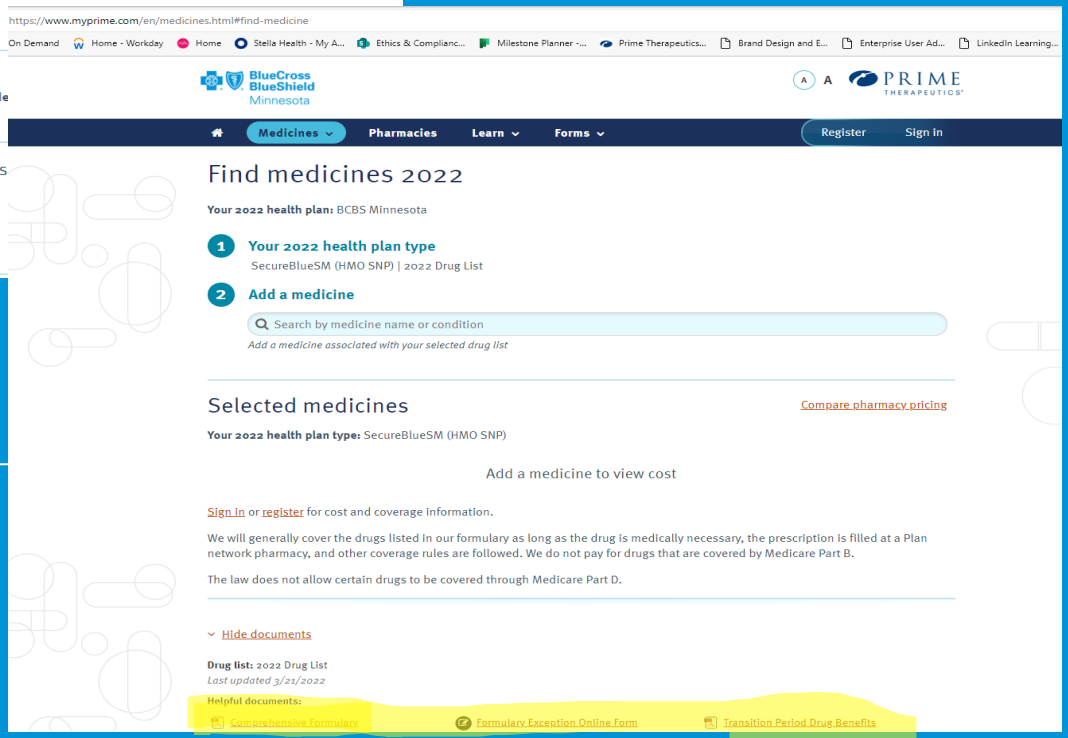
BlueCross BlueShield Minnesota





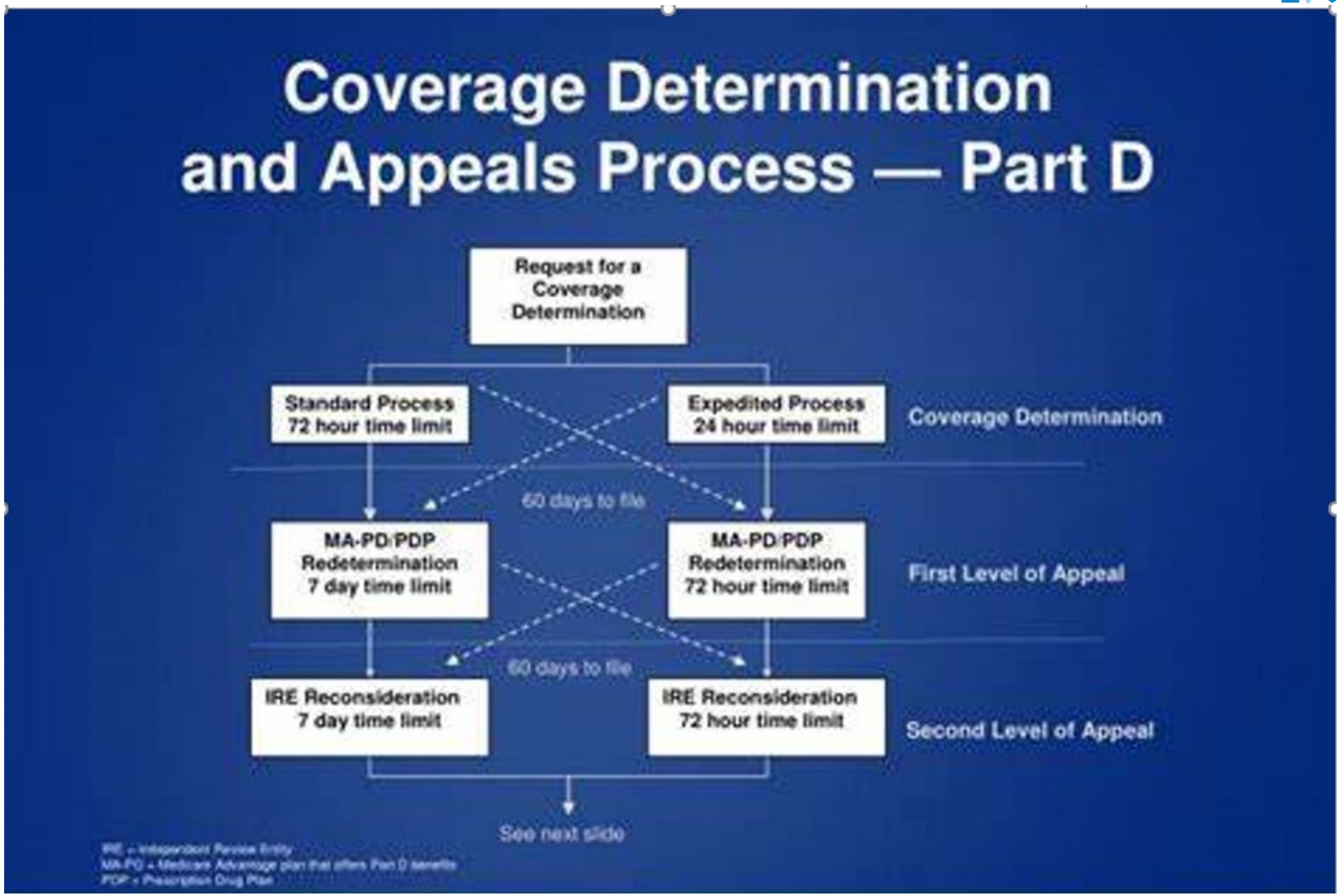
BlueCross BlueShield Minnesota

COVERAGE DETERMINATION & APPEAL PROCESS

Non formulary, Prior Authorization, Step Therapy, Quantity Limit, Tier Exceptions (not applicable to MSHO)

COVERAGE DETERMINATION AND APPEAL PROCESS FOR PART D

BlueCross BlueShield Minnesota



APPOINTMENT OF REPRESENTATIVE

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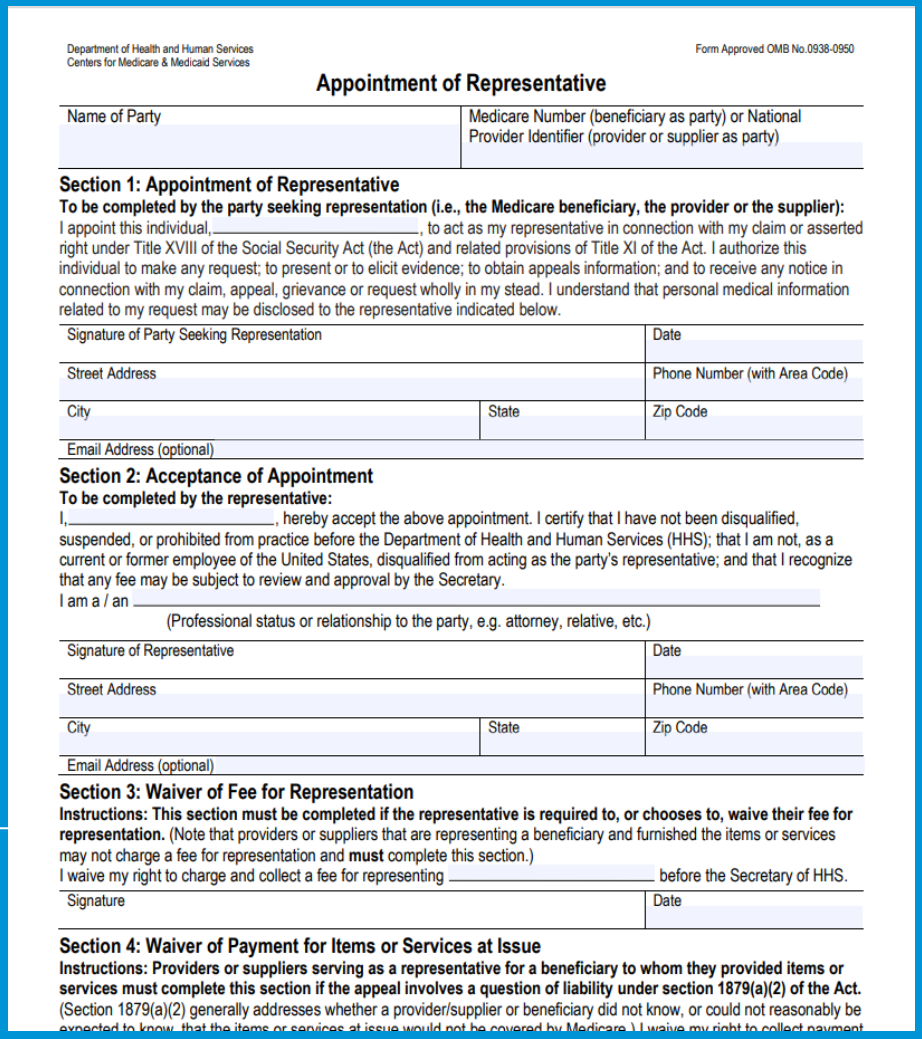
Appointment of Representative form

