5.0 Pharmacy Management

5.1 Pharmacy Benefits

The Health Plan is committed to effectively managing prescription drug benefit costs and providing members with affordable access to prescription drugs. Pharmacy benefits for many of our members are administered through FLRx, the Health Plan’s internal pharmacy benefit administrator. Providers should direct pharmacy benefit authorizations or inquiries to the FLRx Pharmacy Help Desk. The FLRx Pharmacy Help Desk telephone numbers and address are listed on the Contact List in Section 2 of this manual.

Note: Prescription drug benefits are added to many health benefit programs by means of a rider. Not all health benefit programs include a prescription drug benefit. Member ID cards for programs that include drug benefits administered through FLRx include an FLRx logo on the ID card.

5.2 Medication Guides

The Health Plan makes available to employers a variety of formularies, including both the three-tier and closed formulary drug benefit plans. The Pharmacy and Therapeutics (P&T) Committee, composed of practicing community physicians and clinical pharmacists, defines the drugs in each category. The committee meets regularly to review the drugs on the Medication Guides.

The three-tier and closed medication guides can be viewed on the Health Plan’s Web site, excellusbcbs.com. From the Provider page, click on Prescription Drugs. Provider offices that do not access the Internet may request a paper copy from the FLRx Pharmacy Help Desk. (See Contact List in Section 2.)

https://www.excellusbcbs.com/providers/prescription_drugs/provider_three_tier_drug_list.shtml

5.2.1 Three-Tier Drug Plan

This drug benefit design provides three tiers of coverage with a graduating scale of patient copayment/coinsurance based on the tier assignment of the prescribed drug. Members play a vital role in controlling the rising cost of prescription drugs, and this three-tier benefit gives them the incentive to make informed decisions about the medications they take.
The three tiers are categorized as:

- **Tier One.** Generally, generic drugs. Generic drugs have the same active ingredients, strength and effectiveness as their brand-name counterparts but at a substantially lower cost.
- **Tier Two.** Generally, brand-name products selected because of their overall value.
- **Tier Three.** All other prescription drugs. This includes FDA approved drugs that are pending placement by the FLRx Pharmacy and Therapeutics Committee.

The three-tier prescription benefit focuses on cost-sharing. Members using Tier Three drugs will be responsible for the highest out-of-pocket expenses.

### 5.2.2 Closed Formulary

The closed formulary prescription drug benefit is designed to provide value. Under a closed formulary, only specific drugs in each therapeutic class are covered.

- **Formulary Generic Drugs.** Generic drugs that meet Health Plan requirements for a Formulary Generic drug. Generic drugs have the same active ingredients, strength and effectiveness as their brand-name counterparts, but at a substantially lower cost. Not all generic drugs will be Formulary Generic drugs.

- **Formulary Brand Drugs.** Prescription drugs that have been selected as Formulary Brand drugs because of their overall value.

The closed formulary design ensures that members and practitioners have adequate options in each therapeutic category. Formulary drugs include most generic and selected brands. Medications classified as non-formulary are generally not covered under the benefit. Non-formulary medications must meet medical necessity criteria through an exception process in order to be covered under the member's prescription benefit. (See later paragraphs headed *Prescription Drugs Requiring Prior Authorization.*)

**Note:** The names of non-formulary drugs are italicized on the 3-Tier Medication Guide of Commonly Prescribed Drugs.

### 5.2.3 Closed Formulary for Child Health Plus and Family Health Plus

The Health Plan's Child Health Plus and Family Health Plus prescription benefits are managed by FLRx. Both plans use the same unique closed formulary.

The *Closed Formulary Prescription Drug List for Child Health Plus and Family Health Plus Members* can be viewed on the Health Plan’s Web site from the area describing either program. To view it, one must go in as a member or guest and select *Health Plans*, then select coverage "I can purchase on my own, not through an employer" from the scroll down menu.

Providers who do not access the Internet from the office may obtain a paper copy upon request from the FLRx Pharmacy Help Desk. (See the *Contact List* in Section 2 of this manual.)
5.3 Online Edits
The FLRx online drug claims processing system provides safety and accuracy checks. As a prescription is filled, the system checks it against a series of safety and quality criteria, including:

- **Quantity Limits.** Limits apply based on standard FDA-approved dosing and established, clinically appropriate dosing parameters.
- **Dose Efficiency.** Quantity limits may also apply when a prescription calls for multiple pills (of specific medications) to be taken daily when a single, higher-dose pill is available, and the use of multiple pills is not supported by medical necessity.
- **Drug Utilization Review (DUR) Messaging.** Messages assure member safety by providing information about possible drug interactions, duplications and dosing errors.

