Pharmacy Product Guidelines FAQ

PacificSource HEALTH PLANS

Drug list overview

1. How does a maximum allowable cost (MAC) incentive work?

MAC pricing is a payment model contractually agreed to in the marketplace by all participants. It includes payors and pharmacies and helps ensure that employers and members—those purchasing health insurance benefits—get the lowest possible price on generic drugs.

MAC A Only available to large custom groups	Regardless of the reason or medical necessity, if the member receives a brand-name drug or if their doctor prescribes a brand-name drug when a generic is available, the member will be responsible for the brand-name drug's copayment and/or coinsurance—**plus the difference in cost between the brand name and generic drug.**
MAC B Standard for large fully insured groups, standard individual, and small group plans (including those purchased on the exchange)	MAC B applies when a member selects a brand-name drug. Unless the physician requires the use of a brand-name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If the member receives a brand-name drug when a generic is available, they will be responsible for the brand-name drug's copayment and/or coinsurance—**plus the difference in cost between the brand name drug and its generic equivalent.** If the physician requires the brand-name drug, the prescription will be filled with the brand-name drug, and the member will be responsible for the brand-name drug's copayment and/or coinsurance.
MAC C Only available to large custom groups	Regardless of the reason or medical necessity, if the member receives a brand-name drug or if their physician prescribes a brand-name drug when a generic is available, the member will be responsible for the brand-name drug's copayment and/or coinsurance.

The cost difference between the brand-name and generic drug or MAC doesn't apply toward the plan's deductible or out-of-pocket limit. An example:

	Drug Cost	Copay
Brand	$125	$40
Generic	$50	$5

MAC is the equivalent of the brand drug cost minus generic drug cost—but the amount does not apply toward the member's out-of-pocket limit.

If a member fills a brand drug when a generic is available, the member pays:

- **MAC A: Physician requires brand or member prefers brand over generic**
  Brand copay ($40) + MAC (brand drug cost – generic drug cost or $125 – $50 = $75) = $115
- **MAC B: Member prefers brand over generic**
  Brand copay ($40) + MAC (brand drug cost – generic drug cost or $125 – $50 = $75) = $115
  MAC B: Physician requires brand = brand copay $40
- **MAC C: Physician-required or member-required brand = brand copay $40**

Continued >

2. What should I know about drug availability and formularies (drug lists)?

Formularies create efficiencies that can be passed along to employer groups and members. Medications on a formulary are chosen by a panel of experts, known as a pharmacy and therapeutics (P&T) committee. These panels include outside doctors, nurses, pharmacists, and other clinical experts. Following is a drug list overview:

- The P&T committee develops, manages, and updates the formulary. The group meets regularly to discuss new drugs, safety data, FDA-approved prescribing information, clinical trial results, and doctors' recommendations. Medications on the formulary may change at any time.
- A state-based drug list covers at least the same number of drugs in each U.S. Pharmacopeial (USP) Convention category and class as are covered by the state's pharmacy benchmark plan.
- A state-based drug list is a managed formulary. A managed formulary is a preferred list of drugs that cost less and are considered equally effective. Drugs that are not listed (non-formulary) are generally not covered. The member and provider must go through an exception process to have coverage considered for a non-formulary drug. If a member exception is approved, the non-formulary drug is subject to a Tier 3 copayment plus any applicable MAC cost difference described in the section above. A non-formulary specialty medication, if approved, is subject to a Tier 4 copayment plus any applicable MAC penalties.
- A self-funded large group may opt to offer the Preferred Drug List (PDL) instead of the state-based list. The PDL is an open formulary. Drugs not listed are covered unless otherwise excluded by plan design, contract, category, or clinical policy.

Note that all the drug lists (state-based and Preferred) have prior authorization, step therapy, and quantity limit restrictions. For transparency, PacificSource posts all formularies, restrictions, prior authorization, and step therapy criteria on its website.

- If a change is made to the drug lists, members are notified 30 days in advance. For the most current covered medications, members are able to view drug lists at PacificSource.com/find-a-drug. If a change is made to the drug lists, providers are notified 60 days in advance via PacificSource.com.

3. What is the PacificSource Expanded No-Cost Drug List?

The PacificSource Expanded No-Cost Drug List is in addition to the state-based and Preferred Drug lists (not in place of). The Expanded No-Cost Drug List is a category of outpatient preventive drugs that are covered in full at in-network pharmacies ($0 copayment). The PacificSource Expanded No-Cost Drug List includes specific generic drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from recurring. Preventive drugs do not include drugs for treating an existing Illness, injury, or condition.

4. What is the Value-Based Benefit Drug List?

Medications on the Value-Based Benefit Drug List are covered at 100% (prior authorization or step therapy may apply). The Value-Based Benefit Drug List is available to:

- Groups who purchase the value-based benefit design through PacificSource; and
- Self-funded (ASO) groups who wish to purchase the list as an additional benefit to their employees.

