

## Drug List Overview

### 1. How does a maximum allowable cost (MAC) incentive work?

MAC pricing is a payment model contractually agreed to in the marketplace by all participants. It includes payers and pharmacies and helps ensure that employers and members—those purchasing health insurance benefits—get the lowest possible price on generic drugs.

<p><b>MAC A</b></p>	<p>Regardless of the reason or medical necessity, if the member receives a brand name drug or if their doctor prescribes a brand name drug when a generic is available, the member will be responsible for the brand name drug’s copayment and/or coinsurance <b>plus the difference in cost between the brand name and generic drug.</b></p>
<p><b>MAC B</b> Standard for large, fully-insured groups</p>	<p>MAC B applies when a member selects a brand name drug. Unless the physician requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If the member receives a brand name drug when a generic is available, they will be responsible for the brand name drug’s copayment and/or coinsurance—<b>plus the difference in cost between the brand name drug and its generic equivalent.</b> If the physician requires the use of a brand name drug, the prescription will be filled with the brand name drug, and the member will be responsible for the brand name drug’s copayment and/or coinsurance.</p>
<p><b>MAC C</b></p>	<p>Regardless of the reason or medical necessity, if the member receives a brand name drug or if their physician prescribes a brand name drug when a generic is available, the member will be responsible for the brand name drug’s copayment and/or coinsurance.</p>

**The cost difference between the brand name and generic drug or MAC doesn’t apply toward your plan’s deductible or out-of-pocket limit. An example:**

	Drug Cost	Copay
<b>Brand</b>	\$125	\$40
<b>Generic</b>	\$50	\$5

MAC is the equivalent of the brand drug cost minus generic drug cost—but the amount does not apply toward the member’s out-of-pocket limit.

When a member fills a brand drug when a generic is available, the member pays:

- MAC A: Physician requires brand or member prefers brand over generic**  
Brand copay (\$40) + MAC (brand drug cost – generic drug cost or \$125 – \$50 = \$75) = \$115
- MAC B: Member prefers brand over generic**  
Brand copay (\$40) + MAC (brand drug cost – generic drug cost or \$125 – \$50 = \$75) = \$115  
MAC B: Physician requires brand = brand copay \$40
- MAC C: Physician- or member-required brand = brand copay \$40**

## 2. What should I know about drug availability and formularies (drug lists)?

The formulary process is designed to create efficiencies that can be passed along to employer groups and members. Medications on a formulary are chosen by a panel of experts, known as a pharmacy and therapeutics (P&T) committee. These panels include outside doctors, nurses, pharmacists and other clinical experts. Following is an overview of what to know about drug lists:

- The P&T committee develops, manages and updates the formulary. The group meets regularly to discuss new drugs, safety data, FDA-approved prescribing information, clinical trial results and doctors' recommendations in order to keep the formulary up to date. As a result, medications on the formulary may change at any time.
- A state-based drug list covers at least the same number of drugs in each USP (U.S. Pharmacopeial Convention) category and class as are covered by the state's pharmacy benchmark plan.
- A state-based drug list is a managed formulary. A managed formulary is a preferred list of drugs that cost less and are considered equally effective. Drugs that are not listed (i.e., non-formulary drugs) are generally not covered. The member and provider must go through an exception process to have coverage considered for a non-formulary drug. If a member exception is approved, the non-formulary drug is subject to a Tier 3 copayment plus any applicable MAC cost difference described in the section above. Non-formulary specialty medication, if approved, is subjected to a Tier 4 copayment plus any applicable MAC penalties.
- A self-funded large group may opt to offer the Preferred Drug List (PDL) instead of the state-based list. The PDL is an open formulary. Drugs not listed are covered unless otherwise excluded by plan design, contract, category, or clinical policy.

Note that all the drug lists (state-based and Preferred) have preauthorization, step therapy, and quantity limit restrictions. For transparency, PacificSource posts all formularies, restrictions, prior authorization, and step therapy criteria at [PacificSource.com/drug-list](https://www.pacificsource.com/drug-list).

