



Capital BlueCross

An Independent Licensee of the Blue Cross and Blue Shield Association



Questions & Answers

Frequently Asked Questions About Your Three-Tier Prescription Drug Benefit

What is a formulary?

A formulary is a preferred list of commonly prescribed prescription drugs, based on effectiveness, safety, quality, and cost. This list is created, reviewed, and updated by a team of practicing physicians, pharmacists, and health care professionals. A formulary contains a wide range of *Generic* and *Preferred Brand* drugs that have been approved by the U.S. Food and Drug Administration (FDA). Your physician can use this list to choose medications that can help reduce your out-of-pocket expenses.

How often is the formulary updated?

The formulary is updated on a quarterly basis. It is also updated regularly as new *Generic* and *Brand Name* medications become available and as discontinued drugs are removed from the marketplace. A new copy of the formulary is printed each year.

A ***Preferred Medication*** list is also printed on a yearly basis. This is an abbreviated version of the full formulary that lists the most commonly prescribed medications. The *preferred medication* list is provided for your reference but it is not a substitute for the formulary. You can find the *preferred medication* list on the Capital BlueCross Web site at www.capbluecross.com.

How do I know if my drugs are on the formulary?

Please use one of the following:

- Visit www.capbluecross.com or www.express-scripts.com to view the most up-to-date version of the formulary
- A feature called *Price a Drug* on the Express Scripts®, Inc. Web site
- You may also call 1-800-585-5794 to find your cost for each medication

How does the formulary work with the three-tier copayment/coinsurance?

The three-tier (or three-level) copayment/coinsurance works like this:

- Tier one covers *Generic* products—designated “G” on your *Preferred Medication* list
- Tier two covers *Preferred Brand* drugs—designated “P” on your *Preferred Medication* list
- Tier three covers Nonpreferred brand drugs—designated “NP” on your *Preferred Medication* list

With a three-tier program, *Generic* drugs will usually give you the greatest savings followed by *Preferred Brands*. Ask your physician about *Generic* and *Preferred Brand* options that may be available for your condition.

What's the difference between Brand Name and Generic drugs?

A drug's ***Brand Name*** is the name that appears in advertising and is protected by a patent. This patent only allows one company to produce this medication for a certain period of time. Once this time period has expired, a *Generic* or therapeutically equivalent, less expensive drug may then be distributed under a different name.

A ***Generic*** drug is a chemically equivalent, lower-cost version of a *Brand Name* drug. While the color and shape may be different from the *Brand Name* drug, the active ingredients are the same. *Generic* drugs have been rigorously tested by the FDA and approved as safe and effective. *Generic* drugs usually cost much less than *Brand Name* drugs, which in turn helps everyone to keep health care affordable.

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On behalf of Capital BlueCross, Express Scripts® assists in the administration of our prescription drug program. Express Scripts is an independent pharmacy benefit manager.



What's the difference between a Preferred Brand drug and a Nonpreferred Brand drug?

A **Preferred Brand** is a medication that has been reviewed and approved by a group of doctors, pharmacists, and health care professionals. It is designated "**Preferred Brand**" because it has been proven to be safe, effective, and favorably priced compared to other **Brand** drugs that treat the same condition. A **Nonpreferred Brand** is a medication that has also been reviewed by the same team of doctors, pharmacists, and health care professionals. However, these drugs are listed as **Nonpreferred** because they do not have any advantage over available **Generics**, **Preferred Brands** or over-the-counter drugs. Please note that these decisions may change as new information becomes available.

Do I have to use Generics?

The guidelines of your particular benefit plan will dictate whether or not you must use generic drugs. **Capital BlueCross offers the following two generic substitution programs:**

Mandatory Generic Substitution Policy—When a **Generic** is available, it must be substituted for a **Brand Name** product. If a **Generic** is available and is not substituted, you will be responsible for paying the **Brand Name** copayment or coinsurance in addition to the cost difference between the **Generic** and **Brand Name** medications.

Restrictive Generic Policy—If your *physician* specifies a **Brand Name** drug is required by indicating "No **Generic** Substitution Permissible" on your prescription, you will only be charged the **Brand Name** copayment or coinsurance. However, if you request that the **Brand Name** drug be dispensed when a **Generic** equivalent is available, you will be charged the **Brand Name** copayment or coinsurance as well as the additional cost difference between the **Generic** and **Brand Name** medication.

What does the symbol QL in the formulary mean?

Medications that have the symbol QL next to them in the formulary have a **quantity limit**. Quantity limits are part of the Capital BlueCross Drug Quantity Management program (DQM) and are consistent with dosage guidelines approved by the FDA and/or current medical literature. These limits are defined as a specific quantity of medication to be dispensed over a specified period of time or per prescription. Certain high-risk and/or high-cost medications have been identified and included in the DQM program based on multiple factors including safety, effectiveness, and/or cost.

What does the symbol PAR in the formulary mean?

Medications that have the symbol PAR next to them in the formulary require **prior authorization** before you can obtain them as a covered benefit. Specific medical necessity criteria has been developed based on, but not limited to, review of medical literature, FDA recommendations, and manufacturer recommendations. Specific policies are developed with input from practicing pharmacists and physicians. Copies of these policies are available upon request and will be supplied to you at no cost.

The list of medications requiring *prior authorization* is subject to change. For the most current list of drugs requiring *prior authorization*, please log on to www.capbluecross.com. You may also contact Customer Service at 1-800-585-5794 or log onto www.express-scripts.com for additional information.



How can I get a prior authorization?

Your physician or pharmacist needs to provide medical information to the pharmacy benefit manager (PBM). This can be done by calling or faxing the request with supporting clinical information to:

**Express Scripts, Inc.
Prior Authorization Department**

Phone: 1-800-417-8164 Fax: 1-800-357-9577