Commercial and Marketplace Prescription Drug Coverage

The formulary is a comprehensive listing of drugs covered by our plan. Below are some frequently asked questions about your drug coverage, how to use the formulary and how to request drug coverage exceptions.

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2017 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2018 coverage year except when new adverse information about the safety or effectiveness of a drug is released. If the Food and Drug Administration (FDA) deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and our Pharmacy Benefit Manager (PBM) will provide notice to members who take the drug and their providers. In the event of a mid-year non-maintenance formulary change, the printed and web-based versions of the formulary will be updated as of the effective date of the formulary change. The updated versions of the printed formulary will be available upon request. To get updated information about the drugs covered by our plan, please contact us at (318) 361-0900 or (888) 823-1910.

How do I use the Formulary?

There are several ways to find your drug within the formulary:

Medical Condition

The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular Agents". If you know what your drug is used for, look for the category name in the list that begins in the second section of the formulary after the alphabetical list. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug alphabetically beginning on page 1. Both brand name drugs and generic drugs are listed in alphabetical order.

Types of Drugs

Brand name drugs are capitalized (e.g., COUMADIN TAB) and generic drugs are listed in lower-case (e.g., warfarin). The information in the ***Special Code*** column tells you if our plan has any special requirements for coverage of your drug. The formulary includes a key at the bottom of each page for drugs that have a symbol in the ***Special Code*** column.

What are generic drugs and generic substitution?

Our plan 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. Generally, generic drugs cost less than brand name drugs. Generic substitution is the practice of replacing a brand-name drug with the generic version. In most cases generic drugs are preferred on the formulary. Generic drugs are FDA-approved for safety and effectiveness.

The color and shape may be different from the brand-name drug, but they are made using the same strict FDA standards as brand-name drugs. From the Certificate of Coverage (COC) for Commercial/Marketplace plans, if a brand-name drug is requested by the member or provider when a generic is available, the member must pay the generic drug copay plus the difference between the cost of the brand name drug and the cost of the generic drug. However, most brand name drugs with generic equivalents are non-formulary, so coverage of the brand name drug would require a formulary exception approval. The product selection fee is added to the tier 2 cost share on 5 tier formularies.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

Prior Authorization (PA): Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, our plan will not cover the drug.

Quantity Limits (QL): For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 9 tablets per 30 days for Sumatriptan. This is based on criteria including but not limited to safety, potential of abuse, potential of overdose, FDA approved dosing guidelines, and approximation of usual doses per month. To obtain QL override, the physician's or other prescriber's supporting statement must indicate that the request should be approved because the number of doses available under a dose restriction for the prescribing drug is ineffective or likely to be ineffective.

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, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

Specialty Drugs (SP, MSP): A Specialty Drug is a type of prescription drug available on the formulary that is complex and expensive. Specialty Drugs are used to treat serious and/or chronic health conditions such as rheumatoid arthritis, HIV and hepatitis C. Often times these drugs require intensive monitoring and are available through a specialty pharmacy program. These drugs are designated as **SP** on the formulary in the ***Special Code*** column. Drugs designated as **MSP** (Mandatory Specialty Pharmacy Program) are ***only*** available through a specialty pharmacy program.

What if my drug is not on the Formulary?

If your drug is not included in the formulary (list of covered drugs), you should first contact Member Services at (318) 361-0900 or (888) 823-1910 and ask if your drug is covered. If you learn that our plan does not cover your drug, you can ask Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your provider and ask for a similar drug that is covered by our plan. You can also ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

Formulary Exceptions Process

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

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary 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 formulary exception so that we can determine if we will cover the drug you take.

How do I request an exception to the Formulary?

You can ask Vantage to make an exception to the restrictions or limits or for a list of other, similar drugs that may treat your health condition. There are several types of exceptions that you can ask us to make.

- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.
- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level.
- 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.

The prescribing physician or other prescriber should support the request by including an oral or written statement that provides a justification supporting the need for the non-formulary drug to treat the enrollee's condition, including a statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects.

There are several different levels of drug exceptions:

Standard Internal Review

Usually, a request for an exception will only be approved if the alternative drugs included on the plan's formulary or additional utilization restrictions would not be as effective in treating your 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 formulary or utilization restriction exception at (318) 361-0900 or (888) 823-1910.

We will make our decision and notify you or your designee and your prescriber of the decision within seventy-two (72) hours of receipt of the formulary exception request following Vantage's receipt of the request and information sufficient to begin review. If your request for an exception is approved, your medication will be covered at a predetermined cost-sharing level for the duration of the prescription, including refills.

Expedited Internal Review

You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to seventy-two (72) hours for a standard review. These circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. If your request to expedite is granted, we must give you or your designee and your prescriber a decision no later than twenty-four (24) hours of receipt of the expedited formulary exception request and information sufficient to begin review. If approved, we will provide coverage of the non-formulary drug at a pre-determined cost-sharing level for the duration of the urgent need.

Standard External Review

If Standard Internal Review is denied, you can request the denial be reviewed by an Independent Review Organization ("IRO"). A Standard External Review by an IRO can be requested by contacting Vantage at (318) 361-0900 or (888) 823-1910.

Vantage will review internal documentation and any other supporting information to determine if the request is eligible for external review. If eligible for review, the request will be submitted to the Louisiana Department of Insurance for assignment to an IRO. Should the request not be complete or is not eligible for external review, Vantage will provide written notification to you outlining the additional information needed or reasons for its ineligibility.

The IRO's decision regarding your request will be made no later than seventy-two (72) hours following Vantage's receipt of the request. You will be notified in writing of the outcome of your request. If your coverage request is approved, your medication will be covered at a predetermined cost-sharing level for one year to cover the duration of the prescription, including refills.

For assistance filing a request for standard external review, call (318) 361-0900 or (888) 823-1910.

Expedited External Review

If Expedited Internal Review is denied, you can request the denial be reviewed by an IRO by contacting Vantage at (318) 361-0900 or (888) 823-1910.

Vantage will immediately review internal documentation and any other supporting information to determine if the request is eligible for expedited external review. If eligible for expedited external review, the request will be submitted to the Louisiana Department of Insurance for assignment to an IRO. Should the request not be complete or is not eligible for external review, Vantage will provide written notification to you outlining the additional information needed or reasons for its ineligibility.

The IRO's decision regarding your request will be made no later than twenty-four (24) hours following Vantage's receipt of the request. You will be notified by telephone and in writing of the outcome of your request. If your request is approved, your medication will be covered at a predetermined cost-sharing level for one year to cover the duration of the prescription, including refills.

For assistance filing a request for expedited external review, call (318) 361-0900 or (888) 823-1910.

For more information

For more detailed information about your Commercial or Marketplace plan's prescription drug coverage, please review your Certificate of Coverage and other plan materials or call us at (318) 361-0900 or (888) 823-1910.

The formulary changes annually and as Vantage received FDA updates. Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayment/coinsurance may change when your plan renews each year. This document may be available in an alternate format such as large print. Please call Member Services at (866) 704-0109 to request the alternate format. TTY users should call (866) 524-5144. (TTY user: member with a hearing or speech impairment)