- If member would like to have someone else other than provider submit CD/RD/IRE, this document needs to be submitted with CD/RD/IRE. This is also true for grievance or complaints.
- If member is legally not of sound mind or incapacitated, the representative can complete and sign the statement. The representative needs to have appropriate legal papers or legal authority to sign for member.



Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment

COVERAGE DETERMINATION AND APPEAL PROCESS

BlueCross BlueShield Minnesota

How to help a SecureBlue member with the Coverage Determination & appeals process

The forms may be submitted by member/family/representative.

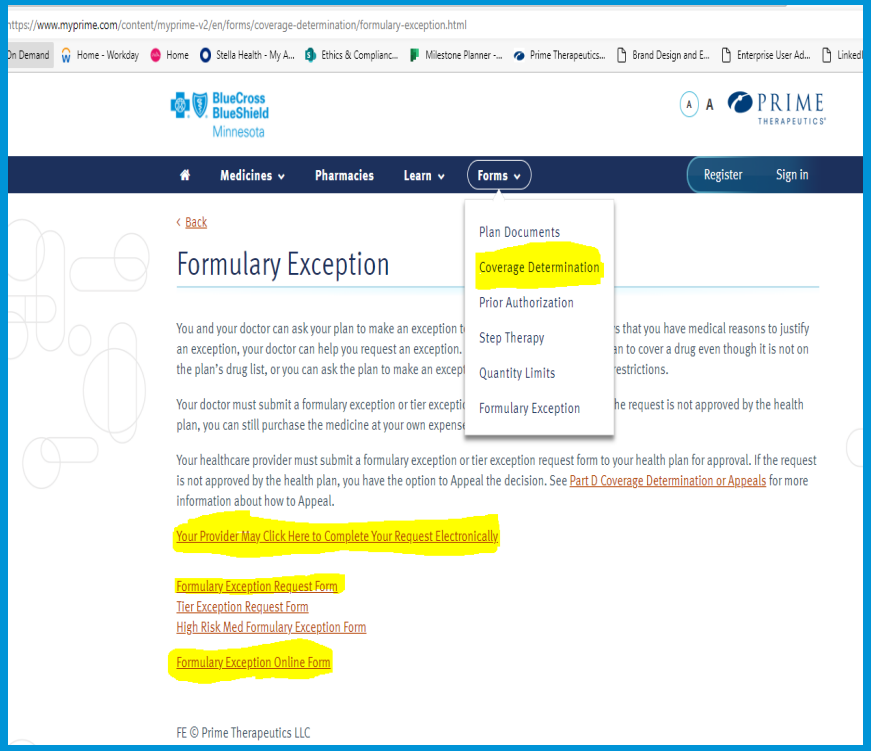
How to submit:

- By Phone
- By Secure email
- By Mail or fax

Standard (7 days TAT) vs expedited (72 Hours)

You can provide online form through MyPrime.com.

Home page for MyPrime.com *



*See slides 5-8 as reference

COVERAGE DETERMINATION AND APPEAL PROCESS

BlueCross BlueShield Minnesota

https://www.myprime.com/en/forms/coverage-determination.html

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Coverage Determination

If your health care provider or pharmacist tells you that we will not cover a prescription drug or charges you more than you think your copay should be, you or your provider may contact us and ask for a Coverage Determination. The following are examples of when you can ask us for a Coverage Determination:

Jump to forms

- If there is a limit on the quantity (or dose) of a drug and you disagree with the limit
- If there is a requirement that you try another drug before we will pay for the drug you are asking for
- If the copay for a drug is higher than expected
- If the drug is listed as non-formulary

If you or your provider do not agree with the outcome of the initial Coverage Determination, you or your provider may Appeal the decision by having your provider request a Coverage Redetermination. This is also called an Appeal.

The process for requesting a Coverage Determination is discussed in more detail in Chapter 9 of your **Evidence of Coverage**, "What to do if you have a problem or complaint (coverage decisions, Appeals, and complaints)."

How to Request a Coverage Determination or Redetermination (Appeal)

There are 3 ways to request a Coverage Determination or Redetermination (Appeal). Any one of these 3 ways to request a Coverage Determination or Redetermination (Appeal) will be accepted.

1. By mail or fax
You and your prescribing health care provider can print and mail or fax one of the forms below.

Prime Therapeutics forms

Medicare Part B versus Part D Determination: Use this form to determine coverage under the appropriate Medicare benefit.

These forms from the Centers of Medicare & Medicaid Services (CMS) can be used by all Medicare Part D prescribers and members

Coverage Determination: Use this form if this is the first time you have asked for coverage of a specific drug.

Coverage Redetermination: Use this form if you want to Appeal a request that has been denied.

Completed forms can be mailed or faxed to:

Mail:Prime Therapeutics LLC
Attn: Medicare Appeals Department
2900 Ames Crossing Road
Eagan, MN 55121
Fax: **1-800-693-6703** (toll free)

2. By Phone

If you call us, we may need to get more information from your prescribing health care provider.

Call Member Services at **1-888-740-6013** (toll free) seven days a week, 8 a.m. - 8 p.m. CT. TTY users should call **711** (toll free).

3. By secure email

To send in a Coverage Determination or Redetermination (Appeal) request by secure email, choose one of the links below. If you submit a secure email, we may need to get more information from your prescribing health care provider.

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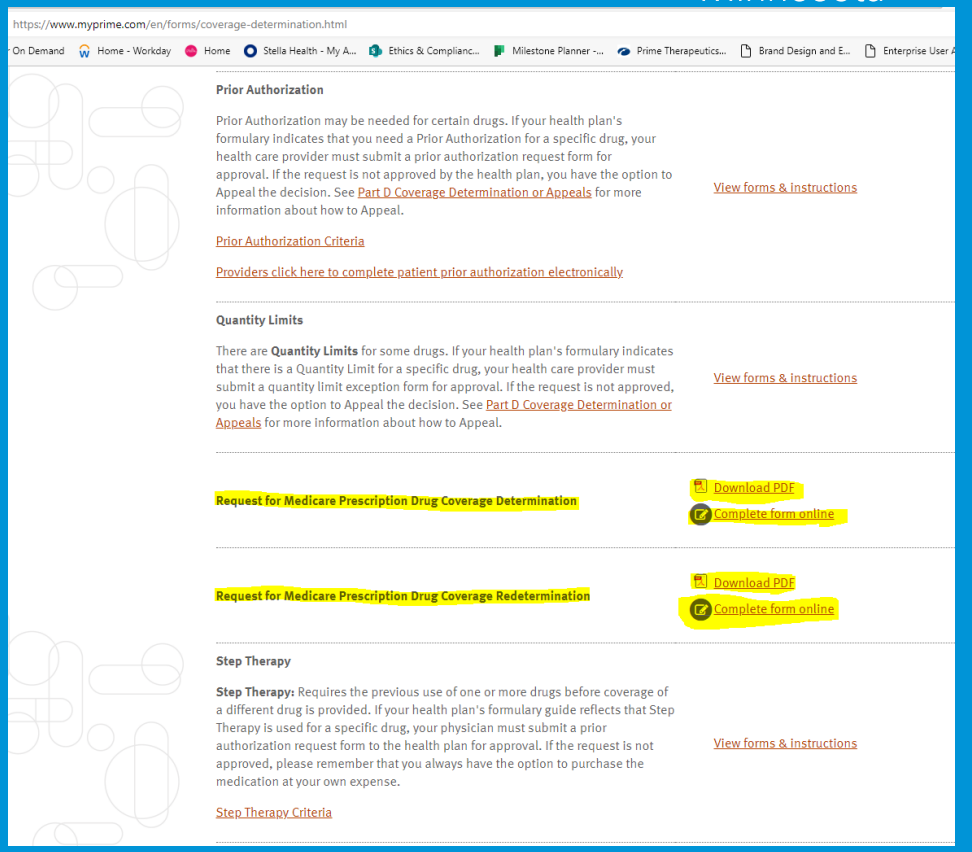
CMS Appointment of Representative

Read more about using the Appointment of Representative form to appoint someone to act on your behalf.

