Chapter 17: Pharmacy and Drug Formulary

Introduction

Health Choice Insurance Co. (Health Choice) is pleased to provide the Health Choice Formulary, which is available on-line at www.healthchoiceessential.com/members/rxdrugs. The medications listed in the formulary should be used when prescribing to Health Choice Insurance Co. members. This is a closed formulary and only the drugs listed in this formulary are covered by Health Choice. Updated hard copies of Health Choice Formulary are available for distribution annually during the first calendar quarter; the printed formulary represents the covered drug list and access provisions as of January 1 of that year. Since changes can occur later than that date, providers are encouraged to check the Health Choice website at www.healthchoiceessential.com/members/rxdrugs, to acquire the most up to date Health Choice Formulary drug list.

To supplement the formulary drug list, periodic updates are posted to the Health Choice Formulary website in the "Formulary Changes" section. Changes include all quarterly Pharmacy and Therapeutics Committee actions including drug additions, drug deletions (usually with "grandfathering" for any current members on that medication), changes to Step Therapies (ST) or Quantity Limits (QLS), or newly designated Prior Authorization (PA) medications.

The drugs listed in the Health Choice formulary have been researched, reviewed, and formally approved by a Pharmacy and Therapeutics (P&T) Committee. The drugs have been specifically selected to provide both clinically appropriate and cost-effective medications for patients who have their drug benefit administered through Health Choice. There may be occasions when an unlisted drug is desired for medical management of a specific patient, in which case the unlisted medication may be requested through the Prior Authorization process.

Health Choice participating providers are welcome to request medications be considered for Health Choice Formulary addition or deletion, by sending their request, with documentation, to Health Choice Insurance Co. Pharmacy Department, 410 North 44th Street, Suite 900, Phoenix, AZ 85008. Providers can utilize the Health Choice Formulary Addition Request Form located under the Forms tab on the website and fax to 1-877-422-8130.

Formulary Drug Selection

The Health Choice P&T Committee will consider new-to-market drugs for inclusion to the formulary as the need for each new product is assessed. The evaluation includes a literature review and expert external opinion may also be sought.

Formal reviews are prepared that typically address the following information: safety, efficacy, comparison studies, approved indications, adverse effects, contraindications/warnings/precautions, pharmacokinetics, patient administration/compliance considerations, medical outcome and pharmacoeconomic studies.

When a new drug is considered for formulary inclusion, an attempt will be made to examine the drug relative to similar drugs currently on formulary. In addition, entire therapeutic classes are

periodically reviewed. The class review process may result in deletion of one or more drugs in a particular therapeutic class in an effort to continually promote the most clinically useful and cost-effective agents.

Health Choice, in partnership with its providers, hopes to provide the best care for our members while maintaining an overall cost-effective approach. We ask that providers consider utilizing generic drugs and preferred brand drugs on the Health Choice Formulary as preferred agents.

Generic Substitution

Health Choice requires network pharmacies to dispense generic drugs when available. Only those generic products that have received an "A" rating by the FDA should be used. If the physician indicates "no generic substitution" and a generic substitution is available, the physician must contact Health Choice for prior authorization and follow the prior authorization guidelines for obtaining a formulary exception. Appropriate documentation will be required describing rationale for no generic substitution.

Formulary Drug List

The Health Choice Formulary is organized into sections. Each section includes therapeutic groups identified by drug class. Products are listed alphabetically by brand or generic name. In some instances a reference brand name may be included to assist in product recognition. Only dosage forms and strengths of drugs cited on the formulary drug list are covered. The Health Choice formulary covers select over- the-counter **(OTC)** products. Some formulary covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** Requires a prescriber get prior authorization prior to coverage of the drug. Prior authorization criteria are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice. Each specific guideline is reviewed and approved by a committee of doctors and pharmacists. Prior Authorization is common for 'specialty' medications.
- **Step Therapy (ST):** Requires members must first try certain drugs to treat a medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the medical condition, Health Choice does not cover Drug B unless Drug A is first tried. If Drug A does not work or is contraindicated for the member, Health Choice will then cover Drug B after the prescriber submits a prior authorization request.
- **Quantity Limits (QL):** Limits the amount of the drug covered per prescription fill or 30 day fill. Exceptions to the quantity limit must be submitted via a prior authorization process.

For a list of medicines that require prior authorization, step therapy, or have a quantity limit please visit our website, www.healthchoiceessential.com/members/rxdrugs. Additionally our formulary drug list will note if a drug needs prior authorization or step therapy or has a quantity limit applied.

Process to Obtain Non-formulary Drugs

Health Choice Insurance Co. provides a formulary benefit for our members. If the medicine is not on our formulary, prior authorization is required.

