Pharmacy Services

At a Glance

UPMC Health Plan's Pharmacy Services Department helps to monitor appropriate utilization and manage health care dollars spent on prescription medications as well as the benefit plans for all lines of business. The department also works with Medical Management to coordinate member care regarding medications.

UPMC Health Plan offers four prescription programs to commercial members — *Your Choice*, a four-tier formulary; *Value Choice*, a three-tier formulary; *First Choice*, a two-tier formulary; and *Open Choice* Preferred Formulary, a two-tier open formulary. There are also separate formularies for UPMC *for Kids* (Children's Health Insurance Program), UPMC *for You* (Medical Assistance), UPMC *for Life* (Medicare), and UPMC Medicare Special Needs Plans (SNP) members.

Each of the formulary programs includes the following features:

- Mandatory generics
- Once-daily dosing initiatives to improve patient compliance
- Lists of preferred drugs, otherwise known as formulary medications
- Prior authorization or step-therapy requirements for selected medications
- Quantity limits (based on FDA guidelines and accepted standards of care)

UPMC Health Plan's formularies are developed by the physicians and clinical pharmacists on the Pharmacy and Therapeutics (P&T) Committee.

The clinical pharmacists also:

- Answer medication-related questions from providers and network pharmacies.
- Develop and conduct prospective and retrospective drug utilization reviews.
- Educate providers, network pharmacies, and members on pharmacy changes.
- Serve as a clinical resource for the provider network.
- Conduct a medication therapy management (MTM) program.
- Provide physician and patient education materials to network practices to support drug selection and use, based on the best objective and clinical evidence.

UPMC Health Plan encourages providers to contact the **Pharmacy Services Department** at **1-800-979-8762** from 8 a.m. to 5 p.m., Monday through Friday, with comments or questions about a member's medication history, duplicate medications, or compliance. Physicians may fax requests for prior authorizations or non-formulary medications to **412-454-7722.**

Obtaining Prior Authorization

- To obtain authorization for a medication that requires a prior authorization or has quantity limits or for a non-formulary medication, providers should visit **www.upmchealthplan.com** to obtain a prior authorization form and submit it by fax to **412-454-7722**.

UPMC Health Plan will immediately communicate all coverage determinations and prior authorization decisions via fax to the physician's office once the review process is completed. If a fax number is not available, UPMC Health Plan will communicate decisions via telephone and will mail a copy of any decision documentation to the provider's office.

Physicians will notify the member of all pharmacy prior authorization decisions rendered by UPMC Health Plan. If a request is denied, UPMC Health Plan will mail the member a letter fully explaining the rationale for the denial of coverage.

Closer Look at Prior Authorization for a UPMC *for You* Member

For UPMC *for You* members, a response will be provided to the request for prior authorization by telephone or other telecommunication device. The response will indicate approval or denial of the prescription within twenty-four (24) hours of the request. If the request for prior authorization is denied, a written denial notice will be issued to the prescriber and the member within 24 hours of receiving the prior authorization request.

Pharmacy Policies

A limited number of medications require authorization before they are dispensed to members. Authorizations may be required for the following reasons:

- To submit for a medication with a prior authorization or a step therapy requirement
- To write any prescription that exceeds UPMC Health Plan's quantity limits
- To request a non-formulary medication
- To request early refills

- Please reference **www.upmchealthplan.com** for a complete list of medications.

In some cases, clinical documentation is necessary in order to review these medication requests. All requests will be reviewed promptly, and the decision will be communicated to the physician or member when applicable.

To obtain authorization for a medication that requires a prior authorization, has quantity limits, or for a non-formulary medication, providers should:

- Reference **www.upmchealthplan.com** and submit a prior authorization form by fax to **412-454-7722**.