- If a change is made to the drug lists, members are notified 30 days in advance. For the most current covered medications, members are able to view drug lists at [PacificSource.com/drug-list](https://www.pacificsource.com/drug-list). If a change is made to the drug lists, providers are notified 60 days in advance via the PacificSource online Provider Bulletin. Recent changes are available at [PacificSource.com/member/drug-news.aspx](https://www.pacificsource.com/member/drug-news.aspx).

## 3. What is the PacificSource Expanded No-cost Drug List?

**The PacificSource Expanded No-cost Drug List is in addition to the state-based and Preferred drug lists (not in place of).** These outpatient preventive drugs are covered in full at participating pharmacies (\$0 copayment). (This list is additional to the drugs required by federal healthcare reform.) The PacificSource Expanded No-cost Drug List includes specific generic drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from recurring. Preventive drugs do not include drugs for treating an existing illness, injury, or condition. For more information, see [PacificSource.com/drug-list](https://www.pacificsource.com/drug-list).

- PacificSource posts the ACA no-cost drug list and the PacificSource Expanded No-cost Drug List on [PacificSource.com](https://www.pacificsource.com): The ACA drug list is a federal requirement and built into the formulary. The PacificSource Expanded No-cost Drug List is a value-added benefit offered by PacificSource.

## 4. Is there a separate ID card for pharmacy benefits?

When using the CVS Caremark® pharmacy network under PacificSource's contract, the pharmacy and medical plan will use the same ID card. The medical ID card includes specific pharmacy billing information and can be presented at the member's participating pharmacy.

## 5. What do the different tiers mean?

Drugs on a formulary are typically grouped into tiers. The tier of a medication helps determine the portion of the drug cost.

PacificSource Expanded No-cost Drug List: No-cost medications that are a value-added benefit specific to PacificSource.

<b>Tier 0:</b>	ACA-mandated drugs and PacificSource Expanded No-cost drugs covered at \$0 copay
<b>Tier 1:</b>	Lowest copays, typically generic medications
<b>Tier 2:</b>	Mid-range copays, typically preferred brand medications
<b>Tier 3:</b>	High copay, typically non-preferred brand medications
<b>Tier 4:</b>	Highest copay, almost always specialty medications specific to the managed formulary
<b>Specialty Medication (SP):</b>	Highest copay PDL; restricted to specialty medications

## Other Benefits Covered Under Pharmacy

### 6. What other items or services fall under the pharmacy benefit?

- **Formulary insulin syringes/lancets/needles:** Included in state-based drug lists; these items are covered at Tier 2. For PDL, see our drug list at [PacificSource.com/drug-list](https://www.pacificsource.com/drug-list).
- **Preferred Test Strips and Glucose Monitoring Devices – OneTouch exclusivity:** PacificSource works to cover drugs and testing supplies that provide the best value for our members. PacificSource covers OneTouch® diabetic testing products exclusively. To help make the transition as smooth as possible for members, we partnered with OneTouch to offer a free blood glucose meter to those with diabetic testing needs. To obtain a free blood glucose meter, please contact PacificSource customer service to request a OneTouch signup code.
- **Continuous Glucose Monitors (CGM):** Dexcom G6 and FreeStyle Libre are covered for type 1 and type 2 diabetics with a prior authorization on drug lists at Tier 2.
- **Compounded Medications:** Compounded by community pharmacies and usually composed of ingredients or combinations of ingredients not approved by the FDA. Without FDA approval, there is no assurance that these compounds are safe and effective in the combinations and formulations being dispensed. In an effort to ensure the safety of our members and control claims expenses, the following summary policy applies:
  - Most compounded medications require prior authorization by PacificSource pharmacists.
  - Compounded medications are authorized only after ALL commercially available or formulary products have been exhausted.
  - Only compound ingredients that are covered on the applicable formulary will be reimbursed under this policy.
  - Compounds above a certain dollar threshold require review.
- **Women’s prescription contraceptives:** \$0 copay if generic, FDA approved, on formulary drug list, supported by the U.S. Health Resources and Services Administration, and provided by a participating pharmacy. When no generic exists, the preferred brand is covered at no cost.
- **Affordable Care Act (ACA) preventive no-cost drug list:** Regardless of drug list, preventive medication recommended by the U.S. Preventive Services Task Force and the CDC are covered at Tier 0 at participating pharmacies. A written prescription is required, even if the drug is over-the-counter.
  - Aspirin to prevent cardiovascular disease (age restrictions apply)
  - Emergency pregnancy prevention
  - Fluoride (age restrictions apply, not applicable to combinations)
  - Folic acid supplement for women (age restrictions apply, not applicable to combinations)
  - Bowel preparation for colonoscopy screening for men and women (age restrictions apply)
  - Tobacco cessation (see formulary for more details)
  - Low to moderate statins (age restrictions apply)

