Provider Manual

Utilization Management
This section of the Manual was created to help guide you and your staff in working with Kaiser Permanente’s Utilization Management (UM) policies and procedures. It provides a quick and easy resource with contact phone numbers, important websites and detailed processes for UM services.

If, at any time, you have a question or concern about the information in this Manual, you can reach our Resource Stewardship Department by calling 1-877-895-2705.
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Section 4: Utilization Management

4.1 Overview of UM Program

The Kaiser Permanente Utilization Management program addresses quality management and resource stewardship across the care continuum. The ultimate goal is to determine what resources are necessary and appropriate for an individual Member, and to provide those services in the appropriate setting in a timely manner. Kaiser Permanente Utilization Management consists of five (5) main categories: Concurrent Review, Transition Care Management, Case Management, Referral Management/Pre-authorization, and Post Service Review.

Kaiser Permanente Utilization Management (UM) is a collaborative partnership between Permanente physicians of the Colorado Permanente Medical Group, UM nurses, and staff that ensure the appropriate treatment plans and resources are utilized for Member health care needs throughout the care continuum. Medical necessity decisions are made by licensed and board-certified Permanente physicians trained in utilization management policy.

No practitioner, provider or other staff member is rewarded for issuing denials of coverage or care. Additionally, financial incentives for Resource Management decisions do not encourage decisions that result in underutilization. Kaiser Permanente will ensure that all benefit/coverage determinations are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Kaiser Permanente will not make decisions regarding issues like hiring, compensation, termination, or promotion based on the likelihood that the person will support the denial of benefits.

To obtain a copy of the complete Resource Stewardship/UM program description, please call 1-877-895-2705.

4.2 Medical Appropriateness

Medically appropriate care is defined as care that is necessary for the diagnosis, treatment, and/or management of a medical, surgical, or behavioral health condition; within accepted standards of medical, surgical, or behavioral health care; and provided in the least intensive setting appropriate to the condition of the Member; not for the convenience of the Member, his/her family and/or provider.

Kaiser Permanente uses evidence based clinical guidelines in its Utilization Management activities. Kaiser Permanente uses nationally developed evidence based clinical criteria and internally developed criteria for appropriate resource management decisions. These criteria are applied along with medical expert opinions, when necessary, in making decisions and are available to practitioners on request. To obtain a copy of Resource Stewardship/UM criteria, or for making an appropriate practitioner reviewer available to discuss any UM denial decision please call 1-877-895-2705. Criteria are sent out via mail, HealthConnect or fax to practitioners, based upon requested delivery method.
All transplant services authorized by the Utilization Management Department at Kaiser Permanente will be evaluated to determine medical appropriateness based on Patient and Site selection transplant criteria developed by Kaiser Permanente’s National Transplant Network.

4.2.1 Notification and Timeliness of Coverage Determination

The UM Department has policies and procedures to ensure the timely notifications of adverse decisions when care is determined not to be medically appropriate.

Notification is made through either:
- Verbal notification - given to the member or authorized representative and the requesting provider after decision is rendered for urgent/expedited coverage determinations.
  - Electronic or verbal notification includes information on how to contact a UM reviewer or UM physician, and how to obtain a copy of the UM criteria applied to make the decision
- Written notification – either generated after the verbal notification is given or as soon as the coverage determination is made.
  - Written notification includes information on how to contact Member Services to file an expedited or standard appeal
  - Instructions where to obtain a copy of the UM criteria applied to make the decision

4.2.2 Timeliness of Decision and Notification

Kaiser Permanente adheres to regulatory timeframes in its decision making, verbal notifications, and written notifications in accordance with the Member’s jurisdiction or line of business. The processing of coverage determinations may vary by Member jurisdiction and/or applicable regulations governed by the laws of the state.

The timeframes for making coverage determinations are driven by the urgency of the request, and the type of review required/conducted: pre-service, concurrent, or post service review.

<table>
<thead>
<tr>
<th>UM ACTIVITY</th>
<th>Time to Make and Issue a Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If All Necessary Information Received</td>
</tr>
<tr>
<td>Emergent Care</td>
<td>Cannot require precertification. Must pay if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed, or if care was authorized by KP personnel.</td>
</tr>
<tr>
<td>Pre-service – Urgent Care</td>
<td>72 hours or sooner if condition requires</td>
</tr>
<tr>
<td>Medicare Expedited Determination (42CFR422.572)</td>
<td>72 hours or sooner if condition requires (must grant expedited review if request is supported by a physician or if standard timeframe could seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function). If request for expedited review is denied, must automatically process as standard request and promptly notify patient orally and in writing within 3 calendar days, including right to file a grievance and right to resubmit request for expedited review with physician support.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Pre-service – Non-Urgent Care</td>
<td>Reasonable period of time appropriate to medical condition, but no later than 15 days.</td>
</tr>
</tbody>
</table>
| **Medicare-Standard Timeframes (42 CFR 422.568)** | **14 calendar days** | date the info is received or the due date.  
The decision may be delayed by up to 14 calendar days if the Covered person requests the delay or if KP justifies a need for additional information and documents how the delay is in the interest of the enrollee - must notify patient of delay in writing and of right to file an expedited grievance. |
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<tr>
<td><strong>Concurrent Request to Extend Treatment</strong></td>
<td>If request to extend is received at least 24 hours prior to the expiration of the prescribed period of time or # of treatments, decision must be issued to Covered person and provider within 24 hours of request.</td>
<td>If request not received at least 24 hours prior to expiration, treat as pre-service request.</td>
</tr>
<tr>
<td><strong>Post-service The Administrative Services Only Third Party Administrator (“TPA”) reviews all post-service claims for self-funded Covered persons.</strong></td>
<td>Issue decision to Covered person and provider within a reasonable period of time, but in no event later than 30 days after the date of request.</td>
<td>Notify Covered person of information required prior to the expiration of the initial 30 days and advise of expected date of decision, can extend up to 15 days. Allow at least 45 days to submit requested information. The 15 days extension begins on the earlier of the date the info is received or the due date.</td>
</tr>
<tr>
<td><strong>Medicare (42 CFR 422.520)</strong></td>
<td>95% of clean claims from non-contract providers must be paid within 30 calendar days –</td>
<td>All other claims must be paid or denied within 60 calendar days from the date of the request.</td>
</tr>
<tr>
<td>Medicare Part D – post service request for payment (423.568)</td>
<td>Notify member of favorable determination (and make Payment) no later than 14 calendar days after receipt of the request</td>
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<tr>
<td><strong>Medicare Part D—Standard Request (42 CFR 423.568)</strong></td>
<td>Determination as expeditiously as the enrollee’s health condition requires, but no later than 72 hours after the date and time the plan receives the physician’s supporting statement.</td>
<td>If coverage is not made within 72 hours, forward the enrollee’s request and case file containing any oral and/or written evidence obtained to the IRE for review within 24 hours of the expiration of the time frame.</td>
</tr>
</tbody>
</table>
| **Medicare Part D—Expedited Coverage Determinations** | 1. A Part D plan sponsor that approves a request to expedite a coverage determination must make the determination, whether favorable or adverse, and notify the enrollee and the physician involved, as appropriate, of its decision as expeditiously as the enrollee’s health condition requires, but no later than 24 hours after receiving the request. (42 CFR 423.572)  
2. If the enrollee’s request involves an exception, the Part D plan sponsor must notify the enrollee and the physician involved, as appropriate, of its determination as expeditiously as the enrollee’s health condition requires, but no later than 24 hours after the date the plan receives the physician’s supporting statement. (42 CFR 423.578) | The Part D plan sponsor must automatically expedite the coverage determination when a request is made or supported by a prescribing physician, and the physician indicates, either orally or in writing, that applying the standard time for making a determination may seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.  
If a Part D plan sponsor does not provide notice of its expedited coverage determination within the required time frame, it must forward the complete case file to the IRE contracted by CMS within 24 hours of the expiration of the adjudication time frame. (42 CFR 423.578(2)) |
4.2.3 Referral Contact List

