

**MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

POLICY TITLE: DRUG FORMULARY

POLICY STATEMENT: Medical Associates Health Plans uses the PBM developed drug formulary. The drug formulary is the cornerstone of drug therapy, quality assurance and cost containment efforts. The drug formulary document is developed by the Optum Rx Pharmacy and Therapeutics Committee (P&T Committee), and it is referred to as the Premium Formulary. The Optum P&T Committee is composed of physicians from various medical specialties, as well as pharmacists who review medications in all therapeutic categories at least annually. From the P&T Committee review, prescription drugs are added or removed from the drug formulary. The Optum P&T Committee reviews new and existing medications on a monthly basis to ensure the MAHP Drug Formulary promotes clinically appropriate, safe, and cost-effective drug therapy that reflects community and national standards of practice.

Note: Formulary meets criteria per the Essential Health Benefits.

PROCEDURE:

A. Formulary Development

1. The P&T Committee is supported by the Clinical Review Committee, Utilization Management Committee and the Formulary Management Committee within Optum Rx. These committees are responsible for reviewing the Medi-Span file weekly, assessing UM needs and drafting new UM criteria as well as revising and updating existing UM criteria and post P&T meetings evaluating the cost of care, assessing tier placement for medications and reviewing manufacturer contracting to advise P&T on the clinical and financial aspects of pharmaceutical products. Pharmaceutical products are reviewed to determine appropriate and inappropriate use and objectively evaluated in the context of medical and scientific evidence concerning safety and effectiveness, when making recommendations concerning utilization review, dose restrictions, and step therapy requirements.
2. Medications are evaluated on the following criteria by the Pharmacy & Therapeutics Committee to determine formulary status: FDA status, pharmacology indications, clinical studies/practice guidelines, place in therapy, availability, availability of other medications in same therapeutic category, warnings/precautions, adverse effects, dosage, and references (relevant findings of government agencies, medical associations, national commissions, and peer-review journals).
3. The prescription drug benefit disclosure provided to the member describes the MAHP Drug Formulary use.

B. Formulary Communication

1. The Premium Formulary is made available in an abbreviated printed version to members, practitioners, and pharmacies and is also available as an electronic booklet through the the MAHP/Health Choices/Live 360 network member and provider portals. The formulary is also available through the Medical Associates Health Plans Internet site at:
<https://www.mahealthcare.com/insurance/products-and-services/managed-care/pharmacy-benefits/>

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, Health Choices Internet site: https://healthchoicesplans.com/wp-content/uploads/2022/12/XMAHP_Medical-Associates-Health-Plan.pdf and the Live 360 internet site: https://65q76e.p3cdn1.secureserver.net/wp-content/uploads/2022/12/Live360_Medical-Associates-Health-Plan.pdf

2. MAHP network practitioners are informed of pertinent drug formulary changes after P&T Committee meetings via Provider Newsletters.
3. The on-site Clinical Pharmacist sends an internal email to MAHP HCS staff to provide any updates on formulary changes. Formulary changes are also brought to the quarterly Utilization Management Committee meetings.
4. If a member/participant is being affected by a formulary change, letters are sent to the member/participant with information related to the change. Prescribing Practitioners are also informed of formulary changes that impact their prescribing habits.

C. Applying the Formulary:

1. MAHP uses the same formulary for all members/participants with a prescription drug benefit. Co-payment structure may vary depending on the employer group and division a member is enrolled with. Lower cost generic drug programs are listed on MAHP's website and are available for member use if needed.
4. When a member/participant presents with a prescription at a participating pharmacy, the pharmacy submits a claim online to MAHP's contracted PBM. The PBM processes the claim according to the defined benefits/limitations and the applicable deductible, coinsurance, or co-pay is charged to the member/participant. If a practitioner has ordered a non-formulary medication, when the claim reaches the PBM, the pharmacist receives a message indicating why the claim cannot be processed. The pharmacist will contact the practitioner to request consideration of a formulary alternative. If no alternative exists, the practitioner/member may contact via phone, fax or email the MAHP Health Care Services Department describing the medical necessity and providing the pertinent clinical data supporting the need for coverage of a non-formulary prescription drug. An exception may be granted for use of some non-formulary medications. (See HCS Policy titled Prior Authorization for Prescription Drugs)

D. Quality Improvement

Optum P&T Quality Improvement:

- A. P&T Committee reports to the Clinical Quality Oversight Committee (CQOC).

Original: 01/99
Revised: 03/99, 03/00, 03/01, 03/02, 03/03, 07/03, 02/04, 04/05, 01/09, 06/10, 01/12, 11/14, 11/15, 02/17, 04/18, 04/19, 04/21, 01/23
Reviewed: 03/06, 03/07, 03/08, 01/11, 01/13, 12/13, 01/14, 04/20