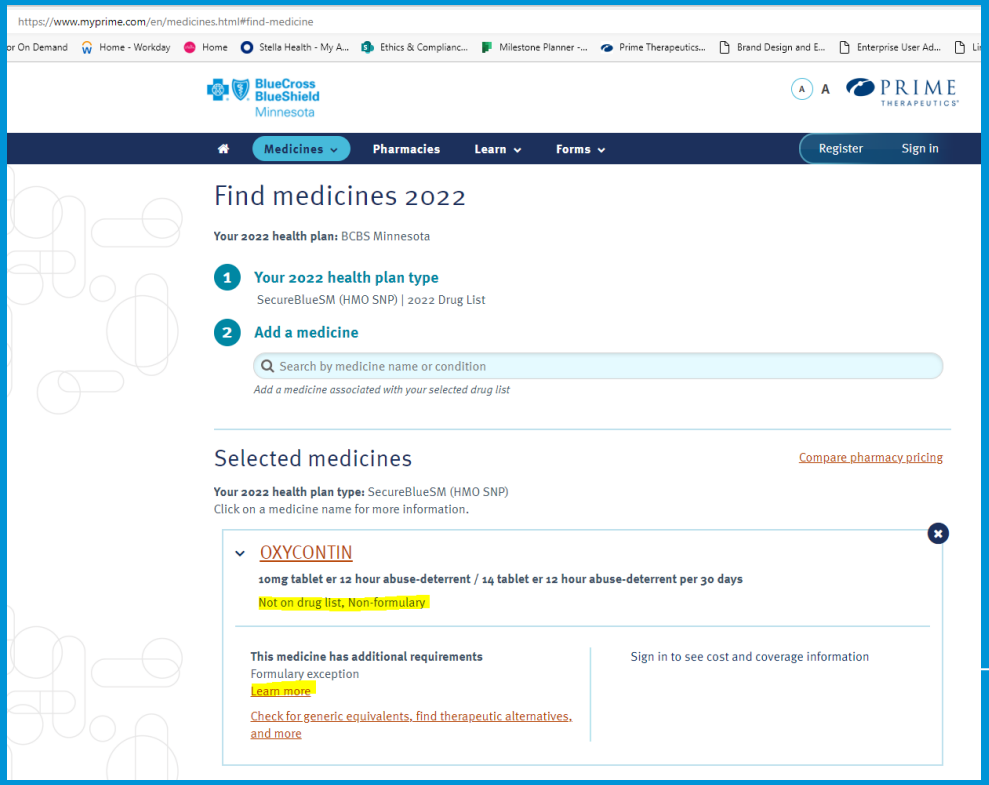
Providers click here to complete patient prior authorization electronically

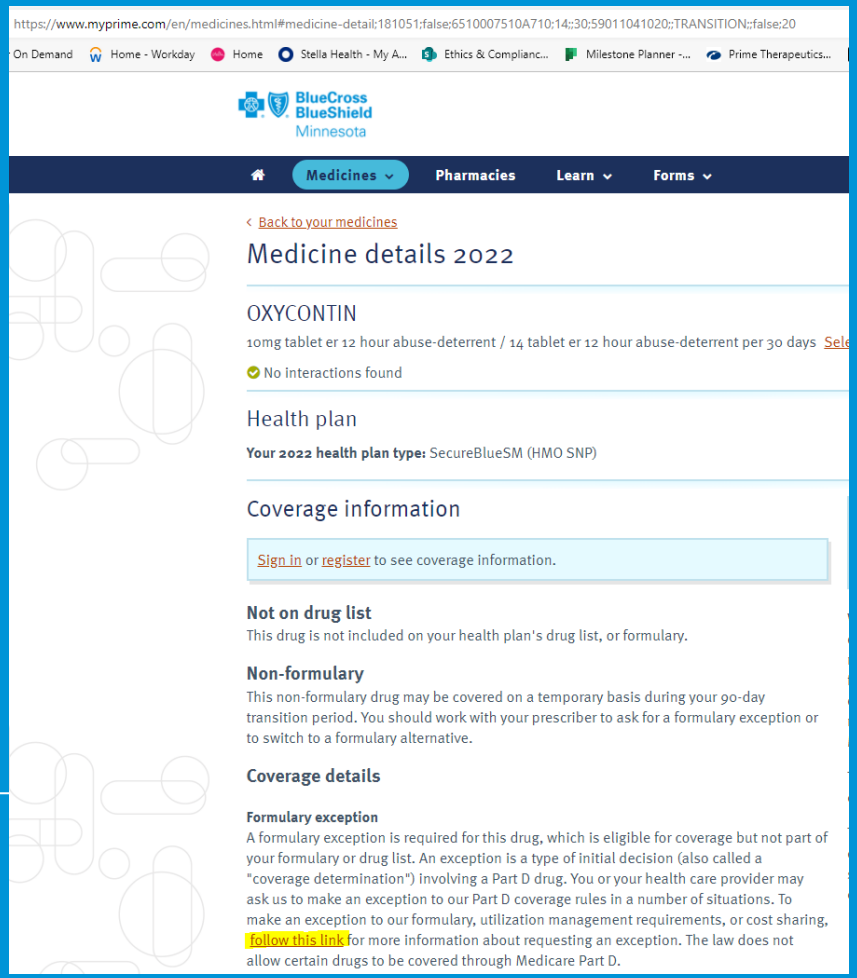


COVERAGE DETERMINATION AND APPEAL PROCESS

BlueCross BlueShield Minnesota

If you are searching for formulary coverage, you can access forms here too





COVERAGE DETERMINATION AND APPEAL PROCESS

BlueCross BlueShield Minnesota

Physician Fax Form (myprime.com)

Online Provider Electronic Submission (CoverMyMeds)

MEDICARE PART D
FORMULARY EXCEPTION
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for Medicare Part D prospective, concurrent, and retrospective reviews.

Please fax or mail this form to: **TOLL FREE** **Fax: 800-693-6703 Phone: 800-693-6651**	**Prime Therapeutics LLC** **Attn: Medicare Appeals Department** **2900 Ames Crossing Road** **Eagan, MN 55121**

The following documentation is REQUIRED. For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary. To submit this form electronically, please click here or go to covermymeds.com.

Per CMS requirements – all standard requests are completed within 72 hours (including weekends)

If you request an expedited review and sign this form, you certify that applying the 72-hour standard review time frame could seriously harm the patient's life, health or ability to regain maximum function. Please check the box to request an expedited review: ☐

PATIENT, INSURANCE and PRESCRIBER/CLINIC INFORMATION **Today's Date:**

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:		Patient Telephone Number:	
Prescriber Name:	Prescriber NPI#:	Specialty:	Clinic Contact Person's Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Clinic Phone #:	Clinic Secure Fax #:
Is the patient a long term care facility resident? ☐ Yes ☐ No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:		LTC Phone #:	LTC Secure Fax #:
Medication Requested:		Strength:	
Dosing Schedule:		Quantity per Month:	

Please list **ALL** diagnoses associated with use of medication. *To be eligible for coverage, drug must be prescribed for a medically accepted indication as defined by Medicare law.

Diagnosis – ICD code plus description: _____
Diagnosis – ICD code plus description: _____
Diagnosis – ICD code plus description: _____

Is the patient currently treated with the requested medication (i.e., this request is for a refill)? ..... ☐ Yes ☐ No

If yes, when was treatment with the requested medication started? _____

List **ALL** previously attempted drugs and indicate any adverse effects requiring discontinuation. Please provide dates of use.

