

Prescription drug guidelines

Our prescription drug plans are administered by FutureScripts®, an independent pharmacy benefits management company who is responsible for providing a network of participating pharmacies, administering benefits, conducting prior authorization reviews, and providing customer service.

When using your prescription drug plan, it's important to know how to find out what's covered by your plan and whether there are any guidelines that apply to those drugs. Our prescription drug plans are designed to provide you with safe and affordable access to covered medications. This document will explain the prior authorization process, age and quantity limits, and a number of other ways we support the safe prescription of covered medications.

**Please note that this document is applicable to the Standard Formulary, Select Drug Formulary, and Value Formulary.

Formulary

The formulary is a list of drugs covered by your prescription drug plan. If you're not yet a member, you can visit ibx.com/rx to view the formulary guides or searchable tools. You can also call [1-888-678-7012](tel:1-888-678-7012) to find out if a drug is included in your plan's formulary. As a member, you can visit ibxpress.com to find drugs on the formulary and view and manage your prescription drug plan. The pharmacy tools and services available will help you to better understand your prescription drug coverage so you can take full advantage of the cost-saving options available to you.*

Visit ibxpress.com to:

- Review your prescription records — what you spent, and when and where your prescriptions were filled
- Locate a network retail pharmacy near you
- Review your coverage and cost-sharing information
- Price a specific drug and compare savings with a generic equivalent
- Access formulary information
- Check on drug-to-drug interactions

To see the formulary status of a drug, or to find out if the drug requires prior authorization, please refer to the formulary guide or searchable tool which can be found on your plan's website ibx.com/rx. You can also call FutureScripts at the number on the back of your ID card if you want to find out whether a drug is included in your formulary.

What you need to know

- How to find out what prescription drugs are covered by your plan
- You may need additional approval from your health plan before you receive prescription drugs
- Age limits apply to some prescription drugs
- Quantity limits apply to some prescription drugs
- Your doctor may request coverage for medications that are not covered by your plan
- You have a right to appeal a coverage decision you disagree with
- How we work with FutureScripts

Prior Authorization

Prior authorization is a requirement that your doctors obtain approval from your health plan for coverage of, or payment for, your medication. Independence requires prior authorization of certain covered drugs to confirm that the drug prescribed is medically necessary and appropriate and is being prescribed according to Food and Drug Administration (FDA) guidelines. Some examples of drugs that require a prior authorization are drugs to treat conditions like hemophilia, cancer, and hepatitis C. The approval criteria were developed and approved by the Pharmacy and Therapeutics Committee, a group of doctors and pharmacists from the area.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by your prescribing doctor, and your available prescription drug therapy history. Their evaluation may include a review of potential drug-drug interactions or contraindications, appropriate dosing and length of therapy, and utilization of other drug therapies, if necessary.

Without prior authorization, your prescription will not be covered at the retail or mail-order pharmacy. The prior authorization process may take up to two business days once complete information from the prescribing doctor has been received. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the doctor wants you to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

Age Limits

The FDA has established specific procedures that govern prescription prescribing practices. These rules are designed to prevent potential harm to patients and to confirm that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals age five and older, such as Zafirlukast (generic for Accolate). The pharmacist's computer provides up-to-date information about FDA rules. If your prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. In addition, an age limit may be applied when certain drugs are more likely to be used in certain age groups. For example, agents to treat Alzheimer's may require prior authorization for use in young adults. The prescribing doctor may request consideration for prior authorization of restricted medications when medically necessary. The approval criteria for this review were developed and approved by the Pharmacy and Therapeutics Committee. Contact your doctor to initiate the prior authorization process. To determine if a covered prescription drug prescribed for you has an age limit, visit your plan's website at ibx.com/rx or call FutureScripts at the number on the back of your ID card.

Quantity limits

Quantity level limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses, standard dosing, and/or length of therapy. We have several different types of quantity level limits that are explained in detail below. The purpose of these limits is to ensure safe and appropriate utilization. If you require more than the limit, your doctor will need to submit a prior authorization request. Note: If applicable, quantity limits will apply if a formulary exception is approved allowing coverage of a non-formulary drug.

Quantity Over Time. This quantity limit is based on dosing guidelines over a rolling time period. For example, if a drug has a quantity limit over a 30-day time period and you went to the pharmacy on January 1, 2018, for one of these medications, the computer system would have looked back 30 days to December 2, 2017, to see how much medication was dispensed. Examples of quantity limits over time are:

- Nuvaring® = 1 ring per 28 days
- Ibandronate 150 mg (generic for Boniva®) = 1 tablet per 30 days
- Naratriptan (generic for Amerge®) = nine 2.5 mg tablets per 30 days, Sumatriptan (generic for Imitrex®) = eighteen 50 mg tablets per 30 days
- Diabetic supplies such as blood glucose test strips = 200 strips per 30 days and lancets = 200 lancets per 30 days.