Prior Authorization Criteria

Prior authorizations are set on a specific drug-by-drug basis and require specific criteria for approval based upon FDA and manufacturer guidelines, medical literature, safety concerns, and appropriate use. Drugs that require prior authorization may be newer drugs for which UPMC Health Plan wants to track usage, drugs not used as a standard first option in treating a medical condition, or drugs with potential side effects that UPMC Health Plan wants to monitor for safety. All prior authorization criteria are reviewed by the Pharmacy and Therapeutics (P&T) committee.

The physician must submit clinical information to UPMC Health Plan and once that information is received, a decision regarding the medical necessity of the requested medication will be made.

- Please reference **www.upmchealthplan.com** for a complete list of medications.

Step Therapy

Step therapy is a process to ensure that UPMC Health Plan preferred medications are used as the first course of treatment. If the preferred medication is not clinically effective or if the member has side effects, another medication may be used as the second course of treatment.

The rules for each step therapy medication are built into the pharmacy computer files. These medications are automatically approved if there is a record that the member has already tried a preferred medication. If there is no record of a preferred medication in the member's medication history, the physician must submit clinical information to UPMC Health Plan. Once that information is received, a decision regarding payment for the requested medication will be made.

- Please reference **www.upmchealthplan.com** for a complete list of medications.

Once-Daily Dosing

To improve adherence to medication regimens, UPMC Health Plan requires once-daily dosing for certain medications. A provider who feels a member needs multiple daily doses may call **Pharmacy Services** at **1-800-979-8762** from 8 a.m. to 5 p.m., Monday through Friday.

Quantity Limits

The United States Food and Drug Administration (FDA) publishes guidelines on the safest and most-efficient ways to use certain medications. For these medications, UPMC Health Plan's P&T Committee follows the FDA and manufacturer's recommended dosing guidelines and limits how much of the medication the member may receive in a certain time period. Providers are encouraged to incorporate these quantity limits into their prescribing patterns.

- Please reference **www.upmchealthplan.com** for a complete list of medications.

For medical exceptions, call **Pharmacy Services** at **1-800-979-8762** from 8 a.m. to 5 p.m., Monday through Friday.

Mandatory Generics

Most formularies require the use of a generic version of a drug if one is available.

UPMC Health Plan (Commercial) Pharmacy Programs

UPMC Health Plan offers four prescription programs to commercial members:

- *Your Choice*, a four-tier formulary
- *Value Choice*, a three-tier formulary
- *First Choice*, a two-tier formulary
- *Open Choice Preferred Formulary*, a two-tier open formulary

Your Choice **(Four-Tier) Pharmacy Program**

Your Choice features a four-tier formulary. Many medications, unless they are benefit exclusions, are reimbursed under this program. This allows for accessibility of multiple medications within a class and permits members and providers to determine the medication that is best for the individual member.

The first tier:

- Has the lowest copayment. It is for generic medications that are A-rated by the FDA. These are therapeutically equivalent to the branded product. When a generic medication is available, providers are encouraged to prescribe the generic medication to their patients.

The second tier:

- Has a slightly higher copayment. It includes those brand-name drugs for which generics are not available. UPMC Health Plan has designated these agents "preferred" based on clinical efficacy, safety profile, and cost effectiveness.

The third tier:

- Includes brand-name medications that are not preferred but which the member may purchase at the highest copayment.

The fourth tier:

- Includes specialty medications. This tier includes high-cost medications and biologicals regardless of how the medication is administered (injectable, oral, transdermal, or inhalant). These medications are often used to treat complex clinical conditions and usually require close management by a physician because of their potential side effects and the need for frequent dosage adjustments. These drugs have the highest copayment.

Your Choice includes a few restrictions that allow us to provide members with a wide range of options at an affordable cost. *Your Choice* requires the member to use a generic version of the drug if one is available. If members have a mandatory generic plan and receive a brand-name drug when a generic is available, the member must pay the brand-name copayment in addition to the retail cost difference between the brand-name and generic forms of the drug.

