Chapter 17:

Pharmacy and Drug Formulary

Reviewed/Revised: 10/1/18, 9/3/19, 1/1/20, 9/3/20, 5/21/21, 7/9/21, 1/3/22, 2/25/22, 10/25/22, 8/1/23, 9/6/23

17.0 INTRODUCTION

BCBSAZ Health Choice is pleased to provide the Plan's Preferred Drug List, which is also available online at www.HealthChoiceAZ.com. The medications listed in the formulary should be used when prescribing to our members. This is a closed formulary and only the drugs listed in this formulary are covered by the Plan except when prior authorization is given.

An online version of the Formulary is posted quarterly on our website. The formulary represents the Plan's prescription drug list. The most accurate Formulary drug listing can be found on our website at: www.HealthChoiceAZ.com. A machine-readable version of the Formulary is available on our website.

Due to the dynamic nature of the pharmacy benefit and availability of medications, periodic updates to the formulary are made and posted to the website. Changes include all Pharmacy and Therapeutics (P&T) Committee actions including drug additions, drug deletions, addition of Step Therapies or Quantity Level Limits (QLs), or newly designated Prior Authorization (PA) medications. Whenever possible, new additions are placed on the Plan's Formulary as soon as possible, to let all providers have the advantage of using that medication for a member. When possible, the Plan will provide a 30 days' notice of formulary and PA criteria change. We may fax a memo to notify providers of updates and changes and may refer providers to view the updated Formulary (Preferred Drug List) on our website. Additionally, members and providers may be notified of changes to the Preferred Drug List via direct letter or through a posted list of formulary changes on the plan website. Effective 10/1/2022, we use AHCCCS FFS prior authorization (PA) criteria. The URL for the AHCCCS FFS PA criteria document is posted on our website along with Pharmacy PA request forms that can be used for PA request submission, Exhibit 17.2 (see Chapter 6: Authorizations and Notifications).

The drugs listed in the Formulary have been researched, reviewed, and formally approved by the Plan's Pharmacy and Therapeutics (P&T) Committee. The formulary contains medications consistent with AHCCCS P&T Committee decisions and the AHCCCS Preferred Drug Lists.

The drugs have been specifically selected to provide both clinically appropriate and cost-effective medications for patients who have their drug benefit administered through BCBSAZ Health Choice. There may be occasions when an unlisted drug is desired for use by a specific patient, in which case the unlisted medication may be requested through the Prior Authorization process.

Preferred Drugs: Medications are provided to our eligible members through a Pharmacy Benefit Manager (PBM) Agreement. The Preferred Drug List (otherwise referred to as Formulary) is developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications. Whenever a claim is submitted for a non-preferred drug (or non-formulary drug), the claim will reject and notify the pharmacy that a prior authorization is required. The Plan encourages the use of medications on our Preferred Drugs List (Formulary), as appropriate, before approving a non-preferred drug unless:

1. The member has previously completed step therapy using the preferred drug(s), or
2. The member's prescribing clinician supports the medical necessity of the non-preferred drug over the preferred drug for the particular member through the prior authorization process.
3. The member has previously tried and failed all formulary alternatives approved to treat their condition.

Participating providers may request medications be considered for Formulary addition or deletion (Exhibit 17.1), by sending their request, with documentation to:

BCBSAZ Health Choice
ATTN: Pharmacy Department
8220 N 23rd Ave.
Phoenix, AZ 85021

17.1 PREFERRED DRUG LIST OR FORMULARY

The Formulary is organized into sections. Each section includes therapeutic groups identified by either a drug class or disease state. Covered generic products are identified with italicized font and a reference brand name included as a reference to assist in product recognition. Covered Brand products are identified with all capital letters. For some AHCCCS select formulary (preferred) drugs, only the brand product will be covered. This is clearly designated on the formulary document.

Covered dosage forms and strengths of the drug are cited in the formulary. Certain drugs may be available within a set monthly quantity restriction, signified by the letters QL, or require prior authorization for coverage.

The formulary covers select over-the-counter (OTC) products. You are encouraged to prescribe them when clinically appropriate, and to prescribe them exactly as they appear in the formulary.

17.2 PRODUCTION SELECTION

Our P&T Committee will consider new-to-market drugs for inclusion to the formulary as the need for each new product is assessed. The evaluation includes an extensive clinical literature review. Expert opinion is sought to provide the committee with information necessary to make a clinical informed decision about drug placement.

Formal reviews are prepared that typically address the following information: safety, efficacy, comparison studies, approved indications, adverse effects, contraindications/warnings/ precautions, pharmacokinetics, patient administration/compliance considerations, and 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. The class review process may result in deletion of one or more drugs in a particular therapeutic class in an effort to continually promote the most clinically useful and cost-effective agents.

