Pharmacy Benefit Program (Central Region Products)

General Information About Pharmaceuticals

Pharmaceutical services

Highmark Blue Shield administers prescription benefits for almost all of its members. The Paid Prescriptions program logo appears on the member's identification card. Medco Health is our pharmacy benefits manager.

Premier pharmacy networks

The prescription drug program offers a wide network of pharmacies that includes most national chains and many local, independent pharmacies. Drug benefits may vary slightly, depending upon the member's group program. Pharmacies have point-of-sale technology that confirms a member's eligibility, benefit design and copayment information at the time of dispensing.

Under most prescription drug programs, members must use one of the participating pharmacies in Highmark Blue Shield's Premier Pharmacy networks. Members may consult their pharmacy directory, visit Highmark Blue Shield's Web site at www.highmarkblueshield.com, or call Customer Service at the number shown on their identification cards to find a network pharmacy that is conveniently located for them.

We also offer members a Home Delivery (Mail Service) option. Under this option, members can get a 90-day supply of medication through the mail. For most prescriptions, the member can save on the cost of the medication when it is obtained via the mail service pharmacy.

Pharmaceuticals: The Formulary

Drug formulary for physicians

The Highmark Blue Shield Drug Formulary is distributed to network physicians on an annual basis. It has two sections: The Open Formulary Section and the Closed/Incentive Formulary Section. The drugs listed in the Closed/Incentive Formulary are a subset of the drugs listed in the open formulary. Please prescribe from the formulary section that applies to the member's prescription drug benefit program. You can tell if the member has prescription benefits by the prescription logo in the upper right hand corner of the member's identification card. However, there is no indication whether it is the open, closed or incentive formulary program. The member should know which formulary applies to them, or you can call our Customer Service Department.

The use of the formulary

The Open Formulary section at the back of the Highmark Blue Shield formulary applies to all members with an open formulary benefit. The Closed/Incentive Formulary section at the beginning of the formulary applies to members whose groups have elected to use the incentive or closed formulary.

Reviewing and revising the formulary

Each section of the formulary is reviewed and updated quarterly by Highmark Blue Shield's Pharmacy and Therapeutics Committee, to promote the use of high-quality, therapeutically safe and cost-effective drug therapy.

The Pharmacy and Therapeutics Committee approves revisions to the formulary on a quarterly basis. These revisions are communicated to providers quarterly and any deletions to the formulary are made only after a minimum of 30 days advance notice to providers.

How to obtain a copy of the formulary

If you would like to receive a copy of the formulary, you may submit the Reordering Request post card, requesting form number 21850. Or you may call our Shipping Control Department at 1-717-302-5105. Information on the formulary status of a drug can also be obtained at www.highmarkblueshield.com.

Formulary drugs
Formulary drugs are those approved by the Pharmacy and Therapeutics Committee. These drugs are selected based on their safety, efficacy, quality and cost. When medically appropriate, physicians and pharmacists are encouraged to use formulary drugs.

Non-formulary drugs
A non-formulary drug is one that has not been approved for coverage by the Pharmacy and Therapeutics Committee based on safety, efficacy or cost. Physicians are encouraged to comply with the drug formulary when prescribing medications for participants. When presented a prescription for a non-formulary drug, a pharmacist should attempt to contact the prescribing physician in order to suggest formulary alternatives. Physicians and pharmacists should be aware that, based on the specific terms of a patient's plan, the patient may pay a higher co-payment or coinsurance for non-formulary drugs than they do for formulary drugs.

Note: Members with a closed formulary benefit do not have coverage for non-formulary drugs. If appropriate, prescribe formulary medications to avoid non-covered expenses.

Generic drug substitution
Many participants' plan designs require generic substitution when an equivalent generic drug is available. In these plans, generic drugs are subject to specific reimbursement levels, such as Maximum Allowable Cost (MAC) price reimbursements. Depending on the participant's plan design, if the patient or physician requests the brand name drug, the participant may be required to pay the cost difference between the brand name drug price and the MAC reimbursement price, in addition to the plan's copayment requisites. In all instances, the pharmacist is reminded to follow state regulations regarding generic substitution.