Maximum daily dose. This quantity limit is based on maximum number of units of the drug allowed per day. For example, if you went to a pharmacy for one of these medications, the computer system will ensure that the amount of medication being requested per day does not exceed the maximum daily dose. Examples of maximum daily dose quantity limits are:

- sedative hypnotic drugs, such as zaleplon (generic for Sonata®) = 1 capsule per day) and zolpidem (generic for Ambien®) = 1 tablet per day
- oral narcotic drugs, such as OxyContin® = 3 tablets per day, oxycodone/acetaminophen (generic for Percocet®) = 6 tablets per day
- proton pump inhibitor drugs, such as esomeprazole (generic for Nexium®) = 2 capsules per day and pantoprazole (generic for Protonix®) = 2 tablets per day

Refill too soon. This limit is in place to encourage appropriate utilization and minimize stockpiling of prescription medications. Based on this edit, you are able to receive a refill of a prescription after 75% utilization. However, if the same prescription is refilled every month at the 75% utilization point, an excess supply will be accumulated. The plan will "look back" over a period of 180 days and calculate the total day supply that has been dispensed.

Day Supply Limit. This limit is based on the day supply and not the quantity. However, quantity limits may apply as well. Day Supply Limits apply to some classes of drugs, such as narcotics. If a quantity limit applies, you will be limited to the maximum daily dose for that drug. The following are examples of drugs that have a day supply and a quantity limit:

- Headache agents, such as butalbital/aspirin or narcotics, such as oxycodone tablets
 - Day supply limit = 5-day supply per 30 days
 - Quantity Limit = 6 per 1 day
 - Maximum quantity allowed without prior authorization = 30 (6 per day x 5 days)
- Cough and cold products, such as hydrocodone/homatropine
 - Day supply limit = 5-day supply per 30 days
 - Quantity Limit = 30 ml per 1 day
 - Maximum quantity allowed without prior authorization = 150 ml (30 ml per day x 5 days)

If your doctor wants to prescribe you a medication therapy that exceeds any of the utilization limits described above, your doctor must request a quantity limit override. You are required to contact the prescribing doctor to initiate the request.

If the exception for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If your doctor wants you to continue the drug therapy as requested after the expiration date, a new request for a prior authorization needs to be submitted and approved in order for coverage to continue.

To determine if a covered prescription drug prescribed for you has a quantity limit or requires prior authorization, call FutureScripts at the phone number on the back of your ID card or see the plan website at ibx.com/rx.

96-hour Temporary Supply Program

The 96-hour Temporary Supply Program applies to certain drugs that require prior authorization.

If your doctor writes a prescription for a drug that requires prior authorization, and prior authorization/preapproval has not been obtained by the doctor, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to you with either no out-of-pocket copay or the appropriate percentage cost-sharing as defined by your benefit.
2. By the next business day, FutureScripts will contact your doctor to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by FutureScripts, the review will be completed and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled and the appropriate prescription drug out-of-pocket cost-sharing will be applied.
5. If denied, notification will be sent to you and your doctor.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/preapproval request will be approved. Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations such as Retin-A® (tube), Enbrel® (two-week injection kit), and erectile dysfunction drugs, and non-formulary drugs.

The process for requesting a prior authorization/preapproval is as follows:

- Your doctor must complete a prior authorization form or write a letter of medical necessity and submit it to FutureScripts by fax at **1-888-671-5285**. The forms are available online at: https://www.futurescripts.com/FutureScripts/for_health_care_professionals/prior_authorization/index.html
The form must be completed and submitted by your doctor.
- FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.
- If approved, the prescribing doctor will be notified of approval via fax or telephone and the claims system will be coded with the approval.
- You may call the Customer Service phone number on your ID card to determine if the prescription is approved.
- If denied, the prescribing doctor will be notified via letter, fax, or telephone.
- You are also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to you and your doctor.

Coverage for medications not on the formulary (specific to Value Formulary members only)

Doctors may request formulary coverage of a non-formulary medication when there has been a trial of at least three formulary alternatives or there are contraindications to using the formulary alternatives. Your doctor should complete a non-formulary exception request form providing details to support use of the non-formulary medication and should fax the request to **1-888-671-5285**. If the non-formulary request is approved, the drug will be paid at the highest applicable cost share. Safety edits like quantity limits will still apply. If the request is denied, you and your doctor will receive a denial letter with the appropriate appeals language.

Appealing a decision

If a request for prior authorization/preapproval or exception results in a denial, you, or your doctor on your behalf (with your consent), may file an appeal. Both you and your doctor will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that you keep your doctor involved to provide any additional information on the basis of the appeal.

Prescription Drug Program provider payment information

FutureScripts administers our prescription drug benefits and is responsible for providing a network of participating pharmacies and processing pharmacy claims. FutureScripts also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. Independence may incorporate certain savings resulting from rebates into reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member copayment.

FutureScripts is an independent company providing pharmacy benefits management services for Independence Blue Cross. Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.



Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: सूचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deutsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh. Hódííłnih koji' 1-800-275-2583.

Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.