Section 24

Pharmacy Benefits

Contents

AZ Blue Pharmacy Benefits for Groups and Individuals Under Age 65

Introduction

The information on pages 24-1 through 24-10 of this Section describes pharmacy benefits in group and individual (under age 65) plans administered by Blue Cross® Blue Shield® of Arizona (AZ Blue) and/or a designated pharmacy benefit manager (PBM).

- For Federal Employee Program® (FEP®) pharmacy benefit information, see page 24-11.
- For Medicare Advantage pharmacy benefit information, see page 24-12.
- For BlueCard® (out-of-area) pharmacy benefit information, check eligibility and benefits.
- For Corporate Health Services (CHS) benefit information, contact the group's third-party administrator (TPA) displayed on the member ID card.

Benefits and cost sharing for prescription medications vary according to the member's benefit plan terms, the medication prescribed, a 30- vs 90-day prescription (for maintenance drugs), and whether the medication is obtained through a retail pharmacy, a specialty pharmacy, a mail order pharmacy, or administered in a physician's office, through home health services, or at other sites of care. If the information in this Section differs from the applicable benefit plan, the terms of the member's benefit plan control.

Determining the member's pharmacy benefits

- **Member ID card (may include plan type and cost-share information)**
  The member's ID card generally displays the type of prescription benefit and the applicable customer service phone number. Abbreviated prescription medication cost-share information may also be displayed.
- **Online resources (including drug list/formulary information)**
  AZ Blue benefit plans include different drug list or formulary options. Drug lists and formularies are updated regularly and displayed online at azblue.com/pharmacy. Be sure to check the member's specific plan information on one of these two webpages:
  - AZ Blue Standard Pharmacy Plans – For most AZ Blue plans.
  - Affordable Care Act (ACA) Plans – For our Affordable Care Act (ACA)-compliant benefit plans (you can identify these plans by looking for "pediatric dental benefits" on the front of the ID card).

  Note: Both webpages include drug lists, formularies, forms, additional resources for prior authorization, and pharmacy coverage guidelines.

Types of prescription coverage

To determine the specific type of prescription coverage for a member, refer to the member's ID card (plan name and/or group number) and select the corresponding option at azblue.com/pharmacy (see details above).

Benefit configurations may include:

- **Open drug list multi-tiered benefits**

  Certain AZ Blue benefit plans do not use a restricted formulary. Most FDA approved medications (except those specifically excluded) are available for varying cost-share amounts based on the type of benefit plan and the medication's assigned "tier." See examples on the next page. Some plans also have a deductible that must be met before copays apply.

  - **2-tier benefits (generic and brand)**
    Plans with this benefit cover prescriptions with copays/coinsurance in one of two cost-sharing tiers: generic and brand. Members usually have the lowest out-of-pocket cost when generic medications are prescribed, and the highest cost with brand medications. The difference in generic and brand copays/coinsurance can be substantial.
  - **3-tier benefits**
    Plans with this benefit cover medications with a copay/coinsurance in one of three tiers.
  - **4-tier benefits**
    Plans with this benefit cover medications with a copay/coinsurance in one of four tiers.

- **High-deductible plans, including HSA qualified plans**
  Deductible and any applicable coinsurance and copays apply. The deductible paid through the pharmacy benefit applies to the medical and pharmacy plan combined deductible and maximum out-of-pocket amounts.
- **Closed formulary tiered benefits**
  Certain benefit plans, such as ACA-compliant qualified health plans, have a restricted, or a closed formulary. Many FDA-approved medications are available at varying cost-share amounts (except those specifically excluded or deemed non-formulary), depending on the type of benefit plan and the medication's assigned "tier." Some plans also have a deductible that must be met before copays apply.

  Coverage of non-formulary medications requires approval by AZ Blue through the prior authorization process.

  - **Closed formulary 4-tier benefits**
    Members pay a fixed-dollar copay for medications in tiers 1-3. Members pay coinsurance for specialty medications in the 4th tier.
  - **Closed formulary coinsurance benefits (including high-deductible plans)**
    Members pay deductible and applicable coinsurance for covered medications.

