HEALTH PARTNERS

2012 Formulary

Introduction

Health Partners, Inc. is pleased to provide the 2012 Formulary. This formulary covers members under Health Partners Medicaid plan. The drugs listed in the Health Partners Formulary are intended to provide sufficient options to treat the majority of patients who require drug therapy in an ambulatory setting. Excluded from coverage are specific manufacturers who have not contracted with the rebate program of the Federal government.

The drugs listed in the Health Partners Formulary have been reviewed and approved by the Health Partners Pharmacy and Therapeutics Committee. These drug products have been selected to **provide the most clinically appropriate and cost-effective medications** for Health Partners members. There may be occasions when an unlisted drug is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through Prior Authorization/ Medical Exception.

Preface

The Health Partners Formulary is organized by sections, which refer to either a drug/ pharmacologic class or disease state. Each section contains a list of drugs selected to be on this formulary. Prescribing a drug product that is available generically is encouraged when appropriate. Prescriptions for generically available non-prescription (OTC) drugs deemed medically necessary by the plan are eligible for coverage. Generally, OTC medications are less costly than prescription alternatives and their use can contribute to cost-effective therapy. The over-the-counter (OTC) products listed in the formulary are covered with a prescription.

Pharmacy and Therapeutics (P&T) Committee

The actions of the Health Partners P&T Committee are communicated through the Provider Newsletter to all physicians and posted on our website. Pharmacy providers in the Health Partners network will be notified through correspondence from the Health Partners pharmacy department.

Product Selection Criteria

The Health Partners P&T Committee will consider all FDA approved drugs for inclusion in the formulary. The evaluation process includes a literature review; expert opinion by respected medical professionals or through TEC (Technical Evaluation Center) may also be sought. Formal reviews are prepared which typically address the following information:

1. Safety
2. Effectiveness
3. Comparison studies
4. Approved indications
5. Adverse effects
6. Contraindications
7. Pharmacokinetics
8. Patient compliance considerations
9. Medical outcome and pharmacoeconomic studies

When a new drug is considered for formulary inclusion an attempt will be made to examine the drug relative to similar drugs currently on formulary. In addition, entire therapeutic classes are periodically reviewed. This review process may result in deletion of a drug(s) in a particular therapeutic class in an effort to continually promote the most clinically useful and cost-effective agents.

Plan Limits

A maximum of 34-day supply of medication is eligible for coverage. The prescriber is urged to prescribe in amounts that adhere to accepted standards of care. The days supply must be accurately determined by the dispensing pharmacist to assure compliance with plan parameters.

Specific limits based on FDA guidelines, medication package inserts and accepted standards of care may apply to medication treatments under clinical review.

Prescription quantities cannot be altered unless approved by the physician, and must be within the limits of the plan's days supply.

Prescribed medications or regimens that are non-formulary require prior authorization.

Immediate Need (5/15-day Emergency Supply)

If a member presents at a pharmacy a prescription which requires prior authorization, whether for a non-formulary drug or otherwise, and if the prior authorization cannot be processed immediately, Health Partners will allow the pharmacy to dispense an interim supply of the prescription under the following circumstances:

If the recipient is in immediate need of the medication in the professional judgment of the pharmacist and if the prescription is for a new medication (one that the recipient has not taken before or that is taken for an acute condition), Health Partners will allow the pharmacy to dispense a 5-day supply of the medication to afford the recipient or pharmacy the opportunity to initiate the request for prior authorization.

If the prescription is for an ongoing medication (one that is continuously prescribed for the treatment of an illness or condition that is chronic in nature in which there has not been a break in treatment for greater than 34 Days), Health Partners will allow the pharmacy to dispense a 15-day supply of the medication automatically, unless Health Partners mailed to the member, with a copy to the prescriber, an advanced written notice of the reduction or termination of the medication at least 10 days prior to the end of the period for which the medication was previously authorized.