1._____ 2._____ 3._____ 4._____

If no available formulary alternatives have been previously tried, please check this box: ☐

Medical Justification: Please provide medical justification for the non-formulary drug exception request. Please address why ALL formulary alternatives on any tier of the formulary for treatment of the same condition not yet attempted would not be as effective or would cause adverse effects.

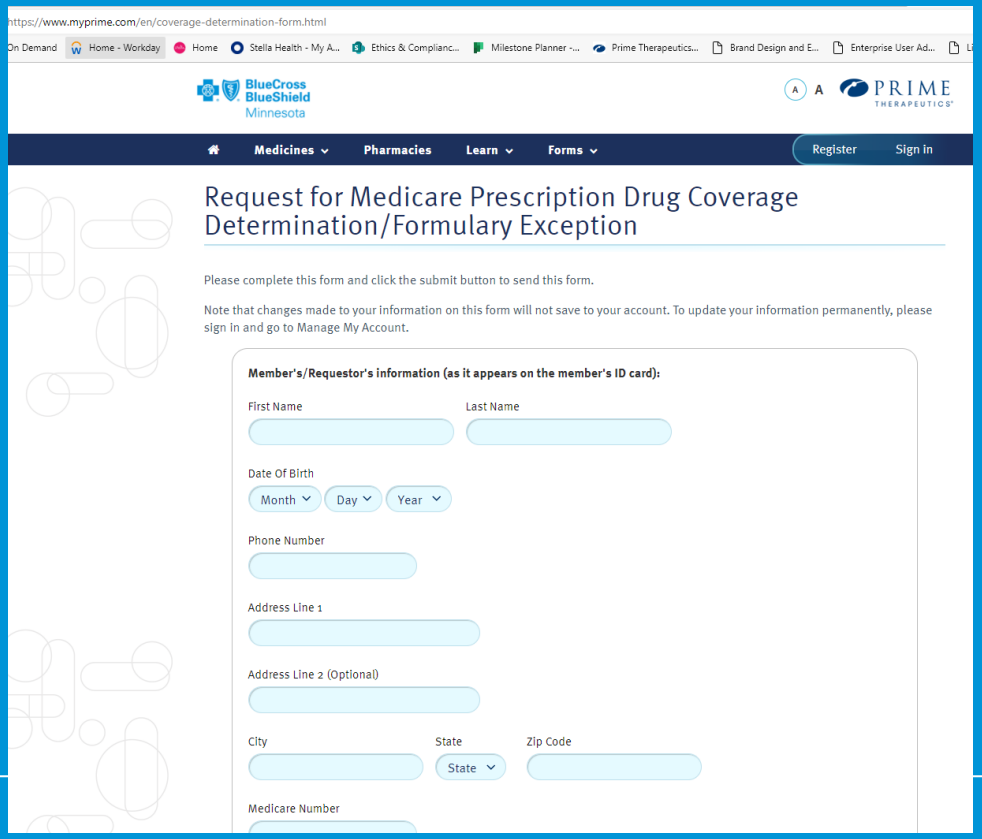
If all formulary agents would not be as effective or would have adverse effects, please provide clinical rationale for perceived ineffectiveness or adverse effects for **each** alternative: _____

_____

_____

_____

Member online submission option:



REDETERMINATION

BlueCross BlueShield Minnesota

https://www.myprime.com/en/forms/coverage-determination.html

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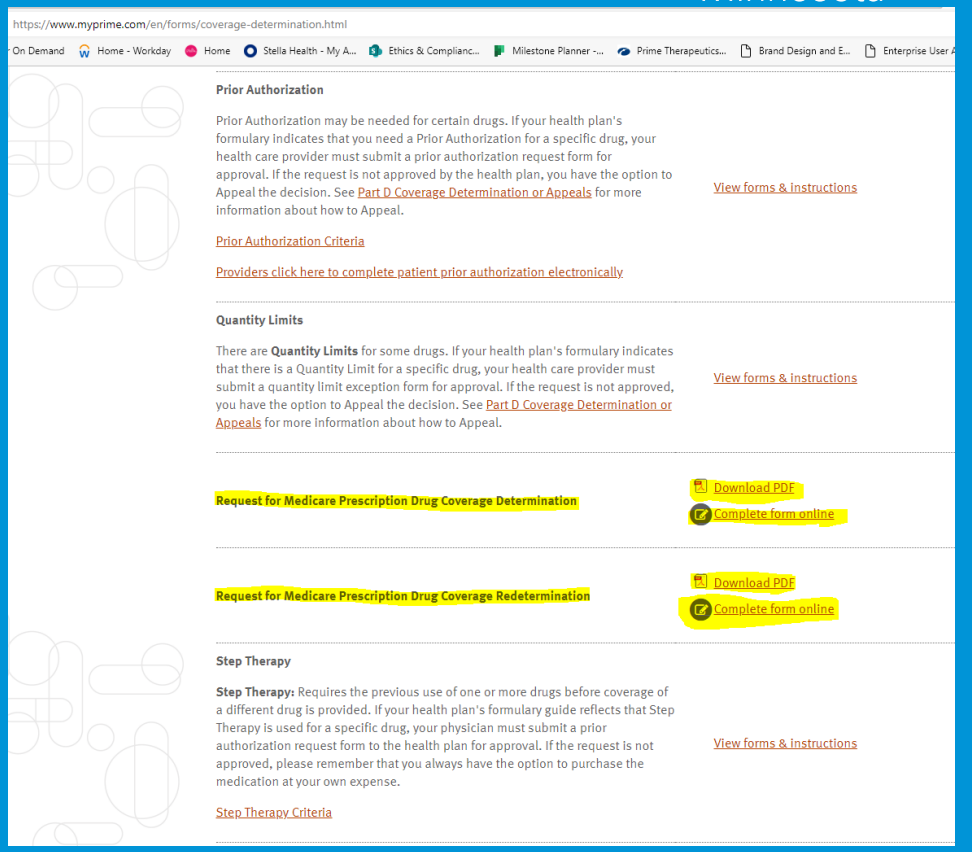


REDETERMINATION

BlueCross BlueShield Minnesota

REDETERMINATION FORM

Request for Redetermination of Medicare Prescription Drug Denial

Because we SecureBlue℠ (HMO SNP) denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
SecureBlue (HMO SNP)
Attn: Medicare D Clinical Review
2900 Ames Crossing Road
Eagan, MN 55121

Fax Number:
1-800-693-6703

You may also ask us for an appeal through our website at bluecrossmn.com/secureblue. Expedited appeal requests can be made by phone at 1-888-877-6424 (TTY: 711), 24 hours a day, 7 days a week.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Member ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

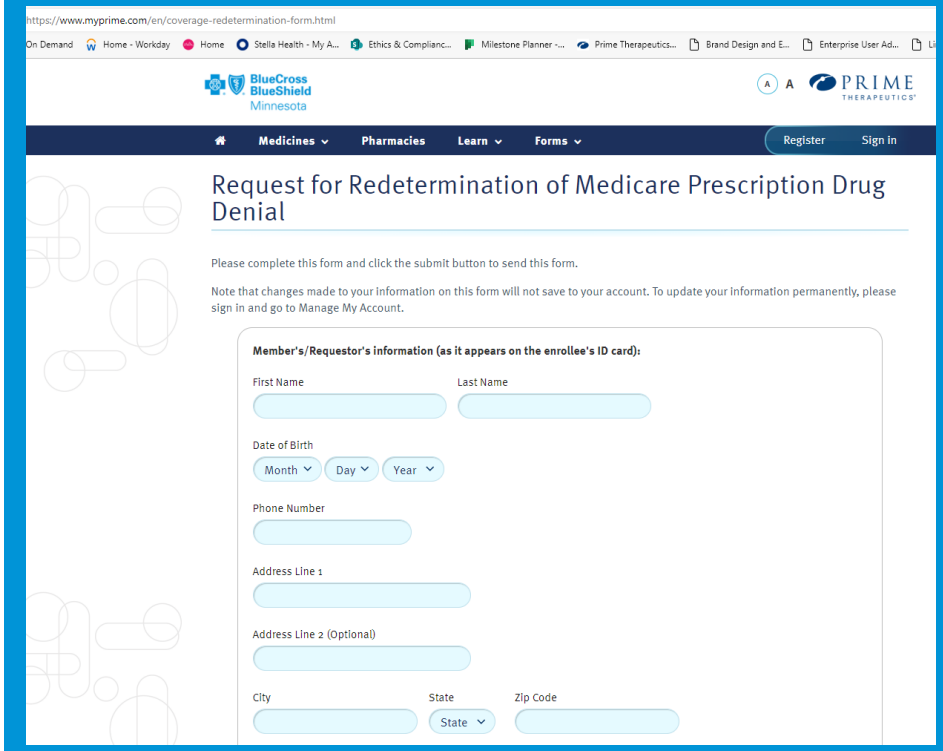
City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed

REDETERMINATION ONLINE FORM



INDEPENDENT REVIEW ENTITY (IRE)

BlueCross BlueShield Minnesota

- The MD, member, or someone member has named to act for them (representative) may request.
- Request can be sent in writing by mail or electronically within 60 days after the date of denial notice.

