Formularies & Preferred Drug Lists

Overview

The Academy of Managed Care Pharmacy defines a formulary, or a preferred drug list, as a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health. Formularies are utilized by various groups or institutions such as hospitals, health plans, PBMs and government agencies.

Medications and devices listed on a formulary are usually determined by a pharmacy and therapeutics (P & T) committee. P & T committees are comprised of a multi-disciplinary group of individuals including pharmacists, physicians, nurses, and other health care professionals. P & T committees meet regularly and are responsible for reviewing new and existing medications and devices and developing, managing, updating, and administering a formulary based on those evaluations. Many P & T committees also develop drug policies and utilization management strategies such as step therapies, quantity limits, and prior authorization programs.

Guidelines for reviewing drugs for inclusion or exclusion on the formulary:

- P & T committees should be provided with information that reflects a comprehensive, accurate and unbiased analysis of the evidence available in the medical literature.
- Drug evaluation monographs and therapeutic class reviews are developed by drug information specialists to assist in the formulary review process.
- When a new drug is approved by the Food and Drug Administration (FDA), a drug monograph that outlines specific, pre-defined characteristics of the medication should be prepared for review by the P & T committee.

How Do PBMs Use Formularies?

- To determine which medications are most cost effective without compromising patient care.
- To define what medications are covered through plans and provide the main component of the pharmacy benefit.
Formularies & Preferred Drug Lists (continued)

- Unique medications warrant full examinations.
- Medications that are “me too” or similar to others in a therapeutic class may be presented in a therapeutic class review so consideration can be given to the differences between the medications in each therapeutic class.

If a P & T committee determines through these comprehensive evaluations that one drug provides a clear medical benefit over the other, therapeutically equivalent drugs in that same therapeutic category, the drug is usually added to the formulary, regardless of cost. If there are drugs in the same therapeutic category that have very similar efficacy and safety profiles and no unique properties that would make it a better drug, then manufacturer rebates and net costs usually become deciding factors as to which drugs should be added to the formulary.

Formulary Types and Goals

**Open formulary:** In an open formulary, a payer determines that all formulary and non-formulary drugs will be covered, though specific classes of medications, such as cosmetic drugs or infertility agents, may be excluded. Members utilizing an open formulary are incentivized to use formulary agents by varying tier structures.

PBMs place their formulary and non-formulary medications into tiers with associated co-payments with each tier.

- **Tier 1:** The first tier is usually generic products. Co-payments for this tier are typically low, to encourage utilization of lower costing, generic medications.
- **Tier 2:** The second tier is normally name brand, non-specialty formulary medications.
- **Tier 3:** The third tier is for non-formulary, non-specialty brand names, and these will be associated with the highest level of co-payments.

The development of a tiered co-payment structure is to encourage patients to use the most clinically appropriate, cost-effective drugs without compromising care. There is data that suggests that high spreads between co-payment tiers results in significantly higher generic utilization rates and increased formulary adherence. Multi-tiered co-payment structures are associated with a 5% to 15% decrease in overall drug spending. For that reason, four, five, and six tiered co-payment structures are beginning to emerge to steer members to preferred generics and preferred specialty medications.

**Closed formulary:** In a closed-formulary, non-formulary drugs are “blocked” and not reimbursed by the payer. Non-formulary medications have equally effective products available on the formulary, normally at much lower costs. Formulary exception policies allow patients access to non-formulary medications when medically appropriate, usually through a prior authorization process. Closed formularies historically have not been common; however, because of rising costs of pharmaceuticals and poor formulary adherence, many plans are looking more closely at utilizing closed formularies as tools for maximizing drug rebates and minimizing overall costs to members and plans.
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<td><strong>Distinguishing Features</strong></td>
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| **How Often it’s Updated** | **Additions to the formulary** – Additions are made four times per year in January, April, July, and October.  
**Deletions to the formulary** – Deletions are made two times per year in January and July. |
| **National Preferred Formulary** |
| **Distinguishing Features** | MedTrak’s national preferred formulary promotes rebatable drugs within each therapeutic class, but excludes a select number of drugs in order to maximize rebates. This formulary is used by very few MedTrak groups and may be associated with high member disruption. |
| **How Often it’s Updated** | **Additions to the formulary** – Additions are made four times per year in January, April, July, and October.  
**Deletions to the formulary** – Deletions are made two times per year in January and July. |
| **MedTrak Drug List (MDL)** |
| **Distinguishing Features** | The MDL is list of medications for common conditions. This drug list promotes the use of the most effective medications with the lowest available retail cost. The Tier 2 brand drugs average more than $20 less per 30-day supply than their Tier 3 counterparts. Utilization of the lower costing Tier 2 drugs and the higher co-payments for Tier 3 drugs helps plan sponsors reduce their costs. Rebates are not associated with this drug list, but this drug list is very effective for plans who want to aggressively control costs. |
| **How Often it’s Updated** | **Additions to the MDL** – Additions are made two times per year in January, and July.  
**Deletions to the MDL** – Deletions are made annually in January. |
Formularies & Preferred Drug Lists (continued)

Unless a drug has specific negative clinical properties which would warrant an exclusion, FDA approved generic equivalents are automatically added to the National Formulary, the National Preferred Formulary, and the MDL regardless of the formulary status of the originator product.

References: