Pharmacy Program

Overview

Our pharmacy formularies and utilization management programs are designed and managed by evaluating the safety, efficacy and cost-effectiveness of drugs. A pharmacy and therapeutics (P&T) committee, consisting of pharmacists and physicians who represent various clinical specialties, reviews the clinical appropriateness of drugs for inclusion in the formulary and approves the criteria (Pharmacy Medical Necessity Guidelines) for pharmacy benefit drugs and products in a utilization management program, such as prior authorization (PA), step therapy (ST), quantity limitations (QL), and designated specialty pharmacy (SP) programs. A drug coverage committee (DCC) is responsible for clinical and financial decision-making and makes drug coverage and formulary management decisions with consideration to the information provided by the P&T Committee.

The plan formularies are developed by a panel of providers and clinical pharmacists. The formularies include key agents within selected therapeutic classes. These agents offer comparable safety and efficacy yet are more cost-effective than similar agents. Complete lists of covered drugs or products, including specialty drugs included in the SP program, are available on Tufts Health Plan website.

Premium Formulary Prescription Drug Benefit

The Premium formulary is strategically designed to cover a wide variety of categories and classes of drugs. Exclusions may include cosmetic and high-dollar/low-value drugs and products.

The plan offers a 3-Tier and a 4-Tier Premium formulary.

3-Tier Program

Covered medications are categorized into one of three tiers. Copayments are determined by the tier in which the drug is assigned, for up to a 30-day supply per prescription or refill. We encourage patients and physicians to discuss pharmaceutical treatment options that are therapeutically appropriate and most cost effective.

Tier 1 is primarily made up of generic drugs and select brand-name drugs that the plan has determined to be more effective, less costly or to have fewer side effects than similar medications. Members pay the lowest copayment or coinsurance amount for Tier 1.

Tier 2 is primarily made up of brand-name drugs. and higher cost generic drugs.

Tier 3 is made up of drugs that the plan has not included in Tier 1 or Tier 2. Members pay the highest copayment or coinsurance amount for Tier 3 drugs.

4-Tier Program

Covered medications are categorized into one of four tiers. Copayments are determined by the tier in which the drug is assigned, for up to a 30-day supply per prescription or refill. We encourage patients and physicians to discuss pharmaceutical treatment options that are therapeutically appropriate and most cost effective.

Tier 1 is made up of lower cost generic drugs. Members pay the lowest copayment or coinsurance amount for Tier 1 drugs.

Tier 2 is primarily made up of generic drugs and select brand-name drugs.

Tier 3 is primarily made up of brand-name drugs and higher cost generic drugs.

Tier 4 is made up of drugs that we have not included in Tiers 1-3. Members pay the highest copayment or coinsurance for Tier 4 drugs.

Value Formulary Prescription Drug Benefit

We offer a 3-Tier, 4-Tier, and a 5-Tier Value Formulary Drug Benefit. This Drug Benefit covers a variety of classes of medications. Exclusions may include cosmetic and high-dollar/low-value drugs and products.

3-Tier Program

Covered medications are categorized into one of three tiers. Copayments are determined by the tier in which the drug is assigned, for up to a 30-day supply per prescription or refill. We encourage patients and physicians to discuss pharmaceutical treatment options that are therapeutically appropriate and most cost effective.

Tier 1 is primarily made up of generic drugs.

Tier 2 is primarily made up of preferred brand name drugs and some generic drugs.

Tier 3 is primarily made up of preferred specialty drugs and non-preferred brand name and specialty drugs. Tier 3 may also include some higher cost generic drugs.

4-Tier Program

Covered medications are categorized into one of four tiers. Copayments are determined by the tier in which the drug is assigned, for up to a 30-day supply per prescription or refill. We encourage patients and physicians to discuss pharmaceutical treatment options that are therapeutically appropriate and most cost effective.

Tier 1 is primarily made up of generic drugs.

Tier 2 is primarily made up of preferred brand name drugs and some generic drugs.

Tier 3 is primarily made up of preferred specialty drugs, non-preferred brand name drugs, and higher cost generics.

Tier 4 is primarily made up of non-preferred specialty drugs. Tier 4 may also include selected brand and generic drugs.

5-Tier Program

Covered medications are categorized into one of five tiers. Copayments are determined by the tier in which the drug is assigned, for up to a 30-day supply per prescription or refill. We encourage patients and physicians to discuss pharmaceutical treatment options that are therapeutically appropriate and most cost effective.

Tier 1 is primarily made up of lower cost generic drugs.

Tier 2 is primarily made up of higher cost generic drugs.

Tier 3 is primarily made up of preferred brand name drugs and select generic drugs.

Tier 4 is primarily made up of preferred specialty drugs and non-preferred brand name drugs and select higher cost generic drugs.

Tier 5 is primarily made up of non-preferred specialty drugs. Tier 5 may also include selected brand and generic drugs.

Core New Hampshire Formulary

We offer a 4-Tier and a 5-Tier Core NH Formulary. Our Core NH formulary offers a prescription drug benefit for small group and individual markets in the state of New Hampshire that ensures members and their physicians have access to a selection of best-in-class medications while helping to keep premiums as affordable as possible.

4-Tier Core New Hampshire Formulary

Tier 1 is primarily made up of generic drugs, and select brand name drugs. Members pay the lowest copayment or coinsurance amount for Tier 1 drugs.

Tier 2 is primarily made up of preferred brand name drugs and some generic drugs.

Tier 3 is primarily made up of preferred specialty drugs and non-preferred brand name drugs and select generic drugs.

Tier 4 is primarily made up of non-preferred specialty drugs. Tier 4 may also include select brand and generic drugs.

5-Tier Core New Hampshire Formulary

Tier 1 is made up of lower cost generic drugs. Members pay the lowest copayment or coinsurance amount for Tier 1 drugs.

Tier 2 is primarily made up of higher cost generic drugs

Tier 3 is primarily made up of preferred brand name drugs and some generic drugs.

Tier 4 is primarily made up of preferred specialty drugs, non-preferred brand name drugs, and some generic drugs.

Tier 5 is primarily made up of non-preferred specialty drugs. Tier 5 may also include select brand and/or generic drugs.

New-to-Market Drug (NTM) Evaluation Process

New-to-Market drug products are reviewed for safety and clinical effectiveness by the Plan's Pharmacy and Therapeutics (P&T) Committee. Tufts Health Plan will make a coverage determination based on the P&T Committee's recommendation. A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability. In the interim, if a physician believes a member has a medical need for the drug product, an exception to coverage should be requested. An approved coverage exception will have the highest cost share tier. If you have questions regarding coverage status of a drug or product, call Provider Services at 888-204-2404.

Prior Authorization Drugs

The prior authorization program is in place for selected drug products that have a specific indication for use, are expensive, or pose significant safety concerns. Each of these medications has clinical guidelines developed by licensed clinical pharmacists, reflecting the latest in evidence-based medicine. A drug may be recommended for placement in the PA program based on various criteria, including, but not limited to:

- Has the potential to be used exclusively for cosmetic purposes
- Is not considered to be first-line therapy by medically accepted clinical practice guidelines
- Has the potential to be used outside of indications granted by the U.S. Food and Drug Administration (FDA)

Drug products under the PA program require prior approval for coverage through the Utilization Review Process.

Step Therapy Prior Authorization (STPA)

Step therapy prior authorization is an automated form of prior authorization that uses claims history for approval of a drug or product at the point of sale. Step therapy programs help encourage the clinically proven use of first-line therapies and are designed so that the most therapeutically appropriate and cost-effective agents are used first, before other treatments may be covered. Step therapy protocols are based on current medical findings, FDA-approved drug labeling and drug costs.

A drug or product is placed in a STPA program when it meets one or more of the following criteria:

- Is not considered to be first-line therapy by medically accepted clinical practice guidelines
- Has a disproportionate cost when compared to other agents used to treat the same disease or medical condition

Members who are currently on drugs or products that meet the initial step therapy criteria will automatically be able to fill prescriptions for a stepped medication or product. If the member does not meet the initial step therapy criteria, the prescription will deny at the point of sale with a message indicating that prior authorization is required. Providers may submit prior approval for coverage through the Utilization Review process.