Standard Mail:

C2C Innovative Solutions, Inc.
P.O. Box 44166
Jacksonville, FL 32231-4166

For Mail sent by courier such as FedEx or UPS:

C2C Innovative Solutions, Inc.
301 W. Bay St., Suite 600
Jacksonville, FL 32202

Fax Numbers:

For Standard Appeals: (833) 710-0580
For Expedited Appeals: (833) 710-0579

Phone:

(833) 919-0198

Part D QIC Portal Address: https://www.c2cinc.com//Appellant-Signup

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TRANSITIONAL FILLS

TRANSITION FILLS, WHAT ARE THEY

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- Transitional fill is a one time 31-day supply in the first 90 days of enrollment. This is done automatically at the pharmacy. When does this happen:
  - When Medicare members joins a new plan or age into Medicare. This would also include if they switch plans and comes to BluePlus.
  - Current members affected by negative formulary changes year over year
  - This means Utilization Management (UM) drug requirements are waived for one 31day supply during the first 90 days of enrollment. UM is:
    - Prior Authorization (PA)
    - Step Therapy (ST)
    - Quantity Limits (QL)
  - This also means a Non-Formulary drug will be covered for one 31-day supply during the first 90 days of enrollment
- During the Public Health Emergency for Covid-19 members can receive up to a 90-day supply transition fill in their first 90 days of enrollment. Part B vs D determinations are **not** eligible for transition fills

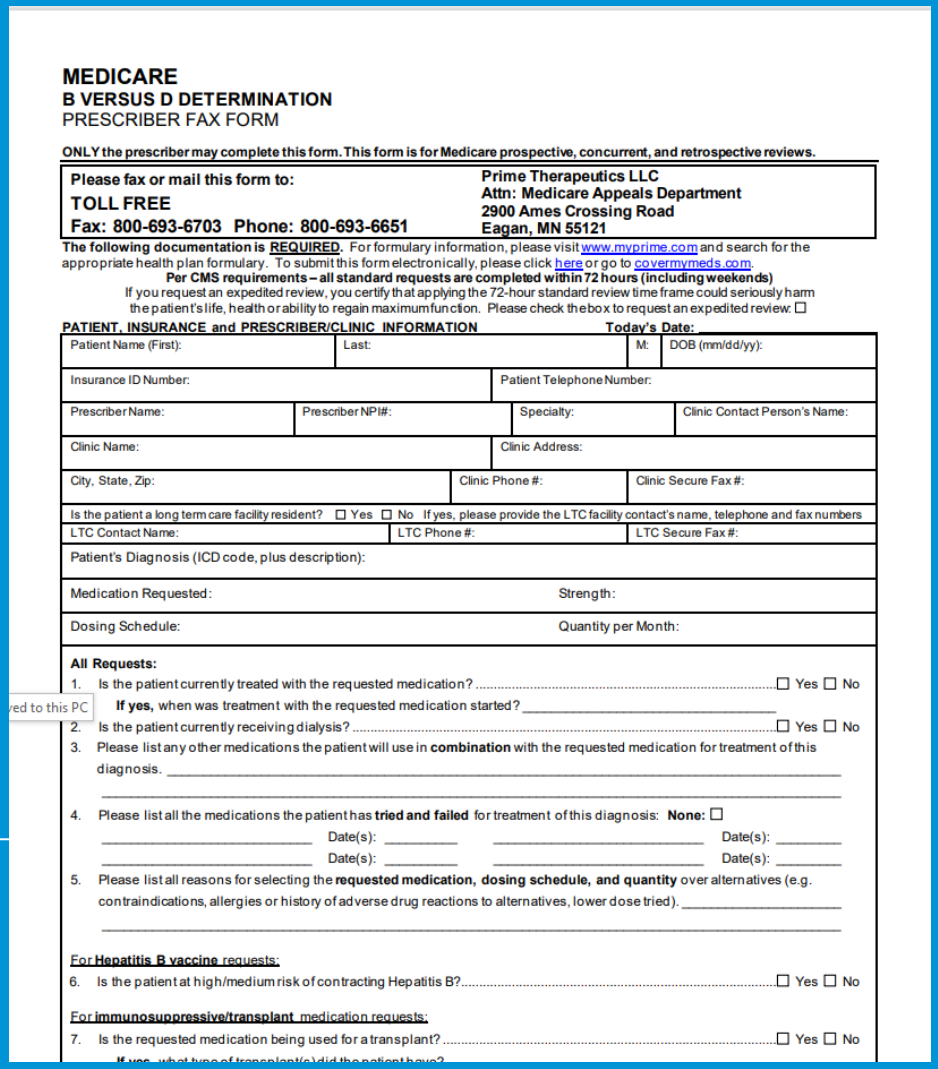
BlueCross BlueShield Minnesota

MEDICARE B VS D

MEDICARE B VS D

- On Medicare, most drugs are covered under Part D but there are some drugs that can be covered under both Part B or Part D depending on what the drug is used for and how it is administered.
- Centers for Medicare & Medicaid Services (CMS) requires Medicare plans to determine if the drug is covered under Part B or D before paying for the drug.
- When a member fills a drug identified as B vs D, this will reject at point of sale. Information has to be submitted on B vs D Determination Form.
- Part B vs D determinations are **not** eligible for transition fills.

Medicare B vs D Determination Form



MEDICARE
B VERSUS D DETERMINATION
PRESCRIBER FAX FORM

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The following documentation is REQUIRED. For formulary information, please visit www.myprime.com and search for the appropriate health plan formulary. To submit this form electronically, please click here or go to covermymeds.com.

Per CMS requirements – all standard requests are completed within 72 hours (including weekends)
If you request an expedited review, you certify that applying the 72-hour standard review time frame could seriously harm the patient's life, health or ability to regain maximum function. Please check the box to request an expedited review: ☐

PATIENT, INSURANCE and PRESCRIBER/CLINIC INFORMATION **Today's Date:**

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:		Patient Telephone Number:	
Prescriber Name:	Prescriber NPI#:	Specialty:	Clinic Contact Person's Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Clinic Phone #:	Clinic Secure Fax #:
Is the patient a long term care facility resident? ☐ Yes ☐ No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:		LTC Phone #:	LTC Secure Fax #:
Patient's Diagnosis (ICD code, plus description):			
Medication Requested:		Strength:	
Dosing Schedule:		Quantity per Month:	

All Requests:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Is the patient currently receiving dialysis? ☐ Yes ☐ No
3. Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. _____
4. Please list all the medications the patient has **tried and failed** for treatment of this diagnosis: **None:** ☐
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
5. Please list all reasons for selecting the **requested medication, dosing schedule, and quantity** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____

For **Hepatitis B vaccine** requests:
6. Is the patient at high/medium risk of contracting Hepatitis B? ☐ Yes ☐ No

For **immunosuppressive/transplant** medication requests:
7. Is the requested medication being used for a transplant? ☐ Yes ☐ No
   If yes, what type of transplant(s) did the patient have?