Also, quantities are limited to a 30-day supply for controlled substances and for medications defined as specialty. A 90-day supply of most drugs is available at retail and from the mail-order pharmacy, **Express Scripts, Inc. (ESI)**. The ESI customer service center is available 24/7 at **1-877-787-6279** or by logging in to request refills online. **TTY users may call toll-free 1-800-899-2114.**

Your Choice drugs are listed alphabetically in the Pharmacy Benefit Guide. This is a listing of the most commonly prescribed drugs and represents an abbreviated drug formulary that is at the core of this pharmacy benefit plan.

Benefit exclusions are listed in the "Medications Not Covered by *Your Choice*" table in the Pharmacy Benefit Guide.

Prescription drugs not covered on the formulary are listed in “Non-Covered Medications with Covered Alternatives” section of the Pharmacy Benefit Guide.

Your Choice Pharmacy Program Guide

- Please reference **www.upmchealthplan.com** to view the *Your Choice* Prescription Drug Formulary.

Value Choice (Three-Tier) Pharmacy Program

The *Value Choice* pharmacy program provides good value by offering a variety of high-quality, cost-effective generic and select brand-name prescription drugs. When a member requires a prescription medication, providers have the opportunity to select from a wide range of generic drugs. In addition, when generic drugs are not available, providers can choose from certain brand-name medications. Specialty medications are also available through this plan.

Closer Look at *Value Choice*

Value Choice allows members to take full advantage of the savings offered by generic drugs over the higher-priced brand-name alternatives.

The first tier:

- Has the lowest copayment. It is for generic medications that are A-rated by the FDA. These are therapeutically equivalent to the branded product. When a generic medication is available, providers are encouraged to prescribe the generic medication to their patients.

The second tier:

- Has a slightly higher copayment. It includes those brand-name drugs for which generics are not available. UPMC Health Plan has designated these agents "preferred," based on clinical efficacy, safety profile, and cost effectiveness.

The third tier:

- Includes specialty medications. This tier includes high-cost medications and biologicals, regardless of how the medication is administered (injectable, oral, transdermal, or inhalant). These medications are often used to treat complex clinical conditions and usually require close management by a physician because of their potential side effects and the need for frequent dosage adjustments. These drugs have the highest copayment.

The *Value Choice* program requires a member to use a generic version of the drug if one is available. This means that if a member receives a brand-name drug when a generic is available, the member must pay 100 percent of the contracted rate for the brand-name drug. The contracted rate is a special rate negotiated by UPMC Health Plan and should offer a cost savings over the standard retail rate. Also, quantities are limited to a 30-day supply for controlled substances and for specialty medications. A 90-day supply of most drugs is available at retail and from ESI.

If a member needs a **generic prescription drug** that is not listed in the table, the member will pay 100 percent of the contracted rate for that drug. If the member requires a **brand-name drug** that is not listed on the table, the member will pay 100 percent of the contracted rate for that drug.

Benefit exclusions are listed in the "Medications Not Covered by *Value Choice"* table in the Pharmacy Benefit Guide.

All of the brand-name and specialty medications covered by *Value Choice* are listed in the Pharmacy Benefit Guide. This list includes some commonly prescribed generic drugs.

Value Choice Pharmacy Program Guide

- Please reference **www.upmchealthplan.com** to view the *Value Choice* Prescription Drug Formulary.

First Choice Pharmacy Program

The *First Choice* program features a two-tiered copayment scale for covered prescription medications — one for brand-name medications with a higher copayment, and another for generic medications with a lower copayment.

The first tier:

- Which has the lower copayment, is for generic medications. These are therapeutically equivalent to the brand-name product. When a generic medication is available, providers are encouraged to prescribe the generic medication to their patients.

The second tier:

- Which has a slightly higher copayment, is for preferred brand-name drugs. UPMC Health Plan has designated these agents "preferred," based on clinical efficacy, safety profile, and cost effectiveness.

