Clarivate™

Fingertip Formulary Plan

Definitions

Fingertip Formulary Plan Provider Definitions

Plan –plans are the formularies within our database, the names are derived from the health plan provider nomen- clature

Payer –payers are the managed care organizations (e.g. Anthem, BCBS Massachusetts) responsible for the mem- ber benefits

Parent –the business entity that owns the provider organization (e.g. Wellpoint is the parent of Anthem, Cigna is the parent of Healthspring)

PBM –Pharmacy Benefits Manager –this is the company a provider contracts with to handle various functions related to pharmacy benefits: claims processing, formulary development, mail order and specialty vendors

Fingertip Formulary Plan Type Definitions

Commercial – these plans represent those offered by the broad group of Commercial insurers (excluding Blue Cross Blue Shield plans, which are included in the Commercial BCBS plan type).

EGWP (Employee Group Waiver Plan) – these plans represent the formularies offered by employers to their Medi- care-eligible retirees and covered medicare-eligible dependents; these are PDPs.

Employer – these plans represent those offered by the Employer as an insurer and include state and local govern- ment employees.

FED PROG (Federal Program) – These plans are prescription benefits offered under the Department of Defense to Army Base, Naval Base, Air Force Base etc members.

FEHBP (Federal Employee Health Benefit Program) – Healthcare and Prescription programs/coverage offered to employees, spouses and retirees of certain Federal Agencies and Organizations.

HIX – these plans represent those for the State Health Exchanges. Each metal type is a sub-type of HIX (platinum, gold, silver, bronze).

Managed Medicaid – these plans represent those offered by managed Medicaid insurers.

Medi-Medi – these plans represent the formularies that are part of the CMS demonstration programs; they apply to members currently receiving both Medicare and Medicaid benefits.

Medicare MA/PDP/SN – these plans represent those offered by the various Medicare insurers (MA = Medicare Advantage, PDP = Prescription Drug Plan, SN = Special Needs).

Municipal – these plans represent those offered by federal, state and local governments.

PACE (Program for All inclusive Care for the Elderly) – Members of PACE program have to be 65 yrs or older, reside in a PACE program service area, be evaluated and determined to be eligible for nursing home care BUT still be able to live independently at home in their community. The program takes care and coordinates all their healthcare needs including medications.

PBM – these plans represent the template formularies offered by the Pharmacy Benefit Managers to their clients.

PVT HIX (Private HIX) – These Private HealthCare Exchange Programs are basically HIX plans but that are contract- ed by private companies.

State Medicaid – these plans represent those offered by the states for the FFS (Fee-For-Service) Medicaid populations.

Union – these plans represent those offered by the unions to their members.

Fingertip Formulary Plan Pharmacy Benefit Tier Status Definitions

Tier - Description

1. This drug is available at the lowest co-pay. Most commonly, these are generic drugs.
2. This drug is available at a middle level co-pay. Most commonly, these are "preferred" (on formulary) brand drugs. For this standard benefit design, drugs at this level are frequently considered to have a lowest brand- ed copay (LBC).
3. Preferred –This drug is available at a preferred co-pay. Most commonly used when tiers 1 and 2 apply to preferred generic and non-preferred generic drugs, respectively. For this benefit design, drugs at this level are frequently considered to have a lowest branded copay (LBC).
4. This drug is available at a higher level co-pay. Most commonly, these are "non-preferred" brand drugs.
5. This drug is available at a higher level co-pay. Most commonly, these are "non-preferred" brand drugs or specialty prescription products.
6. This drug is available at a higher level co-pay. Most commonly, these are "non-preferred" brand drugs or specialty prescription products.
7. This drug is available at a higher level co-pay. Most commonly, these are "non-preferred" brand drugs or specialty prescription products.

NC –Not Covered. Drugs that are not covered by the plan.

N/A –Not Available. Formulary data for this drug/health plan are not available.

Note: Individual plans may vary and formulary information changes. You are encouraged to contact the prescription drug benefit provider for the most current formulary information.

Fingertip Formulary Plan Pharmacy Benefit Restrictions Definitions

Restriction Code - Description

PA –Prior Authorization. Drugs that require prior authorization. This restriction requires that specific clinical criteria be met prior to the approval of the prescription.

QL –Quantity Limits. Drugs that have quantity limits associated with each prescription. This restriction typically limits the quantity of drug that will be covered.

ST –Step Therapy. Drugs that have step therapy associated with each prescription. This restriction typically re- quires that certain criteria be met prior to approval for the prescription.

Note: Individual plans may vary and formulary information changes. You are encouraged to contact the prescription drug benefit provider for the most current formulary information.

Fingertip Formulary Plan PBM Function Definitions

Claims Processing – The entity that controls the claims adjudication process for a payer.

Formulary Management – The entity that controls provision of the formulary for a payer. This entity controls the Pharmacy Committee that defines the medications contained in the formulary. It can be a payer or PBM.

Mail Order Provider – The entity(ies) that a member must use to receive their pharmacy benefit via mail order. There is often a cost-savings associated with use of these entities.

Retail Management – The entity controlling prescription management in the retail setting.

Fingertip Formulary Plan Status Definitions

Preferred – The status assigned to a drug based on the benefit design of the chosen formulary. This status is usual- ly associated with the lowest tier for a brand or generic drug; or is a designation given to a drug following review by a Pharmacy Committee. This status includes drugs listed on a Preferred Drug List for Medicaid plans.

Covered – (Medicaid population) The status given to a drug that is not reviewed for inclusion to the Preferred Drug List (formulary), but is being covered by the state. These drugs may be managed with other restrictions.

Non-Preferred – The status assigned to a drug based on the benefit design of the chosen formulary. This status is usually associated with the highest tier for a brand or generic drug; or is a designation given to a drug following review by a Pharmacy Committee. This status also includes drugs listed as Off-PDL for Medicaid plans.

Specialty – The status given to a specialty product when it is covered with a copay/co-insurance dedicated to spe- cialty drugs. Specialty drugs are usually injectable, require special handling, or are expensive.

Not Covered – The status given to a drug that is listed as Not Covered by a particular payer or employer. Please note that this status is slightly different than a Tier Status of Not Covered, as Managed Medicaid Plans that list a drug as NC (PA) fall under the "Non-Preferred" status.

Excluded – The status given to a drug that has been excluded from coverage by a particular payer or employer.

Medical Status Definitions

Preferred – The status assigned to a drug based on the benefit design of the chosen plan. This status is a designa- tion given to a drug following review by the medical department or committee.

Covered – The status given to a drug being covered under the medical benefit, when additional preference is not designated by theplan.

Non-Preferred – The status assigned to a drug based on the benefit design of the chosen plan. This status is a designation given to a drug following review by the medical department or committee.

Fingertip Formulary Copay/Coinsurance Methodology

The copay/coinsurance information in Fingertip is researched at the formulary level and is not drug specific. The appropriate copay/coinsurance will display according to the drug's designated tier. Each tier is representative of a given drug status and is driven by the benefit design of the formulary. The benefit design for a given for- mulary is dictated by where a brand is considered preferred. Outside of that tier, any brand would generally be considered not-preferred, or not covered. The vast majority of formularies are designed to have specific tier(s) for a generic, brand, non-preferred brand, specialty drug, etc. The copay/coinsurance that displays for that a tier is representative of all drugs.

Have a Question?

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