Health Partners will respond to the request for prior authorization within 24 hours from when the request was received. If the prior authorization is denied, the recipient is entitled to appeal the decision through several avenues. The 5-day or 15-day requirement does not apply when the pharmacist determines that taking the

medication, either alone or along with other medication that the recipient may be taking, would jeopardize the health and safety of the recipient.

Formulary Product Descriptions

This formulary lists all specific strengths and dosage forms that are covered. **When a strength or dosage form is specified, only the product identified will be covered. Other strengths/ dosage forms of the referenced product are not covered.**

For specific questions please contact the Health Partners Pharmacy department at 215-991-4300.

Generic Substitution

Generic substitution is the process by which a generic equivalent is dispensed rather than the brand name product. The appropriate use of generic drugs is one method of providing cost conscious drug therapy. Health Partners will not cover any drugs by companies that do not participate in the Federal Rebate Program or are DESI drugs. Generic drugs must be prescribed and dispensed when an A-rated generic drug is available. Brand necessary prescriptions for drugs with A-rated generics require prior authorization.

The MAC list sets a ceiling price for the reimbursement of certain multisource prescription drugs. This price will typically cover the acquisition of most generics but not branded versions of the same drug. The products selected for inclusion on the MAC list are commonly prescribed and dispensed and have usually gone through the FDA's review and approval process. This process assures the following requirements have been met:
The generic drug will contain the same active ingredient(s) and be the same strength and dosage form as the brand name counterpart.

The FDA has given the generic an "A" rating compared to the branded counterpart indicating bioequivalence and has determined the generic is therapeutically equivalent to the referenced brand. The ratings of generic drugs are available by referring to the FDA reference *Approved Drug Products with Therapeutic Equivalence Evaluations* (Orange Book).

When the above two criteria are met, a generic can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the brand name product.

State laws or regulation may indicate the ability to practice generic substitution for selected products or categories of drugs.

There are now many brand name products that are repackaged or distributed under a generic label. These generic versions should always be considered therapeutically equivalent and substitutable for the source branded product irrespective of rating.

Drugs Efficacy Study Implementation (DESI) Drugs

Health Partners does not reimburse for DESI drugs. DESI drugs are those drugs first marketed between 1938 and 1962 which were approved as safe, but not required to show effectiveness for FDA product approval. The DESI program subsequently made a determination of fully effective for most of these products and they remain in the marketplace. A few DESI products remain classified as less than fully effective while awaiting final administrative disposition. Also classified as DESI are many products listed as identical, similar, or related to actual DESI products.
Examples of DESI Drugs include:
Midrin
Vytone
Anusol HC
Donnatal
Tigan
Naldecon

Prior Authorization (PA)

To ensure that select medications are utilized appropriately, Prior Authorization may be required for the dispensing of specific products. These medications may require Prior Authorization for the following reasons:

- Non-formulary medications, or benefit exceptions required by medical necessity
- All brand name medications when there is an A-rated generic equivalent available
- Medications and/or treatments under clinical investigation
- Medications used for non-FDA approved indications
- Prescription costs that exceed $1000 per claim
- Prescriptions that exceed set plan limits (days supply, quantity, cost)
- Prescriptions processed by non-network pharmacies
- New-to-market products
- High end oral and self administered injectable medications
- Medications with Health Partners P&T Committee approved treatment guidelines

To request a prior authorization the physician or a member of his/her staff should contact Health Partners either by fax at (866) 240-3712, or phone at (215) 991-4300. All non-emergency requests can be faxed 24 hours per day; calls should be placed from 9:00 A.M. to 5:00 P.M., Monday through Friday.

In the event of an immediate need after business hours, the call should be made to Health Partners Member Services at (800) 553-0784. The call will be evaluated and routed to a pharmacist-on-call.