5.4 Prior Authorization
Some drugs require prior authorization before they can be dispensed. FLRx has developed a list of medications requiring Prior Authorization, Letter of Medical Necessity (LOMN), or Step Therapy Exception Requests. The list is subject to change. The most current version is available on the Health Plan’s Web site or from the FLRx Pharmacy Help Desk.


5.4.1 Prescription Drugs Requiring Prior Authorization
FLRx has available a drug-specific prior authorization form for each drug or drug category. For those drugs requiring prior authorization, prescribing practitioners must complete and submit the appropriate prior authorization form.

The most current version of each form is available on the Health Plan’s Web site. From the Provider page, click on Prescription Drugs. From the menu on the left, select Prior Authorization Forms. At this point, the provider will be prompted to either log in or register. Providers who are not currently registered may do so directly by completing the required information. Providers who do not know their Web access ID numbers should contact Trading Partner Support. (See Contact List in Section 2 of this manual.)

https://www.healthcareplan.com/apps/Security/DisplayLogin

Practitioners may also call the FLRx Pharmacy Help Desk to request the appropriate form. FLRx will fax or mail the form directly to the requestor. (Telephone numbers and addresses are listed on the Contact List in Section 2.)

**Prescribing practitioners must complete all required fields on the prior authorization forms. FLRx will return incomplete forms for correction before a review determination can be made.**

Practitioners are to fax Prior Authorizations, Letters of Medical Necessity or Step Therapy Exceptions to the FLRx Pharmacy Help Desk. (The fax number is included on each form.) An automatic server will fax back the responses to the practitioner’s office within 48 hours of receiving each request.
Offices without access to a fax machine may call or write to the FLRx Pharmacy Help Desk to request prior authorization approval. To expedite the process, providers should have all required information available prior to placing the call.

5.4.2 Step Therapy Program

The Step Therapy program promotes the use of clinically sound generics and cost-effective therapeutic alternatives in select therapeutic classes. The program provides recommendations for prescribing first-line medications. The program applies to members with prescription drug benefits that include prior authorization requirements.

As part of the program, FLRx requires prior authorization for certain drugs within select categories. The Step Therapy program applies to new starts who have not had a trial of the recommended generic or lower-cost drug within the last year. For example, a patient who is prescribed Cozaar® for the first time and has had a trial of Avapro® will NOT require prior authorization.

For the most current list of Step Therapy Prescribing Recommendations, refer to the Health Plan’s Web site or contact the FLRx Pharmacy Help Desk.

5.4.3 Exception Process

The Health Plan has an exception process in place. To request an exception to the formulary, prior authorization or the quantity/dose limits, the prescribing physician must complete a Request for Drug Evaluation form and fax it to the FLRx Pharmacy Help Desk at the number listed at the bottom of the form. The Request for Drug Evaluation form is available on the Health Plan’s Web site. See the above paragraphs regarding prescription drugs requiring prior authorization for instructions to access the form. It is with the drug-specific prior authorization forms.

5.5 Mandatory Specialty Medication Benefit

Specialty medications covered under the prescription drug benefit (self-administered medications) can be ordered from our specialty pharmacy network. The participating national vendor, CuraScript Pharmacy, will supply and ship all self-injected medications covered under the pharmacy benefit directly to the patient.

Certain prescription drug benefits require that select specialty medications must be purchased from our participating network specialty pharmacy in order to receive coverage under the prescription drug benefit. For more information about national vendors and the medications affected, refer to the Health Plan’s Web site.

https://www.excellusbcbs.com/providers/prescription_drugs/specialty_rx.shtml

5.6 Medical Specialty Drugs

Medical specialty drugs are covered under a member’s medical benefit, as they are typically administered by a health care provider in the office, at an infusion center, at an outpatient facility or in some cases, by home care agency employees or otherwise via home infusion. (Drugs covered under a member’s prescription drug benefit are typically those drugs that can be self-administered.)
The following medical specialty drugs are covered under the medical benefit (when administered by a health care professional) and require prior authorization:

- Actimmune
- Amevive
- Aralast
- Aranesp
- Botox
- Epogen
- Flolan
- IVIG
- Macugen
- Procrit
- Prolastin
- Remicade
- Remodulin
- Synagis
- Ventavis
- Xolair
- Zermaira

*Please note that this list is subject to change, as additional drugs will continue to be added to the program.*

Prior authorization is handled through the Medical Specialty Medication Review Program; a centralized unit that implements medical necessity and courtesy reviews for certain medications covered under the medical benefit. The Medical Specialty Medication Review Program unit is staffed with clinical pharmacists, physicians, and nurses. As part of the program, the Health Plan encourages the use of specialty pharmacies that will ship the drug to the provider's office and bill the Health Plan directly.

**How does the Medical Specialty Medication Review Program work?**

- The provider faxes the completed Medical Specialty Medication Review Form to the specialty pharmacy. (Determination of which specialty pharmacy to use depends on the drug.)
- The specialty pharmacy verifies eligibility and benefits coverage and forwards the review form to the Medical Specialty Medication Review Program unit.
- Once approved, the specialty pharmacy dispenses and ships the medication to the provider for administration. The specialty pharmacy will bill the Health Plan directly for the cost of the medication.

Because the prior authorization instructions and forms are unique to each specialty medication, it is important that the provider contact the Medical Specialty Review Program unit to obtain prior authorization forms and specialty pharmacy information. (See Contact List in Section 2 of this manual.)

### 5.7 Programs to Help Patients Save Money

#### 5.7.1 Generic Trial Program

The **Generic Trial** program promotes the use of cost-effective generic alternatives by providing a free fill of select generic medications - at **no cost to patients**.

The first time a patient fills a prescription for one of the generic medications included in the trial program, the first 30-day copay will automatically be waived. (Providers will not need to write a separate prescription for the free fill.)

The focus of the program is to encourage a generic selection when appropriate, instead of a marketed and sampled brand alternative. The entry of new generics and cost-effective therapeutic alternatives in
many of the commonly prescribed therapeutic classes has provided an opportunity to promote these therapies as first choice consideration. The Health Plan's experience has shown that more than 90 percent of all patients who start on a generic medication will stay with it.

Generic drugs provide a valuable way to reduce the overall cost of health care – without compromising quality. Generic drugs are made with the same active ingredients and have the same quality, strength and purity as brand name drugs – yet typically cost one quarter the price of the brand. The average cost of generic medications included in the Generic Trial program is $6 for a 30-day supply, compared to $87 for brands.

The Generic Trial program was developed and endorsed by the community physicians and pharmacists on the Health Plan’s Drug Utilization Review advisory committee.

**Program Guidelines**

- The program applies to new starts only.
- Write the prescription for the generic medication.
- At the point of service, the first 30-days supply of medication will process at no cost to the patient.
- The cost of all refills and future prescriptions will be at the patient's usual generic copayment/coinsurance amount.
- Only one free 30-day trial per generic medication is permitted.
- The patient may receive one 30-day trial of any generic medication included in the program.

The list of the medications and doses eligible for the Generic Trial program is available on the Health Plan's Web site or from the FLRx Pharmacy Help Desk.

**5.7.2 Generic Advantage Program**

The Health Plan’s prescription drug benefit is designed to encourage value when selecting prescription drugs. The Generic Advantage Program for maximum allowable cost is part of that drug benefit. This program applies to a list of brand name drugs that have Food and Drug Administration (FDA) approved generic alternatives.

**How It Works**

If a member purchases a brand name medication when there is a generic equivalent available, he/she will pay:
- the generic copayment/coinsurance amount; and
- the difference between the pharmacy's charge for the more costly brand name medication and the FLRx price for the less expensive generic.

The list of brand name medications with generic equivalents is available on the Health Plan's Web site, or from the FLRx Pharmacy Help Desk.
https://www.excellusbcbs.com/providers/prescription_drugs/programs_to_help_patients_save_money/generic_advantage.shtml
5.7.3 Half-Tablet Incentive Program

The Health Plan has a voluntary Half-Tablet Incentive Program to help members save money. It is not a benefit change or mandate. The program promotes use of one-half of a double strength tablet for certain doses of selected medications. See the Half-Tablet Guidelines chart on the Health Plan's Web site. Providers who do not access the Internet from the office may request a copy from the FLRx Pharmacy Help Desk. Please note, however, that the list is subject to change.

https://www.excellusbcbs.com/providers/prescription_drugs/programs_to_help_patients_save_money/half_tablet_program_providers.shtml

Splitting tablets can reduce a member's out-of-pocket costs by as much as 50 percent, as follows:

- If the member pays a percentage of drug costs through a coinsurance program, the coinsurance will be based on a lower medication cost.