For general or specific Resource Stewardship inquiries, please call 1-877-895-2705 or fax to 1-866-529-0934. Staff is available to accept collect or toll-free calls during normal business days and hours (Monday through Friday 8:30 a.m. – 4:30 p.m.) Individuals who are deaf or hard of hearing may contact us by calling Relay Colorado at 1-800-659-2656 (toll free TTY or dial 711). Staff will provide a telephone interpreter to assist with UM issues to individuals who speak limited or no English free of charge. After normal business hours for the Colorado service area, please call our toll free number, 1-877-895-2705, your message will be forwarded to our UM staff; your call will be returned the next business day.

For Northern Colorado Mental Health or Chemical Dependency Outpatient Services:

Northern Colorado Behavioral Health Patient line: 970-807-7177

For Northern Colorado and Denver/Boulder Inpatient Admission Concurrent Reviews:

BH Utilization Management Nurse
Jen Szczepanski, BSN, RN
Phone: 303.367.2848
Fax: 303.344.7610

BH Physician Reviewer
Lee Clark, MD
Phone: 303-367-2903

For Denver/Boulder Mental Health or Chemical Dependency Outpatient services, call Behavioral Health Access Center 303-471-7700

**Highline Center Mental Health**
10350 E. Dakota Avenue
Denver, Colorado 80247

**Ridgeline Behavioral Health Center**
9139 S. Ridgeline Blvd.
Highlands Ranch, CO 80129

**Hidden Lake Mental Health**
7701 Sheridan Boulevard
Westminster, Colorado 80003

For Southern Colorado Behavioral Health Inpatient and Outpatient referrals:

Value Options Member Service Line: 866-702-9026
4.3 Referral Authorization Policy

You are required to contact Kaiser Permanente Resource Stewardship at 1-877-895-2705 and obtain referral authorization before services are rendered, or to determine whether a service requires prior authorization. Service prior authorization requirements are listed below. Failure to obtain prior authorization may result in denial of payment.

Prior written authorization ensures that only necessary and benefit-covered services are provided to our members and that you, in turn, are paid for those services. Authorization is provided with the use of the Prior Authorization Request form (see 4.5.11 below).

When interpreting requirements for prior authorization, please consider the general notes and list of services that require prior authorization. Services listed below are not exhaustive and are subject to change. For the most recent updated prior-authorization list, please utilize the link below:


**Services that require prior authorization:**

- Acute Rehab (inpatient+)
- Adult Preventative Services**
- Allergy Treatment and Injections**
- Ambulance Transportation (non-emergent)
- Autism Services
- Bariatric Surgery
- Blood Services (Denver/Boulder)
- Biofeedback
- Cardiac Rehab (no auth required for SoCo, NorCo or contracted Denver/Boulder providers)
- Chemical Dependency Services
- Children’s Specialty Clinic Services
- Chiropractic Services (Medicare Only)
- Dental (medical) services including oral maxillary services and temporomandibular joint treatment (TMJ)
- Dialysis Services
- DME/Orthotics/ Prosthetics+
- ENG/EEG/EMG Services**
- Family Planning and Surgical Sterilizations
- Gamma and Cyber Knife
- Genetics Counseling or Testing
- Home Health Services+
- Hospice+
- Hyperbaric Oxygen Therapy
- Implantable Devices
- Infertility Services
- Infusion Services
In Office Medications and Injectables
- Growth Hormone
- Asthma Management, e.g. Xolair
- CHF Management, e.g. Flolan, Tracleer
- Immunization for RSV, e.g. Synagis
- Immunosuppressive Management, e.g. Humira, Remicade, Enbrel, Tysabri, Ocrenica, Actemra
- Osteoporosis Treatment, e.g. Reclast, Prolia, Boniva, Xgeva, Zometa

- Inpatient hospital services
- Lapband Adjustment
- LTAC (Long Term Acute Care)
- Mental Health Outpatient Treatment
- Mental Health Services
- Observation Bed
- Office Circumcision Procedure
- Outpatient physical, occupational, speech therapy
- Outpatient Surgery and Related Services (excluding GI Scopes, NorCO and SoCO)
- Pain Management including epidural steroid injections
- Plastic Surgery
- Podiatry Services
- Pulmonary Rehabilitation
- Radiation/Oncology
- Radiology: MRI (including open and standing), MRA, CT/CTA, PET and Nuclear Med studies (Care Core National in SoCO and NorCO)
- Routine Well Child Preventive Services
- Sleep Study
- SNF (Skilled Nursing Facility)
- Therapeutic Abortions
- Transgender Services
- Transplants (organ and tissue)