17.3 COST INDEX

In partnership with our providers, we provide the best care for our members while maintaining an overall cost-effective approach. We ask that providers consider the relative costs when choosing an agent which can best treat the patient, e.g., FDA approved generic drugs are often the Plan's formulary preferred agents.

17.4 GENERIC SUBSTITUTION

We use a mandatory generic drug substitution policy consistent with AHCCCS requirements. Unless specifically directed otherwise by AHCCCS, the substitution of a generic drug in place of a brand name drug is required if the generic drug is available and contains the same active ingredient(s) and both products, the brand name and generic, are chemically identical in strength, concentration, dosage, form and route of administration. Generic substitutions shall adhere to State Board of Pharmacy rules and regulations. We will not transition to a biosimilar drug until AHCCCS has determined that the biosimilar drug is overall more cost-effective to the state than the continued use of the brand name drug. All exceptions to the generic substitution and biosimilar policy are found on the Plan's formulary document.

We require network pharmacies to dispense generic drugs when available unless AHCCCS preferred brand is noted on the formulary. If the physician indicates "no generic substitution" and a generic substitution is available, the physician must contact the Plan for prior authorization and follow the prior authorization guidelines for obtaining a formulary exception. Appropriate documentation will be required describing medical necessity for the requested brand drug.

In some cases, only the brand product will be covered for AHCCCS preferred drugs. This is clearly designated on the Plan formulary when applicable. Dispensing pharmacies receive messages to ensure that brand products are used in these situations. If needed a pharmacist will reach out to the prescriber to provide this information and work collaboratively to assist the member connect with their medication.

17.5 DISPENSING LIMITATIONS

Members receive up to a 90-day supply of most medications or diabetes blood glucose testing supplies at one time. Specialty medications, medications that are not considered maintenance medications, and controlled substance medications may be limited to a shorter day supply.

Members prescribed new oral oncology regimens are limited to a 14-day supply for the first two fills of the oncology drug in order to assess the tolerability of the drug by the member. After the first two 14-day fills, the member may fill up to 30 days at a time of the oncology drug.

Hospital overrides of medications may occur as hospitals and emergency departments are frequently not familiar with our Formulary. Hospital discharge overrides may be provided for coverage of a 14-day supply of a medication in order to provide time for the member to contact their provider. When this occurs, it is the responsibility of the PCP to prior authorize medication when needed to complete a medically necessary treatment course or convert the member to a Formulary product.

17.6 E-PRESCRIBING

All providers must implement and use e-prescribing for all medications prescribed for members including controlled substances. The use of electronic prescribing (e-prescribing) is meant to improve the quality of healthcare for patients as well as increase efficiency for providers. E-Prescribing is a clinicians' ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care. Thus, clinicians can safely and efficiently manage member's medications while reducing the risk for errors. Additional benefits include reducing phone calls between clinicians and pharmacies and providing member convenience by avoiding additional trips to pharmacies to drop off prescriptions. Prescriptions should be written to allow generic substitution whenever appropriate. We monitor rates of e-prescribing at the individual prescriber level, provider level and by population as per **AHCCCS ACOM Chapter 321 Payment Reform- E-Prescribing.**

17.7 BEHAVIORAL HEALTH MEDICATIONS

Our Formulary includes medications to treat behavioral health disorders and meets the AHCCCS Mental Health Parity requirements. Appropriate physician assessment and documentation describing the condition is required to facilitate the coverage of medications for these conditions.

Behavioral health medications prescribed by the PCP for the treatment of anxiety, depression, attention deficit hyperactivity disorder (ADHD), and opioid use disorder (OUD) are covered consistent with the AHCCCS and the Plan's Preferred Drug Lists. We request providers use currently accepted standard medical screening tools for diagnosis and follow up evaluations in order to confirm accurate diagnosis and prevent delays in medication approvals.

Coverage of medically necessary, federally reimbursable behavioral health medications for members prescribed by PCPs and behavioral health providers requires that monitoring and adjustments of behavioral health medications is well documented and conforms with evidence-

based practices and guidelines. For Opioid Use Disorder, the PCP must be registered to prescribe medication assisted therapy (MAT) or refer the member to a behavioral health provider for MAT and the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

We provide coverage for behavioral health medications prescribed by providers registered with AHCCCS. Most antipsychotic medications can be prescribed without need for prior authorization if the prescriber is on the Plan's behavioral health prescriber list. Antipsychotic medications prescribed by a primary care provider without behavioral health certification may require additional prior authorization review by the plan.