5. What is the PrudentRx program?

The PrudentRx copay optimizer program can help members lower their out-of-pocket costs to $0 for eligible specialty medications by using manufacturer coupons. Specialty medications include drugs prescribed for some rare diseases, and which typically cost several hundred dollars per month. PrudentRx is an optional benefit for select self-funded groups in Idaho, Montana, and Oregon. HSA plans are not eligible for the program.

Continued >

6. Is there a separate ID card for pharmacy benefits?

When using the CVS Caremark® pharmacy network under PacificSource's contract, the pharmacy and medical plan will use the same ID card. The medical ID card includes specific pharmacy billing information and can be presented at the member's in-network pharmacy.

7. What do the different tiers mean?

Drugs on a formulary are typically grouped into tiers. The tier of a medication helps determine the member's portion of the drug cost.

Tier 0:	ACA-mandated drugs and PacificSource Expanded No-cost drugs covered at a $0 copay
Tier 1:	Lowest copays, typically generic medications
Tier 2:	Mid-range copays, typically preferred brand medications
Tier 3:	High copays, typically non-preferred brand medications
Tier 4:	Highest copays, almost always specialty medications specific to the managed formulary
Specialty Medication (SP):	Highest copay PDL; restricted to specialty medications
PrudentRx	Copay optimizer program available to select self-insured large groups; refer to member handbook

Other benefits covered under pharmacy

8. What other items or services fall under the pharmacy benefit?

- **Formulary insulin syringes/lancets/needles:** Included in state-based drug lists; these items are covered at Tier 2.
- **Insulin copay cap for Oregon, Montana, and Washington:** These states enforce a cap of $35 copay per 30-day supply of insulin maximum (if filling a 90-day supply, it would be a $105 maximum). Insulins cannot be subject to a deductible prior to the cap. The $35 per 30-day supply maximum applies regardless of how the member's benefits are structured (for insulin only).
- **Preferred test strips and glucose monitoring devices—OneTouch exclusivity:** PacificSource works to cover drugs and testing supplies that provide the best value for our members. PacificSource covers OneTouch® diabetic testing products exclusively. To help make the transition as smooth as possible for members, we partnered with OneTouch to offer a free blood glucose meter to those with diabetic testing needs. Members can visit OneTouchSamples.com/mpp or call **877-764-5382** and provide their PacificSource member identification number to receive a voucher to be used at their local retail pharmacy.
- **Continuous glucose monitors (CGM):** Dexcom G6, G7, and Freestyle products are covered with an approved prior authorization for type 1 and type 2 diabetics at Tier 2.
- **Compounded medications:** Compounded by community pharmacies and sometimes composed of ingredients or combinations of ingredients not approved by the FDA. Without FDA approval, there is no assurance that these compounds are safe and effective in the combinations and formulations being dispensed. In an effort to ensure the safety of our members and to control claim costs, the following policy applies:
  - Compounds above a certain dollar threshold will require prior authorization.
  - Most plans have a $300 compound ingredient limit, but there are some large groups with customized compound dollar-amount limits. For example, if the benefit reads, "prior authorization (PA) applies after $300," this means that compounds with all covered/formulary ingredients that cost more than $300 will need a PA (due to cost); compounds costing less than $300 with all covered/formulary ingredients will continue to pay when billed by the pharmacy.

Continued >

- Many compounded medications require prior authorization (see appropriate formulary).
- Compounds that require prior authorization are only payable after ALL commercially available or formulary products have been exhausted.
- Only compound ingredients that are covered on the applicable formulary will be reimbursed under this policy.

- **Women's prescription contraceptives:** $0 copay if generic, FDA approved, on formulary drug list, supported by the U.S. Health Resources and Services Administration, and provided by an in-network pharmacy. When no generic exists, the preferred brand is covered at no cost.
- **Affordable Care Act (ACA) preventive no-cost drug list:** Regardless of drug list, preventive medication recommended by the U.S. Preventive Services Task Force and the CDC are covered at Tier 0 at in-network pharmacies. A written prescription is required, even if the drug is over-the-counter. Age limits may apply.

Children

- COVID-19
- Dengue
- Diphtheria, Tetanus, Pertussis
- Haemophilus Influenza Type B
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Adults

- COVID-19
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

Preventive vaccines are covered at Tier 0 at in-network pharmacies regardless of the formulary drug list.

