CHRISTUS Health Plan

Individual & Family Plan
Pharmaceutical Management Procedures

The Formulary

A formulary is a list of prescription drugs covered by a health plan, designed to promote the use of the most cost-effective medications. This is important because prescription drug costs are rising faster than other healthcare expenses. Contributing factors to this increase include:

- Increased advertising for newer, higher-cost drugs
- An aging population that requires more medications
- The significant costs associated with research and development for new treatments.

Without a formulary, CHRISTUS Health Plan members would face higher healthcare costs, in part due to rising drug prices. Our formulary helps ensure that we can continue offering affordable and comprehensive pharmacy benefits to our members.

CHRISTUS Health Plan formularies are developed and continuously updated by a committee of physicians and pharmacists. A Pharmacy & Therapeutics Committee reviews new medications and evaluates the latest information on existing drugs. This committee updates the formularies based on advancements in medicine, ensuring that they reflect the most current research and medical standards. These updates consider factors such as:

- Drug labeling information
- Clinical outcome studies published in peer-reviewed medical literature
- Standard drug reference compendia
- Regulatory approvals and status
- Evidence-based guidelines from medical associations, government agencies, or national commissions
- Expert opinions from professionals in relevant clinical fields
- Other relevant factors

By integrating the latest research, the committee ensures that our formularies continue to meet the highest standards of safety, effectiveness, and cost-efficiency.

The Pharmacy & Therapeutics Committee determines how medications are covered on the formulary based on the following criteria:

Efficacy: Preferred medications must be as effective as, or superior to, other available alternatives for most patients.

Safety: Preferred medications must demonstrate safety that is comparable to or greater than other available options.

Health Outcomes (when available): Preference is given to medications that have been proven to improve overall health outcomes.

Drug Interactions: Preferred medications must have the same or lower potential for drug interactions compared to other alternatives.

Pharmacokinetics: Medications with evidence showing that less frequent dosing improves patient compliance and outcomes are given consideration.

Contraindications: Medications that do not have restrictions limiting their use to specific patient populations are preferred.

Generic Availability: The decision to add generics to the formulary is based on safety, cost, demonstrated equivalence to the brand-name drug, and adherence to existing drug contracts.

While we do not require that your doctor only prescribe preferred formulary drugs, you may save time and money by asking if a newly prescribed medication is on our formulary. If it is not, ask whether a preferred generic or brand-name version is available on the CHRISTUS Health Plan formulary.

The formulary, including any restrictions and preferences, is available through an online search and also can viewed on our website as a printable document. It applies only to outpatient prescription medications dispensed by participating pharmacies and does not include inpatient medications or those obtained from and/or administered by your doctor. For any questions regarding drug coverage, please contact Member Services at 1.855.481.8152.

A summary of the most recent formulary changes is also available on our website. In addition to the specific drug limitations and restrictions listed in the formulary, certain classes of medications (such as supplements or weight loss medications) may not be covered. Please refer to your benefit documents or call Member Services to determine which medications are excluded under your benefit plan.

If your doctor believes a non-formulary drug is medically necessary, they can request an exception. The process for requesting a coverage exception is outlined in the section of this document titled 'Process for Requesting a Medication Coverage Exception.'

Restrictions

Prior Authorization

One of CHRISTUS Health Plan's (CHP) strategies for managing rising prescription drug costs is requiring prior approval, or authorization, before certain medications are covered. Medications that require prior authorization are typically not recommended as the first-line treatment option or may be limited to specific diagnoses. Prior authorization may also be necessary for high-cost drugs.

The prior authorization program ensures that medications are prescribed in a safe, appropriate, and cost-effective way. The Pharmacy & Therapeutics Committee determines which drugs require prior authorization and establishes the criteria for coverage.

If a drug requires prior authorization, it will be denied at the pharmacy until the health plan reviews the necessary clinical information provided by your doctor and approves coverage. Please be prepared to submit supporting clinical documentation showing that the member has tried and not responded to a formulary option. For assistance with a medication request review, please call 800.753.2851.

Step Therapy

Step therapy is a type of prior authorization that involves an electronic review of your prescription history to confirm that the appropriate generic or first-line medications have already been tried. If you have previously used the preferred drug(s), the claim will process normally, and you will pay the applicable copayment at the pharmacy. However, if the preferred drug(s) are not found in your prescription history, the claim will be

rejected at the pharmacy, and your doctor will need to submit additional clinical information to the health plan for further review. Contact 800.753.2851 for medication request review.