Exceptions for Coverage of Non-Formulary Drugs For Members with a Closed Formulary

Rationale

We anticipate that the vast majority of our members will be well served by the drugs listed on the closed formulary; however, some patients may require a non-formulary drug. An exception process has been established to allow physicians to request coverage of a non-formulary drug.

Criteria for approval
Exceptions will be approved only when the clinical pharmacy reviewer and/or medical director agrees that the physician has demonstrated one of the following:

- The failure of therapy with the alternative drugs listed in the formulary.
- Medical rationale for reasonable expectation of harm to the member if he or she takes the formulary medication.

Supportive documentation is required
Whenever possible, documentation should include laboratory results, physical exam findings or other quantitative data to support the exception request. If expectation of harm is indicated, the physician must document specific reasons.

Filing an exception request
To file an exception request, please complete the *Prescription Drug Medication Request Form (form number 22645)*. You can find a copy of this form in the appendix. Detailed instructions for completing this form appear on the reverse side of the form. The exception form and instructions for its use are also included in the introduction of the Highmark Blue Shield Drug Formulary.

Physicians can obtain copies of this form via the Reordering Request post card or by calling our Shipping Control Department at 1-717-302-5105.

Submitting the exception form

The Prescription Drug Medication Request Form can be:

Faxed to: 1-412-544-7546

Or

Mailed to: Highmark Blue Shield
Prescription Drug Program
P.O. Box 279
Pittsburgh, PA 15230

Expedited exception requests

Criteria for expedited exception requests are as follows:

- The physician filing the exception request states that an expedited review is necessary based on the member's medical condition such that the time frame required for the standard appeal process would compromise the member's life, health, or functional status.
- The member is discharged from an acute care environment with a prescription for a non-formulary drug that the requesting physician determines is necessary to complete a specific course of therapy.
- The physician wishes to prescribe a non-formulary drug that requires administration in a time frame that will not be met if the standard exception request process is used.

A voice-mail system exists to handle expedited exception requests only. You may call 1-800-656-2485 at any time to leave a message on the system. Please use the *Prescription Drug Medication Request Form* as a guide when leaving information on the system. This will avoid unnecessary delays in processing your request. A decision will be rendered expeditiously as the member's health requires, but no later than one business day, not to exceed 72 hours of the request being left on the voice mail messaging system if adequate information has been provided by the provider.

You may be contacted for more information

When the Medical and Pharmacy Affairs department receives the exception request, they review it for completeness. If they need more information, they will contact your office.

If your office receives such a request, please respond immediately.

When an exception request is approved

Both the physician and the member will be notified of the approval. Coverage for non-formulary maintenance medication will be approved with an unlimited authorization date. This will make further exception requests unnecessary for the member.

When an exception request is denied

Both the physician and the member will be notified of the denial. The physician's and the member's denial letter explains the right to file a grievance if he or she considers the decision unacceptable.

Appeals and grievances

Members who are impacted by the closed formulary may file a grievance through the Initial Grievance Committee. Information on the initial grievance process appears in the member's handbook.

Home Delivery (Mail Service) Pharmaceutical Service

Home delivery service

Home delivery service is a standard component of our prescription drug benefit. Members may call the Member Service telephone number on their identification card to obtain a home delivery order form.

Advantages of using the home delivery service

Members may prefer to use the home delivery prescription service. This service enables members to obtain up to a 90-day supply of either generic or brand name drugs, for either one or two times the retail generic or brand copayment, or applicable coinsurance, depending on the group.

How to assist members in using the home delivery service

If a member must begin taking a new maintenance drug immediately, you may need to write two prescriptions. The member can have one of the prescriptions filled at a local pharmacy to begin taking the medication immediately. (It is recommended that this prescription be written for a two-week supply.) The member can send the other prescription to the home delivery service for up to a 90-day supply.

How members may use the home delivery service

Members can obtain home delivery forms for maintenance drugs by calling the Member Service telephone number on their identification card or by visiting our Web site at www.highmarkblueshield.com.