Basic coverage requirements
To be covered, prescription medications must, at a minimum, meet all of the following criteria:

- The medication must be approved by the U.S. Food and Drug Administration (FDA) for the diagnosis for which the medication has been prescribed.
- The quantity of the medication must be medically appropriate for the diagnosis and for the specific patient. See information below on drug wastage for injectable medications.
- The medication must be dispensed by a pharmacy located in the U.S. and by a pharmacist licensed in the U.S., unless the medication is needed for an urgent or emergency medical situation while the member is traveling outside the U.S. Claims for medications dispensed outside the U.S. will be subject to the U.S. dollar exchange rate on the date the claim is paid.
- The medication must not be excluded by a different provision under the member's benefit plan. For more information, see page 24-4.

For pharmacy coverage guidelines, see page 24-6 and visit the pharmacy resource pages at azblue.com/pharmacy.

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Drug wastage

Drug wastage occurs with injectable medications when the entire single-dose vial or single-dose pre-filled package of a drug cannot be administered and the unused portion must be discarded.

- **Eligible for reimbursement**
  Drug wastage may be eligible for reimbursement for single-use vials or single-dose pre-filled packaging. Specific documentation and billing procedures must be followed:
  - **Required documentation:** AZ Blue may request the following records to determine if drug wastage is eligible for reimbursement:
    - Drug name
    - Time and date drug was administered
    - Route of administration
    - Drug amount administered
    - Amount of drug available in the single-use vial or single-dose pre-filled package
    - Drug amount wasted and reason for wastage
    - Claim information verifying units administered and units discarded (JW modifier)
  - **Required billing procedures:** When submitting claims for discarded drug amounts, use modifier JW on a separate line detailing the discarded amount.
- **Not eligible for reimbursement**
  Drug wastage is not eligible for reimbursement for medication vials labeled as multi-dose or multi-use (these vials contain more than one dose of medication and typically include an antimicrobial preservative to help prevent the growth of bacteria).

Prescription medication coverage limitations

Coverage of prescription medications is subject to AZ Blue and PBM limitations including, but not limited to, prior authorization, quantity, age, and refill. **These limitations can change at any time without prior notice.**

The list of prescription medication limitations is available online by going to azblue.com/pharmacy and selecting the plan name or group number displayed on the member's AZ Blue identification card. You will be directed to the applicable formulary and coverage documents, and the corresponding customer service center. Or you may call 1-866-325-1794 to verify member benefits and limitations.

When the proposed medication use will exceed or differ from AZ Blue prescription medication limitations, members or providers can ask AZ Blue or the designated PBM for an exception. To request an exception, fax a request letter with supporting documentation to 602-864-5810. There is no guarantee that a review will result in approval of the requested coverage, quantity, or use.

Benefit-Specific Exclusions

The fact that a medication is recommended or prescribed by a physician does not make it a benefit. In AZ Blue standard pharmacy plans, prescription medication benefits are subject to all general exclusions in the member's benefit plan, plus any specific limitations and exclusions. Large groups may choose to omit certain standard exclusions in their plan or may add other exclusions.

Most benefit plans have additional benefit exclusions, often for the following reasons:

1. Medications for which the principal ingredient(s) are already available in greater and lesser strengths or combinations, as described in the AZ Blue Excluded Drugs List (available at azblue.com/pharmacy), in addition to all other exclusions in the member's benefit book.

2. Medications which modify the dosage form (tablet, capsule, liquid, suspension, extended release, tamper resistant) of drugs already available in a common dosage form, as described in the AZ Blue Excluded Drugs List, in addition to all other exclusions in the member's benefit book.

For a list of the above specific exclusion details, go to azblue.com/pharmacy, click the appropriate plan type link, then look under "Other Forms and Resources" and click the "Excluded Drugs List" link.

Benefit-specific exclusions
Exclusions are detailed in the member's specific benefit book. Here are some common exclusions that often generate provider questions:

- Medications designed for weight gain or loss, including but not limited to, Xenical ® and Meridia®, regardless of the condition for which it is prescribed
- Medications for sexual dysfunction
- Medications packaged with another or multiple other prescription products
- Medications packaged with over-the-counter medications, supplies, medical foods, vitamins, or other excluded products
- Medications to improve or achieve fertility or treat infertility
- Medications used for any cosmetic purpose
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging, or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled, or damaged

More Information about AZ Blue Pharmacy Benefits

Claim adjudication and member cost share

AZ Blue uses a pharmacy benefit manager (PBM) to adjudicate pharmacy benefits and claims. The amount of the member's cost share will depend on the member's benefits and the medication tier (for multi-tier benefits) at the time the medication is filled and billed by the pharmacy. The medication's assigned tier may change at any time, without notice, which can result in higher or lower cost-share amounts. Notification is given to members affected by changes that result in a higher cost share.

