2018 CHANGES TO MEDICARE ADVANTAGE FORMULARY AND PRESCRIPTION MANAGEMENT PROGRAMS

IMPORTANT INFORMATION FOR PRESCRIBING PHYSICIANS

One of our most important concerns is the safe and effective use of prescription drugs. As a prescribing physician in our network, please note that effective Jan. 1, 2018, Highmark is making the following changes that may impact your patients with Medicare Advantage coverage through Highmark.

- Not covered: a medication will be removed from the Formulary
- Tier change: a medication will move up a tier, meaning a higher patient cost-sharing
- Quantity level limits: a medication will have limits in place so only a certain amount can be received at one time; limits are in place to ensure safe and effective use of the medication
- Prior authorization: a medication may only be covered if the plan determines that the use is medically necessary based on pharmacy policies approved by the Pharmacy & Therapeutics Committee

We have mailed letters to the prescribing physicians whose patients are impacted, and have also mailed a letter to your patients notifying them of drugs they may be taking that will be subject to cost increases or will not be covered on the formulary. We have advised them to work with their doctor to identify a formulary alternative if clinically appropriate or to submit a coverage determination to the plan for clinical review for consideration.

Specifically, what we conveyed to your patients is that in many cases they can continue to receive medications subject to a cost increase with no authorization required. However, in some cases a medication that is subject to a cost increase may be obtained at a lower cost if his/her doctor submits a medication request to Highmark for consideration. Highmark will then review the request and notify them and their doctor of the decision. Also, exception requests can be considered for drugs on the non-preferred generic tier, the non-preferred brand tier and for generic drugs on the preferred brand tier. Drugs that are not covered, required a prior authorization or exceed the quantity level limit cannot be authorized unless a medication request is submitted by their doctor and approved by Highmark.

Due to timing of claims processing, the information in the letters mailed to prescribing physicians and members was based on the last fill or most recent fill date for each impacted medication as of August 19, 2017. You or your patient may have made changes since that date that are not reflected in the mailing.

The Highmark Part D Formularies for 2018 can be referenced to make an informed decision regarding the safe and cost effective formulary alternatives that may be clinically appropriate. Formulary information can be found on the Provider Resource Center. The formulary contains a wide range of prescription drugs broken into tiers. Drugs in the lowest tiers generally cost less and are often generic equivalents to brand-name drugs. Drugs in the higher tiers typically cost more and are frequently brand-name drugs. The formulary is a valuable reference that can assist in discussions about potential alternatives. You may view Highmark formularies any time online on the Provider Resource Center.

We appreciate your attention to these important changes that promote the safe and cost-effective medications for your patients, our members.

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