Once a member places an order, the member's information remains on file. Any subsequent refills do not require an order form. For refills, the member can call the toll-free number, send in the refill form with the applicable copayment, or visit Highmark Blue Shield's Web site at www.highmarkblueshield.com.

As a convenience to patients, physicians may fax new prescriptions directly to Medco Health. Call 1-888-EasyRxl for details regarding how to fax a prescription to the mail order pharmacy.

Prescription Drug Management Programs

Highmark Blue Shield's Pharmacy and Therapeutics Committee has approved all of the following program policies. This Committee is composed of network physicians and pharmacists who consider the safety, efficacy and appropriate use of medications when reviewing these policies. Changes and updates to these criteria are distributed quarterly via a formulary update, which is distributed to all network providers.

Managed prescription drug coverage (MR*x*C) programs

The managed prescription drug coverage (MR*x*C) program consists of online edits that encourage the safe and effective use of targeted medications. Many of the criteria are automated to reduce the administrative burden on physicians and to reduce member disruption. The classes of drugs included are the Cox-II inhibitors, gastrointestinal medications, agents used for acute migraine, oral antifungals and Oxycontin. The drugs in this category are covered with certain restrictions in place, which are outlined here.

I. Cox-II Inhibitors

The cyclooxygenase-2 (COX-II) inhibitors are oral nonsteroidal anti-inflammatory agents used in the treatment of rheumatoid arthritis, osteoarthritis, management of acute pain or primary dysmenorrhea. Currently, representatives for this class of drugs includes rofecoxib (Vioxx), celecoxib (Celebrex) and valdecoxib (Bextra).

The COX-II inhibitors require prior authorization based upon independent risk factors for NSAID induced gastropathy. Members meeting any of the following six criteria will not be required to obtain a prior authorization. If any claims are in the pharmacy computer system for the above drugs, the prescription will automatically process at the pharmacy with no paperwork needed.

1. The member is 65 years of age or older.
2. The member is receiving oral anticoagulant (coumarin type) therapy.
3. The member is receiving oral corticosteroid therapy.
4. The member is receiving heparin or related agents.
5. The member is receiving platelet aggregation inhibitors (Ticlid, Plavix, dipyridamole).
6. The member has previously received an approval for a COX-II inhibitor.

Unlike the first 6 criteria, requirements 7, 8 and 9 cannot be assessed in the claims system. **(For members who do not meet the first six criteria but meet other requirements (7, 8 or 9), providers should contact 1-800-753-2851 for prior authorization processing. A representative will gather all necessary information to complete the review process.)**

7. The member has a history of peptic ulcer disease, NSAID-related ulceration, clinically-significant GI bleed coagulation defect or erosive esophagitis.
8. The member has a history of intolerance or therapeutic failure to at least 3 NSAIDs.
9. The member is receiving low-dose aspirin.

II. H2 Antagonists and Proton Pump Inhibitors

Concurrent utilization management for drugs used in the treatment of gastroesophageal reflux disease, peptic ulcer disease, NSAID ulcer prophylaxis and hypersecretory conditions is conducted. Specific dosing edits are set for each drug based on the manufacturer's recommended dose and duration of therapy. Additional information will be required for patients who require high dose, long-term therapy, as many patients can be maintained on a lower dose. This edit covers high-dose therapy for 90 days. The lower doses listed in parentheses below are covered without the prior authorization requirement and without any time restriction.

If a member requires continual high-dose treatment for longer than 90 days, the provider may call 1-800-753-2851 to have the case reviewed.