17.8 PSYCHOTROPIC MEDICATION MONITORING

We require at a minimum, assessments for psychotropic medications which include the following:

- a detailed medical and behavioral health history;
- a mental status examination;
- a diagnosis with target symptoms;
- a review of medication allergies for previously and currently prescribed psychotropic medications including side effects and/or potential drug-drug interactions;
- a list of all current medications prescribed by the PCP and medical specialists including over the counter (OTC) medications and supplements;
- documentation of psychotropic medication monitoring parameters such as heart rate, blood pressure, weight, BMI, labs, including serum drug levels, Abnormal Involuntary Movement Scale (AIMS) and QTc interval, as indicated.
- For sexually active females of childbearing age: review of reproductive status (pregnancy)
- For post-partum females: review of breastfeeding status.

Consistent with national guidelines addressing the monitoring of psychotropic medications, the provider must establish policies and procedures for monitoring of drug levels of lithium, valproic acid, carbamazepine, renal, liver, and thyroid function, glucose metabolism, BMI as well as screen for metabolic syndrome and movement disorders. See Exhibit 17.3, Minimum Laboratory Monitoring for Psychotropic Medication.

Medications prescribed for youth must be monitored for efficacy, side effects and adverse events at every visit with a registered nurse, physician assistant, psychiatric nurse practitioner, or physician. Children are more vulnerable than adults with regard to developing a number of antipsychotic induced side effects including higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and metabolic abnormalities (Journal of Clinical Psychiatry 72:5 May 2011). Therefore, all psychotropic medications prescribed for children less than 6 years of age require prior authorization.

When initiating treatment with a controlled substance (i.e., amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis or for short term addition of agents

when the member is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber, review of the member's Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database report should be conducted, and findings documented.

17.9 BEHAVIORAL HEALTH REPORTING REQUIREMENTS

We adopted the AHCCCS system requirements for monitoring for adverse drug reactions, adverse drug events, and medication errors. Drug therapy management of complex behavioral health conditions may lead to polypharmacy which increases a member's risk for adverse medication consequences. Commonly used psychotropic medication combinations include medication combinations used to treat multiple disorders, medication combinations that offer unique treatment advantages for a single disorder, and medication combinations to address side effects of an effective agent. All of these therapeutic approaches require assessment of reported information.

We follow AHCCCS requirements regarding the prescribing of multiple psychotropic medications to a person being treated for a behavioral health condition and requires specific documentation.

- Intra-class Polypharmacy: Defined as 2 or more medications prescribed at the same time within the same class, other than for cross-tapering purposes. The person's medical record (see Chapter 18: Behavioral Health Services) must contain documentation specifically describing the rationale and justification for the combined use.
- Inter-class Polypharmacy: Defined as 4 or more medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record (see Chapter 18: Behavioral Health Services) must contain documentation specifically describing the rationale and justification for the combined use.
- Polypharmacy in Children aged Birth to Five: Defined as use of 2 or more psychotropic medications at a time. The medical record must contain documentation specifically describing the rationale and justification for the combined use consistent with national practice guidelines for children birth to five years of age.

The above reference events are identified, reported, tracked, reviewed, and analyzed.

17.10 BEHAVIORAL HEALTH DISPENSING LIMITATIONS

Out-of-area prescription refills of non-controlled medications

We maintain a comprehensive pharmacy network that includes many pharmacy chains. Members needing to fill prescriptions while out-of-area should have their prescription transferred to a pharmacy that is located in the area where the prescription will be picked up. Members who run out or lose their medications while out-of-area should contact their prescriber to determine the appropriateness of calling in a prescription to a contracted pharmacy near the member's location or to a local pharmacy with a chain pharmacy in that area. If the pharmacy is not registered with AHCCCS the member can call member services to request an out of area override or pay for the prescription, then submit a reimbursement request to us. Members

needing urgent after-hour or weekend refills of medications may have their pharmacist call our Pharmacy Benefit Manager, CVS\Caremark at (800)364-6331 to request an emergent override or receive compassionate dispensing of limited supplies of non-controlled substances, at the discretion of the dispensing pharmacist. Other options include presenting to local behavioral health agencies or urgent care centers. Use of emergency rooms for dispensing of routine psychotropic medications is discouraged. In emergency situations valid member-incurred costs for covered behavioral health medications can be reimbursed by sending a copy of the receipt and relevant documentation to us.

