Health Alliance Plan®
by Henry Ford Health

Qualified Health Plans Drug Formulary for HMOs and PPOs

USE THE DRUG LIST, ALSO CALLED A FORMULARY, TO FIND OUT WHICH PRESCRIPTION DRUGS ARE COVERED UNDER ALL QUALIFIED HEALTH PLANS.

This document has answers to common questions about our drug list and prescription coverage.

The drug list is current as of the date shown after the Table of Contents and before the Drug Formulary List.

Qualified Health Plans (QHP) are Affordable Care Act-compliant plans that cover essential health benefits and follow established limits on cost-sharing.

When it refers to “we,” “us” or “our,” it means Health Alliance Plan by Henry Ford Health. When it refers to “plan” it means qualified health plans.

If you have questions about your health plan, please call Customer Service at the number on your ID card or log in at **hap.org** and send us a message.

Please note: A drug's coverage status may change prior to it being updated in the drug list. The listing of a drug does not imply coverage for all benefits. Some dosage forms or strengths of an existing drug may not be covered. Consult the interactive Drug Search Tool for the most up-to-date information. Please contact Customer Service for more details.

Q&A

Q. What does “drug” mean?

A. In your health plan documents, the words “drug” and “medication” mean the same thing. They both refer to medicine used to help prevent, treat, or manage health conditions.

Q. What is the drug list?

A. The drug list, also known as a **formulary**, is a list of covered prescription drugs. Prescription drugs are medications you can obtain from pharmacies and administer to yourself. Medical drugs, such as drugs infused at home, may also be included in your drug list. Our drug list is developed with a team of healthcare providers, including

doctors and pharmacists. It contains the prescription drugs believed to be a necessary part of a quality treatment program. The prescription is then filled at an in-network pharmacy.

The status of covered drugs can change over time. For example:
• We may add new drugs to the list as they are approved by the Food and Drug Administration.
• We may remove drugs as we learn more about how safe they are and how well they work.
• We may change the tier levels of drugs on the list. Tier levels determine your copay and other out-of-pocket costs for drugs.

From time to time, we may add or remove quantity limits, the need for prior authorization or other criteria for coverage.

Q. Where can I find the drug list?

A. You can search for covered drugs on our interactive Drug Search tool or download a drug list. The Drug Search tool and the Drug list are available at hap.org/prescription-drug

Q. How do I use the interactive Drug Search tool?

A: If you are using a computer, click on the “Search 20XX Small business/Individual Plan drugs” button. [XX refers to your plan year.] The Drug Search tool will display. You only need the first three letters of the drug name to search. Type the drug name in the search box, press enter. You will get a list of drugs that match your search request. Select the drug you are looking for, press enter. The display will show the full drug name, therapeutic class, drug tier status and any criteria for coverage such as quantity limits or prior authorization

Q. How do I use the drug list?

A. The drug list is a list of covered generic and brand name drugs and is organized by categories. Each category represents the type of medical conditions that the drugs are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular Drugs.” If you know what a drug is used for, look for the category name in the list. Then look under the category name for the drug.

You can also look for your drug in the Index that is at the end of the document. The Index provides an alphabetical list of all drugs included in this document.

If you are using a computer, you can search for a specific drug within the formulary, just select Ctrl-F and enter the name of the drug in the search box. The cursor will highlight the drug you are looking for.

Q. What is included in the formulary drug list?

A. The drug list includes the following information

• The name of the covered drug. Brand name drugs are capitalized (e.g., JANUVIA) and generic drugs are listed in lower-case (e.g., metformin). **When a generic drug is listed on the formulary, only the generic is covered.**

• The covered drug cost-sharing level or Tier. Every drug on the formulary is in one of six cost-sharing Tiers. Refer to your Summary of Benefits and Coverage for your cost-sharing information. Tier classes:

