Pharmaceutical Management

Community Plans

2025

McLaren HEALTH PLAN COMMUNITY

Customer Service: 888-327-0671 (TTY: 711)

Pharmacy Administration: 810-244-1660

McLarenHealthPlan.org

Introduction

Pharmaceutical management promotes the use of the most clinically appropriate, safe and cost-effective medications. McLaren Health Plan (MHP) works together with a Pharmacy Benefits Manager to administer drug formularies that fit industry standards and meet all required regulations. MHP offers one Community drug formulary which includes one or more medications in each therapeutic class covered under a member's pharmacy benefit:

- On/Off Marketplace Drug Formulary: Used by Individuals and Families

In addition to the full drug formulary, MHP created a Quick Formulary Guide for the Community formulary. The guide lists commonly prescribed medications that are covered by MHP. The guide is sorted by drug class and is included in new member packets. The guide is also on our website at McLarenHealthPlan.org or you can get a copy by calling MedImpact at 888-274-9689.

Prescription Drug Coverage

If a member has pharmacy coverage it will be described in either a Drug Rider or in the member's Certificate of Coverage and Schedule of Copayments and Deductibles. All individual members have MHP pharmacy coverage.If the member has prescription drug coverage it is described in the benefit information he or she received in the MHP new member packet. Please contact MedImpact at 888-274-9689 for prescription drug coverage-related questions.

G-3245 Beecher Road • Flint, Michigan • 48532
tel 888-327-0671 • fax 833-540-8648
McLarenHealthPlan.org

Covered Benefits

- Federal legend drugs identified on a MHP Community Drug Formulary
- Select over-the-counter (OTC) items, identified on the drug formulary, prescribed by a prescribing provider
- Diabetic supplies limited to needles, syringes, lancets and diabetic test strips*

*MHP has a preferred manufacturer of diabetic test strips.

Non-Covered Benefits

- Cosmetic medications or medications prescribed for cosmetic purposes
- Medications used for investigational or unproven uses
- Medical foods or agents that are not regulated by the Food and Drug Administration
- OTC medications not listed on the drug formulary
- Vaccines

In addition, the drug benefit does not reimburse for drug products acquired for or administered at an inpatient hospital, outpatient hospital, emergency room/clinic, or a physician's office/clinic.

Medication Copayment Tiers

Pharmacy copayments are determined based on the member-specific MHP plan and by the placement of medications into copayment levels, also known as Tiers, on the drug formulary. The MHP Community formularies have the following tiers:

- Tier 1/Formulary Generic: Formulary preferred generic medications, lowest copay
- Tier 2/Formulary Brand Name: Formulary preferred brand name medications, medium copay
- Tier 3/Non-Preferred Brand Name or Generic: Brand name and generic medications which have been designated as non-preferred, highest copay
- Preventive: Zero copay
- Specialty

G-3245 Beecher Road • Flint, Michigan • 48532
tel 888-327-0671 • fax 833-540-8648
McLarenHealthPlan.org

Dispense as Written (DAW) and Generic Mandate Policy

There is automatic generic substitution required on all prescriptions covered by MHP.

If a prescribing provider requests a brand name when a generic version is available (DAW-1), reimbursement to the pharmacy will be at the established Maximum Allowable Cost (MAC) limits. The member will be charged the difference in price between the brand name product and the generic product, plus any applicable copay, unless a prior authorization request (see page 7), has been approved by the health plan.

If a member requests a brand name medication when a generic version is available, DAW-2 designated on the prescription, reimbursement will be at the established MAC limit. The member will be responsible for the difference in price between the brand name product and the generic product, plus any applicable copay.

If a pharmacy is out of stock of a generic medication and chooses to dispense the brand name product, reimbursement to the pharmacy will be at the MAC limit. The member has the option of obtaining the generic drug, covered in full, at another pharmacy within MHP's pharmacy network.

Step Therapy Edits

Step Therapy (ST) Edits allow MHP to define a logical sequence of therapeutic alternatives. MHP provides coverage for medications indicated with ***ST*** (Step Therapy restricted) after a predetermined previous, or concurrent drug therapy sequence has been met.

Prior Authorization/Drug Exception Request

MHP has placed a Prior Authorization (PA) restriction on certain medications within the drug formularies. PA means the medication requires special approval before it will be considered for coverage under MHP. A medication may require a PA due to safety concerns or to ensure a more cost-effective formulary alternative cannot be used.

