

**PLEASE READ:** THIS DOCUMENT  
CONTAINS INFORMATION ABOUT THE  
DRUGS WE COVER IN THIS PLAN.

WHA Care+ HMO



## 2010 Comprehensive Formulary

(LIST OF COVERED DRUGS)

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Western  
Health  
Advantage



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## What is the WHA Care+ HMO Comprehensive Formulary?

A formulary is a list of covered drugs selected by WHA Care+ HMO in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. WHA Care+ HMO will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a WHA Care+ HMO network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

## Can the Formulary change?

Generally, if you are taking a drug on our 2010 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2010 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2010. To get updated information about the drugs covered by WHA Care+ HMO, please visit our website at [www.westernhealth.com/careplus](http://www.westernhealth.com/careplus) or call Member Services at 916-563-2250 or 1-888-563-2250 toll-free, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY/TDD users should call 1-888-877-5378.

## How do I use the Formulary?

There are two ways to find your drug within the formulary:

### **Medical Condition**

The formulary begins on Page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Heart: Hypertension and Lipids". If you know what your drug is used for, look for

the category name in the list that begins on Page 1. Then look under the category name for your drug.

### **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page I-1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

### **What are generic drugs?**

WHA Care+ HMO covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

### **Are there any restrictions on my coverage?**

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** WHA Care+ HMO requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from WHA Care+ HMO before you fill your prescriptions. If you don't get approval, WHA Care+ HMO may not cover the drug.
- **Quantity Limits:** For certain drugs, WHA Care+ HMO limits the amount of the drug that our plan will cover. For example, WHA Care+ HMO provides two (2) inhalers per prescription for Albuterol. This is considered a standard one-month supply.
- **Step Therapy:** In some cases, WHA Care+ HMO requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, WHA Care+ HMO may not cover Drug B unless you try Drug A first. If Drug A does not work for you, WHA Care+ HMO will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on Page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at [www.westernhealth.com/careplus/](http://www.westernhealth.com/careplus/).

You can ask WHA Care+ HMO to make an exception to these restrictions or limits. See the section, "How do I request an exception to the WHA Care+ HMO formulary?" on Page iii for information about how to request an exception.

## What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Member Services and confirm that your drug is not covered. If you learn that WHA Care+ HMO does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by WHA Care+ HMO. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by WHA Care+ HMO.
- You can ask WHA Care+ HMO to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the WHA Care+ HMO Formulary?

You can ask WHA Care+ HMO to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, WHA Care+ HMO limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty tier.

Generally, WHA Care+ HMO will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception, you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

## What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 34-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 34-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 34-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 34-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

A *level of care change* is a change in treatment setting; e.g., a change from acute to subacute setting, or home to nursing home setting. Enrollees that experience a level of care change *within* the first 90 days of enrollment in the plan will be able to receive a transition supply upon request at the point of sale.

Enrollees that experience a level of care change *after* the first 90 days of enrollment in the plan will be able to receive a transition supply upon request by contacting Medco as follows:

- Claims for medications that are *non-formulary* or that require *prior authorization* will initially reject at point of sale with a message that indicates a transition supply may be available. The patient, physician or pharmacist will be directed to contact Medco to request a transition supply. Upon receipt of a request for a transition supply, the requestor will be asked if the patient *has experienced a level of care change*. If the requestor indicates that the enrollee has experienced a level of care change, a transition supply of up to 34 days of medication will be authorized. The enrollee will be able to fill the transition supply at the retail pharmacy. Medco will initiate a prior authorization or exception for the medication with the prescribing physician.

- The patient will be mailed a letter within three (3) business days of the temporary fill, which will include an explanation of the temporary nature of the transition supply an enrollee has received; instructions for working with the plan sponsor and the enrollee's prescriber to identify appropriate therapeutic alternatives that are on the plan's formulary; an explanation of the enrollee's right to request a formulary exception; and a description of the procedures for requesting a formulary exception.

NOTE: In situations where the enrollee has not experienced a change in level of care, a temporary supply will not be provided. The request will be treated as a regular non-formulary or prior authorization request. This means that Medco will contact the physician to initiate a prior authorization or exception with the prescribing physician. Once the information is received from the physician, the patient and physician will receive letters indicating the outcome of the prior authorization or exception request.

### For more information

For more detailed information about your WHA Care+ HMO prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about WHA Care+ HMO, please call our Member Services Department at 916-563-2250 or 1-888-563-2250, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY/TDD users should call 1-888-877-5378. Or visit [www.westernhealth.com/careplus/](http://www.westernhealth.com/careplus/).

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit [www.medicare.gov](http://www.medicare.gov).

WHA Care+ is a Medicare-approved HMO Plan.

## WHA Care+ HMO Formulary

The formulary that begins on Page 1 provides coverage information about some of the drugs covered by WHA Care+ HMO. If you have trouble finding your drug in the list, turn to the Index that begins on Page I-1.

The first column of the chart lists the drug tier. A description of covered drug tiers follows:

- Tier 1 – Generic drugs
- Tier 2 – Preferred Brand drugs
- Tier 3 – Non-Preferred Brand drugs
- Tier 4 – Injectable and Specialty drugs

The second column lists the drug name. Brand-name drugs are capitalized (e.g., AZOPT) and generic drugs are listed in lower-case italics (e.g., *miostat*).

The third column describes how the drug is administered.

The information in the last three columns tells you if WHA Care+ HMO has any special requirements for coverage of your drug. These special requirements include:

**PA = Prior Authorization:** Requires approval from WHA Care+ HMO before you fill your prescriptions.

**ST = Step Therapy:** Requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

**QL = Quantity Limits:** WHA Care+ HMO limits the amount of certain drugs that the WHA Care+ HMO Plan will cover.

See the section “Are there any other restrictions on my coverage?” for additional details about these special requirements.

## Limited Pharmacy Access Drugs with Special Handling Requirements

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether they're administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. These limited pharmacy access drugs can be obtained through Accredo, Medco's specialty pharmacy.

Accredo deals exclusively with providing medications to treat complex conditions. The quality services of Accredo include:

- Toll-free access to specially trained pharmacists 24 hours a day, 7 days a week
- Personalized counseling from our dedicated team of registered nurses and pharmacists
- Expedited, scheduled delivery of your medications at no additional charge
- Refill reminders
- Necessary supplies, such as needles and syringes, provided with your medications

For more information, call the Accredo Specialty Pharmacy at 1-800-501-7260.

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**For any Medicare Advantage inquiries:**

Member Services Representatives are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. An interactive voice response system is available from 5:00 p.m. to 8:00 p.m., Monday through Friday, and from 8:00 a.m. to 8:00 p.m., weekends and holidays.

**For Part D prescription drug benefit inquiries:**

Member Services Representatives are available from 8:00 a.m. to 8:00 p.m., 7 days a week.

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Suite 100  
Sacramento, CA 95833

888.877.5378 tty

916.563.2250 local

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