Pharmacy benefits explained

As your employees review their Priority Health benefits, they may have questions regarding their pharmacy coverage. Please refer to this helpful guide of frequently asked questions, or reach out to your Priority Health Account Manager.

What is a formulary?
A formulary is a list of drugs. Each insurance carrier creates and administers their unique approved drug list.

How does Priority Health determine which drugs to cover?
Our approved drug list is carefully reviewed by our Pharmacy and Therapeutics Committee. The committee is comprised of doctors, pharmacists and other health care professionals from the Priority Health network. They meet six times a year to review currently covered drugs and new drugs based on cost, safety and efficacy. Because of this attention to detail, members can be confident that our list is up-to-date with the highest quality, most effective choices to meet their needs.

Where can my employees find the Approved Drug List (formulary) to find out if their drug is covered?
They can visit ***priorityhealth.com/formulary/employer***. They will need to select "Employer Sponsored: Traditional" or "Employer Sponsored: Optimized" when asked what type of drug list they have. Please inform your employees which approved drug list is offered in their plan.

Can my employees find out in advance how much they will be expected to pay for a drug?
Yes, members can check online to shop and review the estimated cost of prescriptions and find lower cost alternatives, if available. Members can log in to their Priority Health member account to access the tool. They can also call Customer Service for assistance at the number on the back of their Priroity Health member ID card.

Why do some drugs have additional requirements before members can obtain them?

Quantity limits and prior authorization

Certain medications may have monthly quantity limits (QL) or require prior authorization (PA) to ensure safe and appropriate use. Doctors are responsible for submitting on behalf of the member and may submit a request by calling or faxing it to Priority Health. Requests must be approved in advance in order for a drug to be covered.

Step therapy

Some medications require step therapy because there are other similar drugs that are proven to be just as safe and effective but cost less. This provides a safe alternative and saves the member money. If the lower cost drug isn't effective or if it's deemed medically necessary, a member's doctor can work with Priority Health and request an exception. If a member has already completed the step therapy requirements in the past, they can ask their provider to send the information to Priority Health for review.

How do you help transition prescriptions from a previous carrier?

We understand new Priority Health members may need additional time to work with their doctor for any medications that require step therapy or prior authorization. Most prescriptions that require step therapy or prior authorization can be filled one time without fulfilling those requirements if they are filled within 120 days of the plan's start date. The drugs are typically given in a 30-day supply unless they have quantity or dosage limits. After the prescription is filled, the member will receive a letter in the mail from Priority Health informing them their drug requires step therapy or prior authorization. Members will need to obtain prior authorization or complete the step therapy requirements before filling that prescription again.

What are drug tiers?

"Tiers" are simply a way of grouping prescription drugs by cost and value. Different insurance carriers categorize drugs into tiers according to their specific approved drug list, so it is important for members to check Priority Health's approved drug list to see which tier their drug is classified.

- **Tier 1 ($):** This tier includes low-cost generic drugs—proven to be as safe as brand-name drugs—and, on some formularies, select brand-name drugs.
- **Tier 2 ($$):** Includes preferred and lower cost brand-name drugs, and some higher cost generic drugs. If you must take a brand-name drug, you should work with your doctor to choose one that is covered here, and the most affordable.
- **Tier 3 ($$$):** Non-preferred and expensive brand-name drugs, as well as higher-cost generic drugs. These drugs may cost you a significant amount out of pocket so you should ask your provider if a tier 1 or 2 option can be prescribed instead.
- **Tier 4 ($$$$):** Includes very expensive brand-name and generic drugs, and preferred specialty drugs used to treat complex conditions. Specialty drugs often have high costs and may have special handling or storage requirements. They are usually dispensed by trained personnel at specialty pharmacies. If you need to take a specialty drug, you should work with your doctor to choose one that is covered here. These drugs do not typically have a specific copay. Instead, you may pay a percentage of the total cost, up to a maximum amount per prescription.
- **Tier 5 ($$$$$):** Non-preferred specialty drugs, and the most expensive brand-name and generic drugs are covered here because they offer limited clinical value. Most have a similar lower-cost option offering the same clinical value on tiers 1 through 4. Ask your provider about alternatives. These drugs typically do not have a specific copay. Instead, you may pay a percentage of the total cost, up to a maximum amount per prescription.

Additional questions from employees?

Members can call the Priority Health customer service number located on the back of their member ID card. Our customer service specialists can answer questions on drug costs, drug alternatives, claims questions and drug requirements.