Drug Formulary

- a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

- The primary purpose of the formulary is to encourage the use of safe, effective and most affordable medications.

- A formulary system is much more than a list of medications approved for use by a managed health care organization.
• A formulary system includes the methodology an organization uses to evaluate clinical and medical literature and the approach for selecting medications for different diseases, conditions and patients.

• Policies and procedures for the procuring, dispensing, administering and appropriate utilization of medications are also included in the system.

• Formulary systems often contain additional prescribing guidelines and clinical information which assist health care professionals to promote high quality, affordable care for patients.

• Finally, for quality assurance purposes, managed health care systems that use formularies have policies in place to give physicians and patients access to non-formulary drugs where medically necessary.
Medications are often designated as preferred or non-preferred drugs by the pharmacy and therapeutics committee (P&T) or DUR board of the state Medicaid agencies or contracted managed care organization.

In most cases, providers are permitted to prescribe preferred drugs without seeking prior authorization.

However, if a drug is listed as non-preferred on the PDL, the providers are usually required to obtain approval from the state Medicaid agency or managed care plan before the drug is paid for.

States may subject a drug to such prior authorization consistent with the requirements of section 1927(d)(5) of the Act.
Per the Social Security Act Section 1927(d)(5)

Prior authorization (PA) programs are intended to:

- Impart cost savings by preventing unnecessary prescribing of medically inappropriate drugs
- Provide a response to PA requests for covered outpatient drugs within twenty-four (24) hours
- Allow pharmacies to dispense up to a three (3) day emergency supply of covered outpatient drugs while PA approval is being sought
- Be no more stringent than FFS criteria
Prior Authorization

• Prior authorization typically means that the Medicaid agency or the contracted managed care organization will not pay for Medicaid beneficiaries’ medication unless the provider has obtained permission before prescribing the drug.

• The criteria for prior authorization often reflect evidence-based standards consistent with the compendia listed in 1927(g)(1)(B).

• A Medicaid program may require the trial of another agent prior to the use of a specific drug

• Example: Alavert®

• “The request for Alavert Oral Tablet Disintegrating 10 MG does not meet our Second Generation Antihistamines criteria. In order for us to approve this drug, you must meet our criteria.

• To meet our criteria, you must first try one of the following formulary drugs (a formulary is a list of covered drugs) used to treat your condition: loratadine (tablets, solution), cetirizine (tablets, solution), levocetirizine tablets.

  • Our pharmacy records and information sent in by your doctor do not show that formulary drugs were tried and whether or not they helped your condition.
  • If you have already tried these drugs and they caused an adverse effect or did not work, please ask your doctor to provide medical records showing that you have tried these drugs.
  • Otherwise, please see your doctor for a new prescription for a formulary drug.”
A state Medicaid agency or contracted managed care organization may impose quantity limits on medications as a way to promote safe and appropriate use of a medication, ensuring that they are not overprescribed.

Example: **Fluconazole oral tablet 150 mg**

“The request for Fluconazole Oral Tablet 150 MG does not meet our Quantity Limit Exception Criteria.

Your doctor asked us to approve Fluconazole Oral Tablet 150 MG a quantity of 15 for 90 days. That is more than our limit of 2 per 30 days.

In order for us to approve the drug for the quantity your doctor requested, you must meet our criteria.

To meet our criteria your doctor must: 1) tell us that you have taken the drug at the quantity allowed and it did not work for you, and 2) submit a medical reason why the quantity allowed would not work well for you.

The other strengths of fluconazole tablets do not have a quantity limitation.

Please ask your doctor to send us this information.”
## Covered Prescription Drug Denial Report

