PhilRx FAQ

PHIL

Medication Access, Simplified.

General

What makes a “clean” script?

- **Patient information:** first and last name, DOB, address, cell phone number, email
- **Provider information:** first and last name, NPI and/or DEA, address, office phone and fax, signature (if script is faxed)
- **Medication information:** name, strength, patient directions (SIG), quantity, # of refills
- **Other:** ICD-10, tried and failed including duration of treatment, chart notes
    - **IMPORTANT:** Some payers require the ICD-10 before the tried/failed medications can be input into the PA. Please message the importance of including ICD-10 with tried/failed medications to ensure we can input this information before sending the PA to the HCP for review and submission to the payer.
    - If the script it sent via fax, the written date and HCP signature are needed

Will there by live PhilRx reps available to address questions from office staff and patients?

- Yes. Phone lines are open between 9am-9pm EST Monday through Friday and 9am-5pm EST on Saturday and Sunday and holidays.
    - Office staff: email mdhelp@phil.us or call 855.977.0975
    - Patients: login to my.phil.us or email help@phil.us

General

How does the rep portal differ from the program dash?

- The rep portal will only show scripts that have been pending HCP action for 48 hours. The program dash shows all scripts, not just scripts pending action. If you don't see anything in the rep portal that means the provider's scripts are on track. The following statuses will surface when HCP action is needed:
  - In Progress: Patient Enrollment
    - Need patient info from prescriber
      - Missing phone number
      - Incorrect/Landline phone number
      - Missing address
      - SMS failed

  In Progress: Obtaining Coverage
  - Need Rx clarification from prescriber
    - Missing/invalid SIG
    - Missing/invalid quantity
  - Need Info from Prescriber
    - Missing HCP info
    - Invalid HCP info
    - Open question with prescriber
  - Need PA submission from Prescriber

Program Dash

How does an order get pended and what does this status mean?

- Generally orders are placed in a pended status when Phil has made multiple attempts to obtain the information we need to continue processing the prescription, and the patient or provider has not responded.
- Program Dash statuses are explained in the Status dictionary and pasted below:

Program Dash Status	Details
Pended: Pharmacies not contracted	We do not have a contracted partner for this prescription and have contacted the patient for their preferred local pharmacy. We have not heard back from the patient with this information.
Pended: Insurance exception	Phil has contacted the patient via SMS/Email 3 times for additional details regarding their insurance coverage but have not heard back.
Pended: Patient Decision	Patient decided to pend the order.
Pended: Need patient coupon or waiver	Patient has not enrolled in the coupon/waiver and we do not want to present a high copay to the patient. Phil has contacted the patient 2 times vis SMS/Email with this information.
Pended: Payment exception	The patient approved their payment and entered a payment method that failed. Phil has since contacted the patient 3 times via SMS/Email regarding their payment method and have not heard back.

Program Dash

Pended Statuses Continued:

Program Dash Status	Details
Pended: Need patient to opt out of insurance mail order	The patient's plan requires them to use a specific mail order pharmacy and we have contacted them to opt out before we can proceed with their order. Phil has contacted the patient once with this request.
Pended: Prescriber Action	We need additional information from the HCP before we can proceed with the order and have not heard back. Phil contacted the HCP 3 times and have not heard back.
Pended: No payment approval	Phil has contacted the patient for payment 3 times and the patient has not approved payment on their order.
Pended: SP mandated transfer	The plan requires the patient fill with a specific pharmacy and we are waiting for the patient to provide the transfer pharmacy to us. We have contacted the patient once with this request before pending.
Pended: Prescriber denied request for more refills	Phil contacted the HCP for additional fills for the patient but they did not approve them

Provider Workflow

Where does a provider or MA need to enter the patient's cell phone number?

- Enter the patient's cell phone number in the notes to the pharmacist

How does the provider/office staff enter chart notes?

- There is a notes to pharmacist/additional information section located in most EMR systems. If a provider isn't able to attach chart notes via their EMR when they send a script to PhilRx, they can make a note in the EMR that they will be sending chart notes via fax.

What is PhilRx's role in the PA process?

- PhilRx will begin the PA Process through CoverMyMeds® (CMM) by pre-filling all provided information in the PA. We then notify the provider that the PA is ready for review and monitor for submission and determination.