- The second tier also includes specialty medications which are high-cost medications and biologicals regardless of how the medication is administered (injectable, oral, transdermal, or inhalant). These medications are often used to treat complex clinical conditions and usually require close management by a physician because of their potential side effects and the need for frequent dosage adjustments. These drugs have the higher copayment.

The Non-*First Choice* segment includes medications that are not typically covered by *First Choice.* If the member previously took a *First Choice* drug and it was not successful in treating his or her condition, the provider should contact UPMC Health Plan for approval for a specific Non-*First Choice* drug. These drugs have the highest copayment.

If a medication featured in the *First Choice* program is ineffective or causes an adverse reaction, providers, at their discretion, may prescribe the Non-*First Choice* medication without seeking prior authorization if use of the *First Choice* medication is indicated in the member's pharmacy profile.

First Choice requires the member to use a generic version of the drug if one is available. If a member has a mandatory generic plan and receives a brand-name drug when a generic is available, the member must pay the brand-name copayment in addition to the retail cost difference between the brand-name and generic forms of the drug. Also, quantities are limited to a 30-day supply for controlled substances and for medications defined as specialty. A 90-day supply of most drugs is available at retail and from ESI.

First Choice drugs are listed alphabetically in the Pharmacy Benefit Guide. This is a listing of

the most commonly prescribed drugs and represents an abbreviated drug formulary that is at the core of the pharmacy benefit plan.

Benefit exclusions are listed in the "Medications Not Covered by *First Choice"* table in the Pharmacy Benefit Guide.

Prescription drugs not covered on the formulary are listed in the “Non-Covered Medications with Covered Alternatives” section.

First Choice Pharmacy Program Guide

- Please reference **www.upmchealthplan.com** to view the *First Choice* Prescription Drug Formulary.

Open Choice Preferred Formulary Pharmacy Program

The *Open Choice* program features a two-tier open formulary.

The first tier:

- Has the lowest copayment, and is for generic medications.

The second tier:

- Has a higher copayment, and is for brand-name drugs. The second tier also includes specialty medications. These drugs have the higher copayment.

Open Choice Preferred Pharmacy Program Guide

- Please reference **www.upmchealthplan.com** to view the *Open Choice Preferred* Prescription Drug Formulary.

UPMC for Kids (CHIP) Pharmacy Program

UPMC *for Kids* Pharmacy Program (Two-Tier)

The UPMC *for Kids* pharmacy program features a closed, two-tiered formulary for covered prescription medications — one tier for generic medications, and another for preferred brand-name medications. The program requires mandatory generic utilization when available. Members must fill prescriptions at a participating pharmacy.

Some copayments may apply. The UPMC *for Kids* member identification (ID) card has copayment information printed on the front. Members are responsible for copayments when the prescription is picked up at the pharmacy or when ordering a medication through the mail-order program.

If a medication is ordered through the mail-order program and a 90-day supply is provided, the member will only have to pay two copayments instead of three. Specialty medications, controlled substances and over-the-counter medications cannot be ordered through the mail-order program. UPMC *for Kids* uses **Express Scripts (ESI)** for the mail-order program. ESI can be reached at **1-877-787-6279**; TTY users may call toll-free at **1-800-899-2114**. See copayment table below:

Table J.1

UPMC *for Kids* – Copayment Chart			
Pharmacy *(including diabetic supplies)*	**Free CHIP**	**Low-Cost CHIP**	**Full-Cost CHIP**
Retail			
Generic Drug	$0	$6 for 30-day supply	$10 for 30-day supply
Brand Drug	$0	$9 for 30-day supply	$18 for 30-day supply
Mail Order			
Generic Drug		$12 for 90-day supply	$20 for 90-day supply
Brand Drug		$18 for 90-day supply	$36 for 90-day supply

The UPMC *for Kids* pharmacy program utilizes prior authorization programs, step therapy, quantity limits, once-daily dosing, and benefit exclusions.

- Please reference **www.upmchealthplan.com** to view the *UPMC for Kids* Prescription Drug Formulary.

