PHARMACY PROGRAM

The following topics are covered in this chapter:

Tufts Health Plan Pharmacy Programs

Pharmacy and Therapeutics Committee

Tufts Health Plan manages the pharmacy program 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 drugs in a pharmacy program, such as prior authorization (PA), step therapy (ST), quantity limitations (QL), designated specialty pharmacy (SP) and designated specialty infusion (SI) programs. A drug coverage committee (DCC) consisting of Tufts Health Plan staff 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 Tufts Health 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 and SI programs, are available on Tufts Health Plan's public Provider website.

Tiered Pharmacy Copayment Programs

Tiers are subject to change throughout the year. When a drug becomes available in generic form, its brand-name counterpart may move to a higher tier or non-covered (NC) status. When a prescription drug becomes available over the counter, Tufts Health Plan may discontinue coverage of that drug or product. The most up-to-date listing of covered drugs or products and copayment tiers are available on Tufts Health Plan's Commercial formularies. The formularies also contain information about drugs or products included in Tufts Health Plan pharmacy programs described below.

3-Tier Pharmacy Copayment Program

Under the 3-Tier Pharmacy Copayment Program, all covered drugs or products, including specialty medications, are placed on one of three tiers. The 3-tier program gives members and physicians a wide range of drug product choices when a prescription is written. It is important for the member and provider to work together to determine which drug or product is most appropriate.

- **Tier 1:** Medications on this tier have the lowest member cost-sharing amount
- **Tier 2:** Medications on this tier have a higher member cost-sharing amount
- **Tier 3:** Medications on this tier have the highest member cost-sharing amount

Note: Most generic drugs are covered on tiers 1 and/or 2

Note: Infertility drugs are not included in the 3-tier copayment program for members of Commercial Rhode Island plans. Members who receive prior authorization for coverage of infertility drugs will pay a separate infertility cost share for each drug they utilize.

4-Tier Pharmacy Copayment Program

If the member's plan includes a 4-tier copayment design, providers have the option to write a prescription for any covered prescription drug or product. There may be instances when only a Tier 4 drug is appropriate, which will require a higher cost share from the member.

The 4-tier copayment program contains specialty drugs, many of which are included in the designated SP program. Designated SP program drugs include but are not limited to medications used in the treatment of infertility, hepatitis C, growth hormone deficiency, multiple sclerosis, rheumatoid arthritis, and cancers treated with oral medications.

The 4-tier program places all covered prescription drugs into one of the following tiers. Most generic drugs are covered on tiers 1 and/or 2.

- **Tier 1:** Medications on this tier have the lowest member cost-sharing amount
- **Tier 2:** Medications on this tier have a higher member cost-sharing amount
- **Tier 3:** Medications on this tier have a higher member cost-sharing amount
- **Tier 4:** Medications on this tier have the highest member cost sharing amount; limited to a 30-day supply

Note: Infertility drugs are not included in the 4-tier copayment program for members of Commercial Rhode Island plans. Members who receive prior authorization for coverage of infertility drugs will pay a 20% coinsurance for each drug they utilize.

"Dispense as Written" Prescriptions (DAW)

In most instances, Tufts Health Plan members who are prescribed a covered brand-name drug that has a generic equivalent will receive the generic at the pharmacy and will pay the applicable tier cost share for that generic, unless the prescriber writes a "dispense as written" or "no substitutions" prescription for a brand-name drug. In this instance, the member may pay the member cost share amount applicable to the brand name drug.

In New Hampshire and Rhode Island, the member may elect to fill the brand product and pay a higher member cost share amount if the brand product is covered. In Massachusetts, members do not have the option to self-select to fill a brand name medication.

Note: Medications for which there are no generic equivalents will not be affected.

New-to-Market Drug (NTM) Evaluation Process

Tufts Health Plan delays the coverage determination of new-to-market (NTM) drug products until the P&T Committee has reviewed them. During the evaluation period, which starts when the drug or product is first available on the market, the P&T Committee reviews the safety and effectiveness of these new drug products as information becomes available. In the interim, if a physician believes a member has a medical need for the drug product, a request can be submitted under the utilization review process. If you have questions regarding coverage status of a drug or product, call Provider Services at 888.204.2404.

Prior Authorization Programs

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. 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. For additional information, refer to Tufts Health Plan's Commercial pharmacy programs and pharmacy medical necessity guidelines on the Provider website.

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

Some types of step therapy include requiring the use of generics before brand name drugs, preferred before non-preferred brand-name drugs, and first-line before second-line therapies. Medications included on step one of a step therapy program are usually covered without prior authorization. All other medications or products subject to step therapy are not covered unless a member tries and fails one or more medications or products on a previous step, or is unable to tolerate, or has a contraindication to all medications or products on the previous step.

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 authorization requests to Tufts Health Plan using the utilization review process for members who do not meet the step therapy criteria at the point of sale or who do not have claims history in the Tufts Health Plan system. For more information, including which drugs or products are currently included in a STPA program, refer to the Pharmacy Programs section of the Provider website. Step therapy requirements may be updated periodically.

Quantity Limitations Program (QL)

The quantity limitations program restricts the quantity of a drug or product for which a member is covered in a given time period. It also serves to prevent high and/or inappropriate doses of medication at the point-of-sale. These quantities are based on recognized standards of care, such as FDA recommendations for use, and may be updated periodically. Physicians can prescribe the medications within the quantity limitation without having to request prior authorization. If a physician believes that a member needs a quantity greater than the program limitation, a request can be submitted under the utilization review process. Refer to Tufts Health Plan's Pharmacy Programs for additional information.

Noncovered Drugs (NC)

Certain prescription drugs or products are not covered 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 noncovered. Tufts Health Plan updates these lists periodically. If a physician believes that a member has a definite medical need to continue on a noncovered drug product, a request can be submitted under the Utilization Review Process. Providers should contact Provider Services or refer to Tufts Health Plan's Pharmacy Programs with any questions regarding specific drugs or products.

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.

Designated Specialty Infusion Program for Drugs Covered Under the Medical Benefit (SI)

The designated specialty infusion (SI) program offers clinical management of drug therapies, nursing support and care coordination to members with acute and chronic conditions. Tufts Health Plan has designated specialty infusion providers for a select number of specialized drugs and administration services.

These drugs may be administered in the home or an alternate infusion site, based on the availability of infusion centers and/or determination of the most clinically appropriate site for treatment. These drugs are covered under the member's medical benefit rather than the pharmacy benefit and generally require support services, medication dose management, and special handling, in addition to the drug administration services. Drugs include, but are not limited to, those used to treat hemophilia, pulmonary hypertension, and immune deficiencies.

For questions about the designated SI program, refer to Tufts Health Plan's online formularies or contact Commercial Provider Services at 888.204.2404. Drugs in the designated SI program are listed throughout the formulary with **SI** to indicate inclusion in the program. When appropriate, other designated specialty infusion providers and prescription drugs are identified and added to this program.

Utilization Review Process

Tufts Health Plan pharmacy programs help manage the pharmacy benefit. Requests for medically necessary exceptions to either the programs listed above or drugs on the list of noncovered drugs should be completed by the physician and sent to Tufts Health Plan. The request must include clinical information that supports why the drug is medically necessary for the member. Coverage decisions are made on a case-by-case basis considering the individual member's health care needs. Refer to the Commercial Pharmacy Prior Authorization Submission by State for information on which prior authorization form to use based on state and product.

For additional information, refer to the pharmacy medical necessity guidelines in the Provider Resource Center. If Tufts Health Plan does not approve the request, the member has the right to appeal. The appeal process is described in the member's benefit document.

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.