G-3245 Beecher Road • Flint, Michigan • 48532
tel 888-327-0671 • fax 833-540-8648
McLarenHealthPlan.org

If a prescribing provider feels a medication that requires a PA is medically necessary, then a prior authorization form, found on page 7, should be completed by the prescribing provider and faxed to the number indicated on the form. Please contact MedImpact at 888-274-9689, if you have questions regarding the PA process or the status of a PA request.

Note: If the member needs an emergency supply of a medication that requires prior authorization, please contact Customer Service at 888-327-0671 for assistance.

Compounded Medications

All compounded medications require PA. Upon approval, the medication must be obtained at an in-network compounding pharmacy. Paper claims submitted by an out-of-network compounding pharmacy will not be accepted.

Mail Order Pharmacy

MHP has contracted mail order pharmacies. Our members can fill up to a 90-day supply of **brand name** medications through mail order after a 30-day trial has been completed. Mail order brochures are available on our website or by calling Customer Service.

Specialty Pharmacy Medications

Medications on a drug formulary identified with a Specialty Pharmacy (SP) restriction must be obtained through an MHP approved specialty pharmacy. The specialty pharmacy will mail the specialty pharmacy medication to the member's home or to the prescribing provider's office. All specialty pharmacy medications are limited to a maximum 30-day supply. Medications used to treat cancer, endometriosis, hepatitis C, multiple sclerosis, osteoporosis and rheumatoid arthritis are **some** examples of specialty pharmacy required agents.

G-3245 Beecher Road • Flint, Michigan • 48532
tel 888-327-0671 • fax 833-540-8648
McLarenHealthPlan.org

Dose Optimization and Quantity Limits

Quantity limits (QL) are used to ensure patient safety, increase patient compliance and decrease pharmacy costs. Medications with quantity limits are identified on a drug formulary with a QL restriction. The health plan may limit the quantity of a medication to:

- a specified quantity per day, month or year
- a specified quantity per lifetime
- a specified quantity across a drug class

Note: If a prescribing provider feels a different quantity is medically necessary for a patient, a request for PA (see page 7) should be submitted to the health plan for review.

Drug Formulary Review and Modification

A committee of health professionals (doctors, pharmacists and nurses) meets throughout the year and maintains the MHP Community drug formularies. The following changes have an impact on the Community drug formularies:

- drug recalls
- marketplace withdrawals/product discontinuation
- new generic availability
- new medication releases

Prescribing providers may ask for a modification to any drug formulary by contacting our Pharmacy Administration Department at 810-244-1660, or by faxing a written request to 810-600-7929. Requests for formulary modification will be reviewed by our Pharmacy Administration Department and taken to the Quality, Safety, and Service Improvement Committee (QSSIC) for determination.

MedImpact

McLaren HEALTH PLAN

Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Attn: Prior Authorization Department
10181 Scripps Gateway Court
San Diego, CA 92131
Phone: 1-800-788-2949
Fax: 858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a formulary drug requiring prior authorization (PA), a non-formulary drug for which there is no suitable alternative available, or any overrides of pharmacy management procedures such as step therapy, quantity limit or other edits. Please complete this form and fax to MedImpact Healthcare Systems, Inc. at (858) 790-7100 or please call (800) 788-2949 with this information. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

Review Criteria:
The following criteria are used in reviewing medication requests:
1. The use of Formulary Drug Products is contraindicated in the patient.
2. The patient has failed an appropriate trial of Formulary or related agents.
3. The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.

☐ **REQUEST FOR EXPEDITED (URGENT) REVIEW:** BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Medication Request Information (please complete each section of this form prior to transmittal): *Denotes Required Fields

PATIENT INFORMATION			PHYSICIAN INFORMATION	
*Name:			*Name:	
*ID#:			*Specialty:	
*Date of Birth:	*Height:	*Weight:	ID# / DEA#:	
*Health Plan:			*Phone: (-	*Fax: ( ) -
*Diagnosis (ICD-10 Code, if known):				
REQUESTED DRUG INFORMATION			**PHARMACY INFORMATION**	
*Requested Drug:			Name:	
Dose:	Strength:		Phone: ( ) -	Fax: ( ) -
Quantity: (per month)	Dosage Form: (Oral, Injection, etc)		Length of Treatment: (Please be specific.)	
Reason for Medication Request (Please be specific, give detail.):				
Other Medications Tried and/or Failed (Please be specific, give detail.):				
Other Pertinent History (Relative or pertaining to this request.):				

Revised: 10/18

MHPC42723006