Description of Tier	Copay
Preventive – FDA approve drugs that are covered at zero cost share per the Affordable Care Act when Health Care Reform (HCR) rules are met.	Zero Cost Share
Select Generic Drugs – FDA approved drugs that contain the same active ingredient(s), identical in concentration and strength to their brand name drug. Drugs in this tier are comprised of low-cost generic drugs.	Tier 1
Generic and Select Brand Drugs – FDA approved generic and brand name drugs that meet rigorous quality, safety and cost-effectiveness guidelines, with a slightly higher out of pocket cost than Select Generic Drugs.	Tier 2
Preferred Brand – FDA approved brand name drugs that meet rigorous quality, safety and cost-effectiveness guidelines.	Tier 3
Non-Preferred Brand and Generic Drugs – FDA approved generic and brand name drugs that meet rigorous quality, safety and cost-effectiveness guidelines that are considered non-preferred by us, which may also include higher cost generics.	Tier 4
Preferred Specialty Drugs – brand, generic or biosimilar drugs approved by the FDA that are used to treat complex and/or chronic illnesses and require close supervision and monitoring. The drugs in this category include injectable/infusible and certain orally inhaled drugs that may require prior authorization. To assure safe and quality care; these drugs must be obtained by a contracted specialty pharmacy.	Tier 5
Non-Preferred Specialty Drug – brand, generic or biosimilar drugs approved by the FDA that are used to treat complex and/or chronic illnesses and require close supervision and monitoring. The drugs in this category include higher-cost injectable/infusible and certain orally inhaled drugs that may require prior authorization. To assure safe and quality care; these drugs must be obtained by a contracted specialty pharmacy.	Tier 6
Medical Drugs – These are drugs that are infused or administered in doctor's office or facility, that are covered under your medical benefit and may be required by us to be obtained from a Specialty Pharmacy.	Tier 7

• Drug Coverage rules and limits as follows:

PA (Prior Authorization) – Ask your doctor to get prior authorization from us before you fill your prescription for this drug. Without prior approval, we may not cover this drug.

QL (Quantity Limit) – We limit the amount of these drugs that are covered for each prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

ST (Step Therapy) – Before we will provide coverage for this drug, you must first try other drug(s) to treat your medical condition. This drug may only be covered if the other drug(s) does not work for you.

SP (Specialty Pharmacy) –This specialty drug can only be obtained from Pharmacy Advantage by calling them at (800) 456-2112.

HCR (Healthcare Reform) – You must meet the Healthcare Reform requirements for preventive use to obtain the drug at zero cost sharing

Not Covered-Excluded - These medications may be excluded per contracts or other policy documents.

Q. What is a generic substitution?

A. When an FDA-approved generic drug is available, your prescription will be filled with the generic form of the medication. Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your health plan less money than a brand name drug.

Q. What are specialty drugs?

A. Specialty drugs are biologics or prescription drugs that require close monitoring for safety and efficacy. For this reason, we contract with Pharmacy Advantage, a specialty pharmacy, from whom you can obtain specialty drugs. Specialty drugs require prior authorization, and Pharmacy Advantage can help you and your doctor submit a request. You or your doctor can contact Pharmacy Advantage at (800) 456-2112

Q. What are maintenance drugs?

A. Maintenance drugs are medications prescribed for chronic, long-term conditions. These medications are taken on a regular, recurring basis. Examples of chronic conditions that may require maintenance drugs are high blood pressure, high cholesterol and diabetes.

The Maintenance Drug List (MDL) contains well-established medications that are proven safe and effective. They are considered first-line therapy options for common chronic conditions. Most of these drugs are available as generic drugs. The list contains the most common dosage forms and strengths of a drug. Less common forms or strengths may not be covered as a maintenance drug. Check your formulary drug list for the MDL notation to confirm whether your medication is a maintenance drug. Refer to your plan documents for your copay information.

You can get a 90-day supply of drugs listed on your plan’s Maintenance Drug List if:

- It is filled at an eligible 90-day network retail pharmacy or through the Pharmacy Advantage home-delivery service
- Your physician writes the prescription for a 90-day supply

Q. What are covered alternatives?

A. Covered alternatives are medications that your health plan covers and that may treat your condition similarly to the medication originally prescribed. The listed covered alternatives may not include all covered medication options. Check your drug list for covered medications. Your doctor may choose one of these covered medications before requesting coverage for a drug not on your covered drug list. It is best to first talk to your doctor or pharmacist about whether another drug on the covered drug list will work for you.

Q. Are there any requirements or limitations on my coverage?

A. Some covered drugs have extra requirements or limits on coverage. The coverage requirements are listed on the drug formulary. These requirements and limits may include:

• **Prior authorization (PA).** Some drugs on our drug list have criteria you must meet before we cover them. You or your doctor need to get approval from us before you fill your prescriptions for these drugs. Without prior approval, we may not cover these drugs.

