

Pharmacy Policy Bulletin

Title: Formulary Exception Policy

Policy #: Rx.01.61

Application of pharmacy policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Some medications may be subject to precertification, age, quantity, or formulary restrictions (ie limits on non-preferred drugs). Individual member benefits must be verified.

This pharmacy policy document describes the status of pharmaceutical information and/or technology at the time the document was developed. Since that time, new information relating to drug efficacy, interactions, contraindications, dosage, administration routes, safety, or FDA approval may have changed. This Pharmacy Policy will be regularly updated as scientific and medical literature becomes available. This information may include new FDA-approved indications, withdrawals, or other FDA alerts. This type of information is relevant not only when considering whether this policy should be updated, but also when applying it to current requests for coverage.

Members are advised to use participating pharmacies in order to receive the highest level of benefits.

▶ Intent:

The intent of this policy is to communicate the criteria for formulary exception requests.

▶ Description:

The Company utilizes a tiered cost-sharing structure for medications covered under the pharmacy benefit. Members should refer to their benefit booklet for more information.

The following tier exceptions requests will be considered:

A. Select Drug Formulary

- A. Non-preferred drug to be covered at the:
 - 1. Preferred (Formulary) tier if the product is a brand medication; or
 - 2. Generic tier if the product is generic medication
- B. All other tiers are restricted to the benefit design and thus are not eligible for a tier exception

B. Value Formulary

- A. Non-formulary medication to be covered at the highest level of cost share. These exceptions are not eligible for tier reduction.
- B. Non-preferred drug to be covered at the:
 - 1. Preferred tier if the product is a brand medication; or
 - 2. Generic tier if the product is generic medication
- C. All other tiers are restricted to the benefit design and thus are not eligible for a tier exception.

C. CHIP:

- A. Non-preferred drug medication to be covered at the:
 - 1. Preferred tier if the product is a brand; or
 - 2. Generic tier if the product is generic
- B. Brand medication to be covered at the generic benefit level

The following tiers are defined by the benefit and are not eligible for a tier exception:

- A. Specialty tier
- B. Generic tier

This policy does not apply to the Premium Formulary

▸ **Policy:**

Select Drug Formulary

A non-preferred drug will be covered at the preferred tier for brand medications as listed below when there is documentation of inadequate response or inability to tolerate at least three preferred or generic tier alternatives in the same drug class (when available).

- A. Brand medication to preferred tier or
- B. Generic medication to generic tier

Value Formulary

- A. **Non-formulary exceptions:** A medication that is non-formulary, will be covered at the highest level of cost share when there is documentation of inadequate response or inability to tolerate at least three preferred or generic tier alternatives in the same drug class (when available). Safety edits (age and quantity limits) will apply to non-formulary requests.
- B. **Non-preferred drug exceptions:** A non-preferred drug will be covered at the preferred (formulary) tier for brand medications as listed below when there is documentation of inadequate response or inability to tolerate at least three preferred or generic tier alternatives in the same drug class (when available).
 - 1. Brand medication to preferred (formulary) tier or

2. Generic medication to generic tier

CHIP (IN Focus ID 10093453)

A brand medication may be covered at the generic benefit level when there is documentation of an inadequate response or inability to tolerate at least three generic alternatives in the same drug class (when available).

Compounded Products

A non-preferred compounded product may be covered at the preferred (formulary) tier when there is an inadequate response or inability to tolerate/use all other formulary alternatives.

Note: Compounded products are specially made products to meet the needs of an individual member and are not considered generics and thus not eligible for an exception to the generic tier.

Premium Formulary

This policy does not apply to the premium formulary.

▸ Black Box Warning:

N/A

▸ Guidelines:

Refer to the specific manufacturer's prescribing information for administration and dosage details and any applicable Black Box warnings.

BENEFIT APPLICATION

Subject to the terms and conditions of the applicable benefit contract, the applicable drug(s) identified in this policy is (are) covered under the pharmacy benefits of the Company's products when the medical necessity criteria listed in this pharmacy policy are met. Any services that are experimental/investigational or cosmetic are benefit contract exclusions for all products of the Company.

▸ References:

N/A

▸ Applicable Drugs:

i Inclusion of a drug in this table does not imply coverage. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.

N/A

▸ Cross References:

Age Edits Rx.01.2

Compounded Products Rx.01.134

Experimental/ Investigational Policy Rx.01.33

Quantity Level Limits for Pharmaceutical Covered under the Pharmacy Benefit Rx.01.76
Opioid Management Policy Rx.01.197

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