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COMPOUNDED DRUGS

COMPOUNDED DRUGS

- What is a compounded drug? A drug specifically mixed and prepared for a patient.
- When a compound drug is ordered, each ingredient is reviewed individually in BCBSMN claims processing system. If any of the ingredients are non-formulary or require a prior authorization (PA), a coverage determination is required, and the Rx will deny at point of sale
  - **Link for MD electronic PA form(CoverMyMeds)**
  - **Physician Fax Form (myprime.com)**
  - **Coverage Determination online submission**
  - **Coverage Determination pdf**

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UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT

BlueCross BlueShield Minnesota

- Utilization Management includes Prior Authorization (PA) , Quantity Limits, and Step Therapy
- How to submit for any of these 3 UM programs:
  - **Link for MD electronic PA form(CoverMyMeds)**
  - **Physician Fax Form (myprime.com)**
  - **Coverage Determination online submission**
  - **Coverage Determination pdf**

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PAPER CLAIMS REIMBURSEMENT

PAPER CLAIM REIMBURSEMENT

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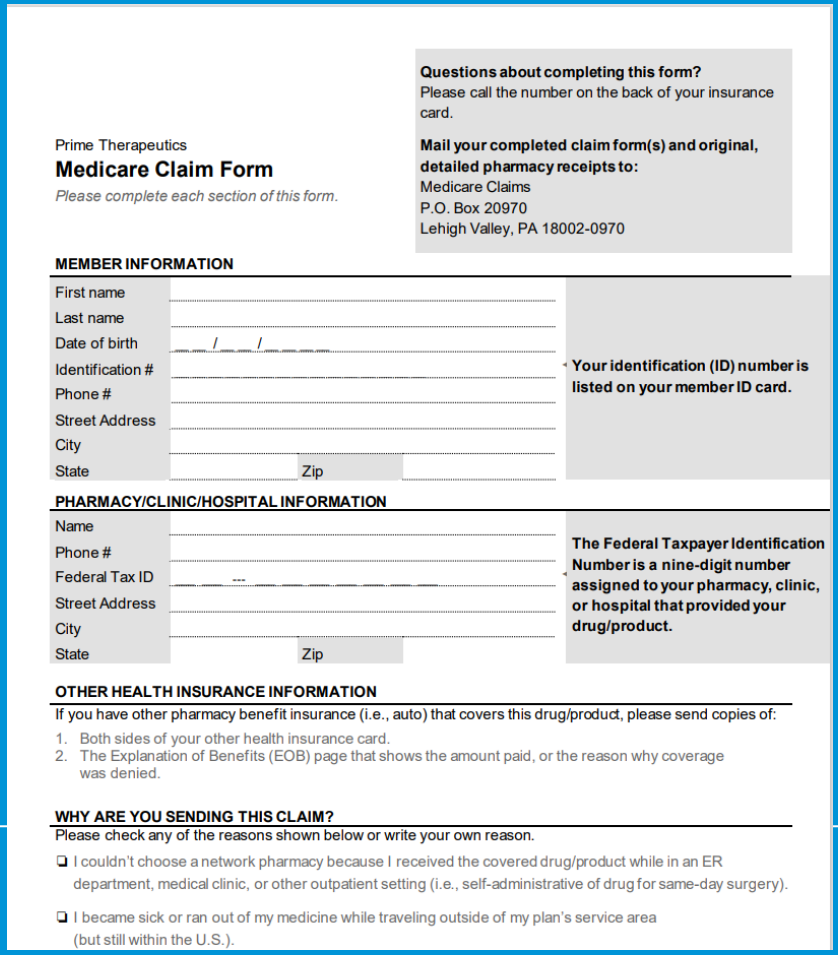
Medicare Part D Claim Reimbursement Form

- Reimburse member for all or portion of the amount for an OTC/Part D drug that member believes incorrectly charged.
- Options for reimbursement:
  - Pay bill & submit for reimbursement
  - Not pay the bill & submit invoice
  - Mail form to address on the form or fax to 1-800-693-6703
- Requests for reimbursement must be in writing
- Must include copy of paid receipt or unpaid invoice



Questions about completing this form?
Please call the number on the back of your insurance card.

Mail your completed claim form(s) and original, detailed pharmacy receipts to:
Medicare Claims
P.O. Box 20970
Lehigh Valley, PA 18002-0970

Prime Therapeutics

Medicare Claim Form

Please complete each section of this form.

MEMBER INFORMATION

First name
Last name
Date of birth ___/___/_____
Identification #
Phone #
Street Address
City
State Zip

Your identification (ID) number is listed on your member ID card.

PHARMACY/CLINIC/HOSPITAL INFORMATION

Name
Phone #
Federal Tax ID ___---_____
Street Address
City
State Zip

The Federal Taxpayer Identification Number is a nine-digit number assigned to your pharmacy, clinic, or hospital that provided your drug/product.

OTHER HEALTH INSURANCE INFORMATION

If you have other pharmacy benefit insurance (i.e., auto) that covers this drug/product, please send copies of:

1. Both sides of your other health insurance card.
2. The Explanation of Benefits (EOB) page that shows the amount paid, or the reason why coverage was denied.

WHY ARE YOU SENDING THIS CLAIM?

Please check any of the reasons shown below or write your own reason.

❑ I couldn't choose a network pharmacy because I received the covered drug/product while in an ER department, medical clinic, or other outpatient setting (i.e., self-administrative of drug for same-day surgery).

❑ I became sick or ran out of my medicine while traveling outside of my plan's service area (but still within the U.S.).

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90-DAY BENEFITS AT RETAIL

MAIL ORDER OPTIONS

HOME DELIVERY OPTIONS

90-DAY BENEFIT & HOW TO OBTAIN

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New in 2022

90-day supply benefit

- SecureBlue members may obtain a 90-day supply of their regular daily used medications. This is an expansion of this previous benefit.
- Benefits of filling medications as a 90-day supply:
  - Improved adherence
  - Increased convenience due to few trips to pharmacy
  - In COVID environment; safer

How Care Coordinator can help here

- Assist member with 90-day supply through:
  - Retail Pharmacies
  - Mail Orders
    - **Link to Alliance Rx Mail Order**
    - **Link to Express Script home delivery**
    - **Link to Express Script Order Form**
    - **Express Script 1-866-223-5618 to start**
- Home delivery is option in 2022
- **BCBSMN Pharmacy Directory pdf**

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SPECIALTY PHARMACY

SPECIALTY PHARMACY

- Currently, BCBSMN have several Specialty Pharmacies covered within our network
- Specialty medications are for diseases such a Rheumatoid Arthritis, MS, HIV, transplants, Oncology, etc,….
- Typically include specialist to counsel and educate on the health condition
- They discuss how to reduce disease progression, achieve treatment goals, manage any side effects and find most effective way to take the medications
- BCBSMN Pharmacy Network

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OVER THE COUNTER BENEFITS

WRAP LIST

CVS SUPPLEMENTAL BENEFIT

WRAP LIST (AKA OTCS)

BlueCross BlueShield Minnesota

- OTC drugs covered by Medicaid part of the SecureBlue benefits
- These are embedded within 2022 formulary. Will have (OTC) by it
- These OTCs can be obtained from the pharmacy and filled just like a prescription

2022

Name of Drug	What the drug will cost you (tier level)	Necessary actions, restrictions, or limits on use
Analgesics		
acetaminophen caps	$0 (OTC)	
acetaminophen chew tab 80 mg	$0 (OTC)	
acetaminophen chew tab 160 mg	$0 (OTC)	
acetaminophen elixir	$0 (OTC)	
acetaminophen gel	$0 (OTC)	
acetaminophen liqd	$0 (OTC)	
acetaminophen pack	$0 (OTC)	
acetaminophen soln 160 mg/5ml	$0 (OTC)	
acetaminophen soln 325 mg/5ml	$0 (OTC)	
acetaminophen suppos	$0 (OTC)	
acetaminophen susp	$0 (OTC)	
acetaminophen syrup	$0 (OTC)	
acetaminophen tabs	$0 (OTC)	
acetaminophen tbcr	$0 (OTC)	
acetaminophen tbdp	$0 (OTC)	
acetaminophen w/ codeine soln 120-12 mg/5ml	$0/$1.35/$3.95 (Tier 1 - Generic)	QL (2700 mls/30 days)
acetaminophen w/ codeine tab 300-15 mg	$0/$1.35/$3.95 (Tier 1 - Generic)	QL (360 tablets/30 days)
acetaminophen w/ codeine tab 300-30 mg	$0/$1.35/$3.95 (Tier 1 - Generic)	QL (360 tablets/30 days)
acetaminophen w/ codeine tab 300-60 mg	$0/$1.35/$3.95 (Tier 1 - Generic)	QL (180 tablets/30 days)
analgesic combinations	$0 (OTC)	
aspirin buffered	$0 (OTC)	
aspirin buffered (al hydrox-mg hydrox-ca carb)	$0 (OTC)	
aspirin buffered (cal carb-mag carb-mag oxide)	$0 (OTC)	
aspirin chew	$0 (OTC)	
aspirin suppos	$0 (OTC)	
aspirin tabs	$0 (OTC)	
aspirin tbec	$0 (OTC)	
aspirin-calcium carbonate	$0 (OTC)	
belladonna alkaloids & opium suppos 16.2-30 mg#	$0 (OTC)	
belladonna alkaloids & opium suppos 16.2-60 mg#	$0 (OTC)	
butalbital-acetaminophen tab 50-325 mg#	$0/$1.35/$3.95 (Tier 1 - Generic)	QL (180 tablets/30 days)
butalbital-acetaminophen-caffeine cap 50-300-40 mg#	$0/$1.35/$3.95 (Tier 1 - Generic)	QL (180 capsules/30 days)
butalbital-acetaminophen-caffeine cap	$0/$1.35/$3.95 (Tier 1 - Generic)	QL (180 capsules/30 days)