Compounded medications

Compounded medications are medications that contain at least one FDA-approved component and are custom-mixed by a pharmacist. Compound prescriptions are only available through the retail pharmacy benefit when dispensed by pharmacies contracted by AZ Blue. Compounded prescriptions are *not available* through the mail order or specialty pharmacy benefit.

Prior authorization may be required for compounded medications. The provider can request prior authorization using the Prior Authorization Request Form, available on our pharmacy pages under Additional Resources > Provider Resources (Prior Authorization). Or call us at 1-866-325-1794.

Designated Prescription Network Program

This AZ Blue program is designed to offer increased oversight of usage and access for certain drugs. It requires some members (as determined by AZ Blue or the PBM) taking certain covered medications to obtain prescriptions for those medications from one designated eligible provider and to have those prescriptions filled from one designated pharmacy or provider.

- Both members and providers are informed of the member's required participation in the program through prior authorization approval letters.
- AZ Blue or the PBM specifies which pharmacies or providers are eligible to dispense the medications to members in the program. This information is also communicated through prior authorization approval letters.
- Benefit-specific exclusions apply to designated medications when prescribed by an ineligible provider or dispensed by an unapproved pharmacy or provider. The prior authorization process will identify those exclusions.

Diabetic equipment and supplies

Most benefit plans cover the following diabetic equipment and supplies:

- Test strips for glucose monitors
- Visual reading and urine testing strips
- Syringes, pen needles, and lancets

Exceptions[1]

For benefit plans with open formularies, we do not make exceptions concerning the tier to which a medication is assigned, or the copay or coinsurance that will apply, regardless of the medical reasons requiring use of a particular medication. For closed formulary plans, a request can be made for an exception to allow coverage for a non-formulary medication.

Immunizations (refer to vaccinations on page 24-8)

[1] For more information or to confirm the member's plan type, go to azblue.com/pharmacy or contact AZ Blue pharmacy customer service at 1-866-325-1794.

More Information about AZ Blue Pharmacy Benefits

Injectable medications

- Injectable and oral medications that can be self-administered may require prior authorization and are billed under *pharmacy* benefits.
- Injectable medications that must be administered by a healthcare professional may require prior authorization and are billed under *medical* benefits.
- When the administered dose of an injectable medication is *more* than the HCPCS billing unit description, the units billed must correspond with the *smallest* dose available from the manufacturer that would provide the medically appropriate dose for the individual patient.

When prescribing or providing injectable medications for a member, it is important to know the member's specific coverage for that medication. Information regarding injectables is available on the AZ Blue website at azblue.com/pharmacy by selecting the applicable option according to plan type or employer group. Or call 1-866-325-1794 to verify benefits.

Limited medical benefit coverage

Some AZ Blue benefit plans for large (100+) groups exclude coverage for prescription medications because these large groups "carve out" this benefit. Generally, these groups have a prescription benefit manager other than AZ Blue or AZ Blue's contracted PBM.

Mail order

Most benefit plans have an in-network benefit for mail-order medications. Members must use the specific network mail-order provider to receive this benefit. Compound prescriptions are not available through the mail-order provider.

Mandatory generics

Many benefit plans incentivize members to use generic medications over brand name medications when generics are available, by imposing higher cost share on the brand name drug. Providers are encouraged to prescribe or permit generics. Exceptions can be made when a medication is approved through step therapy in which the recommended alternative medications have been tried and failed, or when AZ Blue or the PBM requires the use of the brand name medication as the preferred medication. Medications with step-therapy requirements are indicated by the ST acronym in the drug list or formulary.

Medication lists

The presence of a medication on any AZ Blue or PBM drug list or formulary does not guarantee coverage of that medication for a particular member. Benefit plan limitations and exclusions and other factors will determine if coverage is available. The assignment of a medication to any particular tier does not constitute a recommendation regarding the use of a medication.