**GENERAL NOTES:**

- Southern Colorado (SoCO) & Northern Colorado (NorCO): members do not require a referral for in-network providers.
- Denver/Boulder (D/B): Members require a prior authorization for non-Kaiser Permanente Plan Medical Office providers and services.
- Failure to obtain authorization prior to service initiation may result in payment denial.
- Cross Market access is limited to services within Kaiser Permanente Plan Offices.
- This list is a guide for which services require pre-authorization. Services listed are not exhaustive and are subject to change. Actual benefits are still dictated by plan design.
- Services that require an authorization assume they are billed independently.
- Any emergency admissions require notification within 24 hours or the next business day. Failure to provide notification may result in payment denial.
- **Prior Authorization required when in a Hospital clinic or Ambulatory Surgery Center (ASC) setting.
- + Contact your Continuing Care representative about your specific authorization criteria and process.

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4.3.1 Hospice Benefit

Hospice is appropriate for patients whose life expectancy is 6 months or less and have accepted the hospice philosophy of comfort care rather than cure.
Commercial and HMO Members must use a contracted hospice provider.

Medicare Advantage Members may choose any Medicare Certified Hospice. Hospice care is carved out of the benefit and paid by Medicare directly to the hospice provider.

4.3.2 Palliative Care

The following services are coordinated and administered by the Kaiser Permanente Palliative Care Department:

1) Inpatient Palliative Care Consultation: Providers can call for an inpatient consultation if they believe that their patients are seriously ill and that consultation with a interdisciplinary team would benefit their patients/families in discussing goals of care.

2) Outpatient Palliative Care: There are home and clinic-based palliative care programs available to members with serious illness and who need help managing pain or other troubling symptoms, understanding and coping with complex illness, finding comfort and control, as well as discussing wishes, goals, and planning ahead. Each program has specific eligibility guidelines, but when a patient is referred to outpatient palliative care, a Palliative Care Specialist RN or LCSW will contact the patient to assess palliative care needs and can then schedule patient for a visit with the appropriate team/service. To refer to any outpatient palliative care program in Health Connect, type in ref pal in order entry and select REF Palliative Care. If you need further assistance, you may page a Palliative Care Specialist RN or LCSW on-call at 303-203-1376. Pages are returned M-F 8:00 am – 4:00 pm.

4.4 Exemption Process for a Non-Contracted Provider Referral

If you are requesting authorization for services from a provider who is not included or covered by the Membership Agreement, please provide this information within the Prior Authorization Request Form via fax or AffiliateLink to the Kaiser Permanente Central Referral Center Department at 1-866-529-0934.

4.5 Referral Procedures

*The routine referral is the most frequently issued referral. After being seen or treated by a Colorado Permanente Medical Group, P.C. (CPMG) physician, or an affiliated network provider, the member may be referred to an affiliate practitioner, provider or facility. Denver/Boulder Service Area member may self refer for consultations (routine office visits) to specialty-care departments within Kaiser Permanente.*

Southern and Northern Colorado Service Area members may self-refer for consultations (routine office visits) to Plan Physicians identified as eligible to receive direct referral as outlined in the Kaiser Permanente Physician and Provider Directory, which is available on
Kaiser Permanente's website, www.kp.org or by contacting Provider Services at 1-(866) 866-3951.

The completed Referral Approval form is sent to the affiliated provider via AffiliateLink, fax or mail. All information related to pre-authorization of services is coordinated through the Central Referral Center, unless otherwise noted herein.

Kaiser Permanente
CENTRAL REFERRAL CENTER
Hours of Operation Monday through Friday 8:30 a.m. – 5:00 p.m.
Phone 1-877-895-2705
FAX 866-529-0934
It is your responsibility to obtain the written authorization prior to rendering services. Authorization is required prior to claim submission.

Clinical information is required in some cases. Printed clinical records may be faxed with the Authorization Request form. After consultation, please send clinical information reports and/or results to the referring provider.

Except in emergency cases, an affiliated provider may not refer Kaiser Permanente members to another provider without obtaining prior authorization. A Referral Approval form, authorized by a CPMG physician, is required for all secondary referrals. Please call the Central Referral Center if assistance is needed. Failure to comply with contract terms regarding secondary referrals will result in a deduction from future compensation to cover the cost of the unauthorized services by an unauthorized provider.

An approved Referral Form with the authorization number will be returned by KP Health Connect/AffiliateLink, fax, or mail to the requesting Provider and to the service provider. The member will be notified by telephone and/or mail.

4.5.1 Behavioral Health

Follow these steps to request a referral for any inpatient mental health or chemical dependency services:

In Denver/Boulder and in Northern Colorado, follow these steps to request a referral for any inpatient, acute treatment unit or partial hospital admission for mental health or chemical dependency issues:

1. Review the need for psychiatric or chemical dependency admission, verify benefits, and receive authorization for admission by paging the on-call psychiatrist at 303-203-5563.

In Southern Colorado, you are required to contact Value Options at 866-702-9026 to obtain a referral authorization for an admission.
Follow these steps to request a referral for any outpatient mental health or chemical dependency services:

In Denver/Boulder, all mental health and chemical dependency services are provided within the Kaiser Permanente Behavioral Health Clinics. Referrals to outside providers must be preapproved by the Behavioral Health Department. You are required to contact Kaiser Permanente’s Behavioral Health Access Center at 303-471-7700 to request a referral before services are rendered. Failure to obtain a referral may result in denial of payment.

In Northern Colorado, you are required to contact Kaiser Permanente’s Northern Colorado Behavioral Health Department triage team at 970-207-7177 to obtain a referral before services are rendered. Failure to obtain a referral may result in denial of payment.