How much of the PA will be filled out when it's sent back to the office? Will they just need to hit "submit"?

- In most cases providers will just click SUBMIT upon receipt from PhilRx, but some plans may have one or more questions that need to be completed before the PA can be submitted for a determination. **For example,** some payers require the ICD-10 before the tried/failed medications can be input into the PA. Please message the importance of including ICD-10 with tried/failed medications to ensure PhilRx can pre-populate the PA with this information before sending to the HCP for review and submission to the payer.

Provider Workflow

Why are some of my providers receiving “blank” PAs from PhilRx?

CoverMyMeds has recently switched its PA interface to a new view both on the pharmacy and HCP side. Our understanding is the goal of this change is to only display the absolute necessary PHI to the user, obscuring some of the PHI (patient demographics) PhilRx pre-fills in the PA.

This new HCP view has resulted in the patient address to appear as if it has not been completed and is required that the HCP complete (see screenshot below). This info has been pre-populated by PhilRx, but the patient address information is obscured on the HCP side. This is a CMM-side display where PhilRx has no influence and cannot impact how it appears for HCPs.

As such, PhilRx has instructed HCPs to continue to use the “old view” in CMM (there is a toggle option in the new display view). However, CMM will be phasing out this old view option, so PhilRx requests your support with the following:

1. Reassure HCPs that PhilRx is pre-populating patient demographic info. They can still click submit even though the information is highlighted in red.
2. If they are unable to submit as the form indicates there is something missing, we recommend they check the diagnosis code (ICD-10) field first, as this is commonly missed and may not have been sent with the original script for PhilRx to pre-fill.
3. If there are any HCPs that are struggling with submission, please encourage them to contact PhilRx at (855) 977-0975; option 2, and we are more than happy to assist.

Provider Workflow

Will PhilRx submit the PA to the payer for a determination?

- PhilRx will initiate PAs via CMM. When the PA is ready, it will be sent to the HCP (along with the CMM key) for review and submission to the payer. PhilRx can't submit the PA directly to the payer. The PA needs to be submitted by the HCP/office staff.

What if the office doesn’t click “submit” on the PA?

- PhilRx will make three attempts to have the office review and submit the PA. We also send weekly HCP summaries with any outstanding/open PAs listed. After these three outreach attempts, the prescription status will change to pending PA submission.

How does the office change their fax/email/phone number?

- They can either contact PhilRx through email mdsupport@phil.us or phone 1-855-977-0975

Provider Workflow

What if the PA can't be submitted via CoverMyMeds?

- If a PA can't be submitted via CoverMyMeds, we will notify the HCP that a PA is required via their preferred communication method (email/fax) and will provide them with the details on how to submit (e.g. call this number or visit this website)

What should the provider do if the PA "times out" in CMM?

- The provider should click the "renew" button in CMM. Any patient/provider demographics and drug information that was sent with the script and input by PhilRx will populate, but any clinical questions from the second part of the form will need to be re-entered.

What if a patient already has a PA on file?

- If the patient has an approved PA on file we will get a covered claim when we run the eBV and the patient will proceed to copay approval. If the patient has a denied PA, we need proof of denial to immediately process for the $0 copay. Otherwise, we will proceed with the standard workflow and initiate a PA in an attempt to gain coverage.

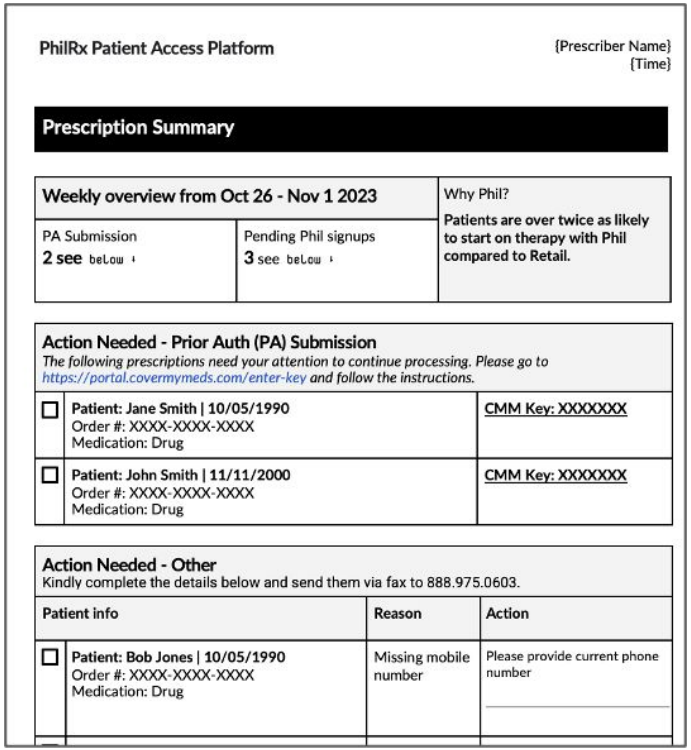
What does missing SIG mean?