Pharmacy coverage guidelines

These are pharmaceutical and administrative criteria developed by AZ Blue or its PBM, based on review of published peer-reviewed medical and pharmaceutical literature, and other relevant information. AZ Blue and the PBM use the guidelines to help determine whether a medication or other products such as medical devices or supplies are eligible for coverage under a member's retail, mail-order or specialty benefit. For current pharmacy coverage guidelines go to azblue.com/pharmacy, select the plan type and access coverage guidelines under Additional Resources.

Note: Certain large groups may carve out or customize pharmacy coverage guidelines. Call the pharmacy benefits customer service number on the back of the member's ID card.

More Information about AZ Blue Pharmacy Benefits

Pharmacy network
AZ Blue contracts with a PBM to provide a network of pharmacies for AZ Blue members. Some plans require members to use an in-network pharmacy to receive coverage for medications.

Preferred biosimilar requirements
We require the use of preferred biosimilars(s) before a non-preferred option will be covered. A biosimilar is a biologic medication that has been evaluated by the FDA and approved after it has been proven to be almost identical to the original reference biologic. There are no substantive clinical differences in terms of safety and efficacy, and only minor differences are allowed in the inactive components. You can find the Biosimilar Step Therapy guidelines at azblue.com/pharmacy. Select the plan type and look under "Additional Resources > Pharmacy Coverage Guidelines."

Prescription vitamins
Some benefit plans may include coverage for oral prenatal vitamins and prescription-strength vitamin K and vitamin D when a prescription is written by a physician. Be sure to check plan-specific coverage information. Additional vitamins may be covered under the preventive medication benefit – see below for more information.

Preventive medications
Non-grandfathered benefit plans are required to cover certain preventive medications with no out-of-pocket costs for the member if the medication is obtained from an in-network pharmacy. Grandfathered plans may cover certain preventive medications, but member cost share generally applies. Information on preventive medications can be obtained online at azblue.com/pharmacy by selecting the applicable option by plan name or group number. Or call 1-866-325-1794 to verify benefits.

Prior authorization
Prior authorization is required for certain medications. The lists of medications that require prior authorization for AZ Blue fully insured individual and group plans are available online at azblue.com/pharmacy. For most benefit plans, there are separate prior authorization requirements lists for medications obtained through the retail/mail-order pharmacy benefit, the specialty medication benefit, and the home health benefit.

- AZ Blue partners with Cover My Meds® and Surescripts® for electronic prior authorization of medications covered under pharmacy benefits. You can request prior authorization through these vendors for benefit plans that use AZ Blue pharmacy benefits.
- Other options for requesting prior authorization are available at azblue.com/pharmacy and also via the AZ Blue provider portal (in the Practice Management menu under Prior Authorization). Or call 1-866-325-1794. There is no coverage if required prior authorization is not obtained.
- **eviCore** provides prior authorization on our behalf (for most AZ Blue benefit plans and AZ Blue Medicare Advantage plans) for certain medical oncology and other specialty drugs (for non-inpatient care) that must be administered by a healthcare provider and are covered under medical benefits. More information is available on our provider resource page at evicore.com/healthplan/azblue. Use the eviCore online tool to request or view status of prior authorization requests.

The list of specific medications that require prior authorization can change at any time without prior notice.

More Information about AZ Blue Pharmacy Benefits

If prior authorization is required, but the member must obtain the covered medication outside of AZ Blue's prior authorization business hours, the member may be required to pay for the medication at the time it is dispensed. The member may then file a claim with AZ Blue for reimbursement. The claim will not be denied for lack of prior authorization, but all other exclusions and limitations of the member's benefit plan will still apply.

Rebates

AZ Blue may receive rebate payments on certain pharmaceutical products used by AZ Blue members. These rebates are not reimbursable to members or providers.

Separate deductible information

In addition to the medical plan deductible, some plans have separate deductibles for retail and mail-order pharmacy coverage. Amounts paid toward the retail and mail-order pharmacy deductible do not typically count toward the medical plan deductible.