- **Preventive vaccines:** Regardless of formulary drug list, all are covered at Tier 0 at participating pharmacies.
 

<ul style="list-style-type: none"> <li>– Seasonal Influenza–Trivalent, Quadrivalent, or Fluzone</li> <li>– Intradermal Influenza Vaccine</li> <li>– Pneumonia</li> <li>– Zoster (Zostavax)–age restrictions</li> <li>– Tetanus, Diphtheria Toxoids</li> <li>– Hepatitis A &amp; B</li> <li>– Pneumonia (age 0-18)</li> <li>– Haemophilus (age 0-18)</li> <li>– Haemophilus B / Hepatitis (age 0-18)</li> </ul>	<ul style="list-style-type: none"> <li>– Meningococcal, Haemophilus B, Tetanus (age 0-18)</li> <li>– Inactivated Poliovirus</li> <li>– Rotavirus</li> <li>– Measles, Mumps, Rubella, Varicella</li> <li>– Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Hepatitis B, or combo (age 0-18)</li> <li>– Hepatitis A or Hepatitis B</li> <li>– Human Papillomavirus (Gardasil)–age restrictions</li> </ul>	<ul style="list-style-type: none"> <li>– Varicella</li> <li>– Measles, Mumps, Rubella</li> <li>– Meningococcal</li> <li>– Tetanus</li> <li>– Tetanus, Diphtheria, Pertussis</li> <li>– Japanese Encephalitis</li> <li>– Rabies</li> <li>– Yellow Fever</li> <li>– Anthrax</li> <li>– Typhoid (injection only)</li> </ul>
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- **Diabetes management for pregnancy (Oregon only):** \$0 copay for covered medications and supplies that are medically necessary to manage a woman’s diabetes during pregnancy from conception through six weeks postpartum. Notification to the pharmacy department is required.
- **Prenatal vitamins:** As part of your PacificSource pharmacy benefit, if a member is pregnant, or between the ages of 15-45, they can receive certain provider-prescribed prenatal vitamin supplements at no cost. We offer this benefit to ensure improved access to important vitamins prior to and during pregnancy, to promote healthy fetal development and to optimize healthy baby outcomes. This program is free for our members with pharmacy benefits.
- **Medication Therapy Management (MTM) Program:** PacificSource has identified specially trained pharmacists throughout our service area who are contracted to help members get the best results from their medications while keeping out-of-pocket costs down. Our MTM pharmacists work with the member and their providers to assist with medication cost, side-effects, drug interactions, and duplicate therapy. Members receive help in understanding and organizing their medications to optimize therapeutic outcomes. Modeled after the Medicare Part D MTM program, this innovative clinical initiative is offered to all high-utilizing commercial members with PacificSource. Whenever clinical pharmacists are a part of the primary care team, MTM services are delivered in a local, face-to-face clinical environment. MTM services are also available by phone for patients who visit a primary care clinic without pharmacists on staff.
- **Enhanced Safety and Monitoring Solution (ESMS) Program:** The Enhanced Safety and Monitoring Solution program provides continued monitoring to prevent high utilization of narcotic prescriptions including provider shopping, polypharmacy, or potentially fraudulent activity. We investigate unusual medication utilization patterns and notify the member and provider for coordination of care.
- **Partial Fill Program:** PacificSource initiated a partial fill program to help keep costs down by allowing a member to make sure they can tolerate a drug before getting a full prescription. The partial fill program focuses on high-cost oncology medications that aren’t widely tolerated. Patients are dispensed certain medications in a limited amount for half the usual copay; a 15-day trial is set up before the entire 30-day cycle can be filled.
  - **How does it work?** A week into the first fill of the medication, a CVS Specialty™ CareTeam pharmacist or nurse contacts the member. The healthcare professional asks the patient about side effects to assess their level of tolerability. The CareTeam also answers questions and concerns about the treatment. If the trial period is a success, the member will continue taking the drug. After the initial trial, all future fills will be for the full amount. The program provides quality care to the member along with cost containment and reduced waste.