- **Travel vaccines:** Vaccines for travel purposes are excluded from coverage unless indicated otherwise in the Member Handbook.
- **Diabetes management for pregnancy (Oregon only):** $0 copay for covered medications and supplies that are medically necessary to manage a woman's diabetes during pregnancy from conception through six weeks postpartum. Notification to the PacificSource Pharmacy team is required.
- **Prenatal vitamins:** As part of your PacificSource pharmacy benefit, if a member is pregnant, or between the ages of 15-50, they can receive the following prenatal vitamin supplements at no cost when prescribed by a provider:
  - M-Natal Plus Tab
  - Multi Pre-Natal Tab
  - Neo-Natal Tab Pre-Natal
  - Neo-Natal Vitamin Tab 27-0.8mg
  - Niva-Plus Tab
  - One Vite Tab 27-0.8mg
  - Pre-Natal Tab
  - Pre-Natal Tab Plus
  - Pre-Natal Plus Tab 27-0.8mg
  - CVS Pre-Natal Tab 27-0.8mg
  - Pre-Natal Plus Tab 27-1mg
  - Pre-Natal 19 Tab
  - Pre-Natal One Tab Daily
  - PNV-DHA Cap
  - Se-Natal 19 Tab
  - Tri-Natal RX Tab 1
  - Trinate Tab

  We offer this benefit to ensure improved access to important vitamins prior to and during pregnancy, to promote healthy fetal development and to optimize healthy baby outcomes. This program is free for our members with pharmacy benefits.

Continued >

- **Enhanced Safety and Monitoring Solution (ESMS) Program:** The Enhanced Safety and Monitoring Solution program provides continued monitoring to prevent high utilization of narcotic prescriptions, including provider shopping, polypharmacy, or potentially fraudulent activity. We investigate unusual medication utilization patterns and notify the member and provider for coordination of care.
- **Partial Fill Program:** PacificSource initiated a partial fill program to help keep costs down by allowing a member to make sure they can tolerate a drug before getting a full prescription. The partial fill program focuses on high-cost oncology medications that aren't widely tolerated. Patients are dispensed certain medications in a limited amount for half the usual copay; a 15-day trial is set up before the entire 30-day cycle can be filled.
  - **How does it work?** A week after starting the medication, a CVS Specialty™ CareTeam pharmacist or nurse contacts the member to check for side effects and answer questions. If the trial period is a success, the member will continue taking the full dose of the drug. The program provides quality care to members along with cost containment and reduced waste.

9. When is prior authorization required?

Drugs that require prior authorization must be reviewed by our clinical pharmacists before they will be covered by the plan. This process typically requires communication with the provider.

10. How do step therapy (ST) medications get paid?

Step therapy drugs are covered only after other lower-cost related medications have been tried first or determined to be inappropriate or ineffective.

11. What are the criteria for quantity limits (QL)?

Quantity limits may be in place on some drugs because of higher strengths, which are based on dosing guidelines determined by the FDA or manufacturer labeling. The goal is to ensure cost effective therapies and patient safety. Requested exceptions to quantity limits are reviewed by clinical staff on a case-by-case basis.

12. What does "SP" mean in drug search results?

SP is an abbreviation for specialty drugs, and may include biotech drugs. These specialty or biotech drugs are used to treat chronic or genetic disorders. Specialty drugs must be filled at an in-network specialty pharmacy. For available specialty pharmacies, go to PacificSource.com/find-pharmacy.

13. What is continuation of therapy coverage?

Continuation of therapy applies to large groups (51 or more employees). To ease the transition for new large groups or existing large groups transitioning to a new drug list, we offer a "90-day transitional period" option, which allows formulary medications to pay without requiring prior authorization (PA), step therapy (ST), or quantity limits (QL). Non-formulary drugs and excluded drugs will still need an exception approval. We send the member a letter detailing how to get authorization to continue the medication after the 90-day period.

14. What is a copay accumulator program?

Copay accumulator programs are offered by drug manufacturers to help patients with the cost of brand medications and specialty drugs. When a member uses a copay assistance or manufacturer coupon to reduce their out-of-pocket (OOP) costs, only the dollar amount directly paid by the member to the pharmacy will accumulate toward the deductible and/or OOP. For example, if a member is prescribed the specialty drug Humira and uses a copay assistance card to reduce the out-of-pocket to $5, only the $5 will apply to the member's deductible and/or OOP.

Continued >

The PacificSource pharmacy difference

We're here to provide you with expertise and resources. Whether you are a pharmacy professional, provider, or broker, you have access to region-specific answers to navigate the complex pharmaceutical marketplace.

- **Local clinical pharmacists:** PacificSource has clinical pharmacists available for consulting with members and providers. They're part of our pharmacy team, providing answers to medication-related issues.
- **Coverage determinations:** PacificSource clinical pharmacists, with support of PacificSource medical directors, make clinical coverage decisions. PacificSource does not outsource clinical pharmacy reviews to outside vendors.
  - **Commercial help desk:** Springfield, Oregon: 7:00 a.m.–5:00 p.m. Pacific time, Moxnday–Friday **541-225-3784** or **844-877-4803,** TTY: 711. We accept all relay calls.
  - **Help desk Email:** Pharmacy@PacificSource.com
- **PacificSource Pharmacy prior authorization:** We ask providers to submit medication authorization requests online via the InTouch (OneHealthPort) portal. This provides fast and efficient turnaround on medication authorization requests.
- **PacificSource.com:** Additional pharmacy details are readily retrievable online. Because pharmacy information is subject to changes, updates are posted regularly.