Medications Not Covered by UPMC *for Kids*

Medications that are considered to be benefit exclusions by the Pennsylvania Children's Health Insurance Program (CHIP) will not be covered. These include the following:

- Drugs used for cosmetic purposes
- Drug Efficacy Study Implementation (DESI) drugs
- Experimental drugs
- Infertility agents
- Weight loss drugs
- Anabolic steroids
- Biological
- Blood or blood plasma
- Drugs labeled for investigational use
- Drugs used for hair growth
- Impotency drugs
- Urine strips

UPMC *for Kids* Pharmacy Program Guide

- Please reference **www.upmchealthplan.com** to view the *UPMC for Kids* Prescription Drug Formulary.

UPMC for You (Medical Assistance) Pharmacy Program

UPMC *for You* Pharmacy Program (Two-Tier)

The UPMC *for You* pharmacy program features a closed, two-tiered formulary for covered prescription medications — one tier for generic medications, and another for preferred brand-name medications.

The program requires mandatory generic utilization when available and includes limited over-the-counter products when written on a prescription. The program covers smoking cessation aides and birth control.

The UPMC *for You* pharmacy program utilizes prior authorization programs, step therapy, quantity limits, once-daily dosing, and benefit exclusions.

- Please reference **www.upmchealthplan.com** to view the UPMC *for You* Prescription Drug Formulary.

Medications Not Covered by UPMC *for You*

The following medications are benefit exclusions and will not be covered:

- Antiobesity medications
- DESI drugs
- Drugs labeled for experimental/investigational use
- Drugs used for cosmetic purposes or hair growth
- Fertility agents
- Drugs from manufacturers not participating in the federal Drug Rebate Program
- Erectile dysfunction medications

Program Limits

The UPMC *for You* pharmacy program limits some members to six prescriptions, new or refills, per calendar month. UPMC *for You* can approve more than six (6) prescriptions through a benefit limit exception process. Exceptions to the numerical limits may be granted for members who meet certain criteria.

- The following specifications apply to the six-prescription limit:
  - Original prescriptions and refills for the same prescription will count as individual scripts in the month they are dispensed and be applied to the benefit limit.
  - Early refills of the same prescription will be counted in the calendar month they are dispensed, even if the early refill occurs within the same calendar month.
  - If the days' supply is greater than 30 days, the additional days' supply will not count toward the next calendar month(s). Each prescription will count once if applicable regardless of the days' supply.
  - Over-the-counter (OTC) drugs, generic drugs, and brand-name drugs will be counted toward the benefit limit.
  - Medical supplies are not counted under the pharmacy limit if billed via a procedure code.
  - A five-day emergency supply of a prescribed medication does not count toward the member's six-prescription per month limit and does not require a BLE approval.

- An exception for a prescription medication that exceeds the benefit limit will be automatically approved and the claim paid if the prescription is for a drug in one of the following classes listed below:

Table J.2

Automatic Exception – Drug Classes		
Anti-anginal	Cancer	Mood Stabilizers
Anti-arrhythmics	Chronic Kidney Disease	Multiple Sclerosis
Anti-coagulant/anti-platelet	Diabetes	**Narcotics***
Anti-convulsants	Enzyme Deficiency Agents	Opiate Dependency Agents
Anti-depressants	Family Planning	Oral Steroids
Anti-emetic*	Glaucoma	**Proton Pump Inhibitors***
	Gout	Pulmonary Hypertension
Anti-hypertensive	Hemophilia Agents	Serious Mental Illness
Anti-infective	Hepatitis	Statins for plaque stabilization
Anti-Parkinson's	HIV/AIDS	Thyroid
Anti-psychotics	Immune Deficiency Agents	Triptans
Asthma and COPD	Immunosuppressant	Vaccines

- The categories marked with an asterisk (*****) are automatically approved for a benefit limit exception only if the member's paid claim's history (on file with UPMC *for You* or Express Script, Inc.) shows the specific diagnosis or condition listed.