If is the member's responsibility to check the formulary list for their medication, then notify their physician if not on the list. Sharing this information with their physician helps ensure that members are getting the medications they need. For the current list of approved Formulary medicines, PROVIDERS can contact Member Services toll-free at 855-452-4242 or visit our website, www.healthchoiceessential.com/Members/rxdrugs. Pharmacy Prior Authorization form is located at: http://www.healthchoiceessential.com/docs/providers/forms/PharmacyMedicaitonPriorAuthorizationForm.pdf

Please follow pharmacy prior authorization process provided below to obtain Non-formulary Drugs.
http://www.healthchoiceessential.com/docs/providers/forms/PharmacyMedicaitonPriorAuthorizationForm.pdf

Pharmacy Prior Authorization

Prior-Authorization requests are commonly initiated by the prescriber by calling or faxing in a request to Health Choice Prior Authorization department. Commonly, the Health Choice Pharmacy/Medication Prior Authorization (PA) Request Form located on the provider website under Forms is used.

The following information is needed to initiate a request:

- Member name, Date of Birth and Health Choice Insurance Co. member ID number
- Medication Name, Strength and Dosing
- Indication for Use
- Physician's Name, Phone Number, and Fax Number

Additionally, the prescriber will need to provide specific medical information related to the request. Once complete information is received, the pharmacist team will review the information and approve or deny the request based on established protocols. Decisions will be made within a specified timeframe.

- If the prior authorization request is APPROVED, the doctor who initiated the request and the member will be notified and the pharmacy will be able to process your prescription for payment.
- If the prior authorization request is DENIED, the doctor and member will be notified and a denial letter explaining the denial reason will be sent. The letter will include instructions for appealing the denial.

Prior Authorization Timelines, Determinations and Notifications

Timelines

Standard: Up to 72 hours - Request that Health Choice must provide a decision as expeditiously as the member's health condition requires, but not later than 72 hours following receipt of the authorization request.

Expedited: Up to 24 hours – Expedited means that the provider indicates or Health Choice determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Heath Choice must make an authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 24 hours following the receipt of the authorization request.

Determinations

Authorizations will be completed in one of the following standard methods:

- ✓ **Approved –** The information received met all Health Choice requirements, and authorization is granted. No further action is required by the office except to notify the member and facilitate the member in obtaining the approved services. The requesting provider office is responsible for informing the member that services have been authorized by Health Choice.
- ✓ **Denied** - The information received did not meet all Health Choice requirements, and authorization is not granted. The requesting provider and member will receive a denial notification letter.

Notification of Determinations

Approval: When an approval is issued, Health Choice will inform the member and prescriber of the decision. Written information which communicates the approval will be sent to the member and to the requesting provider (or their designee).

Denial: When a denial is issued, Health Choice will inform the member of the denial of service by sending a Notice of Action (NOA) letter. The NOA will give the reason for denial in clearly understood language. Additionally, written information which communicates a denial of service will also be sent to the requesting provider (or their designee). Provider denial letters are sent to the prescriber or facility that initiated the request for the prior authorization and will contain varying degrees of detail in order to explain the basis for denial.

Dispensing Limitations

Health Choice members are eligible to receive up to a 30-day supply of medication at retail and a 90- day supply at our mail order pharmacy.

Hospital overrides of formulary medications may occur as hospitals and emergency departments are frequently not familiar with Health Choice formulary choices. When this occurs, it is the responsibility of the prescriber or Primary Care Physician (PCP) to submit a prior authorization request for the medication only when needed to complete a medically necessary treatment course, but to otherwise convert the patient to a Health Choice formulary choice.

Replacements of medications that are lost, stolen, or damaged, are not covered.

Special Medication Program

Health Choice utilizes Orchard Specialty Pharmacy and other specialty drug providers for select specialty medications to provide certain medically necessary, specialty medications for Health Choice Insurance Co. members. These very specialized medications are used to treat chronic disorders such as multiple sclerosis, chronic hepatitis, cystic fibrosis, rheumatoid arthritis and hemophilia, hepatitis C etc. These specialty medications are designated on the formulary drug list after the drug name. Also, a list of these medications and their Prior Authorization criteria can be found in our Health Choice Formulary at www.healthchoiceessential.com/members/rxdrugs.

Physicians may request a specialty medication by using the Health Choice Pharmacy/Medication Prior Authorization Form. The completed PA form and supporting documentation should be faxed to the Health Choice Prior Authorization Department at 1-855-432-2495.

You may also contact the Health Choice Pharmacy department for additional assistance at 1-855-452-4242.