Out-of-area prescription refills of controlled substance medications

Controlled substance medications are tightly controlled by federal and state regulations. These medications require a current printed and signed prescription, or a valid electronic prescription. Prescribers may not be permitted to call these medications into pharmacies and running out of these medications is typically not a behavioral health emergency; therefore, members should be advised to plan ahead to ensure adequate supplies of these medications. In an emergency situation, options for acquiring a needed prescription include presenting to local behavioral health agencies or urgent care centers. Use of emergency rooms for dispensing of routine psychotropic medications is discouraged. Lost and stolen controlled substances require a new prescription and verification of the original prescriber's consent to fill early.

Discharge medications from inpatient facilities

Inpatient facilities should dispense at least a 3 to 5 day's supply of medications for the convenience of families and members at discharge and provide members prescriptions with enough medications and/or refills to last until the first scheduled prescriber appointment. As per policy, Chapter 3 section 3.12 Appointment Availability, this should be within seven days (and in no case more than 30 days). If the prescriber is concerned about safety issues, it is advised to write smaller quantities per prescription with a greater number of refills AND ensure that the member is prioritized to receive a post-discharge follow-up within clinically appropriate time frames.

If the member is on controlled substances, they should be provided enough to last until the first prescriber appointment. Discharge prescriptions and medications dispensed may be communicated electronically to the outpatient facility to better coordinate care and allow for identification of potential medication misuse.

Medications during transitions between RBHAs, agencies or prescribers

It is the responsibility of the member's current prescriber, including the PCP, to ensure that persons transitioning have adequate supplies of medications to last until the appointment with the next prescriber (Chapter 3 section 3.12 Appointment Availability). It is the responsibility of the provider assuming the person's care to ensure that the person is scheduled with an appointment within clinically appropriate time frames such that the person does not run out of medications and does not experience a decline in functioning. In no case should the timeframe extend longer than 30 days from identification of need. See also Chapter 18: Behavioral Health Services.

Use of samples

Providers are strongly discouraged from using medication samples for medications not on the Preferred Drug List, as members may not be able to continue those medications as part of the prior authorization process. Use of samples is not considered to establish continuity of care. Members provided samples must still satisfy all standard plan criteria, including trial and failure of formulary alternatives, before a prior authorization may be approved. Providers who consistently use non-preferred drug list samples may be subject to corrective action.

17.11 SPECIALTY MEDICATION PROGRAM

We use CVS Specialty Pharmacy, to provide certain medically necessary, specialty medications for Plan members. These very specialized medications are used to treat chronic disorders such as multiple sclerosis, chronic hepatitis, cystic fibrosis, rheumatoid arthritis and, hepatitis C, etc.

Physicians may request a specialty medication by utilizing the BCBSAZ Health Choice Pharmacy Medication Prior Authorization Form found on our website. The completed PA form and supporting documentation should be faxed to the Prior Authorization Department at (877) 422-8130. **DO NOT SEND THIS FORM DIRECTLY TO THE SPECIALTY PHARMACY.**

17.12 CONTROLLED SUBSTANCES

We require prescribers to utilize the Controlled Substances Prescription Monitoring program (CSPMP) when prescribing controlled substances to their patients. This database tracks the prescribing and dispensing of controlled prescriptions and can assist in the avoidance of inappropriate use of these medications.

We comply with state mandated opioid prescribing limits and AHCCCS required utilization management edits (e.g., Prior Authorization, concomitant therapy edits, 5-day limit for short acting opioids).

Additionally, we comply with AHCCCS requirements that allow PCPs to treat members with medication-assisted treatment (MAT) for opioid use disorder (OUD). PCPs providing MAT shall meet all regulatory requirements established for the medication type administered. AHCCCS preferred drugs for the treatment of OUD are available on the Plan's Formulary (preferred drug list). The prescribing PCP is encouraged to select appropriate medications from this list or submit a prior authorization request for a non-preferred product.

To promote safe prescribing practices, we encourage providers to adopt and utilize electronic prescribing of controlled substance medications. Please see Exhibit 17.6 for additional information on e-prescribing.

17.13 PHARMACY AUTHORIZATIONS

We manage the pharmacy benefit by developing a Formulary (Preferred Drug List). Prescribers should utilize the Plan's Drug Formulary when prescribing medications for members. Refer to the AHCCCS Medical Policy Manual Chapter 300, Policy 310-V to learn about AHCCCS mandated formulary requirements.

If the Provider determines that the patient requires a medication that is listed as requiring prior authorization and/or not listed on the plan Formulary, the physician must request prior authorization using the current BCBSAZ Health Choice Prior Authorization Request Form along with appropriate documentation to support the request. Providers should also note references to step therapy (ST) edits, and quantity limits (QL) prior to requesting PA. Providers are strongly encouraged to check the online Formulary and Prior Authorization Criteria documents to obtain the most up-to-date formulary and clinical coverage requirement information.