H2 Antagonists	
Zantac® (ranitidine)	High dose is 300 mg or more per day (150 mg per day, is covered)
Tagamet® (cimetidine)	High dose is 800 mg or more per day (600 mg per day, is covered)
Axid® (nizatidine) (non-formulary)	High dose is 300 mg or more per day (150 mg per day, is covered)
Pepcid® (famotidine) (non-formulary)	High dose is 300 mg or more per day (150 mg per day, is covered)

Proton Pump Inhibitors	
Prilosec® (omeprazole)	High dose is more than 20 mg per day (20 mg per day is covered)
Nexium® (esomeprazole)	High dose is more than 40 mg per day (40 mg per day is covered)
Prevacid® (lansoprazole) (non-formulary)	High dose is more than 30 mg per day (30 mg per day is covered)
Aciphex® (rabeprazole) (non-formulary)	High dose is more than 20 mg per day (20 mg per day is covered)
Protonix® (pantoprazole) (non-formulary)	High dose is more than 40 mg per day (40 mg per day is covered)

III. Migraine Therapy

Concurrent utilization management for drugs used in the treatment of migraine headaches is conducted. Specific dosing edits are set for each drug based on the manufacturer's recommended dose and duration of therapy. The list below illustrates the established limits for the amounts of various abortive agents used in the management of migraine headaches. The use of prophylactic medications is strongly encouraged in those patients who suffer from frequent migraines.

Imitrex®	
(generic – sumatriptan)	Retail – 800 mg within the last 25 days
Tablets	Mail – 2,400 mg within the last 75 days
Injection	800 mg/month
Nasal Spray	4 Kits/month
(Imitrex: 1 injectable kit = 40 mg nasal = 200 mg oral)	160 mg/month
Zomig®	Retail – 40 mg within the last 25 days
(generic – zolmitriptan)	Mail – 120 mg within the last 75 days
Amerge®	Retail – 20 mg within the last 25 days
(generic – naratriptan)	Mail – 60 mg within the last 75 days
Maxalt®	Retail – 120 mg within the last 25 days
(generic – rizatriptan)	Mail – 360 mg within the last 75 days
Migranal NS®	Retail – 8 ml within the last 25 days
(generic – dihdroergotamine)	Mail – 24 ml within the last 75 days
Axert®	Retail – 100 mg within the last 25 days
(generic – almotriptan)	Mail – 300 mg within the last 75 days
Frova® (non-formulary)	Retail – 30 mg within the last 25 days
(generic – frovatriptan)	Mail – 90 mg within the last 75 days
Reipax® (non-formulary)	Retail – 240 mg within the last 25 days
(generic – eletriptan)	Mail – 720 mg within the last 75 days

If a member requires a higher dose of these migraine medications, the provider may call 1-800-600-2227, option #1, or fax the request to 1-412-544-7546, for clinical review.

IV. Oral Antifungals

The oral antifungals itraconazole (Sporanox®) and terbinafine (Lamisil®) are indicated for various types of fungal infections. Current recommendations for the treatment of onychomycosis are a three-month treatment regimen followed by several months without therapy, as it takes six months to a year for the outgrowth of a healthy nail. This edit will cover 90 days of therapy every six months for the treatment of onychomycosis.

If the member has had prescriptions filled for any antineoplastic, antiretroviral and/or antirejection drugs, the claim for the antifungal will automatically process at the pharmacy with no authorization needed. This will allow uninterrupted care for those members who are likely to require long-term antifungal therapy (or prophylaxis) because of HIV/AIDS, cancer, or organ transplantation. For those members who require extended anti-fungal therapy and do not meet the criteria above, the provider may call 1-800-600-2227, option #1, or fax the request to 1-412-544-7546, for clinical review.

Anti-Fungal Therapy	
Sporanox® (itraconazole)	18,000 mg within the last 180 days
Lamisil® (terbinafine)	22,500 mg within the last 180 days

V. Oxycontin

Oxycontin is a sustained release formulation of oxycondone hydrochloride indicated for the management of moderate to severe pain. Oxycontin was added to the Managed Rx Coverage Program effective September 1, 2002 due to the numerous problems (abuse, diversion and deaths) with the use of the drug. Oxycontin is limited to 60 tablets per 30 days with provisions to allow up to 120 tablets per 30 days for special dosage requirements.

For those members who require an Oxycontin dose outside of the criteria above, the provider may call 1-800-600-2227, option #1, or fax the request to 1-412-544-7546, for review.