In Southern Colorado, you are required to contact Value Options at 866-702-9026 to obtain a referral before services are rendered. Failure to obtain a referral may result in denial of payment.

4.5.2 Skilled Nursing Facility (SNF)

Kaiser Permanente contracts with selected Skilled Nursing Facilities to provide nursing and therapy rehabilitation to members who meet Medicare guidelines for admission. Hospital Case Managers are trained on how to place eligible members in a contracted SNFs where KP Care Coordinators follow their rehab progress weekly.

4.5.3 Home Health/Hospice Services

4.5.4 Adult Home Health

Members must be homebound and require the skill of a nurse or therapist to be eligible. Providers may order these services by faxing an order to one of our contracted Home Health Agencies. (HealthConnect users can utilize the Home Health Referral letter.)

4.5.6 DME

DME provided by Apria (oxygen equipment, PAP, mobility devices other than custom wheelchair, hospital beds, patient lifts, negative pressure wound therapy) can be ordered per the National Ordering Guide. Wound, urology, and ostomy supplies can be
ordered by faxing orders to Bryam Medical. (HealthConnect users can utilize the DME Referral letter.)

4.5.7 Required Documentation When Requesting a Referral

To request a referral for a service, you need to submit a completed referral request/Prior Authorization form to the KP UM Department. The Prior Authorization form is attached below in section 4.5.11. It may also be obtained by calling the Central Referral Center at 1-877-895-2705. Detailed information regarding referral procedures, including information required for a referral for specific types of services starts in Sections 4.3. Referrals are reviewed for medical appropriateness based on Milliman criteria, Medicare, and Kaiser Permanente guidelines. If your request is approved, we will issue an authorization number, which must be used when submitting claims. If your request is denied, we will notify you and the Member and provide information regarding the process for appealing the determination.

Note the following limitations on referrals:

- Referrals are valid as detailed on the authorization unless terminated or revoked by KP.
- If the referral expires or you recommend additional or different services, you must seek an extension or modification of the referral.
- Only one (1) visit or service is allowed per referral, unless otherwise indicated.
- A referral is valid only if:
  - The Member is eligible on the date of service and
  - The Member has coverage for the services under the Membership Agreement.

4.5.8 Pre-Service Review

Pre-service review is primarily handled by the Central Referral Center in Resource Stewardship. Pre-service reviews are processed according to the urgency of the request.

Urgent care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (1) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or (2) in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Selected procedures and services must be reviewed by the nurses prior to authorization.
4.5.9 Concurrent Review (Inpatient/Outpatient)

Inpatient admissions (acute and sub-acute) are reviewed by Inpatient Quality Resource Coordinators. Ambulatory service concurrent review is performed by Rehabilitation Services and Continuing Care. The above reviews are performed for medical, surgical, and behavioral health care settings. Concurrent review involves a combination of reviewing medical records against approved criteria; gathering information from practitioners, providers, and patients; and consulting with UM physician and nurse managers as needed.

Concurrent review is performed on care delivered in acute, sub-acute, and ambulatory settings:
- Observation (short stay)
- Acute inpatient hospitals
- Outpatient rehabilitation facilities
- Partial Hospitalization and Intensive Outpatient behavioral health services

For Continuing Care, Skilled Nursing Facilities and Acute Rehabilitation facilities have weekly Care Coordinator review. Home Health services review is for recertification and/or visits above the initial authorization.

4.5.10 Post-Service Review (Retrospective)

The Central Referral Center staff use approved criteria to perform retrospective utilization review of medical, surgical, or behavioral healthcare services that required, but did not receive, pre-authorization.
### 4.5.11 Referral Form

A Referral Form can be found at the following link: (example below)


**Colorado prior authorization request form**

Fax to: 866.529.0934

Requests will not be processed if they are missing Clinical Information, CPT or ICD codes

For preauthorization questions, please call: 877.895.2705

<table>
<thead>
<tr>
<th>Priority of Request</th>
<th>Type of Request</th>
<th>Region</th>
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<tbody>
<tr>
<td>☐ Routine (processed in 14 days)</td>
<td>☐ Initial Request</td>
<td>☐ Denver / Boulder</td>
</tr>
<tr>
<td>☐ Urgent (Care required within 72 hours)</td>
<td>☐ Modification Request*</td>
<td>☐ Northern Colorado</td>
</tr>
<tr>
<td>Additionally Check if Surgery ☐</td>
<td>☐ *Existing Auth #:</td>
<td>☐ Southern Colorado</td>
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**MEMBER INFORMATION**

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<thead>
<tr>
<th>KP #:</th>
<th>Date Of Birth:</th>
<th>Phone:</th>
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<tbody>
<tr>
<td>Last Name:</td>
<td>First Name:</td>
<td>Middle:</td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
<td>State:</td>
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**SERVICE INFORMATION**

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<thead>
<tr>
<th>Date or Range of Service:</th>
<th>☐ Inpatient</th>
<th>☐ Outpatient</th>
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<tbody>
<tr>
<td>Place of Service (Name):</td>
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<tr>
<th>CPT / HCPC</th>
<th>Quantity / # of Visits</th>
<th>Procedure / Description</th>
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**Referred By**

Physician:

Specialty:

Phone:

ICD Code:

Description:

Comments:

**Referred To**

Physician:

Group name:

Specialty:

Phone:

Office Fax:

Fax Auth To:

Address:

City: State: Zip:

August 2014
4.6 Emergency Care and Inpatient Admission

Emergent request for care: A request for care arising from a sudden, severe, and unexpected sickness, injury, or condition (including severe pain) that a prudent layperson would believe threatens his or her life or limb (or with respect to a pregnant woman, the health of the woman or her unborn child) in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. Emergent care does not require prior authorization.

Once the patient is evaluated (screened) and stabilized in the emergency room, the contracting facility is responsible for notifying KP of all emergency admissions (Observation or Inpatient services). Calls must be received within 24 hours or next business day of the admission (Observation or Inpatient services). Failure to notify Kaiser Permanente within this time frame may result in the denial of payment for services. Contact the Telephonic Medicine Center at 303-743-KPMD (5763) to notify Kaiser Permanente of admissions (Observation or inpatient services.)