17.14 TIME FRAMES FOR HEALTH PLAN PRIOR AUTHORIZATION REVIEW

As defined by the AHCCCS Medical Policy Manual, Chapter 1000, and Medical Management/Utilization Management: "Chapter Overview" we implemented policies for processing and making determinations for Pharmacy prior authorization requests for medications consistent with the following requirements.

- A decision to a submitted prior authorization request for a medication is provided by telephone, fax, electronically or other telecommunication device within 24 hours of receipt of the submitted request for prior authorization **if all information required to render a decision is present**,
- A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication device within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within three to seven days from the initial date of the request, consistent with regulatory turnaround times associated with each type of request.
- At least a 5-day supply of a covered outpatient prescription drug may be provided to the member in an emergent situation upon request. [42 CFR 438.3(s)(6)].

17.15 PRIOR AUTHORIZATION DETERMINATIONS

Prior Authorization requests which are submitted on behalf of Plan members will be processed and completed in one of the following standard methods:

- Approved - The information received met all criteria for coverage requirements, and authorization is granted. No further action is required by the office except to notify the member/facility and facilitate the member in obtaining the approved services. The requesting provider office is responsible for informing the member services have been authorized.
- Denied - The information received did not meet all criteria for coverage requirements, and

authorization is not granted. The requesting provider and member will receive a denial notification letter.

- Request for additional information: In some instances when PA has been requested, the documentation received is missing key information to support meeting coverage criteria or medical necessity for the service; submitted records are insufficient to render an authorization decision.
    - When this occurs, additional information is requested within 24 hours receipt of the submitted request via fax.
    - When additional information cannot be obtained within 3 days to meet NCQA and AHCCCS PA timeframes, we will render a decision based on the information available.
- Partial approval- The information received met criteria for coverage and/or medical necessity requirements, however the documentation provided does not support the full amount, duration and/or scope of service at the time of request. In this situation, a partial authorization is granted, and a notice of adverse benefit determination will be issue that will describe what is needed to obtain full approval.

17.16 Authorization Denials (Adverse Benefit Determinations)

When a denial is issued, we must inform the member of the denial of service and the reason for denial in clearly understood language in the form of a "Notice of Action" (NOA) letter utilizing the AHCCCS 'Notice of Adverse Benefit Determination" letter template. AHCCCS requires NOA letters to communicate the basis for a denial in "easily understood" language, therefore member NOA letters will be written in a simplistic fashion in order to comply with this specific AHCCCS requirement. For more information about what a member can do if they receive an NOA, please see Chapter 15: Claim Disputes, Members Appeals and Member Grievances.

In some cases, upon communication with the Plan the provider chooses to prescribe a preferred drug instead of the originally requested drug. We aren't required to provide a Notice of Action when the prescribing clinician agrees with the change to the preferred drug. A prior authorization request will be reviewed for the non-preferred drug when the prescribing clinician is not in agreement with transition to the preferred drug. In accordance with AHCCCS Contractor Operations Manual (ACOM) Policy 414 for Service Authorizations, when a prior authorization request is denied or a previously approved authorization is terminated, suspended, or reduced, the Plan will issue the appropriate Notice of Action.

Written information which communicates a denial of service will also be sent to the requesting provider (or their designee). A copy of the Notice of Action mailed to the member is faxed to the provider which includes the reason for denial. For additional detail regarding the denial, the provider may contact the Pharmacy Prior Authorization Department.

After a denial decision has been made, denial communications to the member and prescriber will be generated to be faxed and mailed within the appropriate PA timeframes.

17.17 PHARMACY TRANSITION OF CARE PROCESS

New enrollees (within their first 30 days) taking prescription drugs that are not on our Preferred Drug List (formulary), or formulary drugs that are subject to certain restrictions, such as prior authorization or step therapy, will receive a transition fill of up to a 30-day supply at a retail pharmacy to prevent a gap in therapy and to enable the prescriber to seek authorization for future fills. Within 7 days of the transition fill enrollees and their prescribing provider (if appropriate) will receive a letter instructing them to consult with their prescribing provider and decide if they can switch to a Formulary drug or submit for coverage of the non-formulary medication via the Plan's pharmacy prior authorization process.

We will not pay for additional fills for the drug(s), unless the prescriber submits a request for coverage or medical necessity review and the Plan pharmacy PA department, under the direction of the Medical Director, approves the request. If coverage is approved, the approval will be valid for up to 12 months, unless prescribed for a lesser period or criteria dictates a more clinically appropriate duration of coverage for the specific medication authorized.