Table J.3

Claim History Automatic Approval – Drug Classes
***Anti-emetics:** ➢ When there is a paid claim in the past 90 days for cancer medication, or a paid claim in the past 180 days with a diagnosis of cancer or pancreatitis.
***Narcotics:** ➢ When there is a paid claim in the past 180 days with a diagnosis of cancer or sickle cell anemia.
***Proton pump inhibitors** ➢ When there is a paid claim in the past 180 days with a diagnosis of gastrointestinal (GI) bleeding, Barrett's esophagitis, or Zollinger Ellison.

- For those medications that are not automatically approved for an exception, the prescribing provider may request a benefit limit exception (BLE) by submitting a **"Pharmacy Benefit Limit Exception Request Form."**

UPMC Health Plan Pharmacy Services
Fax: 412-454-7722
For urgent requests, call 1-800-979-8762.

- The BLE is reviewed by the Medical Director and can be granted if the member meets one of the following criteria:
  - has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member; or
  - has a serious chronic systemic illness or other serious health condition and denial of the exception will result in rapid, serious deterioration of the health of the member; or
  - granting a specific exception is a cost-effective alternative for UPMC *for You*; or
  - granting an exception is necessary in order to comply with federal law.

All prior authorization requirements continue to apply and documentation of medical necessity for the medication will be reviewed concurrent to consideration of the benefit limit exception.

- A provider may not bill a member for services that exceed the limits unless the following conditions are met:
  - The provider has requested an exception to the limit and the request was denied.

- The provider advised the member, before the service was provided, that the services require a BLE and he or she will be responsible for payment if the request for an exception is denied.

To obtain a benefit limit exception and prior authorization forms, providers should go online to **www.upmchealthplan.com**. The applicable form(s) should be submitted by fax to **412-454-7722.** UPMC Health Plan will process all requests within 24 hours. The prescribing provider will be notified of the decision by fax.

- Please reference **www.upmchealthplan.com** to view the *UPMC for You Pharmacy Benefit Limit Exception Request form*.

Limits do not apply to:

- Members younger than 21 years old.
- Pregnant women (including the postpartum period, which ends the last day of the month in which the 60-day period after delivery ends).
- Nursing facility residents.
- Members who reside in an intermediate care facility for the mentally retarded and other related conditions (ICF/MR/ORCs).

Copayments

The UPMC *for You* pharmacy program requires some members to pay a copayment for certain medications.

Pharmacy copayments will apply to members in the adult and general assistance benefit categories, as well as members who are 18 to 20 years old. Copayments are as follows:

- Brand-name prescription and brand-name over-the-counter pharmaceutical drugs – $3 per prescription
- Generic prescription and generic over-the-counter pharmaceutical drugs – $1 per prescription
- If a 90-day supply of a maintenance medication is approved, then the member will be responsible for only one (1) copayment. Members in the other UPMC products would be charged three (3) copayments for a 90-day supply of a maintenance medication at a retail pharmacy

Providers (including pharmacies) are responsible for the collection of applicable copayments for rendered services. According to state and federal law, however, if a member cannot afford to pay the copayment, providers must render covered services to the member despite non-payment of the copayment. Providers may bill the member for the amount of the copayment after rendering services.

The following prescription drug classes are excluded from copayments for members in the **adult benefit category** and members who are 18 to 20 years old:

- Anti-hypertensives
- Anti-diabetics
- Anti-convulsants
- Cardiovascular preparations
- Anti-psychotics
- Anti-neoplastics
- Anti-glaucoma drugs
- Anti-Parkinson's drugs
- AIDS drugs
- Anti-depressants

Pharmacy copayments do not apply to:

- Pregnant women (including the postpartum period, which ends 60 days after delivery).
- Recipients who are younger than 18 years old.
- Nursing facility residents.
- Emergency supplies.
- Family planning supplies.
- Members who reside in intermediate care facility for the mentally retarded and other related conditions (ICF/MR/ORCs).
- Drugs, including immunizations, when dispensed by a physician.
- Recipients eligible under the Breast and Cervical Cancer Prevention Treatment Programs (BCCPT).
- Title IV-B Foster Care and IV-E Foster and Adoption Assistance.