For Behavioral Health admissions to any inpatient mental health or chemical dependency services, page the on-call psychiatrist at 303-203-5563. In Southern Colorado, you are required to contact Value Options at 866-702-9026 to obtain a referral for an admission.

Provide the following information:
- Member Name
- Member Identification Number
- Your name
- Admitting Hospital or Facility
- Admitting Diagnosis
- Proposed Treatment and LOS
- Date of Admission

Current arrangements with contracted and select non-contracted facilities include on-site review by Quality Resource Coordinators or other licensed professional staff, during normal business days (Monday - Friday) and during normal business hours (8:30 am - 4:30 pm). No additional advanced scheduling is required. If/when new facilities are reviewed by Quality Resource Coordinators or other licensed professional staff, specific arrangements will be made with each facility to assure adherence to facility rules and expectations.

4.7 Case Coordination/Management

Our Care Coordination team is comprised of Transitions of Care RN’s and RN Care Coordinators. The role of the Transition of Care RNs is to deliver evidenced based care to members that are discharged from the hospital or skilled nursing setting. Each Transitions of Care RN is trained to deliver a set of interventions that is tailored to the individualized member and their risk of readmission to the hospital. The Transitions of Care RNs’ provide a follow-up phone call within 48 hours of the discharge; the focus of
the call is patient education, medication reconciliation and education, and working with
the member to ensure that post hospital follow-up is complete. This team works in
collaboration with providers to proactively assess, identify, coordinate, monitor and
evaluate medical problems and service needs of the Member’s condition.

4.7.1 Complex Case Management

Kaiser Permanente offers enhanced care management for patients suffering from both
chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF)
conditions with recent hospitalizations. This special case management program
(Complex Case Management) is facilitated by our RN Care Coordination team to assist
patients in regaining an optimal health status and improved function.

Southern Colorado Service Area: 719-282-2560 or 1-877-870-6735 or TTY: 719-282-
2569 or 1-877-870-7646 (Toll Free).

Northern Colorado Service Area: 970-207-7180 or 1-877-870-6735 or TTY: 970-207-
7181 or 1-877-870-7646 (Toll Free).

Business hours are Monday through Friday, 7:00 a.m. to 7:00 p.m.

4.8 Disease Management

The disease management program is managed by the Population Care & Prevention
Services (PPS) Department, in collaboration with Primary Care, Pharmacy, Specialty
Departments, and the Care Management Institute (“CMI”), an NCQA-certified disease
management program that was formed in 1997 to support and promote Kaiser
Permanente nationally by delivering evidence-driven, cost effective, population-based
care for priority populations. CMI-led, inter-regional collaborations have defined and
revised care management programs for priority populations such as asthma, diabetes,
coronary artery disease, and heart failure. Kaiser Permanente is committed to delivering
culturally competent care and supporting patients in self-care, self-management of
chronic conditions and shared decision making.

4.8.1 Asthma Program

The Asthma disease management program provides specialized support to practitioners
and their patients diagnosed with asthma. Staffed by registered nurses, the
Asthma/COPD Care Coordinators (ACCs) work closely with Primary Care, Specialty
Care, Nursing and Pharmacy to:

- Outreach to patients with an Emergency Department (ED) visit for an asthma
  exacerbation;
• Provide patient education when requested by the Primary Care Physician or specialists in the Allergy or Pulmonology Department;
• Perform Spirometry to better assess asthma;
• Provide education for staff to correctly perform and document spirometry;
• Implementation of region-wide use of the “Albuterol Refill Protocol”;
• Develop asthma action plans in collaboration with patients.

The asthma program is also supported by the Allergy Department, which sees patients who were hospitalized for asthma. In addition, the Clinical Pharmacy Department supports our regional asthma program from a medication therapy perspective and outreaches unique groups of patients who are at risk.

If you believe your patient may benefit from this program, please contact 303-338-4545 or 303-338-4428 (TTY).

4.8.2 Chronic Obstructive Pulmonary Disease (COPD)

The care for members with COPD is supported by COPD disease management and Case and Care Coordination departments. The COPD Program collaborates with Primary Care to reduce hospitalization and emergency department visits utilizing patient reported out comes to improve symptom control and decrease the impact on daily activities. The COPD Governing Board oversees all COPD population management efforts. The Asthma/COPD Care Coordinators (ACCs) work closely with Primary Care, Specialty Care, Nursing and Pharmacy to:

• Identify patients at risk for hospitalization and provide education, smoking cessation advice and support, symptom recognition and information on medications in an effort to help them manage their disease and prevent ED visits and/or hospitalizations to maintain best quality of life.
• Outreach to newly diagnosed COPD patients that do not have a confirmatory spirometry.
• Give Pneumovax vaccine during visit if needed

Registered Nurse Care Coordinators focus on preventing readmissions of COPD patients by:

• Outreaching to patients with phone call within 24-72 hours post hospital discharge;
• Facilitate scheduling of 3-5 day post discharge appointment with PCP;
• Making appointments to have spirometry at 4-6 weeks after an exacerbation to look for changes in spirometry that would necessitate a change in their management;
• Referring patients who have had 2 or more COPD ED visits or hospitalizations in the prior 12-month period to the Pulmonology department.

If you believe your patient may benefit from this program, please contact 303-338-4545 or 303-338-4428 (TTY).
4.8.3 Diabetes Care Program

While the vast majority of diabetes management is handled by primary care physicians, practitioners and eligible patients are supported by various care teams within the Diabetes Care Program.

1. Quality Support Team
   This team reviews several quality gap lists and sends charts to the primary care team with recommendations to resolve gaps. This proactive management is designed to improve:
   - Lipid Lowering (LL) therapy
   - Hypertension control
   - A1C screening and control
   - Retinal screening
   - Diabetes foot exam screening

2. Centralized Glycemic Management RNs
   Our centralized team of registered nurses provide a wealth of diabetes services and focused outreach to patients with type 2 diabetes (DM2) over the age of 18 on insulin. Glycemic Management RNs will evaluate the patient holistically to provide patients with, but not limited to:
   - Direct patient phone line for any diabetes question or concern (303-614-1628)
   - Reminders for all members with diabetes (type 1 and type 2) when labs or primary care visits are due
   - Focused outreach and individualized goal development
   - Longitudinal medication titration and follow up for DM2 patients on insulin
   - A1c results management and quality gap review for DM2 patients on insulin
   - Self-monitoring consultation
   - Educational materials
   - Community resource information
   - Lifestyle coaching

   Support is also provided to primary care teams in the management of patients with diabetes through an advice/consult line 303-614-1728 (Toll Free 1-877-452-1250) or 1-800-659-2656 (TTY).