- SIG tells the pharmacy what they should include on the drug's label to ensure the patient will know how and when to take the medication. Missing SIG means the script did not include instructions on how to administer the medication

Provider Workflow

What information is included on the HCP weekly summary fax?

- The HCP weekly summary fax includes a list of **active orders created in the last 30 days and orders that were canceled in the last 7 days**
- The fax is sent to HCPs every Monday morning via fax, email, or both depending on the preference of the office
- The fax is organized into sections based on orders that require attention from the provider, orders that require attention from the patient, and orders that are being shipped or have recently shipped in the last 7 days.
    - For **action needed items**, there are instructions for the office to submit PAs or follow up with information that PhilRx needs to move orders forward
    - For **recently filled prescriptions**, this will include the patient's name, date of birth, medication (including day supply), and the copay they received.
    - Orders that are **pending payment** from the patient will only show on the HCP summary if 72 hours have passed since the patient was initially notified their price is available to approve



PhilRx Patient Access Platform

{Prescriber Name}
{Time}

Prescription Summary

Weekly overview from Oct 26 - Nov 1 2023		Why Phil?
PA Submission **2 see** below ↓	Pending Phil signups **3** see below ↓	**Patients are over twice as likely to start on therapy with Phil compared to Retail.**

Action Needed - Prior Auth (PA) Submission

The following prescriptions need your attention to continue processing. Please go to https://portal.covermymeds.com/enter-key and follow the instructions.

☐	**Patient: Jane Smith | 10/05/1990** Order #: XXXX-XXXX-XXXX Medication: Drug	CMM Key: XXXXXXX
☐	**Patient: John Smith | 11/11/2000** Order #: XXXX-XXXX-XXXX Medication: Drug	CMM Key: XXXXXXX

Action Needed - Other

Kindly complete the details below and send them via fax to 888.975.0603.

	Patient info	Reason	Action
☐	**Patient: Bob Jones | 10/05/1990** Order #: XXXX-XXXX-XXXX Medication: Drug	Missing mobile number	Please provide current phone number

Provider Workflow

What is the process for “paper prescription” accounts?

- The office can call or fax PhilRx directly to process the prescription. The rest of the process will be identical to the normal process outreach cadence with CMM.
  - Phone: 855.977.0975, option 1
  - Fax: 888.975.0603

Will offices have an opportunity to pick a specific pharmacy in PhilRx’s network?

- No, the script will be routed to a pharmacy in the PhilRx network contracted with the patient’s insurance and delivered to the patient

Patient Workflow

What is the timeframe for the patient to receive communication after the prescription has been submitted through EMR to PhilRx? What is the method of communication?

- The patient should receive a text from PhilRx within minutes from the prescription being sent. There are rare occasions when a text message will be delayed, typically because a cell phone number for the patient was not sent with the Rx. If there are any issues with receiving the text, the patient will be contacted by PhilRx within 24 hours. If the patient doesn't engage with the text, PhilRx will call the patient.

If the patient doesn't hear from PhilRx, what should their next step be?

- The patient should contact their HCP to confirm the prescription was sent to PhilRx

What is the process when an SMS fails?

- If an SMS fails PhilRx will make outbound calls from their call center and leave a voicemail. They will also reach out to the HCP to try and get a cell phone number.

How many times will PhilRx contact the patient to enroll and how will they receive that communication?

- The patient is notified 6 times. Initial text on Day 0, text reminder, phone call, and voicemail on Day 1, text reminder and phone call (no VM) on Days 2-5. The final attempt is on Day 5.