UPMC *for You* Pharmacy Program Guide

- Please reference **www.upmchealthplan.com** to view the UPMC *for You* Prescription Drug Formulary.

UPMC for Life (Medicare) and UPMC Medicare Special Needs Plans Pharmacy Program

Beginning January 1, 2006, new Medicare prescription drug coverage called Medicare Part D was offered to everyone with Medicare. The Medicare Part D coverage is intended to help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage.

UPMC Health Plan offers the following plans that include Medicare-approved prescription drug plans:

- UPMC *for Life* HMO Rx
- UPMC *for Life* HMO Rx Enhanced
- UPMC *for Life* HMO Deductible with Rx
- UPMC *for Life* PPO Rx
- UPMC *for Life* PPO High Deductible with Rx
- UPMC *for You* Advantage (HMO SNP)
- UPMC *for Life* Options (HMO SNP)
- UPMC *Community Care* (HMO SNP)
- UPMC *for Life* Prescription Drug Plan

The UPMC *for Life* HMO Rx, UPMC *for Life* HMO Rx Enhanced, UPMC *for Life* HMO Deductible with Rx, UPMC *for Life* PPO Rx, UPMC *for Life* PPO High Deductible with Rx, UPMC *for You* Advantage (HMO SNP), UPMC *for Life* Options (HMO SNP), and UPMC *Community Care* (HMO SNP) are Medicare Advantage Plans. Medicare beneficiaries must have permanent residence within the plan's service area in order to join the plan.

The UPMC *for Life* Prescription Drug Plan, also called a **stand-alone prescription drug plan**, is offered to Medicare beneficiaries who are part of an employer group. This plan covers the Medicare prescription drug coverage only (it does not cover the medical and hospital portion of Medicare or Medicare Parts A and B).

For all UPMC *for Life* and UPMC Medicare Special Needs Plans that include Medicare-approved prescription drug coverage, the Medicare coverage gap applies based on CMS specifications.

The UPMC *for Life* and UPMC Medicare Special Needs Plans pharmacy program utilizes quantity limits, benefit exclusions, step therapy requirements, and prior authorization requirements.

- Please reference **www.upmchealthplan.com** to view the UPMC *for Life* and UPMC Medicare Special Needs Plans Prescription Drug Formulary.

Exception Process

An exception is the request for payment for a prescription drug that is not on the formulary or a request to pay differently from the coverage rules. The request may be submitted to the following address:

UPMC *for Life*/UPMC Medicare Special Needs Plans
U.S. Steel Tower
600 Grant Street, 12th Floor
Pittsburgh, PA 15219
Phone: 1-800-979-8762
Fax: 412-454-7722

Copayment Exception

Copayment exceptions will only be considered for formulary tier 3 agents. Copayment exceptions will allow members to get tier 3 agents at the tier 2 copayment. No exceptions will be made for tier 1, 2, or 4 agents to a lower tier.

Physicians can request copayment exceptions by supplying written or oral documentation showing that the member has tried and failed all lower tiered similar agents or that there are significant clinical rationales for prescribing the higher tiered agent over other lower tiered agents.

Closer Look at Copayment Exceptions

If UPMC Health Plan grants a request to cover a drug that is not on the formulary, a copayment exception cannot be made for the non-formulary drug.

UPMC Health Plan will process all requests within 72 hours. The prescribing provider will be notified of the decision by fax. If the member's health requires, physicians may request an expedited review, which UPMC Health Plan will process within 24 hours.

Medication Therapy Management

UPMC Health Plan has developed a Medication Therapy Management (MTM) program to assist members and physicians with medication management. The program team consists of internal clinical pharmacists, registered nurses, case workers, and support staff. The program identifies members with multiple chronic diseases, multiple chronic medications, and high out-of-pocket medication expenses.