3. Diabetes Clinical Pharmacy Specialist
   A Diabetes Clinical Pharmacy Specialist focuses on adults with uncontrolled blood sugars on oral medications. Support includes titration of oral medications, recommending lifestyle modifications and discussing the need for insulin where appropriate.
4. **Health Education**
   Patients can explore total health resources for themselves and their families, including fitness, nutrition, mind and body health, weight maintenance, and more.

5. **Endocrinology**
   Endocrinology is available as a consultative service for any provider in the region. They manage type 1 diabetes and complicated type 2 diabetes, as well as, all insulin pump patients.

If you believe your patient may benefit from the Diabetes Care Program, please contact 303-614-1728 (Toll Free 1-877-452-1250) or 1-800-659-2656 (TTY).

### 4.8.4 Cardiovascular Disease (including Coronary Artery Disease, Heart Failure, and Hypertension)

The Coronary Artery Disease (CAD) program consists of a collaborative effort between the Cardiac Rehabilitation team, the Clinical Pharmacy Cardiac Risk Service (CPCRS), Primary Care Physicians, and Chronic Care Coordination. These teams work alongside each other to achieve optimal cardiac outcomes.

Cardiac Rehabilitation focuses on optimizing cardiovascular risk reduction to eligible patients following hospitalization for an acute coronary, while CPCRS focuses on long-term management of patients with a history of CAD. Cardiac Rehabilitation services are provided by registered nurses (under the direction of Kaiser Permanente Cardiologists) and CPCRS services are provided by pharmacists (under the direction of Kaiser Permanente primary care physicians). Eligible patients will receive a customized care plan that includes, but not limited to: medication reconciliation, making medication adjustments as needed, quality checks for medication adherence, educational materials and secondary risk-factor modification assistance.

Some patients in the Cardiovascular Disease Management program have needs that extend beyond their cardiac condition. These patients receive services from Chronic Care Coordinators, in addition to services offered by Cardiac Rehabilitation and CPCRS. Chronic Care Coordinators are located in primary care offices and work closely with physician teams. They will facilitate transitions, partner with other coordinators and prevent re-hospitalization by collaborating with primary care and specialty care. Patients with Hypertension are primarily managed by Primary Care Providers along with consultation from specialists as needed.

If you believe your patient may benefit from these programs, please contact Cardiac Rehabilitation at 303-861-3441 or CPCRS at 303-326-7666 (Toll Free 1-866-875-0025). Chronic Care inquiries can be routed through Case and Care Coordination Services at 303-614-1065 or 1-800-659-2656 (TTY).
4.9 Transplant Complex Case Management

All transplant services require a pre-authorization prior to rendering services. Transplant authorizations are issued for three stages of a transplant case:

1. **Pre-transplant Evaluation and Care**: Services provided to a patient being evaluated for transplantation or are waiting for transplantation. This stage usually begins when a patient is listed for transplantation.

2. **Transplant Period**: This stage begins the day of the transplant and concludes at the end of the follow up period as defined in the Agreement. This authorization will cover both inpatient and outpatient services. When services are reimbursed by a case rate payment methodology, the case rate is inclusive of all charges, including, but not limited to, both hospital and physician services.

3. **Post-Transplant**: This stage covers outpatient follow-up services following the transplant period, but may also include inpatient and home health services.

Failure to obtain authorization prior to providing services will result in a denial of payment.

4.9.1 Transplant Authorization Form

The following pages are samples of the Transplant Authorization forms. These forms are intended to provide authorization for treatment and care. If you have any questions related to the services requested on the authorization form, call the Transplant Coordinator that manages the patient’s care:

- Last name starting with A through L: Karla Engle (303) 636-3260
- Last name starting with M through Z: Mary Gay Trott (303) 636-3119
- General Referral questions: 1-877-895-2705

The Kidney Transplant Referral Form can be found at the following link:

The form is in Word to allow for easy editing prior to faxing.

4.10 Drug Formulary Management

Kaiser Permanente uses several drug formularies depending on the type of benefit plan and/or service area the member resides in. Using formulary medications helps Kaiser Permanente maintain a high quality of care for our Members, while helping to keep the cost of prescription medications affordable. Kaiser Permanente uses closed formularies and relies upon the prescription benefit plans to determine if and how non-formulary medications will be covered. Kaiser Permanente also uses medication utilization...
management tools such as quantity limits, step therapy, MD specialty requirement, day supply limitations, and prior authorization requirement for various prescription drugs. These tools may be utilized differently amongst the various drug formularies. You will find detailed information regarding the drug formularies and our various formulary management policies in the sections to follow. To obtain a copy of any of our drug formularies, please visit the provider website at http://www.providers.kaiserpermanente.org/cod/pharmacy.html. For a hard copy request, please contact Member Services at 303-338-3800 or 1-888-681-7878.

4.10.1 Drug Formularies

Kaiser Permanente uses closed formularies, which means that only those medications included in the formulary are covered under the Member's prescription drug benefit. Non-formulary or medications with limitations/restrictions may be covered but require authorization through the medication exception process as described in Section 4.11. The drug formularies are developed, updated and maintained by groups of Kaiser Permanente physicians, pharmacists, and nurses who meet regularly to evaluate medications that are most effective, safe, and useful in caring for our Members. Drugs are selected for the formulary based on a number of factors including safety, efficacy and cost. Kaiser Permanente reviews and updates the formularies regularly throughout the year.