Patient Workflow

How do refills work?

- **Automatic Refills:** If patients are set up for automatic refills, the refills are automatically processed based on the "Days of Supply" as written by their doctor. PhilRx will send a notification 7 days in advance to let them know that we will be processing a refill via email or text message, depending on their communication preferences. This gives patients ample opportunity to pause the prescription if they do not need a refill at that time.
- **Manual Refills:** If patients have government-sponsored insurance, they will be set up for manual refills. Commercially insured or uninsured patients may also request manual refills. If patients are set up for manual refills, they will receive an automatic notification from PhilRx when their refill is ready to process, and they will need to log into their account to approve the refill. If the patient would prefer manual refills, from their MyPhil account, they can pause their order until they are ready for a refill, or they may update their refill preference to manual.

What happens if a patient pauses their automatic refills?

- PhilRx will send a notification 7 days in advance of their refill being ready to process to remind patients their order is paused and they need to unpause to get their fill

Patient Workflow

Can the specialty pharmacy that a provider is committed to send the Rx to PhilRx if they receive a denial?

- Just like any pharmacy, a pharmacist can transfer a Rx to another pharmacy but they must obtain permission from the patient first. The denial may be accepted by the patient's plan, but they may also request a new PA, which would further delay the patient receiving their shipment.
    - **Keep in mind the benefits of sending scripts to PhilRx**:
        - **Patient experience:** simple, mobile driven support to unlock the best price, automated refills, and free delivery
        - **Provider experience:** in workflow, PA support, more patients start and stay on therapy

Does the patient need to supply a credit card even with a zero-dollar copay?

- PhilRx does not require a payment method when the patient's copay is $0. To maintain compliance with PBM requirements, the patient digitally signs an authorization through the MyPhil portal during their first fill. This gives PhilRx permission to dispense the first fill and continue sending refills automatically.
    - If the patient's first fill was free and they have a copay for refills, we will request a payment method in order to dispense the refill. After the patient provides their payment method once, we will keep it on their account to make dispensing automatic refills easier. If the patient's copay increases again for future fills, we contact them to have them review the new price before we ship their next fill.
    - If the patient opts out of our auto-refill program, we will request their permission to dispense each fill and during this time, they will be able to review pricing and other order details before approving. We do keep the patient's payment method on file for refills after it is provided once even if the patient has opted out of auto-refill. This helps minimize errors if the patient has to add their card information multiple times."

Patient Workflow

How quickly can patients expect to receive their order once a PA is submitted to the payer for review?

- Time to receipt will vary. Once a PA is submitted the script will continue to process. This includes adjudication of the script, patient approval of the copay (even if it's $0), fulfillment by the partner pharmacy, and delivery.

TRANSFER OUT: What happens if an insurance plan mandates the patient go to their mail order pharmacy?

- PhilRx is contracted with most plans across our partner pharmacy network. In the rare instance that we are not contracted with the patient's plan or do not have a partner pharmacy who can bill their insurance and ship to their address, the patient will be offered the option to transfer their prescription to a local pharmacy with the goal of getting them the best price possible using their insurance. This will show up as **"Pended: Pharmacies not contracted"** in the Program Dash. The patient will be notified and asked to provide the name, address, and phone number of their preferred pharmacy so the prescription can be transferred. Since PhilRx does not manage or always have access to the plan's preferred pharmacy network, we encourage the patient to contact member services to confirm which pharmacies are in-network and accepted by their insurance before they tell us which pharmacy we should transfer the prescription to. If required, PhilRx will initiate a prior authorization (PA) prior to transferring out the prescription so the order may be covered by the patient's plan at their local pharmacy. If the script is transferred out, the patient is not able to get the PhilRx pricing and will instead get the retail pharmacy pricing.

Patient Workflow

What name appears on the cell phone if PhilRx calls a patient?

- The call comes from Healthcare
- The numbers PhilRx will use to reach out to the patient:
  - 744-579
  - 855-977-0975

How is the product shipped?

- Shipping will vary based on program business rules. The patient will receive a tracking number via text with the pharmacy name.

Can PhilRx process Tricare scripts?

- Yes, but the patient may be required to use a Tricare preferred pharmacy

What days of the week does Phil ship?

