Benefits of 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, pharmacy benefit managers (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.
- Unique medications warrant full examinations.

How Do PBMs Use Formularies?

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

- 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 that one drug provides a clear medical benefit over the other agents 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 administration of copay tier structures.

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

- **Tier 1**: The first tier is usually reserved for generic products. Co-payments for this tier are typically low, to encourage utilization of lower costing, generic medications.
- **Tier 2**: The second tier is used for 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 goal 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 to suggest that high spreads between co-payment tiers results in significantly higher generic utilization rates and increased formulary adherence. Specifically, 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.
Benefits of Formularies & Preferred Drug Lists (continued)

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<td>National Formulary</td>
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| **Distinguishing Features** | • Promotes rebatable drugs within each therapeutic class  
|                        | • There is little member disruption for plans that choose the National formulary |

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| **Distinguishing Features** | • Promotes rebatable drugs within each therapeutic class, but excludes a select number of drugs in order to maximize rebates  
|                               | • This formulary is not as common among MedTrak’s Plan Sponsors and may be associated with a higher member disruption than the National formulary |

**Formulary Changes**

MedTrak works with a national P&T committee, who meets at least quarterly to make recommendations for formulary changes. The MedTrak formulary committee convenes after the national P&T committee and evaluates and implements their recommendations.

- **Additions to the formulary** – Additions are made on a monthly basis. Since formulary additions do not negatively affect members, information regarding formulary additions is provided via blast emails to our clients and updating of the MedTrak website.

- **Deletions to the formulary** – Deletions are made two times per year in January and July. Formulary deletions can negatively impact members. For this reason, members with current claims for a drug changing to non-formulary status will receive a letter from MedTrak’s Clinical Care Center explaining the change and offering formulary alternatives.

Formulary changes are communicated at least 30 days prior to the change taking place. The only exception would be when a drug is immediately deleted from the formulary due to safety or efficacy issues, or, is immediately added to the formulary due to its uniqueness or greatly improved safety and/or efficacy profile.

**References:**