Vaccinations

AZ Blue benefit plans that have a retail pharmacy benefit also provide coverage for certain preventive vaccines with no out-of-pocket costs for eligible members when the vaccine is administered by a certified pharmacist in a retail in-network pharmacy setting. A list of covered vaccines can be accessed via azblue.com/pharmacy by selecting the applicable plan type and looking under Additional Resources > Additional Drug Lists. Or call 1-866-325-1794 to verify benefits.

COVID-19 vaccinations are covered under the retail pharmacy benefit in accordance with state and federal recommendations.

Specialty Medications

Specialty pharmacy and home health/home infusion benefits and providers
Unless otherwise restricted by benefit plan provisions[2], AZ Blue or the PBM specifies if a specialty medication will be covered under the member's specialty pharmacy benefit or the medical home health/home infusion benefit. Members must use the designated benefit. See the specialty medication lists at azblue.com/pharmacy for details. For additional clarification, call AZ Blue Prescription Benefits Customer Service at 1-866-325-1794.

For clinical criteria, see our pharmacy coverage guidelines or evidence-based criteria, which can change without notice. Pharmacy coverage guidelines are available at azblue.com/pharmacy. Select the resource page corresponding to the member's plan type.

Specialty pharmacy providers (for specialty medications covered under the prescription benefit):

- OptumRx Specialty Pharmacy – *exclusively* for specialty medications covered under the member's *prescription* benefit. Call 1-866-618-6741 to establish service. Note: Avella Specialty Pharmacy is now OptumRx Specialty Pharmacy.
- Additional AZ Blue-contracted specialty pharmacies may be used if a medication is not available through the designated specialty pharmacy (such as a limited distribution medication).

Home health/home infusion providers (for specialty medications covered under the medical benefit):

- For OptumRx Specialty Pharmacy (including Avella), call 1-866-618-6741.
- For AZ Blue -contracted specialty pharmacy and home health and home infusion providers, use the **Find a Doctor** Provider Directory at azblue.com/directory.

Specialty infusion medications with site-of-service requirements
Certain specialty infusion drugs require a medical necessity review that includes site-of-service criteria.

- Our preferred sites of service for administering these drugs are the non-hospital outpatient alternatives (the patient's home, a free-standing infusion center, or a physician's office).
- Only in cases where a higher level of care is medically necessary will the service be covered in an outpatient hospital setting.

For specific site-of-service requirements for these infusion drugs, use the AZ Blue proprietary medical policy search tool.

Benefit-specific exclusions

- The specialty medication benefit has specific exclusions in addition to general exclusions, applicable to all benefits. Generally, specialty medications are subject to the same exclusions as medications available through retail and mail-order pharmacies. (See sample list of benefit-specific exclusions on page 24-4.)
- The specialty medication benefit is in-network only. Medications obtained from a pharmacy not contracted with AZ Blue as a specialty pharmacy are not covered. Exceptions may be made in emergency situations.

[2] Some AZ Blue plans may have specialty medication benefits only when obtained through a AZ Blue-contracted specialty pharmacy. Prior to rendering services, verify benefits and network requirements.

Specialty Medications

Cancer specialty medications – OptumRx split fill program for the first three months
Under some benefit plans that have the *prescription* specialty benefit through OptumRx Specialty Pharmacy, certain cancer treatment medications that are also classified as specialty medications will be eligible for the split fill program. (See information above about OptumRx Specialty Pharmacy, the exclusive specialty pharmacy for specialty medications under the member's prescription benefits.)

Under this program, the first time the medication is prescribed, the member receives a 15-day supply and pays one half of the Tier 1 retail/mail-order Pharmacy copay. If side effects are experienced, the provider may change the medication. If the member continues with the original medication, the prescription may be refilled every 15 days, with the same copay arrangement, during the first three months of the treatment. If the member continues to tolerate the medication, they may refill the prescription for up to 30 days or longer after the first three months of treatment.

Prior authorization for specialty medications

1. **Specialty injectable medications**

   - Injectable medications that must be administered by a healthcare professional may require prior authorization and are billed under ***medical*** benefits. To check prior authorization requirements for these medications, visit our Prior Authorization & Medical Policies page or log in to the AZ Blue provider portal and go to Practice Management > Prior Authorization.