- If the member pays a flat dollar copayment for prescriptions, the copayment will be cut in half automatically, at the point of purchase.

Some of the drugs listed on the guidelines chart are already scored and very easy to snap or cut in half. For those medications that require tablet splitters, tablet splitters are available at most pharmacies for $3.00 to $5.00. While the Health Plan does not cover the cost of the splitter, savings on even one month of medication will, in most cases, more than make up for this one-time investment in a tablet splitter.

Note: The program applies only to the medications listed and does not apply for patients requiring a daily dose higher than what a half tablet would yield.

The decision to take advantage of this program is shared between the prescribing physician and the member. Once both agree to follow the program, the physician must write a new prescription for the higher strength tablet. Most often, physicians begin with a 30-day trial (15 tablets) to determine if the program is beneficial for the patient.

5.8 Quality Care Dosing Guidelines

Based on the recommendations of the community physicians and clinical pharmacists on the Drug Utilization Review Committee, the Health Plan applies daily dose limitations where the use of multiple pills to achieve a daily dose is not supported by medical necessity. The Quality Care Dosing Guidelines chart lists the medications affected and their respective efficient doses. The most current chart is available on the Health Plan's Web site or from the FLRx Pharmacy Help Desk.

https://www.excellusbcbs.com/providers/prescription_drugs/programs_to_help_patients_save_money/providers_efficient_drug_dosing.shtml

5.9 Mandatory Mail Order for Maintenance Drugs

Some prescription drug benefits require select medications be purchased through the mail service pharmacy for coverage. The most current list of medications that must be purchased through mail service is available on the Health Plan's Web site under the Find a Pharmacy heading. Providers who do not access the Internet from the office may request a copy from the FLRx Pharmacy Help Desk.
5.10 Medicare Part D Prescription Drug Benefit
The Health Plan offers the Medicare Part D prescription drug benefit for its Medicare Advantage (MA) products: Blue Choice Senior Direct, Medicare Blue Choice Optimum, Medicare Blue PPO Plan Two, Medicare Blue PPO Plan Three, and Medicare Blue PPO Plan 201.

The Medicare Part D Prescription Drug benefit was designed for the unique medication needs of Medicare beneficiaries.

**FORMULARY**
The Centers for Medicare & Medicaid Services (CMS) established requirements for the drugs covered under Part D. The Medicare Part D formulary focuses on drug categories and medications used in the Medicare population. It has a strong emphasis on the use of generics and cost-effective choices for key conditions.

The Medicare Part D formulary, as well as other program information, is available on the Health Plan's Web site.
https://www.excellusbcbs.com/providers/prescription_drugs/drug_lists_for_medicare_plans.shtml

5.11 Other Web-Based Pharmacy Services
Both members and providers can access the following pharmacy services through the Health Plan’s Web site.

*Medication Research*
The Pharmacy Web page includes a link to the HealthWise® Knowledgebase, which offers access to information about health plan topics, medical tests, medications and support groups.

*Pharmacy Locator*
The Pharmacy page of the Health Plan's Web site also provides:
- Search capability for more than 61,000 nationwide pharmacies that participate in the FLRx network. There are also selected pharmacies that participate in the FLRxPlus network.
- Information about the mail service pharmacy network available to members who have prescription drug coverage.
- Information about the FLRx Specialty Rx Care Program that helps manage the high costs of biotech medications by using specialty pharmacies that focus on monitoring and distributing these new, high-cost medicines.

*Drug Information Line*
The clinical pharmacists of FLRx Pharmacy Management are available to answer questions via e-mail. FLRx pharmacists can answer questions on a broad range of topics, including:
- New clinical data
- Adverse reactions
- Optimal drug selection
- Therapeutic uses
- Drug interactions
- Monitoring parameters
- Drugs in the news

FLRx makes every effort to answer questions as soon as possible. However, please allow three business days for a response.