

What is a Drug Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. They were selected because they are safe, effective, and a better value compared to other drugs. The Drug Formulary includes brand name and generic drugs. We will generally cover the drugs listed in our Drug Formulary as long as the drug is medically necessary, the prescription is filled at our network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Certificate of Coverage.

Can the Drug Formulary change?

Your formulary is reviewed on an ongoing basis, and could change. If you are affected by a change you will be notified by mail 90 days in advance of the change. The drug you are using will continue to be covered during the 90 days. This will allow time for you to consult with your doctor to find an alternative Drug Formulary medication. Notices are not sent if a brand drug becomes available as a generic.

How do I use the Drug Formulary?

There are two ways to search the Drug Formulary, by drug category and drug name alphabetically. The drugs are listed by drug category, such as Ulcer Drugs, and are based on the condition the drug is used to treat. If you know what your drug is used for, look under that category for the name of your drug. Drugs are also listed alphabetically. You can use the alphabetic listing if you know the name of your drug. Both generic and brand name drugs are listed. All small letters indicate that it's the generic drug name, example: lisinopril tab . All capitalized letters indicate that it's a brand name drug, example: MOBIC TAB . The Drug Formulary is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar when you are looking at the document on a computer or smartphone. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

What is a generic drug?

Alliant Health Plans covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. A generic drug is identical--or bioequivalent--to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically available at substantial discounts from the branded price. Health professionals and consumers can be assured that FDA

approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- be identical in strength, dosage form, and route of administration
- have the same use indications
- be bioequivalent
- meet the same batch requirements for identity, strength, purity, and quality
- be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

Do I have to use generics?

A generic drug is a drug that is the same as its brand name drug in dose, safety, strength, how it is taken, and how well it works. The FDA requires that all generic drugs be safe and effective. Generics have the same benefits and risks as the brand name. Generics are filled by the pharmacy unless your benefit or your provider tells the pharmacy to fill the brand name drug. Your pharmacy may ask your provider to switch your drug to a lower cost drug that is not the brand drug's generic. This is done when a similar drug in the same drug class is used to treat the same condition. This cannot be done without your provider's approval. This is common when another drug would be as effective but has a lower cost.

Are there any restrictions in my drug coverage?

Some drugs on the Drug Formulary may have additional requirements or limits on coverage. These requirements may include:

Prior Authorization: Our plan requires you or your doctor to get prior authorization (PA) for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, Alliant Health Plans may not cover the drug. Prior Authorization means you must meet certain criteria to get coverage for a drug. Prior authorization rules are noted on the formulary. Some reasons you may need prior authorization:

- The drug is not used for your health condition or for certain use.
- The dose is higher than what is usually expected.
- There are other drugs that should be tried first.
- The drug can be misused / abused.

Your provider can submit a form showing you have met the prior authorization rules. Your request will be reviewed and you will be notified of the decision.

Quantity Limits (QL): For certain drugs Alliant Health Plans limits the amount of the drug that our plan will pay for. For example, our plan provides 30 tablets per 30 days per prescription for Crestor. Quantity limits are shown on the formulary. You are covered for up to the amount posted. These limits are based on standards of care and FDA guides. If your provider believes you have to take more than the amount allowed, they may submit an exception request.

Step Therapy (ST): In some cases our plan requires 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 try Drug A first. If Drug A does not work for you, we will then cover Drug B. These drugs require a “step” to be covered. This means you need to try a different drug before the step therapy drug. Step therapy rules are noted on the formulary. Your provider can submit a form showing you have met the step therapy rule.

Specialty Pharmacy Drugs (SP and MSP): Some medications require special handling processes and are limited in availability. Our plan has a specially chosen pharmacy to fill the prescriptions for these types of medications. These drugs are identified on your Drug Formulary by the letters **SP** and **MSP**.

What are some examples of drug restrictions on the Drug Formulary? Below are some examples of drug names, special codes, tiers and drug categories. The Special Code indicates a restriction or additional drug requirement.

(This reference is for example only.)

Drug Name	Special Code	Tier	Category
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	SP	ANALGESICS ANTI-INFLAMMATORY
ADCIRCA TAB	LMSP-PA	SP	CARDIOVASCULAR AGENTS - MISC.
HUMALOG INJ	ST	3	ANTIDIABETICS
SUMADAN KIT	-	NC	DERMATOLOGICALS
vancomycin cap	QL-ST	1	ANTI-INFECTIVE AGENTS - MISC.
VARUBI TAB	QL-RS	2	ANTIEMETICS

(See Drug Formulary Abbreviations for definitions of codes and tiers.)

What other common limits may apply?

Other common benefit limits may include:

- Charges for supplies and medicines with or without a prescription, unless covered
- Charges for prescription drugs which require prior authorization
- Charges for cosmetic drug treatments

- Non-FDA approved prescriptions
- Over-the-counter drug items, except those covered
- Charges for supplies and medicines purchased from a non-network pharmacy
- Drugs recently approved by the FDA until reviewed for the formulary

What if my drug isn't on the Drug Formulary?

If your drug is not listed in the Drug Formulary you should contact pharmacy customer service at 1-866-333-2757 to ask if your drug is covered. If you learn that our plan doesn't cover your drug you have two options:

- You can ask pharmacy customer service for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a drug that is covered by our plan.
- You can ask us to make an exception and cover your drug. See below about how to request an exception.

How do I request an exception to the Drug Formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

- You can ask us to cover a drug even it is not on our Drug Formulary. If approved, this drug will be covered at a pre-determined cost-sharing level and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a Formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, we will only approve your request for an exception if the alternative drugs included on the Drug Formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your medical condition and/or would cause you to have adverse medical effects. You should contact us to ask us for an initial coverage decision for a drug list, tiering or utilization restriction exception. When you request a drug list, tiering or utilization restriction exception you should submit a statement from your prescriber or doctor supporting your request. Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by

waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing customer in our plan you may be taking drugs that are not in our drug list. Or, you may be taking a drug that is on our drug list but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a drug list exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a customer of our plan. For each of your drugs that is not on our drug list or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a customer of the plan less than 90 days. In order to accommodate unexpected transitions of our customers that do not leave time for advanced planning, such as level-of-care changes due to discharge from a hospital to a nursing facility or to a home our plan will allow a one-time 31-day supply (unless the prescription is written for fewer days).

How can I save money on my drugs?

Ask your doctor if there are any lower cost generic alternatives available for any of your current medications. If your medication is not covered on the Drug Formulary list, talk with your doctor about alternative medications which are covered in the Drug Formulary list.