     For most AZ Blue members, eviCore provides prior authorization on our behalf for specialty drugs covered under medical benefits (for non-inpatient care). For more information (including clinical guidelines and applicable drug codes), visit our provider resource page at evicore.com/healthplan/azblue.

   - Injectable and oral medications that can be self-administered may require prior authorization and are billed under ***pharmacy*** benefits. To check prior authorization requirements for these medications, access the Specialty Medication List (Pharmacy) at azblue.com/pharmacy.
     - Call AZ Blue Provider Assistance at 602-864-4320 or 1-800-232-2345
     - For **group number 029653,** call OptumRx at 1-866-391-2370

2. **All other specialty medications**
   Check the Specialty Medication List (Pharmacy) at azblue.com/pharmacy for prior authorization requirements and how to make a request for a specific member. Select the appropriate prior authorization form for the medication being requested and fax the form to the number at the top of the form.

Clinical criteria for certain specialty medications can be viewed on the AZ Blue provider portal at "Practice Management > Medical Policies > MCG Care Guidelines." Other specialty medications are included in the pharmacy coverage guidelines at azblue.com/pharmacy.

Federal Employee Program (FEP) Pharmacy Benefits

FEP pharmacy benefits are designed and administered at a national level, not by AZ Blue. For current information, visit fepblue.org/pharmacy.

Formularies

FEP benefit plans include Standard Option, Basic Option, and FEP Blue Focus. All plans have multi-tiered benefits, but the specific tiers and member costs vary by plan option. FEP Standard Option uses a comprehensive formulary, FEP Basic Option has a managed formulary and FEP Blue Focus uses a closed formulary. See more formulary information at fepblue.org/pharmacy/prescriptions. Members can search for the lowest medication price by using the FEP Prescription Drug Cost Tool.

Exclusions

Standard Option has an excluded drug list and Basic Option has a managed-not-covered list. For Blue Focus, if the drug is not on formulary, it is not covered. For more information and links to the current lists of excluded/not-covered drugs, visit fepblue.org/pharmacy/prescriptions. The Discount Drug Program offers discounts for some non-covered medications.

Prior approval

Certain medications require prior approval. CVS Caremark manages the FEP pharmacy prior approval process. See the online list of medications requiring prior approval and get more information on the pharmacy FAQs page.

To request prior approval (including quantity increases), use the ePA (electronic prior authorization) option through Cover My Meds or Surescripts, or contact the FEP clinical call center at 1-877-727-3784 (Monday through Friday, between the hours of 7 and 9 p.m., EST). For more information about ePA, visit the Caremark ePA webpage.

Specialty medications

Specialty medications may be covered under medical benefits or pharmacy benefits. Some medications are covered under both types of benefits. The FEP Specialty Drug Pharmacy Program is administered by CVS Specialty.

The Specialty Drug Pharmacy Program provides members with specialty drugs (often the most cost-effective option) and pharmacy care management services. The specialty drug list indicates drugs that require prior authorization and shows which ones are covered only under medical benefits or only under pharmacy benefits. You can find a link to the list, along with information about filling specialty drug prescriptions, at fepblue.org/pharmacy.

PBM phone numbers (available 24/7)

Retail Pharmacy Benefits (CVS Caremark)	**1-800-624-5060**
Mail Order Pharmacy Benefits (CVS Caremark)	**1-800-262-7890**
Specialty Drug Benefits (CVS Specialty)	**1-888-346-3731**

CVS Caremark (including CVS Specialty) is a separate, independent company that provides and is solely responsible for providing pharmacy services to FEP providers and members. It does not provide AZ Blue products or services.

Medicare Advantage Pharmacy Benefits

AZ Blue Medicare Advantage (MA) plans cover all Medicare Part D drugs listed on the MA formulary when the drug is deemed medically necessary for the member's condition, the prescription is filled at an in-network pharmacy, and other plan rules are followed. A team of healthcare providers selects the drugs for the formulary that represent the prescription therapies believed to be necessary for a quality treatment program. The formulary is submitted to and approved by CMS each year.

Over the counter (OTC) drugs are not considered prescription drugs and are not covered under the pharmacy benefit plan. For updated information about the drugs covered by AZ Blue MA, see the AZ Blue MA formulary (prescription drug list).