- It's dependent on the pharmacy, but most scripts ship Monday-Friday. PhilRx will process new scripts up to 9PM EST on Friday. Shipping processing cutoff requires the patient to approve payment several hours prior to final courier pick up time.

Patient Workflow

I see that a patient's PA was approved but I do not see the cost for the patient. What does this mean?

- The script status and sub status will help you to understand what is happening with the prescription. In this case, we expect that the status is pending, and the sub-status is pending pharmacy not contracted. That means this patient is one of the rare occasions that a plan is not contracted within our network.

Will PhilRx sign patients up for automatic refills?

- Yes, PhilRx will contact the patient 1 week prior to the expected dispense if they haven't already signed up for automatic refills

Process for Refill Too Soon scripts?

- When the pharmacy processes a prescription and the insurance returns a rejection of "refill too soon", the insurance will provide the earliest date they will allow the patient to have the prescription filled. Our system will automatically schedule the refill to that date. The patient will receive a text and an email notifying them of the insurance requirement and modified refill date. The patient will also be notified via text and email when their refill is available and getting set to fill.

What languages does PhilRx support?

- Enrollment messages are sent in English and Spanish. Additionally, PhilRx utilizes a third-party language line (150+ languages supported) to help support additional language needs as required during phone calls with the patient. If a patient does not respond to initial text-based outreach, PhilRx will reach out to the patient via a phone call to assist and can conference in the 3rd-party language support.

Rejection Codes

PA required rejections

- 608: Step Therapy, Alternative Drug Therapy Required Prior to Use of Submitted Product Service ID
- 78: Cost exceeds maximum
- MR: Product not on formulary
- 21: Missing or invalid Product/Service ID

Plan requirements rejections: this messages that the patient may be covered, but some details (typically quantity and days supply) need to be changed before the plan tells us whether the patient is covered or a PA is required:

- 73: Additional Fills are Not Covered. (Plan mandates specific pharmacy usage. Sometimes the patient can opt out of this requirement, so we notify them and instruct them to call insurance to confirm whether they can continue utilizing Phil's services)
- AG: Days Supply Limitation for Product/Service.
- D/S Exceeded
- M/I Quantity Dispensed

Patient is not insured or needs to update member ID number

- N1: No patient match found
- 52: Non-matched cardholder ID
- 06: Missing or invalid group ID
- 41: Submit Bill To Other Processor or Primary Payer
- 11: Missing or invalid Patient Relationship code

Insurance Exceptions

What are insurance exceptions?

- Insurance exceptions can occur for several reasons
- The claim was rejected by the insurance (prior authorization is required)
- The claim could not be billed to the insurance because additional information is needed.
    - Most insurance exceptions are because the patient provided their medical benefit information instead of the pharmacy benefit information that we need.
        - We attempt locating the patient's insurance information. If we are unable to obtain it, we contact the patient 3 times via their preferred method of communication and leave 2 voicemails with instructions around how to resolve the exception.
- The patient's plan is inactive or the demographics information the plan has is different from what Phil was provided.
    - To resolve these insurance exceptions, the patient must contact their insurance directly. We contact the patient 3 times via their preferred method of communication and leave 2 voicemails with instructions around how to resolve the exception.

Tier Exceptions

What is a tier exception (TE)?

- Tier exceptions are used to help eligible covered patients potentially lower the patient copay. Per Medicare Part D law, a tier exception request can be submitted when the medication is not excluded from the plan's formulary (Plan Benefit Exclusion - rejection code 70 or Non-formulary - rejection code MR). If the medication was covered without a prior authorization or received a rejection code 75 indicating a prior authorization was needed, PhilRx will initiate a tier exception before offering the plan stated copay to the patient. The original rejection codes are visible in the Coverage Info dropdown of the Program Dashboard. If a tier exception was initiated for an order already, this will be visible in the Order Timeline dropdown section.
    - **If the TE is approved:** the copay may be lowered and we share the reduced copay with the patient
    - **If the TE is denied:** we notify the patient of the original plan-provided copay
    - **If the TE does not get submitted or does not receive a determination:** we offer the patient the original plan-provided copay

Is a Medicare patient who receives a non-formulary rejection and an approved PA eligible for a tier exception to potentially lower their co-pay?

- Non-formulary rejections that are later approved are not eligible for tier exceptions by Medicare law