CVS OTC SUPPLEMENTAL BENEFIT

BlueCross BlueShield Minnesota

2022 OTC Supplemental benefits Catalog $50/quarter

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How to order by ***phone:***

1-888-628-2770 (TTY:711) Monday-Friday 9am-8pm CT

1. SecureBlue member ID
2. Full name, date of birth, and address on file
3. Need to provide codes from catalog you want to order
4. You will be given confirmation number, keep as reference

How to order online at ***CVS Online link:***

1. You will need to create an account
2. You will need the following to create account:
   a. SecureBlue member ID
   b. Date of birth, and email address, and zip code
   c. Each member needs own account
   d. As you add items to your basket, it will deduct from $50

Go to ***a CVS Store***, NOT all CVS pharmacies participate in this benefit. Please call 888-628-2770 (TYY:711) or go to **CVS participating store link** to find which store is by you. Remember to tell cashier you are using OTC Health Solution benefit. Provide member ID card BEFORE cashier scans OTC products

BCBSMN SecureBlue Supplemental Benefit link

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DIABETIC SUPPLIES

DIABETIC SUPPLIES

BlueCross BlueShield Minnesota

BCBSMN Covered Diabetic Supplies

SecureBlue covers Diabetic monitor & test strips:

- Ascensia
- One Touch

SecureBlue covers the following Continuous Glucose Monitors

- Dexcom
- FreeStyle

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MEDICARE APPROVED DIABETIC GOODS

Below is a list of Medicare approved diabetic goods for your health plan.

SecureBlue℠ (HMO SNP) covers these therapeutic blood sugar machines under Part B:

- Preferred Dexcom Monitors
- Preferred FreeStyle Libre Monitors

SecureBlue℠ (HMO SNP) covers the following preferred diabetic goods under Part B:

- Blood glucose test strips and meters: One Touch and Ascensia
- Diabetic lancets and lancet devices: One Touch and Ascensia

What you need to know

The brands above are covered at network pharmacies as well as any other goods noted in your plan facts. Please check your plan scope and cost share to make sure these goods are covered, as other brands may not be covered.

What you need to do

Talk with your doctor to see if these are the right products for you. Show your ID card when buying at a network pharmacy.

Questions? For questions about your drugstore benefits, please call the phone number on the back of your ID card or visit bluecrossmn.com/secureblue.

BlueCross BlueShield Minnesota

BCBSMN MEDICATION THERAPY MANAGEMENT

BCBSMN MEDICATION RECONCILIATION PROGRAM

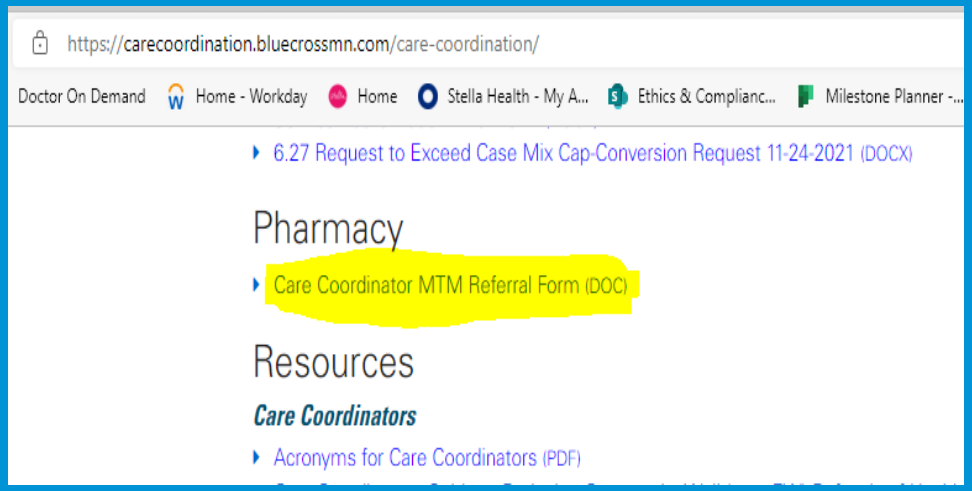
MEDICATION THERAPY MANAGEMENT

BlueCross BlueShield Minnesota

- This is a free Telephonic visit with a pharmacist
- This is also called Comprehensive Medication Review.
- All SecureBlue members have access to MTM
- A Pharmacist reviews all prescribed drugs, OTCs, and herbals use. They will evaluate for
  - Medications not being used correctly
  - Duplicate drugs
  - Unnecessary drugs
  - Need for a drug
  - Drug-drug interactions, drug-disease state concerns, etc,..
  - Plus patient education
- Pharmacist will send member after- visit document including short and long term treatment plans
- Pharmacist will send a copy to member's Primary Care Physician

MEDICATION THERAPY MANAGEMENT

- All SecureBlue members have access to MTM
- How can Care Coordinator help:
- Refer SecureBlue member to MTM
  - **Care Coordinator MTM Referral Form**
  - **1-866-873-5941 to set up appointment**
- Let the SecureBlue member know someone from BCBSMN will contact them to schedule telephonic MTM visit
- **FAQ on MTM**



MEDICATION RECONCILIATION

- Free program for SecureBlue members *following discharge from a hospital or short term SNF stay*
- A pharmacist will do an in person or telephonic review of member's list of discharge medications list to what they were taking
  - Collect an accurate medication history
  - Compare this history to all the transition orders
  - Correct any discrepancies.

- Pharmacist will:
  - Provide SecureBlue member with action plan/medication schedule
  - Send action plan to member Primary Care Physician (PCP)
  - Pharmacist will contact PCP if identified issue(s) is urgent
- The value of Med Reconciliation:
  - Omission of medications
  - Duplication of medications
  - Incorrect dose
  - Side effects from abrupt changes
  - *Decrease re-admissions by up to 50%*

MEDICATION RECONCILIATION

Role of care coordinator in Medication Reconciliation

Contact your SecureBlue member :

a. Let member know about Medication Reconciliation Benefit.

b. Share how this will help them.

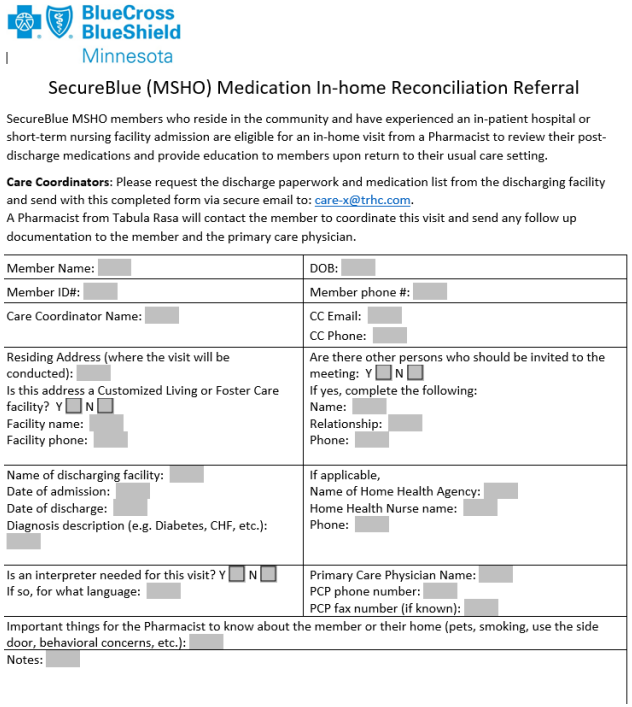
c. Let them know a pharmacist will be contacting them to arrange an in-home visit

d. Contact discharging facility to request discharge paperwork including medication list. If you have difficulty getting this from a facility provider here are some resources to assist:

   a. **HIPPA form to ask for discharge paperwork**

   b. **Letter to provider explaining care coordinator role and access to health protected information**

e. Submit discharge orders and medication list to pharmacist along with this **Medication Reconciliation Referral Form**



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SecureBlue (MSHO) Medication In-home Reconciliation Referral

SecureBlue MSHO members who reside in the community and have experienced an in-patient hospital or short-term nursing facility admission are eligible for an in-home visit from a Pharmacist to review their post-discharge medications and provide education to members upon return to their usual care setting.

Care Coordinators: Please request the discharge paperwork and medication list from the discharging facility and send with this completed form via secure email to: care-x@trhc.com.
A Pharmacist from Tabula Rasa will contact the member to coordinate this visit and send any follow up documentation to the member and the primary care physician.

Member Name:	DOB:
Member ID#:	Member phone #:
Care Coordinator Name:	CC Email: CC Phone:
Residing Address (where the visit will be conducted): Is this address a Customized Living or Foster Care facility? Y ☐ N ☐ Facility name: Facility phone:	Are there other persons who should be invited to the meeting: Y ☐ N ☐ If yes, complete the following: Name: Relationship: Phone:
Name of discharging facility: Date of admission: Date of discharge: Diagnosis description (e.g. Diabetes, CHF, etc.):	If applicable, Name of Home Health Agency: Home Health Nurse name: Phone:
Is an interpreter needed for this visit? Y ☐ N ☐ If so, for what language:	Primary Care Physician Name: PCP phone number: PCP fax number (if known):
Important things for the Pharmacist to know about the member or their home (pets, smoking, use the side door, behavioral concerns, etc.):	
Notes:	

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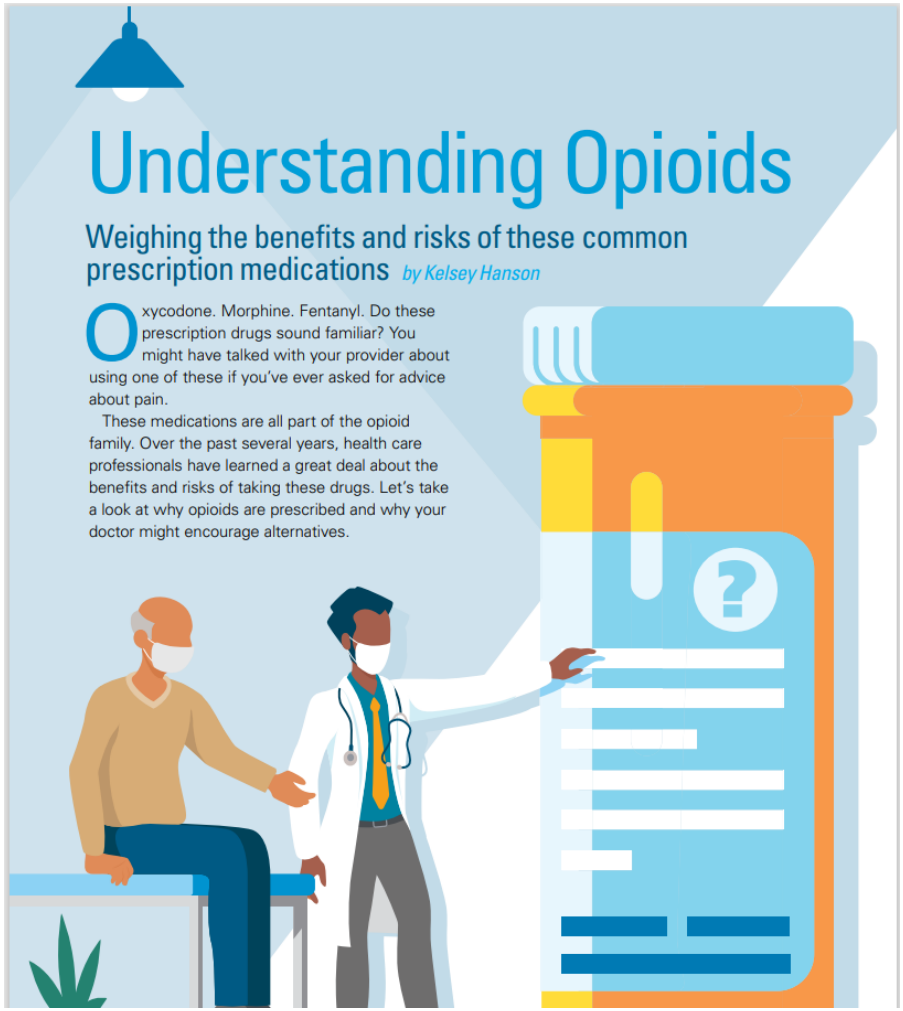
OPIOIDS AND SAFE DISPOSAL OF MEDICATIONS

OPIOID EDUCATION –HOW CARE COORDINATOR CAN HELP



- **Thrive article** (look for April edition)
- Long term use of Opioids
  - What is an opioid?
  - Concerns with opioids
  - Long term effects of opioids use
  - Alternative medications to consider
  - Alternative to medications
    - Acupuncture
    - Musical therapy
    - Chiropractic or spinal manipulation
- BCBSMN does cover Opioid Treatment program
  - Call BCBSMN customer service to learn more
- Refer to MTM Review (slide 40)

Find Naloxone (reversal of overdose of opioid)

SAFE DISPOSAL OF DRUGS

- It is important to dispose of medications no longer needed, old or expired drugs. Do not put dispose them in toilet or in trash. Why?
  - Prescribed medication maybe harmful for someone other than the user
  - Could harm animals if they find them
  - Could be toxic to the environment
  - Could be a temptation for those choosing to misuse or abuse certain medications
- Health plans are providing information on both safe disposal of medications & Drug Take Back sites to members

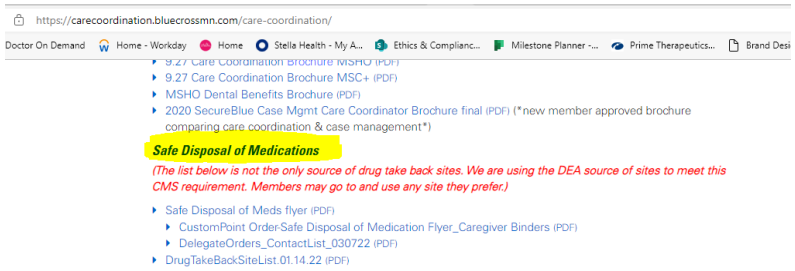
SAFE DISPOSAL OF MEDICATIONS

- How can a Care Coordinator help:
  - Remember to remove name & other information on the label
  - For Care Coordinators, this information is required to be provided to all MSHO community members seen face to face initially and document in case notes. They need to provide 2 locations.
- If take back location is not available, only use as a last resort:
  - Remove drugs from original container. Mix with something undesirable such as coffee grounds, dirt, cat litter.
  - Place in a resealable zipper storage bag, empty can to prevent leaking or spilling out
  - Throw container in garbage

Link to Safe Disposal Of Medication Flyer

Link to Drug Take Back List

Link to Thrive articles



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DOSEHEALTH DRUG DISPENSER

DOSE HEALTH DRUG DISPENSER

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Dose Health's Dose Flip is:

- Small portable smart pillbox
- Help our members to take right pills at the right time
- Can set up with alarms & flashing light to remind members to take their medications
- One pillbox will allow up to two times a day and a second device may be added at no additional charge to facilitate 3-4 times a day

How to use the Dose Health Pill Dispenser

Dose Health Care Coordinator Training Deck

Dose Health Benefit Instructions & FAQ

Blue Plus Dose Flip Referral Form for MSHO members

Fill out form and submit:

1. **referrals@dosehealth.com (email)**
2. **Fax to 844-525-0515**

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OTC COVID AT HOME TEST COVERAGE

OTC AT HOME COVID TESTS AND MEDICARE

BlueCross BlueShield Minnesota

- Medicare does not pay for OTC COVID tests obtained at the pharmacy yet. Anticipate guidance in the Spring 2022.
- Current access to free OTC at home COVID tests are:

MN DHS COVID 19 Testing information

MN DHS Testing Sites

Government free COVID tests

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LOW INCOME SUBSIDY (LIS)

LOW-INCOME SUBSIDY (LIS)

BlueCross BlueShield Minnesota

What is LIS?

- Assists people with limited incomes and resources with paying for their prescriptions. In this program, it helps pay for Medicare Beneficiary plan premiums (up to a benchmark amount) and at the pharmacy
- Copay amount for generic/preferred drugs is $1.35
- Copay for other drugs are no more than $4
- Copays for skilled nursing facilities is $0

- **Additional information on LIS**

QUESTIONS?

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THANK YOU

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