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Drug Name</th>
<th>Strength</th>
<th>Dose Form</th>
<th>Frequency of Administration</th>
<th>Route of Administration</th>
<th>Therapeutic Category of Denied Drug</th>
<th>Reason(s) for Denial</th>
<th>Denial Notice Sent</th>
<th>Initial Approval Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>JOHNSON</td>
<td>COLIN</td>
<td>12/31/1973</td>
<td>Xenical Oral Capsule 120 MG</td>
<td>120 MG</td>
<td>CAPSULE</td>
<td>every 8 hours</td>
<td>ORAL</td>
<td>GI DRUGS, MALIGNANT</td>
<td>The request for Xenical Oral Capsule 120 MG is being prescribed for weight loss. Drugs used for weight loss are not covered under your AmeriHealth Caritas District of Columbia pharmacy benefit. Please refer to your member handbook for details.</td>
<td>Yes</td>
<td>Initial</td>
</tr>
<tr>
<td>876543210</td>
<td>DAVIS</td>
<td>BARBARA</td>
<td>07/21/1965</td>
<td>Janumet Oral Tablet 50-500 MG</td>
<td>50-500 MG</td>
<td>TABLET</td>
<td>twice a day</td>
<td>ORAL</td>
<td>DIABETES, MODIFYING ANTITHROMBOTIC AGENTS</td>
<td>The request for Janumet Oral Tablet 50-500 MG does not meet our formulary criteria. In order for us to approve this drug, you must meet our criteria. To meet our criteria, you must first try the following formulary drugs (or formulary list of covered drugs) used to treat your condition: metformin for type 2 diabetes (metformin requires prior authorization review). Our pharmacy records and information sent in by your doctor do not show that formulary drugs were tried and whether or not they helped your condition. If you have already tried these drugs and they caused an adverse effect or did not work, please ask your doctor to provide medical records showing that you have tried these drugs.</td>
<td>No</td>
<td>Initial</td>
</tr>
<tr>
<td>987654321</td>
<td>JONES</td>
<td>TOM</td>
<td>08/15/1970</td>
<td>Obinbul Oral Tablet 30 MG</td>
<td>30 MG</td>
<td>TABLET</td>
<td>as directed</td>
<td>ORAL</td>
<td>DISABLING MODIFYING ANTITHROMBOTIC AGENTS</td>
<td>The request for Obinbul Oral Tablet 30 MG does not meet our criteria for Specialty Biological Agents for Psoriasis. In order for us to approve this drug, you must meet our criteria. Biological agents are drugs that may slow or stop your condition from getting worse. The requested drugs is not one of our preferred biological agents and you would also need to try one of our preferred biological agents from one of the following groups: a) either Bextra, Humira, or Avastin; b) either Cosentyx or Taltz. Our pharmacy records and information sent in by your doctor do not show that these treatment options have been tried and whether they helped your condition. Please see your doctor for a new prescription for a formulary drug.</td>
<td>Yes</td>
<td>Initial</td>
</tr>
<tr>
<td>123456789</td>
<td>YOUNG</td>
<td>CHERYL</td>
<td>09/18/1972</td>
<td>LumiraOral Tablet 130 MG</td>
<td>130 MG</td>
<td>TABLET</td>
<td>as directed</td>
<td>ORAL</td>
<td>ANTICYTOSPLASTIC AGENTS</td>
<td>The request for LumiraOral Tablet 130 MG does not meet our Oncology Drugs criteria. In order for us to approve this drug, you must meet our criteria. LumiraOral Tablet 130 MG must be approved for the treatment of your condition and its use supported by NCCN guidelines (National Comprehensive Cancer Network). We cannot approve the request because LumiraOral Tablet 130 MG is not approved for the treatment of malignant neoplasms of colon, unspecified, and its use is not supported by NCCN guidelines.</td>
<td>Yes</td>
<td>Initial</td>
</tr>
<tr>
<td>876543210</td>
<td>RODRIGUEZ</td>
<td>JOSE</td>
<td>12/28/1962</td>
<td>Cosentyx Subcutaneous Solution Prefilled Syringe 150 MG/ML</td>
<td>150 MG/ML</td>
<td>SYRINGE</td>
<td>as directed</td>
<td>SUBCUTANEOUS</td>
<td>SKIN AND MUCOUS MEMBRANE AGENTS, MISC</td>
<td>The request for Cosentyx Subcutaneous Solution Prefilled Syringe 150 MG/ML does not meet our criteria for Specialty Biological Agents for Psoriasis. Biological agents are drugs that may slow or stop your condition from getting worse. In order for us to approve this drug, you must meet our criteria. To meet our criteria you must try three of the following treatment options: a topical steroid (like clobetasol), tacrolimus, or betamethasone, a topical medication (topical medications are applied directly to your skin) that is used to treat psoriasis (cicapryl cream, pimecrolimus, or tacrolimus) (this is not taking the drug).</td>
<td>Yes</td>
<td>Initial</td>
</tr>
<tr>
<td>987654321</td>
<td>WALKER</td>
<td>TASHA</td>
<td>08/07/2006</td>
<td>Talcinum External Ointment 0.1 %</td>
<td>0.1 %</td>
<td>OINT (G)</td>
<td>daily</td>
<td>EXTERNAL</td>
<td>SKIN AND MUCOUS MEMBRANE AGENTS, MISC</td>
<td>The request for Talcinum External Ointment 0.1 % does not meet our Safety Edit Exception Criteria for age restrictions. In order for us to approve the requested drug for your age, you must meet our criteria. To meet our criteria your doctor must: 1) submit a medical reason why the drug is needed when your age is below our age limit of 16, and 2) send us current treatment guidelines that support treating someone your age with this drug.</td>
<td>Yes</td>
<td>Initial</td>
</tr>
</tbody>
</table>
Updated Beneficiaries Appeals Notice

Contact Number for Members:

- AmeriHealth Caritas DC - 1-800-408-7511
- MedStar Family Choice DC - 1-888-404-3549
- CareFirst CHPDC-1-855-326-4831
- HSCSN -202-467-2737 or
- 1-866-WE-R-4-KIZ (937-4549)
- Fee For Service Medicaid 1-800-273-4962

Beneficiaries notice will be posted in English and Spanish at http://www.dc-pbm.com/provider/documents
Updated Pharmacy POS Triplicate Form for Beneficiary Notification
Questions?