

GENERAL INFORMATION

We maintain a drug list, also called a formulary, which is an extensive list of safe and effective, FDA-approved, brand name and generic prescription drugs used to treat the most common medical conditions. If your pharmacist tells you that a prescription drug is not covered by your plan and you believe it should be covered, you have the right to request a decision from us to cover that drug.

Formulary exception: A request to obtain a drug that is not on the Health Plans' formulary or a request to waive coverage restrictions such as dosage limits, quantity limits, or step therapy requirements.

HOW DO I KNOW WHAT DRUGS ARE COVERED BY MY PLAN?

The Pharmacy and Therapeutics Committee (P&T), a panel of physicians and pharmacists, develops our drug list and updates it regularly. The list includes quality drugs available to you at reasonable cost. Only those medications that have successfully passed federally required clinical testing and evaluation and have been proven effective are included.

In order to continue to offer a safe and cost effective selection of prescription drugs, the Health Plan periodically makes changes to the Drug List. These changes may include removing medications, adding restrictions, and/or covering a drug at a higher tier.

Updated formularies are posted to the website as changes are made. For a current copy of your formulary or to get updated information about covered drugs, please visit our web site at myHFHP.org or call Customer Service.

WHAT IF MY DRUG IS NOT ON THE FORMULARY?

If your drug is not included on your plan's formulary, you have three options:

- You can ask Customer Service for a list of similar drugs that are covered by the Health Plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by us.
- You can ask your physician to send us information requesting we make an exception and cover your drug.
- You can ask your physician to submit the written authorization request via the online Provider portal (if the Provider is an In-Network Provider) or via fax request (if the Provider is an Out-of-Network Provider)

WHO CAN REQUEST A FORMULARY EXCEPTION?

You, your prescribing doctor or your authorized appointed representative can ask us for a formulary exception. If you authorize a representative to act on your behalf, a copy of the signed Appointed Representative form or Power of Attorney must be on file with the health plan.

HOW TO COMPLETE A REQUEST FOR A FORMULARY EXCEPTION

A copy of our Pharmacy Authorization / Exception Request form can be obtained through the Member Portal or you may call customer service and request a paper copy of the form.

The form will need to be completed in its entirety including: rationale for the exception request, required explanation, and supporting clinical documentation.

Completed forms and supporting documentation can be faxed to:

Non-Specialty: 1-844-814-2258

Specialty: 1-844-814-2259

EXCEPTION PROCESS AND TIMEFRAMES

Standard coverage determination- Any decision made by or on behalf of the Health Plans regarding payment or benefits to which an enrollee believes he or she is entitled. The standard determination is made within 72 hours from the date a complete request is received.

Expedited coverage determination- Is a coverage determination when the Health Plan or the enrollee's physician believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. An expedited determination is made within 24 hours from the date the complete request is received. To request an expedited determination for exigent circumstances, select the "Request For Expedited Review" option in the Request For Commercial Prescription Drug Coverage Decision Form.

WHAT HAPPENS IF MY REQUEST IS ACCEPTED?

Cost-sharing for formulary exceptions

If we approve you or your physician's request for an exception to the Health Plans' formulary the approved drug will be covered at the Tier 4 (non-formulary) or Tier 5 (specialty drug) cost shares depending on the cost of the drug. For additional information on the obtaining a formulary exception, please visit our web site at myHFHP.org or call Customer Service.

Length of approval

Once an exception is granted, the Health Plan does not require the enrollee to request another exception for the duration of the prescription, or one year, whichever is less. This is including refills (or at least through the duration of urgent need for expedited requests), as long as the enrollee remains enrolled in the plan, the physician continues to prescribe the drug and it continues to be safe and effective for treating the enrollee's condition.

WHAT HAPPENS IF MY REQUEST IS DENIED?

If we deny your request, we will send you a written explanation. We may deny your request altogether or in part. For example, if we deny your request for payment for a drug you have already received; we may pay nothing or only part of the amount you requested. If a coverage decision denies any part of your request, you have the right to appeal the decision (request a Redetermination).

If you would like reconsideration of an unfavorable coverage determination, you have the right to request an appeal conducted by an Independent Review Entity (IRE) not connected to the Health Plan. We will abide by the final outcome of your IRE appeal. You have up to four months to request an external review after receiving a final adverse determination from the Health Plan.



PRESCRIPTION DRUG EXCEPTIONS

Health Plans

Underwritten by  Commercial Plans

QUESTIONS

If you have questions about your health benefit plan, there are several ways to contact us to obtain the assistance you need:

By telephone

If you have questions about your plan or need assistance in a language other than English, please contact Customer Service.

Toll-free: 1.855.443.4735

TDD/TTY: 1.800.955.8771

Our Customer Service hours are: **Monday through Friday** from 8 a.m. to 6 p.m.

Health First Health Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.