

What is the HIP Health Plan of New York Medicare Part D Formulary?

A formulary is a list of drugs selected by HIP Health Plan of New York 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. HIP Health Plan of New York will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a HIP Health Plan of New York network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

How do I use the HIP Formulary Web Site Search Tool?

For the most up-to-date listing of HIP Medicare Formulary information, including formulary drugs, alternative medications, drug monographs with images, brand/generic specifications and applicable utilization management procedures, you can utilize the HIP Formulary Web Site Search Tool found on the HIP Medicare Plans and Important Part D Information section of the www.hipusa.com web site and follow these easy steps.

- Click on HIP Medicare Information.
- Click on Formulary Information
- Click on Formulary Part D Search
- Click on Search as a Member
- Enter Information (e.g. drug name or therapeutic class)
- Submit information
- A listing of the medication you requested will display. This listing will provide the available form / dose, a description, brand / generic category, formulary status and notes. The description provides useful information about the medication, such as dosage and common side effects. The notes will tell you if there are any special instructions or prior authorization required to obtain the medication.

What are generic drugs?

HIP Health Plan of New York **covers both brand-name and generic drugs. A generic drug has** the same active-ingredient as the brand name drug. Generic drugs usually cost less than the brand name drugs and are approved by the Food and Drug Administration (FDA).

Can the Formulary change?

Generally, if you are taking a drug on our 2009 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2009 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 improve the safety of your drugs.

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, 2009. To get updated information about the drugs covered by HIP Health Plan of New York, please visit our Web site at hipusa.com or call **Customer Service at 1-800-HIP-TALK (1-800-447-8255)**, seven (7) days a week, 8 am–8 pm. TTY/TDD users should call 1-800-447-4833.

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:** HIP Health Plan of New York requires that you or your physician to get a prior authorization for certain drugs. This means that you will need to get approval from HIP Health Plan of New York before you fill your prescriptions. If you don't get approval, HIP Health Plan of New York may not cover the drug.
- **Quantity Limits:** For certain drugs, HIP Health Plan of New York limits the amount of the drug that HIP Health Plan of New York will cover. For example, HIP Health Plan of New York provides 30 tablets per prescription for Clarinex®. This may be in addition to a standard one month or three month supply. If your Doctor puts you on a maintenance medication for the first time, your Doctor will be requested to prescribe a 30 day supply to make sure you tolerate the medication. After the 30 day fill your Doctor may request a 90 day supply. Maintenance medications are identified in the Medicare Part D Formulary.
- **Step Therapy:** In some cases, HIP Health Plan of New York 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, HIP Health Plan of New York may not cover Drug B unless you try Drug A first. If Drug A does not work for you, HIP Health Plan of New York will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary.

You can ask HIP Health Plan of New York to make an exception to these restrictions or limits. See the section “How do I request an exception to the HIP Health Plan of New York formulary?”

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Customer Service and ask if your drug is covered. If you learn that HIP Health Plan of New York does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by HIP Health Plan of New York. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by HIP Health Plan of New York.
- You can ask HIP Health Plan of New York 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 HIP Health Plan of New York Formulary?

You can ask HIP Health Plan of New York 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, HIP Health Plan of New York 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, **Tier 3**, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred tier, **Tier 2**, 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 the drugs that are in our Specialty tier, **Tier 4**.

Generally, HIP Health Plan of New York 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 your transition to our plan.

For each of your drugs that is not on our formulary or your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-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 up to a 90 day transition supply (unless you have a prescription written fewer days). We will cover more than one refill of these drugs for the first 180 days you are a member of our plan while you are a resident of a long-term care facility. 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 180 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

For more information

For more detailed information about your HIP prescription drug coverage, please review your **Evidence of Coverage** and other plan materials.

HIP Health Plan of New York, please visit our Web site at **hipusa.com** or *call Customer Service at 1-800-HIP-TALK (1-800-447-8255)*, seven (7) days a week, 8 am–8 pm. TTY/TDD users should call 1-800-447-4833.

If you have any 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.

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