Note:
Kaiser Permanente offers benefits in three different service areas across the Front Range. In broad terms these service areas include: 1) the Denver/Boulder metropolitan areas, 2) the Northern Colorado areas generally north of Loveland, CO, and 3) the Southern Colorado areas south of Larkspur, CO. There are many similarities and a few differences between the three service areas which are described in the following sub sections.

HMO Benefits

Denver/Boulder and Northern Colorado – follow a closed formulary titled Colorado Denver/Boulder/Northern Areas formulary – HMO

Southern Colorado – follow the drug formulary titled Southern Colorado formulary – HMO

Marketplace plans

Denver/Boulder, Northern Colorado and Southern Colorado – all three service areas follow the open formulary titled the Marketplace Exchange Drug Formulary
EPO (Self Funded) plans and Federal Employee Commercial Groups

Denver/Boulder, Northern Colorado and Southern Colorado – all three service areas follow the open formulary titled the EPO/Federal Group Commercial Formulary

Medicare Part D Benefits

Denver/Boulder, Northern Colorado and Southern Colorado – all three service areas follow the open formulary titled the Kaiser Permanente Medicare Part D formulary

PPO and POS (Tiers 2 & 3) Benefits

Denver/Boulder, Northern Colorado and Southern Colorado – all three service areas follow the open formulary titled the Denver/Boulder/Northern/Southern Colorado Preferred Product List

These drug formularies and preferred products list can be found within the Community Provider Portal at http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html?

Or you may obtain a copy of any of our drug formularies by contacting Member Services at 1-888-681-7878.

4.10.2 Limitations

Kaiser Permanente uses medication utilization management tools such as quantity limits, step therapy, MD specialty requirement, day supply limitations, and prior authorization requirement for various prescription drugs.

Tools utilized include:

- **Restricted to Specialty:** A drug that needs to be written by a provider specialized in the treatment of certain conditions for the drug to be covered under the member’s prescription benefit. For example, budesonide (oral), a drug used for colitis, may be restricted to providers specialized in Gastroenterology.
- **Prior Authorization:** Some drugs require specific medical criteria be met prior to dispensing the drug for the members prescription benefit.
- **Quantity Limits or Quotas:** For certain drugs, Kaiser Permanente limits the amount of medication dispensed to a certain quantity per copay. For example, the migraine medication Zomig® may be limited to 18 tablets per 30-day copay. In addition, other drugs may be limited to a specific day supply. For example, Tarceva® may be limited to a 30 day supply. Lastly, in the event of a national shortage of a drug, Kaiser Permanente may limit the quantity of the drug dispensed per prescription per copayment.
- **Restricted to Benefit:** Some drugs are not covered unless the member’s benefit specifically covers such medications. For example, Viagra® and similar drugs
used for sexual dysfunction are not covered unless the members prescription benefit specifically states to cover them.

- **Step therapy:** Some medications require a similar therapy be attempted first. For example, before lansoprazole can be dispensed, a drug such as omeprazole must be tried first.

These tools may be utilized differently amongst the various Kaiser Permanente drug formularies. Please refer to the specific drug formulary for details. The drug formularies may be found at: http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html?

To request a Formulary Exception please refer to section 4.11 below

In addition to the limitations listed above, Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs in the event of a drug shortage or as a means to reduce waste or abuse. These specific quantity limitations may not be reflected in the drug formularies. For more information please contact Kaiser Permanente Drug Information at 303-739-3550.

### 4.10.3 Fraud, Waste & Abuse

An important component of our prescription drug program and a requirement of the Medicare Modernization Act (MMA) is the responsibility of Kaiser Permanente to ensure the integrity of the prescription drug program. Kaiser Permanente will work closely with the Centers for Medicare and Medicaid Services (CMS), CMS’ contractors, and others to prevent fraud, waste and abuse of the prescription drug program. If you have questions or want to report suspected or potential fraud, waste and abuse problems, please call our Compliance Hotline at 1-888-774-9100.

### 4.10.4 Therapeutic Interchange

Kaiser Permanente utilizes Therapeutic Interchange programs to promote rational, safe, and effective drug therapy. Prescribing provider approval is required before an exchange occurs. Affiliated providers may be notified of a request for therapeutic interchange via phone, fax, email or mailed letter. This notice will be prior to the implementation of a change.

### 4.10.5 Generic Utilization

To ensure cost effective therapy, generic equivalents are utilized when available and appropriate. Only generic equivalents approved by the FDA are used. Pharmacies may substitute a preferred generic drug for a prescribed name brand drug unless prohibited by the physician as Dispense As Written.
4.10.6 Specialty Medications

Kaiser Permanente utilizes a list of medications which are considered to be specialty drugs. These medications are typically medications which require special dispensing and/or monitoring or are high cost medications. Some prescription drug plans may have a defined copay/coinsurance tier for specialty drugs, and these drugs may be limited to a 30 day supply. To verify a Member's drug coverage, or to obtain or view the Kaiser Permanente Specialty Drug List please refer to the Community Provider Portal at: http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html?

4.10.7 Changes to the Formularies

Kaiser Permanente may add or remove drugs from the drug formularies throughout the year. If we remove drugs from our formularies, add limitations or restrictions, or move a drug to a higher cost sharing tier, affected members and providers will be notified prior to the effective date of the change. CMS requires that plans notify affected members and providers at least 60 days before the date that the change becomes effective or at the time the member requests a refill of the drug. Kaiser Permanente also notifies our pharmacy personnel.

In the event that the FDA deems a drug on the formulary to be unsafe or the drug's manufacturer removes the drug from the market, Kaiser Permanente will remove the drug from our formulary and provide notice to members who take the drug and the providers prescribing the drug. Kaiser Permanente will also notify our pharmacies and pharmacists.

4.10.8 Formulary Addition/Deletion Requests

Our KP Pharmacy and Therapeutics Committee and Formulary Committee will consider requests to add or delete medications on our drug formularies by affiliated providers, members and pharmacists. To download a form to submit a formulary addition/deletion request please visit the Community Provider Portal at: http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html?