Quantity Level Limit Program

The following table contains a list of medications and the corresponding quantity level limits (number of units per prescription) that will be applied when members receive these medications through their prescription drug benefit. The edits do not limit the number of refills. Please note that each medication has both retail and mail-order quantity level limits. Quantity level limits are applied for a variety of reasons: (1) to prevent the stockpiling of medication; (2) to promote adherence to an appropriate course of therapy for reasons of efficacy and safety; and (3) to prevent medication misuse or abuse. Please take these limits into consideration when prescribing the medications listed below.

Quantity Level Limits

Drug Brand Name	Drug Use	Retail Limit	Mail Order Limit
Alora	estrogen replacement	2 boxes (16 patches)	4 boxes (32 patches)
Caverject	impotency	6 injections	18 injections
Climara	estrogen replacement	2 boxes (8 patches)	4 boxes (16 patches)
Cordran Tape	anti-inflammatory	2 tapes	6 tapes
Diastat Rectal Gel	seizures	2 prefilled applicators	2 prefilled applicators
Diflucan (150 mg only)	vaginal candidiasis	1 tablet	1 tablet
Edex	impotency	6 injections	18 injections
Esclim	estrogen replacement	2 boxes (16 patches)	4 boxes (32 patches)
Estraderm	estrogen replacement	2 boxes (16 patches)	4 boxes (32 patches)
Forteo	osteoporosis	1 multi-dose pen	3 multi-dose pens
Fosamax 35mg	postmenopausal osteoporosis	4 tablets	12 tablets
Fosamax 70mg	postmenopausal osteoporosis	4 tablets	12 tablets
Lotronex	irritable bowel syndrome	60 tablets	180 tablets
Miacalcin Nasal Spray	osteoporosis	3 bottles	8 bottles
Muse	impotency	6 suppositories	18 suppositories
NuvaRing	contraceptive	1 device	3 devices
Ortho Evra	contraceptive	3 patches	9 patches
Plan B	emergency contraceptive	1 kit per Rx	1 kit per Rx
Preven	emergency contraceptive	1 kit per Rx	1 kit per Rx
Prozac (90 mg only)	anti-depressant	4 tablets	12 tablets
Relenza	flu	1 Diskhaler and Five Rotadisks	1 Diskhaler and Five Rotadisks
Stadol Nasal Spray	acute pain management	1 inhaler	3 inhalers
Tamiflu	flu	Ten 75mg capsules (5 days supply)	Ten 75mg capsules (5 days supply)
Toradol	acute pain management	20 tablets	20 tablets
Viagra	impotency	6 tablets	18 tablets

Vivelle	estrogen replacement	2 boxes (16 patches)	4 boxes (32 patches)
Zelnorm	irritable bowel syndrome	60 tablets	180 tablets

Prior Authorization Program

Prior authorization is necessary for coverage for certain medications. In these cases, clinical criteria, based on plan coverage conditions approved by the Pharmacy and Therapeutics Committee, must be met or other information must be provided before coverage is considered. The provider must submit documentation of the rationale for the use of the medication before the member is eligible for coverage. Drugs that typically require prior authorization and their uses are listed below.

To request a drug that requires prior authorization, please complete the *Prescription Drug Medication Request Form* (form number 22645) and fax to 1-412-544-7546. A copy can be found in the appendix. If you do not have a form, you may order using the Reordering post card or by calling our Shipping Control Department at 1-717-302-5105.

*Please note, some drugs included under this program may be covered, excluded or require prior authorization depending on the product and/or group specific requirements.

Prior Authorization

Brand Name Drug/Drug Category	Drug Use
***Contraceptives** (oral/injectable)	Non-contraceptive use
Enbrel	Rheumatoid/psoriatic arthritis
Forteo	Osteoporosis
Kineret	Rheumatiod arthritis
Fertility Medications	Infertility
Gleevec	Cancer treatment for CML
Growth Hormones	Hormone deficiency
Humira	Rheumatoid Arthritis
Inteferons	Cancer treatment; liver disease
Provigil	Narcolepsy
***Retin-A**	Acne
Tracleer	Pulmonary arterial hypertension
***Wellbutrin**	Depression
***Zyban**	Smoking cessation