In accordance with Massachusetts state law, when a Massachusetts member has already been prescribed and is stable on a drug subject to step therapy requirements, Tufts Health Plan will allow a one-time transition fill for up to 30-day supply of the requested drug while an exception to step therapy request is being reviewed. Please contact Provider Services at 888-204-2404 to request the one-time transition fill.

Health plans are required to process step therapy exceptions and appeals within 3 business days following the receipt of all necessary information needed to make a medical necessity determination. For urgent requests, health plans are required to respond back within 24 hours following the receipt of all necessary information if additional delay would result in significant risk to the member's health or well-being. For expedited step therapy appeals, please mark the subject line as "24 hours – Expedited".

Quantity Limitations

Quantity limits are designed to limit the use of selected drugs for quality and safety reasons. Administering quantity limits encourages appropriate drug use to assist in reducing drug benefit costs for everyone.

If a member's physician determines that a quantity in excess of that allowed by Tufts Health Plan is medically necessary, they may request an exception for coverage.

Non-Formulary Drugs (NF)

Certain prescription drugs or products are non-formulary because there are safe, comparably effective, less expensive alternatives available. The suggested alternatives are approved by the FDA and are widely used and accepted by the medical community to treat the same condition as those that are non-formulary. If a member has a definite medical need to continue on a non-formulary drug product, an exception to coverage should be requested.

Designated Specialty Pharmacy Program (SP)

Tufts Health Plan's goal is to arrange for its members to have access to the most clinically appropriate, cost-effective services. We have designated specialty pharmacies to supply a select number of drugs used to treat complex disease states. These pharmacies specialize in providing these drugs and are staffed with nurses, coordinators, and pharmacists to provide support services for members. Drugs include, but are not limited to, those used to treat Hepatitis C, growth hormone deficiency, infertility, multiple sclerosis, rheumatoid arthritis, and cancers treated with oral drugs.

Members can obtain up to a 30-day supply of drugs by mail from these specialty pharmacies. For questions about the designated specialty pharmacy program, refer to Tufts Health Plan's online formularies or contact Commercial Provider Services at 888-204-2404. Drugs in the designated specialty pharmacy program are listed throughout the formulary with SP to indicate inclusion in the program. When appropriate, other designated specialty pharmacies and drugs will be identified and added to this program.

Utilization Review and Coverage Exception Process

You may use the exception process to ask us to cover a drug that is excluded or limited. Drugs are excluded from coverage if they are not listed on the plan's formulary or limited if listed on the formulary with limitations.

To request a pharmacy drug prior authorization, refer to the Pharmacy Medical Necessity Guidelines for the specific drug prior authorization requirements on the public Provider website. Requests may be submitted electronically from the provider portal through PromptPA or by visiting Point32Health.PromptPA.com.

You can also submit requests via electronic Prior Authorization (ePA), fax or by mail with the appropriate request form to the Pharmacy Utilization Management Department:

- Fax: 617-673-0988
- Mail: Tufts Health Plan
  Attn: Pharmacy Utilization Management Department
  1 Wellness Way, Canton, MA 02021-1166

We will only grant exceptions for clinical reasons. You must give us a statement that explains why an exception is medically necessary, including why the covered drugs on the Prescription Drug List formulary are not as effective as the requested drug.

Compounded Drug Coverage

Compound drugs are covered if: (1) all the active ingredients in the compound are FDA-approved prescription drugs; and (2) either the patient is under the age of 18 or the plan has given prior approval for coverage of the compound.

CareLink℠

Prescription drug information relevant to individual members is found on the back of CareLink ID cards. The prescription drug benefit can be administered by a variety of pharmacy benefits administrators. The member's ID card indicates where the member should be directed for these services. **Note:** Pharmacy prior authorization requests are reviewed by the

appropriate party identified in the Working with CareLink grid.

PUBLICATION HISTORY
03/01/24 Updated Step Therapy Prior Authorization section