Formulary Exclusion Exception Process

The State Health Plan (Plan) has a custom, closed formulary, which includes drugs that are excluded from the formulary and are not covered by the Plan. This is applicable to the 70/30 Plan and the 80/20 Plan.

A formulary exclusion exception (exception) process is available to support Plan members who, per their provider, have a medical necessity to remain on an excluded drug. The exception process is administered by CVS Caremark®, the Plan's Pharmacy Benefit Manager.

There may be circumstances in which the formulary alternatives may not be appropriate for some members. In this case, a member may be approved for the excluded drug with an exception process. An exception is defined as a situation where the member has tried and failed (that is, had an inadequate treatment response or intolerance) to the required number of formulary alternatives; or the member has a documented clinical reason such as an adverse drug reaction or drug contraindication that prevents them from trying the formulary alternatives.

If a member's exception is approved that drug will be placed into Tier 3 or Tier 6 and the member will be subject to the applicable cost share. It is important to note that in the 80/20 Plan, Tier 3 and Tier 6 medications do not have a defined copay, but are subject to a deductible/coinsurance. Medications that are subject to coinsurance in most cases will result in higher out-of-pocket costs to members.

Exceptions Coverage Criteria

The exception coverage criteria process will determine if the excluded medication is approved or denied. Approval for coverage criteria may be different for each of the targeted therapeutic classes depending on the number of formulary alternatives that are available in that class. Below, lists **example scenarios** on how the process may work and cases where an exception request would be approved if there are one or more than one formulary alternatives available in a therapeutic class.

- If a provider feels changing the course of medication could negatively impact a member's health and therefore the exception is medically necessary.
- If the prescriber provides evidence of trial and failure of 3 formulary alternatives (generics and/or formulary brands) in a class where 3 or more alternatives are available, the request will be approved.

- If the prescriber provides evidence of trial and failure of 2 formulary alternatives (generics and/or formulary brands) in a class where 2 alternatives are available, the request will be approved.

- If the prescriber provides evidence of trial and failure of 1 formulary alternative (generic and/or formulary brands) in a class where only 1 alternative exists, the request will be approved.

In addition to trying or failing formulary alternatives, approval for an excluded drug can also exist if the prescriber provides evidence of an adverse drug reaction or drug contraindication to the formulary alternatives.

In summary, the requested drug will be covered with prior authorization when the following criteria are met:

- Member is using the requested drug for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines).

AND

- The prescribed quantity falls within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Micromedex, current accepted guidelines).

AND

- The member has tried and experienced an inadequate treatment response or has an intolerance to the required number of formulary alternatives.

OR

- The physician (or member) has a documented clinical reason for their patient experiencing any adverse drug reaction or drug contraindication to the formulary alternatives.

Follow the steps below to request an exception for a Plan member:

1. To request an exception, a member's provider should contact CVS Caremark® Customer Care at **888-321-3124**.
2. The exceptions team consists of clinicians who review the exception request, letter of medical necessity and any other relevant clinical information.

3. After the clinical review, the decision (approval or denial) is then communicated to the provider and the member by mail.
4. If the exception request is approved, the exceptions department will enter the necessary override(s). Authorization duration is defined in the specific medication policy.
5. If the exception request is denied based on clinical review, a denial letter is sent to the provider and the member. The denial letter includes directions on how to appeal the denial.

Exceptions are processed within the following time frames from the time that information is received:

- Urgent requests from the member's provider are completed typically within 24 hours. Urgent requests should also be noted as such with the exception request.
- Urgent is defined "urgent as defined by law (that is, your health is in serious jeopardy or, in the opinion of your provider, you will experience pain that cannot be adequately controlled) while you wait to receive approval of your exception."
- Non-urgent requests are completed typically within 72 hours.