Which drugs require prior authorization or step therapy?
You can identify drugs that require prior authorization or step therapy by referring to our formulary document. This resource is available on our website under "Downloadable Formulary" at this link:
https://www.christushealthplan.org/member-resources/individual-families/pharmacy

Quantity Limits
The Pharmacy & Therapeutics (P&T) Committee may impose quantity limits on certain medications or products covered under your pharmacy benefit. These limits are in place for various reasons. For instance, it may be more cost-effective to take a single pill to achieve the required daily dosage rather than two lower-strength pills. Additionally, some medications have quantity limits to ensure that the prescribed dosage has been thoroughly studied and proven to be safe and effective. A list of medications with quantity limits is available on our website under "Downloadable Formulary" at this link:
https://www.christushealthplan.org/member-resources/individual-families/pharmacy

Age Limits
Christus Health Plan may require prior approval of certain drugs and products based on age. (A clinical reviewer will provide drug or product specific age limits upon request during the call.)

Generic Substitution/Preferred Brand Interchange/Therapeutic Interchange
In most cases, generic substitution may be required for brand-name drugs where the U.S. Food and Drug Administration has determined that the generic is equivalent to the brand. However, this requirement is based on the availability of the generic and state regulations regarding drug product selection. If your doctor states that the brand is required, or you request the brand when a generic equivalent is available, you may have to pay a higher out-of-pocket amount based on your benefit plan.

In some cases, CHRISTUS Health Plan covers a preferred manufacturer's version of a multisource brand-name product at a lower coverage tier, instead of the generic. This is often referred to as preferred brand interchange. Whenever preferred brand interchange exists, the preferred brand will be listed on the applicable coverage tier on the formulary.

Specialty Medication
Specialty drugs are typically high-cost drugs, including but not limited to, the oral, topical, inhaled, inserted, or implanted and injected routes of administration. Characteristics of specialty drugs include:

- Used to treat and/or diagnose rare and complex diseases
- Require close clinical monitoring and management
- Frequently require special handling
- May have limited access or distribution

All specialty medications must be filled at a preferred specialty pharmacy. Any specialty medications that are filled at an out of network specialty pharmacy will reject at the point-of-sale as "pharmacy not contracted" and will NOT be covered or reimbursed.

Mail Order
Members can use the mail-order pharmacy to receive medications that can be delivered directly to their home as long as they have a working phone number and an updated home address.

Members can contact 1.800.282.2881 to enroll in the mail-order benefit or for any questions about the mail-order benefit.

Opioids
The quantity of opioid products prescribed (including those that are combined with acetaminophen, aspirin or ibuprofen) will be limited to up to 90 morphine milligram equivalents (MME) per day based on a 30-day supply. Prescriptions that exceed 90 MME daily limits will be subject to UM criteria, such as prior authorization. Members who are opioid-naïve may be subject to additional step therapy requirements (use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation) and quantity limit restrictions (first fill will be limited to seven days).

Medication Coverage Exception (Non-covered drugs)

Non-covered drugs and products requested by you or your provider may be reviewed by calling this number 800.753.2851 when the formulary does not adequately accommodate your clinical needs. Please be prepared to provide supporting clinical documentation to show that the member has tried and failed a formulary option (medical necessity).

Process For Requesting A Medication Coverage Exception
Your doctor, or their appointed representative, can request a medication coverage exception by:

1. Calling the Prior Authorization Hotline at 800.753.2851. The Call Center will ask a number of clinical questions, and depending on the answers provided by your doctor, coverage will either be approved or he/she will be given the opportunity to fax in additional information for further clinical review.

2. Faxing a letter of medical necessity, or the applicable prior authorization request form, to the Prior Authorization Team at 1.877.251.5896.

Your doctor should include the following information with all requests for medication coverage:
- Patient's name
- Patient's date of birth
- Patient's member ID number
- Doctor's name and phone number
- Name, strength and dosing schedule for the drug being requested
- Diagnosis for which the drug is being requested
- Any necessary supporting documentation (i.e., progress notes, laboratory results, published literature supporting safety/efficacy, etc.)
- All drugs previously tried for the diagnosis being treated and the reason for the failure