Formulary changes

Generally, if a member is taking a drug listed on the AZ Blue MA formulary (prescription drug list) at the beginning of the benefit coverage year, we will not discontinue or reduce coverage of the drug during the coverage year except when a new, less expensive generic drug becomes available or if new adverse information about the safety or effectiveness of the drug is released.

Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are taking the drug at the time of removal. For those members, it will remain available at the same cost-share amount for the remainder of the benefit coverage year.

We will notify affected members at least 60 days in advance of the following types of changes:

- We remove a drug from our formulary
- We add a prior authorization requirement to a drug
- We introduce quantity limits and/or step therapy restrictions on a drug
- We move a drug to a higher cost-sharing tier

If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members with active prescriptions.

How to use the formulary

You can search the AZ Blue MA formulary (prescription drug list) by drug name or by category (alphabetically or by therapeutic class).

AZ Blue MA plans cover both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Some drugs may have additional requirements or limits on coverage. These will be indicated in the formulary.

Note about insulin cost share

Members will not pay more than $35 for a one-month supply of a covered insulin product, regardless of the assigned cost-share tier or whether or not the deductible has been paid in full.

Formulary exceptions

MA members may request an exception to our coverage rules. There are several types of exceptions that members can request, such as:

- Request to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-share tier, and the member may not request to have the drug moved to a lower cost-share tier.

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- Request to cover a formulary drug at a lower cost-share tier. For example, if a drug is in Tier 4, the member may request to have the drug covered at the cost share amount that applies to drugs in Tier 3.
- Request to waive coverage restrictions or limits on a drug. For example, if there is a limit on the amount of the drug that will be covered, the member may ask to have the limit waived.

Generally, we will only approve a member's request for an exception if the alternative drug is included on the plan's formulary, and the lower cost-share drug or additional utilization restrictions would not be as effective in treating the member's condition and/or would cause the member to have adverse medical effects.

How to request an exception for an MA Member

An MA member may request an initial coverage decision for a formulary, tier, or utilization restriction exception. The provider must submit a statement supporting the request. Providers may also request a formulary exception on behalf of a member.

Generally, we respond to exception requests within 72 hours of receiving the provider's supporting statement. A request for an expedited decision may be submitted if there is concern that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, the decision is made within 24 hours after we receive the supporting statement from the provider.

To request a formulary exception, you can use the OptumRx pharmacy benefit manager (PBM) preferred electronic prior authorization (ePA) solution. You must include supporting medical information.

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on coverage. A team of doctors and pharmacists developed these requirements and limits to help provide quality coverage to our members by ensuring that the drugs are used in the most safe and effective way, and to help control drug plan costs. For more information about these requirements and limits, see the AZ Blue MA formulary (prescription drug list).

Certain drugs require prior authorization or step therapy, or have quantity limits or generic substitution guidelines:

Prior authorization (PA): Some drugs require prior authorization to ensure that pharmacy coverage guidelines have been met.

- Our PBM (OptumRx) manages prior authorization for Part D drugs.
- AZ Blue and eviCore manage prior authorization for Part B drugs for AZ Blue-administered MA plans. OptumCare Arizona manages prior authorization for the plans they administer.

Quantity limits: We may limit the amount of the drug that is covered per prescription or for a defined period of time. Example: For Drug A, the member may receive up to nine tablets per 28 days.

Step therapy: In some cases, we require the provider to try a particular drug to treat the medical condition before we will cover another drug for that condition. Example: if Drug A and Drug B both treat the medical condition, we may require the provider to prescribe Drug A first. If Drug A does not work, then we will cover Drug B.

Generic substitution: When there is a generic version of a brand-name drug available, network pharmacies may recommend or provide the generic version, unless the provider indicates the brand-name drug must be taken and AZ Blue has approved the request.

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You can find out if a drug is subject to additional requirements or limits by checking the AZ Blue MA formulary (prescription drug list). If the drug is subject to an additional restriction or limit and the member is not able to meet the additional restriction or limit for medical necessity reasons, the provider or member may request an exception (a type of coverage determination). See previous page for information about formulary exceptions.

Drug utilization reviews

AZ Blue MA conducts drug utilization reviews each time a prescription is filled to ensure all members are receiving safe and appropriate care. When we identify potential medication problems, we work with the prescribing provider to resolve issues such as:

- Possible medication errors
- Duplicate drugs prescribed to treat the same medical condition
- Drugs that are considered inappropriate because of the patient's age or gender
- Possible harmful interactions between drugs
- Drug allergies
- Drug dosage errors

Medication therapy management program

AZ Blue's MA Medication Therapy Management Program (MTMP) offers eligible members a one-on-one appointment with a pharmacist who will review the member's current drug therapy. To participate in the MTMP, members must meet all three conditions listed below:

1. The member must have multiple chronic diseases (minimum of three).
    - Bone Disease- Arthritis-Osteoporosis
    - Chronic heart failure (CHF)
    - Diabetes
    - Dyslipidemia (high cholesterol)
    - End-Stage Renal Disease (ESRD)
    - Hypertension (high blood pressure)
    - Respiratory disease – asthma
    - Respiratory disease – chronic obstructive pulmonary disease (COPD)
2. The member must be taking at least eight Part D prescription medications on a regular basis.
3. The total annual allowed cost of the member's prescription drugs is more than $5,330 (includes chronic/maintenance drugs).

How the MTMP program works

The MTMP program is voluntary. We encourage members to participate, but a member may decline to take advantage of it.

- The member meets by telephone with a clinical pharmacist, who reviews the member's prescribed medications, answers questions, and makes suggestions on how to improve the drug therapy and/or reduce costs.
- The pharmacist then communicates with the member's provider to make recommendations and discuss any suggestions that were made to the member.
- The provider decides whether to make any pharmacist-recommended changes to the member's medications.

Medicare Advantage Pharmacy Benefits

Part D prescription drug benefit

All AZ Blue MA members have Part D prescription drug coverage; however, the coverage is not the same for all benefit plans. There are four different "stages", which apply to all the plans. The drug costs depend on which "stage" the member is in, as well as the specific provisions of the member's benefit plan. The following is a description of each drug coverage stage.

Yearly deductible stage – This stage begins when the member fills the first prescription of the year.

Initial coverage stage – Each time the member gets a prescription filled, we track the total cost of the drug (the combined amounts paid by the member and by AZ Blue) . The initial coverage stage continues until the member's year-to-date total drug costs reach the initial coverage dollar limit of $5,030. Once this limit is reached, the member moves into stage 3.

Coverage gap stage – Once the member enters the coverage gap stage, the member pays 25% of the price (plus the dispensing fee) for brand name drugs and 25% of the price for generic drugs. The member stays in this stage until the year-to-date "true out-of-pocket costs" (the member's payments only) toward Part D covered drugs, reach a total of $8,000. Once this amount is reached, the member moves into stage 4.

Catastrophic coverage stage – During this stage, AZ Blue pays most of the cost of the member's drugs for the rest of the calendar year (through December 31), and the member's share of cost will be the greater of:

$ 4.50 for generic drugs OR 5% of the cost of the drug

$ 11.20 for all other drugs OR 5% of the cost of the drug

AZ Blue pays the remainder.

You can find more information about Part D prescription drug benefits in the Summary of Benefits documents on our Medicare Advantage Plan Documents page.

Mail order drug program

Optum Rx provides mail order drugs for AZ Blue MA members. You may use e-prescribe to Optum Rx or fax to 1-800-491-7997. Members must register to obtain drugs through the mail order pharmacy. For more information, visit https://professionals.optumrx.com/ or contact the pharmacy at 1-800-791-7658.

OptumRx phone numbers and request options

Retail Pharmacy Benefits	**Phone: 1-844-883-8523**	**ePA: covermymeds or surescripts**
Mail Order Pharmacy Benefits	**Phone: 1-800-791-7658**	**Fax: 1-800-491-7997 | ePA: covermymeds or surescripts**

OptumRx is a separate, independent company that provides and is solely responsible for providing pharmacy services to AZ Blue providers and members. OptumRx does not provide AZ Blue products or services.

OptumCare Network of Arizona ("OptumCare Arizona") is a separate, wholly owned subsidiary of Optum and is contracted with AZ Blue to provide utilization management and claim/payment processing services for providers and attributed members with certain AZ Blue Medicare Advantage HMO plans.