## 7. What is the process for preauthorization and prior authorization?

Drugs that require preauthorization must be reviewed by our clinical pharmacists before they will be covered by the plan. This process typically requires communication with the provider.

For prior authorization criteria, please see our drug list page at [PacificSource.com/drug-list](https://www.pacificsource.com/drug-list).

## 8. How do step therapy (ST) medications get paid?

Step therapy drugs are covered only after other lower-cost related medications have been tried first or determined to be inappropriate or ineffective. For ST criteria, please see our drug list page at [PacificSource.com/drug-list](https://www.pacificsource.com/drug-list).

## 9. What are the criteria for quantity limits (QL)?

Quantity limits may be in place on some drugs because of higher strengths, which are based on dosing guidelines determined by the FDA or manufacturer labeling. The goal is to ensure cost effective therapies and patient safety. Requested exceptions to quantity limits are reviewed by clinical staff on a case-by-case basis. For the full criteria list, go to [PacificSource.com/drug-list](https://www.pacificsource.com/drug-list).

## 10. When doing a drug search, the abbreviation “SP” appears. What does it mean?

SP is an abbreviation for specialty drugs, and may include biotech drugs. These specialty or biotech drugs are used to treat chronic or genetic disorders.

## 11. What is continuation of therapy coverage?

Continuation of therapy applies to large groups (51 or more employees). To ease the transition for large groups that are new to PacificSource (or existing large groups transitioning from one drug list to another), they can choose a “90-day transitional period” option that allows formulary medications to pay without requiring prior authorization (PA), step therapy (ST), or quality limits (QL). Non-formulary drugs and excluded drugs will still need an exception approval. A letter is sent to the member providing information on how to get authorization to continue filling the medication after the 90-day window.

# The PacificSource Pharmacy Difference

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PacificSource Pharmacy Services are powered by a full department of professionals representing a wide range of Rx-related disciplines. Teams of nurses, health services representatives, customer service personnel, and pharmacy techs are fully integrated on a single platform to ensure PacificSource members are getting optimal access to precise, timely, and personal pharmacy care.

- **PacificSource Pharmacy Helpdesk:**

We provide our pharmacies, providers, and brokers with access to in-house regional pharmacy experts to help navigate the complex pharmaceutical marketplace. PacificSource does not outsource its helpdesk assistance. Support services are staffed by PacificSource-certified pharmacy technicians to address Rx-related questions from pharmacies, prescribers, and members (including access to clinical pharmacists for clinical and benefit questions).

- **Commercial Helpdesk**

Eugene, Oregon: 7:00 a.m.–5:00 p.m. (Pacific Time), Monday–Friday  
(541) 225-3784 or (844) 877-4803

- **Helpdesk Email:** [Pharmacy@pacificsource.com](mailto:Pharmacy@pacificsource.com)

- **PacificSource Pharmacy Preauthorization:**

Online via InTouch (OneHealthPort) at [www.PacificSource.com/providers](https://www.pacificsource.com/providers) or call **(844) 877-4803**. We are requesting that medication authorizations be submitted online via the InTouch (OneHealthPort) portal. This transition is being implemented to allow faster turnaround on medication authorization requests.

- **Local Clinical Pharmacists:**

PacificSource has clinical pharmacists available for consult with members and providers about all medication-related issues.

- **Coverage Determinations:**

PacificSource clinical pharmacists, with the support of our medical directors, make our clinical coverage decisions. We do not outsource clinical pharmacy reviews to outside vendors.