

## State of Connecticut

### Active Employee Prescription Benefit Q & A

**October 1, 2009**

Q. Our new prescription plan includes "mandatory generic substitution". Is that really new, and what does it mean?

A. Our plan has always required mandatory generic substitution. What that means is that when a member is prescribed a brand-name drug which is also available as a generic (just like Motrin or Advil can also be purchased as "Ibuprophen", the member is automatically provided the generic version and pays the generic co-pay (\$5). If the member - without the participation of his/her doctor - insists on receiving the brand name instead, the member pays the generic co-pay, but also pays the difference in costs between the generic drug and the brand name - which is usually quite expensive. The theory behind this is that the only party benefiting from the member getting the brand name, rather than the generic, is usually the pharmaceutical company.

Q. Can you give me an example?

A. Let's say without your doctor saying there's a medical reason, you decide to insist on a brand name drug that costs \$100 per prescription, instead of its generic equivalent which costs \$20. If you take the generic, you pay \$5, but if you take the brand name drug, then add the additional \$80 for the difference in costs (\$100-\$20), for a total of \$85

Q. But hasn't there been some change in this rule with the new plan?

A. The rule hasn't changed. But the process for carrying out the rule when your doctor believes the brand name is medically better for you has changed. Under the old plan, if your doctor thought that there was a medical reason that you needed the brand name drug rather than its generic equivalent, he or she would right "DAW" or "Dispense as Written" on the prescription. Then you would receive the brand name version and pay the brand name co-pay, but not the difference in costs between the brand name and the generic. Now the doctor fills out a separate "medical necessity" form from Caremark to produce the same result.

Q. Has there been any other change in our plan?

A. Yes, our previous "2-Tier" plan has been replaced by a "3-Tier" plan. This involves two different changes. First, the co-pay for generic drugs has been increased from \$3 to \$5. Second, the co-pay for most but not all brand name drugs has been increased from \$6 to \$10. Finally, a smaller group of brand-name drugs has been placed on a third or "non-preferred" tier, and these brands have a \$25 co-pay. No drug can be placed on that tier unless it has been determined by a clinical review process that a clinically equivalent or superior alternative is available as a generic (\$5 co-pay) or preferred brand (\$10). Remember, however, that the mandatory generic substitution rule is the same regardless of what tier the brand-name drug is placed on. Members who choose a brand name when there is a generic equivalent available will always pay the generic co-pay (\$5) plus the difference in costs between the generic and the brand name, unless their doctor fills out the medical necessity form.

Q. I am taking a \$25 co-pay brand name drug that is "non-preferred" but my doctor wants me to continue taking it and not another drug. Can I appeal the \$25 co-pay and only pay \$10?

A. The 2009 SEBAC Agreement states that a \$25 co-pay non-preferred brand name drug shall be available with a \$10 co-pay based upon medical necessity as certified by your doctor. If your doctor believes that continuing to take your non-preferred brand name drug is medically necessary, he or she should contact Caremark at 800-952-9684 to request a medical necessity form.

Q. Why does my doctor have to call the 800 number to get the medical necessity form? Why can't I get a form and give it to the doctor?

A. When your doctor calls for the form, Caremark places a bar code on the form that includes our plan-specific information. When your doctor faxes the form with the bar code information back to Caremark it will be processed much faster than a form without this information.

Q. What reasons would a doctor give to determine that a drug is medically necessary?

A. At least one of the following criteria must be met to determine that a drug is medically necessary:

- (1) The use of the lower-tier alternative is contraindicated, meaning use of this medication could harm rather than help the patient; or
- (2) The patient experiences or is likely to experience significant adverse effects from the lower tier medication, and is reasonably expected to tolerate the Tier III medication; or
- (3) The lower tier alternative results in therapeutic failure (meaning the medication is not effective, as determined by your provider), and the patient is reasonably expected to respond to a Tier III medication; or
- (4) The patient previously responded to a Tier III medication and changing to a lower tier alternative would incur unacceptable clinical risk.

Q. Can Caremark second-guess my doctor if he/she indicates that one of these criteria is met?

A. No.

Q. How often is the three-tier list reviewed?

A. Caremark's Pharmacy and Therapeutics Committee reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

Q. Where do I find out about the co-pay amounts for different drugs?

A. Since new drugs become available all the time it is best to go to the Caremark website at [www.Caremark.com](http://www.Caremark.com) to look up the co-pay amounts for drugs. The Caremark website will always have the most up-to-date list of drugs. Once you register, click on "Look up Co-pay and Formulary Status." Just type in the drug you are looking for and you will see the cost and co-pay amounts for the drug you are asking about as well as alternatives.

Q. What number do I call if I have questions about a drug prescription?

A. You should call the Caremark Customer Service line at 800-318-2572 or visit [Caremark.com](http://www.Caremark.com)

Q. Will I be getting a new card because of the pharmacy changes?

A. No, your current card will work. If you lose your card, you may request a new one by calling Caremark's Customer Service line at 800-318-2572. Don't be confused if your card says "Pharmacare rather than "Caremark". The company - technically known as "CVS-Caremark" - does business under all of these names.

Q. I understand that the new rules were effective July 1, 2009. Wasn't there any sort of transition phase in?

A. Yes. The third tier (\$25 co-pay) does not take effect until October 1, 2009. Prior to that, non-preferred brands had the same \$10 co-pay as preferred brands. In addition, the change in the mandatory generic substitution process requiring a medical necessity form rather than the "dispense as written" designation was delayed until September 1, 2009. The idea, in both cases, was to give doctors and patients the time and information necessary to respond to the new rules.

Q. I went to the pharmacy and picked up a generic drug prescription and paid just \$3.03. I thought the generic co-payment was \$5.

A. If the cost of the drug is less than the co-payment, you pay the lower amount. The Comptroller's Office and the Healthcare Cost Containment Committee have negotiated deep discounts for drugs; sometimes this will result in a co-payment amount lower than the stated amount.

Q. Our plan has always provided certain specific pharmaceuticals products without co-pays, such as insulin and diabetes supplies. Has there been any change in those rules?

A. No.

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