4.10.9 Drug Recalls

In the event of a drug recall Kaiser Permanente will provide timely written notification to prescribing providers and affected members of a Class I recall and other recalls as deemed appropriate. Notifications will be sent within 10 days of a Class I recall or within 30 days of a Class II or Class III recall, public health advisory or product withdrawal notice, if deemed necessary for safety reasons by the Kaiser Permanente Drug Recall Review Group. For a sample drug recall notice please visit the Community Provider Portal at: http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html?
4.11 Exception Process for Non-formulary Medications

There may be occasions when non-formulary or medications with limitations are medically necessary to provide the best care for a Kaiser Permanente member. The Medication Exceptions Process facilitates prescription drug coverage for medically necessary non-formulary, restricted or limited drugs. The following medication exception process exists for these instances.

4.11.1 Medication Exception Request contact information

You may request a medication authorization via the following methods:

- Telephone 1-866-523-0925, Monday through Friday 8:00 a.m. to 5:30 p.m.
- Fax 1-866-455-1053
- Use Cover My Meds services at www.covermymeds.com and choosing the Kaiser Permanente Colorado General Form and using the Fax Request option
- Mail a Medication Request Form to:
  - Kaiser Permanente Pharmacy Benefits Dept.
  - 1975 Research Pkwy, Suite 250
  - Colorado Springs, CO 80920

A medication request form can be found on the Community Provider Portal at: http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html

4.11.2 Medication Exception Process

4.11.2.1 Timeframe

Once Kaiser Permanente receives a medication exception request the Prior Authorization Review Team will log and review it for thoroughness. If a supporting statement of medical necessity is not evident, Kaiser Permanente will request that one be submitted. Once the PA Review Team receives a supporting statement and all necessary information an intensive review will be performed and a determination will be made. Determinations will be made on non-urgent requests for Commercial members within 14 days of receipt of all necessary information and 72 hours for urgent pre-service requests. For Medicare Part D members determinations will be made within 72 hours for non-urgent and within 24 hours of receipt of all necessary information for urgent pre-service requests.

4.11.2.2 Determination

For Non-formulary medication requests approvals will be granted only if there is documentation of ineffectiveness of formulary alternatives or the reasonable expectation of harm from the use of formulary medications. In most cases, members must have failed at least two formulary alternatives or have experienced adverse effects from the
use of formulary medications. For medications with limitations approvals will be granted if there is documentation sufficient to meet the specific criteria related to the limitation. If a request does not meet criteria, formulary alternatives will be recommended.

4.11.2.3 Notification

Notification of a determination will occur the same day as the determination. For approvals Kaiser Permanente will fax the requesting provider a notice of approval including any limitations placed on the approval. For denials Kaiser Permanente will fax a copy of the denial notice the same day as the determination, in addition to mailing the denial notice to the requesting provider.

4.11.2.4 Rights after denial

When medication exception requests are denied, the member has the option of purchasing the drug at full price, requesting coverage through a secondary insurance or appeal the decision. As a provider you also have a right to request a reconsideration (a peer to peer conversation) which is an opportunity to discuss the denial further. You may find more detailed information regarding rights after denial in Section 4.12 below.

4.11.3 Medications requiring authorization

Kaiser Permanente uses drug formularies, which means that only those medications included in the formulary are covered under the Member’s prescription drug benefit. Drugs not appearing on the formulary are considered “Non-Formulary”. Non-formulary medications may be covered without authorization under the member’s benefit for a different co-payment/coinsurance based on the members’ specific prescription benefit coverage. However, in the Denver/Boulder and Northern Colorado service areas, the non-formulary drug is only covered for benefit if approved through the medication exception process.

In addition to the non-formulary drugs, authorization will be necessary if the prescription exceeds the restriction or limitation that is placed on that specific medication. For details regarding the limitations used please refer to the drug formularies on the Community Provider Portal at: http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html?

For specific information regarding the guidelines, restrictions or limitations Kaiser Permanente utilizes please refer to the Community Provider Portal at: http://providers.kaiserpermanente.org/html/cpp_cod/pharmacytoc.html?

4.11.4 Urgent versus Non-urgent requests

There are some instances where a medication request requires an urgent decision. In these cases please mark the request as urgent or expedited. These instances are:

- The drug is necessary to complete a specific course of therapy after discharge from an acute care facility
• The time frame required for a standard/non-urgent review would compromise the member's life, health or functional status
• The drug requires administration in a time frame that will not be met using the standard/non-urgent process

4.11.5 Medicare Part D transition process

Part D plan sponsors are required to establish an appropriate transition process for new and current enrollees to assure timely access to Part D drugs. A transition supply is to be offered when an eligible Part D drug is not on the drug formulary or if the ability for a member to receive that drug is limited. Kaiser Permanente offers an open formulary to our Part D members, thus parts of this process will not apply. In the case of a transition Part D plan sponsors are to cover a temporary 30-day supply (unless the prescription is written for fewer days) during the first 90 days the member’s coverage is effective. The transition process applies to both current enrollees that may be affected by year-to-year formulary changes as well as new enrollees transitioning into Kaiser Permanente. If the member is unable to receive a medication exception for the non-formulary drug or have the drug switched to a formulary alternative, the member will have to pay full price after the first 30-day supply.

If a member resides in a Long Term Care facility we will cover up to a 31-day supply of a transition medication during the first 90 days the members coverage is effective with Kaiser Permanente.


4.11.6 Medicare Part D exceptions

Kaiser Permanente offers an open formulary to our Medicare Part D members. This means that all medications designated as Part D eligible are covered in one of the tiers of the members benefit, and medications specifically excluded from Part D by CMS are not covered. Tier exceptions may apply to Kaiser Permanente Part D members, but are not offered for prescriptions drugs in the specialty tier of the benefit. The official Medicare Part D Coverage Request Form can be found on the KP Medicare Part D information page at:
https://healthy.kaiserpermanente.org/health/care//lut/p/c4/HctNDolwEEDhE02mE4gUdyD0Coq7SRINk_6YsZJ4e9C85ZeHdzzKvlUn11AyR7zh4iVX0bMvm6iskGQN_s9veBRNn8j6xevvZK3BR8GiJdu3w2TAnWYDRDPB2LgOLmSmrnHWun7EV0rDDivobHo/

Or you may use the contact information found in 4.11.1 to submit a request.