**The Formulary**

A formulary is a list of drugs that are covered by a health plan. Its purpose is to encourage use of the most cost-effective drugs. The formulary is necessary because the cost of prescription drugs, especially specialty drugs, is rising faster than other health care costs. Some of the reasons for this trend include:

- More advertising for newer high-cost drugs
- An aging population that uses more drugs
- The high cost of research and development for new drugs

Without a formulary, Balance Members would end up paying more for health care coverage, due, in part, to rising drug costs. Our formulary allows us to continue providing cost-effective pharmacy benefits.

Balance formularies are developed and maintained by a committee of doctors and pharmacists. The Pharmacy & Therapeutics (P&T) Committee studies new drugs and new information for existing drugs. They keep up-to-date on the newest developments in medicine and continually improve our formularies based on the latest research, including the following (where applicable):

- Drug labeling
- Clinical outcome studies from peer-reviewed published medical literature
- Standard drug reference compendia
- Regulatory status
- Evidence-based guidelines published by medical associations, government agencies or national commissions
- Views of professionals in relevant clinical areas
- Other related factors

Our P&T Committee determines how drugs will be covered on the formulary based on the following criteria:

- **Efficacy:** Preferred drugs must be as good as, or superior to, other currently available alternatives for most of the population.
- **Safety:** Preferred drugs must be as safe as, or safer than, other currently available alternatives.
- **Health Outcomes (when available):** Preference is given to drugs which have been shown to improve overall health outcomes.
- **Drug interactions:** Preferred drugs must have similar or less potential for drug interactions compared to other currently available alternatives.
- **Pharmacokinetics:** Consideration is given to drugs with evidence showing that less frequent dosing increases patient compliance and outcomes.
- **Contraindications:** Consideration is given to drugs that do not have factors which would restrict their use to specific patient populations.
- **Generic availability:** Decisions to add generics to the formulary are based on safety, cost, established equivalence to the brand name, and compliance with existing drug contracts.

We do not require that your doctor only prescribe preferred formulary drugs. However, you may save time and money by asking him/her if a newly prescribed drug is on our formulary. If it is

not, ask whether there is a preferred generic or brand-name version that is on the Balance formulary.

You can find the formulary, including any restrictions and preferences, as both a printable document and a searchable database on our website. The formulary applies only to outpatient prescription medications dispensed by participating pharmacies. It does not apply to inpatient medications or the medications obtained from and/or administered by your doctor. Call Member Services with any questions regarding drug coverage.

A summary of the most recent formulary changes can be found on our website. In addition to the drug limitations and restrictions called out in the formulary, certain classes of drugs (such as those for cosmetic uses) may not be covered. Please refer to your benefit documents, or call Member Service to determine which drugs are excluded under your benefit plan.

Your doctor may also request an exception to the formulary. In fact, your doctor can request a coverage exception for any drug that he/she considers to be medically necessary by following the steps outlined under the section of this document entitled "Process for Requesting a Medication Coverage Exception."

**Prior Authorization**

One of Balance's tools to help manage rising prescription drug costs is to require prior approval, or authorization, before drugs are covered. Drugs which require prior authorization are often not suggested as the first-line treatment option, and/or may have limited diagnoses for which they are recommended. Prior authorization may also be required for drugs that are very expensive. The prior authorization program helps to ensure that drugs are used in a safe, appropriate, and cost-effective manner.

Our P&T Committee determines which drugs require prior authorization and the criteria for coverage. Drugs that require prior authorization will be denied at your pharmacy until the health plan has reviewed the necessary clinical information provided by your doctor and approved coverage.

**Step Therapy**

Step therapy is a form of prior authorization. It involves an electronic review of your drug history to ensure that appropriate generic or first-line drugs have been tried already. If you have already tried the preferred drug(s), the claim will process as normal, and you pay the appropriate copayment at the pharmacy. If the preferred drug(s) are NOT in your drug history, the claim will reject at the pharmacy and your doctor will need to provide additional clinical information to the health plan for further review.

***Which drugs require prior authorization or step therapy?***

You can identify drugs that require prior authorization or step therapy by referring to our printable formulary document. This resource is available on our website.

**Quantity Limits**

Our P&T Committee may restrict the quantity of a drug that is covered under your pharmacy benefit.

Quantity limits are required for multiple reasons. For example, it may be more cost-effective to take one pill to reach the required daily dosage rather than two lower strength pills. Other drugs have quantity limits to ensure that your prescribed dosage has been studied and determined to be safe and effective. A list of drugs that have quantity limits is also available on our website.

**Generic Substitution/Preferred Brand Interchange/Therapeutic Interchange**

In most cases, generic substitution may be required for brand-name drugs where the U.S. Food and Drug Administration has determined that the generic is equivalent to the brand. However, this requirement is based on the availability of the generic and state regulations regarding drug product selection. If your doctor states that the brand is required, or you request the brand when a generic equivalent is available, you may have to pay a higher out-of-pocket amount based on your benefit plan.

In some cases, Balance covers a preferred manufacturer's version of a multisource brand-name product at a lower coverage tier, instead of the generic. This is often referred to as preferred brand interchange. Whenever preferred brand interchange exists, the preferred brand will be listed on the applicable coverage tier on the formulary.

**Specialty Drugs**

Specialty drugs are typically high-cost drugs, including, but not limited to, the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Characteristics of specialty drugs are:

- Used to treat and/or diagnose rare and complex diseases
- Require close clinical monitoring and management
- Frequently require special handling
- May have limited access or distribution

Refer to the formulary to identify specialty drugs and to determine if prior authorization and/or quantity limits apply.

**Process for Requesting a Medication Coverage Exception**

Your doctor, or their appointed representative, can request a medication coverage exception by:

1. Calling the MedImpact Prior Authorization Hotline at 1-800-788-2949. The Call Center will ask a number of clinical questions, and depending on the answers provided by your doctor, coverage will either be approved or he/she will be given the opportunity to fax additional information for further clinical review.
2. Faxing a letter of medical necessity, or the applicable prior authorization request form, to the MedImpact Prior Authorization Team at 1-858-790-7100.

Your doctor should include the following information with all requests for medication coverage:

- Patient's name
- Patient's date of birth
- Patient's member ID number
- Doctor's name and phone number
- Name, strength, and dosing schedule for the drug being requested
- Diagnosis for which the drug is being requested
- Any necessary supporting documentation (i.e., progress notes, laboratory results, published literature supporting safety/efficacy, etc.)
- All drugs previously tried for the diagnosis being treated and the reason for the failure