BEAUMONT SPECIALTY PHARMACY

A service of Beaumont Pharmacy Solutions

We are experts in managing your patient's oral and self-injectable **infectious disease** therapies, including:

- all HCV antivirals
- all HIV antivirals
- all adjuvant oral antibiotics and antifungals

REFERRING YOUR PATIENTS IS EASY.

STEP 1

E-prescribe to:
BEAUMONT PHARMACY SOLUTIONS
(Warren, MI)
OR
Fax Rx to: 586-753-4169

STEP 2

Fax the items needed to complete the prior authorization paperwork (see back for checklist) to 586-753-4169

NOTE

Our pharmacy staff uses Epic. Offices using Beaumont Epic Ambulatory EHR do NOT need to fax lab work, progress notes, or anything else stored within the medical record.

BETTER ADHERENCE. BETTER OUTCOMES.

Our program approach produces patient medication adherence rates that exceed nationally published metrics.*

We deliver results through:

- access to a clinical pharmacist 24/7 for both physicians and patients
- assistance with insurance determination, prior authorizations and appeals
- help with enrollment in financial assistance programs to reduce out of pocket expenses
- coordination of self-injection training, if requested
- monthly follow-up calls and refill reminders to enhance patient adherence
- choice of free medication delivery or convenient pickup at one of 10 Beaumont pharmacies

** 2017 Asembia Specialty Pharmacy Summit*

Beaumont Specialty Pharmacy's patient adherence rates exceed nationally published metrics.

Beaumont vs National rates	
Hepatitis C	98.5% vs 91%
HIV	95.8% vs 90%

COMMUNICATION IS KEY.

Our goal is to partner with you, your staff and your patients to ensure the process is as simple as possible. We do this through consistent, clear communication that won't leave you or your patients wondering the status of their treatment.

We provide fax updates to providers:

- upon receipt of referral, PA submission and PA determination
- each time the medication is dispensed
- if the prescription has to be transferred due to insurance requirements

We call patients:

- upon receipt of prescription for registration into the program
- upon insurance authorization determination
- each month to assess therapy progression and schedule refills

PRIOR AUTHORIZATION **REQUIREMENTS**

Please fax the following information to 586-753-4169.

HEPATITIS C TREATMENT:

- ☐ hepatitis C virus (HCV) genotype
- ☐ treatment status
  - ☐ naïve
  - ☐ experienced (indicate previous treatment)
- ☐ fibrosis/cirrhosis status
  - ☐ elastography (fibroscan) findings
  - ☐ imaging confirming cirrhosis (e.g. abdominal ultrasound, US, MRI if applicable)
- ☐ progress notes discussing treatment plan
- ☐ HCV RNA quantitation (viral load)
  - ☐ must be within the past 28 days for Medicaid patients
  - ☐ must be within the past three months for other insurers
- ☐ AST, ALT, T. Bili
- ☐ BUN, SCr, GFR
- ☐ height, weight and pregnancy test results (if childbearing age)
- ☐ current prescription and OTC medications

HIV/AIDS (HUMAN IMMUNODEFICIENCY VIRUS) TREATMENT:

- ☐ progress notes discussing HIV diagnosis