

National Preferred Formulary Changes for 2016 – Frequently Asked Questions

1. Does this formulary change apply to all formularies, including Medicare Part D and Medicaid plans?

No. This formulary change applies to the National Preferred Formulary, Preferred Prescriptions Formulary, National Preferred Specialty, Rx Selections, as well as clone, sync and N-Tier formularies that are based on the National Preferred Formulary. The change also applies to clients with a Medicare Part D Retiree Drug Subsidy.

The formulary change DOES NOT apply to Medicaid and Medicare Part D formularies that are used as part of an EGWP (Employer Group Waiver) or PDP (Prescription Drug Plan) or to custom formularies or the High Performance Formulary.

2. What is the coverage review process a physician and member will have to follow for a medical exception?

Express Scripts will update clients' standard coverage review process to include Express Scripts Standard Formulary Exception criteria, which allows exceptions when medically necessary. Physicians may call or fax a clinical override request. Express Scripts' Coverage Review & Determination team will review clinical criteria questions with the physician. If the criteria are not met, a pharmacist will review the case, and the physician and member are ultimately notified of the determination.

3. Can Express Scripts give me more detail on how many members in my population will be affected?

Yes. Member impact reporting is available through your account team.

4. Will the 2016 National Preferred Formulary be implemented as 100% coinsurance or not covered?

Products no longer covered will reject with an "NDC Not Covered" message at the point of sale. The pharmacy network discount will not apply and patients will need to pay out of pocket the full undiscounted retail cost of the drug if they elect not to switch to a preferred alternative. Rejecting the claim as "NDC Not Covered" is very important because it prevents the pharmacy from submitting any applicable copayment cards.

5. What if a patient had a prior authorization on a drug that will no longer be covered on 1/1? How will these claims be treated?

Even if the member already received prior authorization for a medication, that medication will no longer be covered beginning Jan. 1, 2016. Members may ask their doctor to request a clinical exception to continue taking the medication. The member's physician will need to request a Clinical Coverage Review. Where clinically appropriate, we grandfather patients so they may stay on their current medications without disruption or financial impact.

6. This list includes some specialty medications, how will patients taking specialty drugs be notified?

We have a comprehensive plan in place to help ensure continuation of therapy for specialty patients. In addition to our member communications, Accredo representatives will discuss the transition during December 2015 delivery scheduling calls if members mention the letter or have questions about the formulary changes. During those conversations, if patients request that Accredo contact their physician about a new prescription for a covered alternative, we will do so. Starting in October, Express Scripts will fax information to physicians prescribing affected products. A second wave of physician faxes will go out in December.

7. How will you notify with patients on multiple medications, such as those with diabetes or pulmonary conditions?

We'll conduct special outreach to patients on multiple medications or those with complex conditions, and, where possible, we'll work with affected members to help them make the switch.

8. Can patients use a manufacturer's copayment card to pay for medications not covered in the 2016 National Preferred Formulary?

Copayment waiver cards and coupons typically don't process for excluded drugs. Copayment cards generally only process if the prescription is adjudicated. Insurance, such as 100% copayment, must kick in first for copayment cards to work. Claims for excluded products won't adjudicate through the pharmacy benefit — just like a step therapy or prior authorization edit — rendering the copayment card useless. Copayment cards only pay the difference as the second payer on the maximum amount AFTER the primary payer adjudicates. This conditional language is included in most copayment cards program materials.