• **Quantity limit (QL).** Some drugs have limits on the amount that can be dispensed on each fill, or on the number of fills allowed for treatment of certain conditions. Quantity limits may help reduce waste, enhance patient support and monitoring during therapy initiation, and helps avoid unnecessary costs if treatment is discontinued or changed early.

- Specialty and injectable drugs (except select insulins) and select oral drugs (e.g. opioid analgesics) are limited up to a 30-day supply per fill.
- Some specialty drugs require a 15-day supply at the start of therapy (partial-fill).
- Select higher-cost drugs are limited up to a 30-day supply per fill until you have used the drug for at least 90 days, after which 90-day fill could be allowed at our mail order pharmacy.

• **Step therapy (ST).** In some case we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if drug A and drug B both treat your medical condition, we may not cover drug B unless you have tried drug A first and it did not work for you.

• **Specialty pharmacy (SP).** This specialty drug can only be obtained from Pharmacy Advantage. You can contact them at (800) 456-2112.

Q. What is a transition drug or transition fill?

A. When a new group or member first enrolls in one of our plans, we may allow the member to receive one fill of select medications that are not on our formulary or have coverage restrictions. This one-time fill is called a transition fill, and the medication is called a transition drug (TD). A member may receive up to a 30-day supply of an eligible transition drug within the first 90 days of joining the plan. Only select drugs are eligible for transition drug coverage. If you receive a transition fill, we will send you a letter explaining the drug was a transition and advising you to contact your provider to discuss available formulary options. Your cost for the transition drug or drugs will depend on the plan you are enrolled in. Non-formulary drugs are listed at the highest brand copay tier.

Q. Are there any restrictions on my benefits?

A. Our drug list applies to drugs used in an outpatient setting. In general, it does not include drugs administered in a doctor's office or hospital, which are known as medical drugs. Medical drugs we may list are specialty medical drugs that have to be obtained from our specialty pharmacy, Pharmacy Advantage. For more information, you or your doctor can contact Pharmacy Advantage at (800) 456-2112.

Here are some types of drugs we **do not** cover in any of our plans:

• Over-the-counter medications and their equivalents, unless specified in the drug list

• Drug products used for cosmetic purposes

• Experimental drugs or any drug products used in an experimental manner

• Replacement of lost or stolen medication

Note: Your tier levels, out-of-pocket costs and drug benefit exclusions may vary based on your prescription drug benefit plan. Check your applicable coverage policies such as riders, benefit guide and/or contracts for more details.

Q. What if my drug is not on the drug list?

A. If your drug is not on the list, it is considered **non-formulary.** You, your doctor or your authorized representative can ask us to make an exception and cover your drug. You or the prescribing doctor must provide a supporting statement that the requested drug is medically necessary to treat your condition. It must state that all the covered drugs available for treatment of your condition on the drug list would either not be as effective for you as the non-formulary drug or would harm you.

Our clinical specialist will review your request to decide if the medication will be approved for coverage. The review is based on medical necessity and benefit determination.

It is best to first talk to your doctor or pharmacist about whether another drug on the covered drug list will work for you.

Q. How do I submit a request for a non-formulary drug exception or prior authorization?

A. To request a drug exception for a non-formulary drug or coverage for a drug that requires prior authorization, please submit your request through an electronic prior authorization portal in accordance with the Michigan Law, SB247 State Mandate.

You also can call Customer Service at the number on your ID card or log in to **hap.org** if you need assistance with this process.

If you or your doctor asks for a medication that requires a prior authorization, we must respond to you within 72 hours if the request is urgent or within 7 days if not urgent (some plans allow up to 15 days).

If you or your doctor requests a drug not included in our formulary, we will respond within 24 hours if your request is urgent or 72 hours for non-urgent requests.

If you or your doctor thinks that waiting for a standard decision could seriously harm your health or your ability to function, you can request an urgent decision.

If we approve your exception request for a non-formulary generic or a brand drug, it will be billed at the highest copay for brand name drugs. If we approve your exception request for a non-formulary specialty drug, it will be billed at the highest copay for specialty drugs, and we may require it to be dispensed by Pharmacy Advantage. Non-formulary drugs when approved by the plan are limited for up to a 30-day supply at a time.

Check your applicable coverage policies such as riders, benefit guide and/or contracts for more details.