All members who meet the above criteria are reviewed for potential drug-related problems. Interventions are made based on the type of drug-related issues identified and can include a letter or phone call to the physician or a phone call to the member or member's caregiver.

Areas of assistance available include, but are not limited to, the following:

- A Comprehensive Medication Review with a pharmacist
- Education
- Coordination of transportation to doctor appointments if needed
- Referral to assistance agencies such as the Department of Aging and community resources if needed
- Encouragement of compliance and adherence with medications
- Assessment of support network

Drug Utilization

UPMC Health Plan has developed procedures for the assessment of drug therapy. The purpose of these procedures is to ensure that outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical outcomes. Drug therapy assessments can occur at the point of sale and after dispensing has occurred.

When conducting drug therapy assessments at the point of sale, the dispensing pharmacist will use professional opinion and judgment to determine if a prescribed drug may potentially cause adverse medical results. The pharmacist will consult with the patient and/or provider to take steps in reducing the likelihood that drug therapy will adversely affect the member's health.

When conducting drug therapy assessments after dispensing has occurred, the clinical pharmacist evaluates the drug therapies to determine whether treatment was appropriate and medically necessary. For treatment that was inappropriate or unnecessary, education for members and/or providers will be initiated by UPMC Health Plan to impact members' compliance with drug therapies, providers' prescribing, and pharmacists' dispensing habits.

UPMC *for Life* and UPMC Medicare Special Needs Plans Pharmacy Program Guide

Please select the link below to view the UPMC *for Life* and UPMC Medicare Special Needs Plans Prescription Drug Formulary.

- Please reference **www.upmchealthplan.com** to view the *UPMC for Life and UPMC Medicare Special Needs Plans Prescription Drug Formulary*.

Benefit Exclusions for Medicare*

The following medications, products, or services are not included under the pharmacy plan:

- Medications currently covered by Medicare Part A or Part B
- Over-the-counter drugs (OTCs)
- DESI drugs
- Barbiturates (when used to treat epilepsy, cancer, or a chronic mental health disorder, barbiturates are covered drugs under Medicare Part D)
  Fertility medications
- Agents for cosmetic purposes or hair growth
- Agents for anorexia, weight loss, or weight gain
- Prescription vitamins (excluding prenatal and fluoride preparations)
- Drugs for the symptomatic relief of colds
- Drugs for impotency/erectile dysfunction
- Drugs made by manufacturers who do not participate in the CMS rebate program

Alert - Benefits Exclusions

*Some of these items may be provided under medical benefits. For additional information, contact UPMC *for Life* and UPMC Medicare Special Needs Plans **Provider Services** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

Where to Obtain Prescriptions

In Person

UPMC Health Plan has developed a pharmacy network that includes most major chain pharmacies in addition to neighborhood and independent pharmacies.

- Please visit **www.upmchealthplan.com** to locate network pharmacies.

UPMC Health Plan (Commercial), UPMC *for You* (Medical Assistance), UPMC *for Life*, and UPMC Medicare Special Needs Plans members may receive up to a three (3) month supply at certain retail pharmacies. UPMC *for You* members who are on a maintenance medication have the opportunity to receive a 90-day supply for the cost of one (1) copayment through the 90-day retail pharmacy program.

By Mail

UPMC Health Plan offers mail-order prescription services to its members through **Express Scripts**. The mail-order service may be contacted at **1-877-787-6279**. TTY users should call toll-free **1-800-899-2114**.

Members may have a lower copayment when filling prescriptions through the mail-order service.

Certain specialty medications must be ordered through the **CuraScript mail-order service** for Commercial members. Specialty medications may be ordered by calling **1-888-853-5525.**

Alert

UPMC *for You* members are not eligible for mail-order service.
UPMC *for You* members may use CuraScript for specialty medications, but they are not required to do so.