The physician may use the Health Partners Prior Authorization/Medical Exception form or a letter of request, *but must include the following information* for quick and appropriate review to take place:

- Name and recipient number of member
- Date of birth of member
- Physician's name, license number, and specialty
- Physician's phone and fax numbers
- Name of primary care physician if different
- Drug name, strength, and quantity of medication
- Days supply (duration of therapy) and number of refills
- Route of administration
- Diagnosis
- Medical rationale for request
- Formulary medications used, duration and therapy result
- Additional clinical information that may contribute to the review decision (e.g., labs)

Upon receiving the Prior Authorization Medical Exception Request from the prescriber, Health Partners will render a decision within 24 hours. The Medical Director will review each prior authorization request and make the final decision of approval or denial complete with a signature and date. After Medical Director review, the clinical pharmacist will prepare the request for the denial/approval letter using The Department of Public Welfare (DPW) approved language. DPW approved language is used for all denial letters and mailed to the member or parent/guardian, in the case of a child. A copy of the member denial letter is also faxed to the prescribing physician.

If the Prior Authorization Medical Exception Request is denied, the prescriber can submit a written appeal to Health Partners Complaints & Grievances explaining the medical necessity of the medical treatment in question. At anytime during normal business hours, the prescribing physician can discuss the denial with a clinical pharmacist or can have a peer to peer discussion with the medical director.

Health Partners Specialty and Injectable Medication Program

Health Partners supports appropriate use of injectables and has established procedures for prescribing and suppliers. Under the direction of the Health Partners Pharmacy department, the physician provider has the primary responsibility for obtaining Prior Authorization for medications included in this program. Call the Health Partners Pharmacy department at 215-991-4300 for authorization on specialty medications.

The following medications, although not limited to, can be obtained through the retail pharmacy benefit without prior authorization.

GENERIC NAME	BRAND NAME
ceftriaxone	Rocephin®
cyanocobalamin	Vitamin B-12
epinephrine	Epipen®, Epipen ® Jr.
fluphenazine decanoate	Prolixin Decanoate
glucagon	Glucagon
haloperidol decanoate	Haldol Decanoate
heparin sodium	Heparin
Insulin	
medroxyprogesterone acetate 150 mg only	Depo-Provera
methylprednisolone acetate	Depo-Medrol
methylprednisolone sod. succ.	Solu-Medrol
penicillin g benzathine	Bicillin L.A.
penicillin g potassium	Pfizerpen
sumatriptan	Imitrex
triamcinolone acetonide	Kenalog-40

Quantity Limitations (QL)

All Food and Drug Administration (FDA) quantities apply. Many drug products on the Health Partners Formulary have quantity limits based upon the dosage described in product labeling.

Drugs subject to quantity limits may change. Contact Health Partners Pharmacy department at 215-991-4300 for more information.

Recipient Restriction Program

Health Partners participates in the Pennsylvania Department of Public Welfare Recipient Restriction Program. Members identified through the DUR program with suspected patterns of abuse will be referred to the Recipient Restriction Program. Providers requesting information on this program may contact Health Partners Pharmacy department at 215-991-4300.

Editor

Your comments and suggestions regarding the Health Partners 2012 Formulary are encouraged. Your input is vital to this formulary's continued success. All responses will be reviewed and considered. Please send your comments to:

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Notice

The information contained in the Health Partners Formulary and its appendices is provided by Health Partners solely for the convenience of medical providers. Neither Health Partners warrants or assures accuracy of such information, nor is it intended to be comprehensive in nature. This formulary is not intended to be a substitute for the knowledge, expertise, skill and judgment of the medical provider in their choice of prescription drugs. Health Partners does not assume responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer product literature or standard references for more detailed information.

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Trade names are the intellectual property of the respective product owners.

Legend	
Y	Yes – drug is covered
GP	Generic Preferred – Brand name drug with AB-rated generic available; use generic
PA	Prior Authorization required
QL	Quantity Limits apply
OTC	Over the Counter (not all covered OTC products are listed)