# Compass - Generic Step Therapy Plans (GSTP)

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**Description:** Information regarding Generic Step Therapy Plans (GSTP). GSTPs are a class of progressive plan designs that use a combination of Preferred Formulary and Step Therapy strategies.

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| GSTP Options and Requirements |

Generic Step Therapy Plans (GSTP) are similar to the existing step therapy requirements used by clients today. They are at times more progressive and provide a number of proactive communications to both the member and prescriber.

GSTPs use strategies that promote the use of generic medications to effectively reduce both clients’ and plan members’ pharmacy costs.

There are three **GSTP** options being offered to clients:

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| **Option Type** | **Description** |
| Performance Generic Step Therapy (PGST) | * Generics and preferred brands within targeted therapeutic classes are covered without step therapy or a PA. * Non-preferred brands require use of at least a 30-day supply of a generic within the same class. |
| High Performance Generic Step Therapy (HPGST) | * Uses the standard PDL or client custom drug list aligned to HPGST therapeutic classes. * Similar to Performance Generic Step Therapy, however fewer brands are covered without step therapy or a PA. * Generics and preferred brands within targeted drug classes are covered. * Non-preferred brands require use of 30-day supply of a generic. |
| Traditional Generic Step Therapy (TGST) | * Generics in targeted drug classes are covered without step therapy or a PA. * All brands within targeted drug classes require the use of at least a 30-day supply of a generic within the same class. |

The following requirements are the same for all of the **GSTP** drug classes, as well as for the three current **GSTP** offerings.

* Number of generic alternatives required = **one (1).**

**Note:** A member’s plan determines whether one or two generics must be tried first.

* Duration of therapy for the generic alternative = **at least a thirty (30) day supply.**
* Look-back period, the amount of claim history the system will search through for generic alternatives = **rolling 6 month or one (1) year period**, depending on the drug class.

If all three (3) requirements have been met, then the targeted drug is covered.



**Note:** Since the look back period is a rolling 6 month or 1-year period, once the generic step drug is no longer found in the member’s claim history within that period, the targeted medication will reject again.

**Example:** If a member meets the Step Therapy requirements and receives the targeted brand, no rejection will occur until 6 months or 1 year has passed since a generic step drug was on file.

* After that point, the member must try a generic step drug again or have their prescriber initiate a Clinical PA request to seek approval for continued use of the targeted brand.
* Run Compass - Test Claims (050041) to determine current coverage of the GSTP medication.

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| Identifying GSTP Targeted Drugs and Providing Alternatives |

Perform the steps below:

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| **Step** | **Action** | | |
| **1** | Locate the rejected prescription. | | |
| **2** | View the details of the prescription. | | |
| **If…** | **Then…** | |
| Test Claim | In the **Mail/Retail** **Messages** column of the test claims result screen, click the appropriate reject hyperlink to view the Messaging of the rejected claim. | |
| Mail Service Claim or Retail claim | From the **Claims Tab**, click the **Reject Code** to access the Reject Messaging screen.  **Note:** Utilize the filter options availible to sort the claims mail or retail to find the claim. | |
| **3** | Review the reject messaging for GSTP related messages:  **75** – Prior Authorization Required OR  **75** – Prior Authorization and **76** – Plan Limits Exceeded combined  Description will include steps and GSTP PA team toll free number (**1-877-203-0003**).  **608** – Step Therapy, Alternate Drug Therapy Required Prior to Use of Submitted Product Service ID  **Note:** Preferred product messaging (settlement code 156/Class code 16-Formulary) may also be displayed in addition to GSTP settlement codes. Only use it as guidance if it does not conflict with the GSTP alternatives matrix.   * If conflicts occur (**Example:** Formulary messaging says a certain drug is preferred, but the GSTP matrix says it requires step therapy), then the GSTP matrix takes priority. | | |
| **4** | Once a potential GSTP claim rejection is identified, review the CIF for GSTP information.  **Note:** GSTP information is displayed in the Plan Design sections of the CIF. | | |
| **If…** | | **Then…** |
| GSTP information is found on the CIF | | Proceed to the next step. |
| There are no references to GSTP on the CIF | | Follow the standard process for the type of claim denial. |
| **5** | 1. Click the link in the CIF to access the GSTP Medication Alternatives matrix work instruction. 2. Identify the covered alternatives for the targeted drug and provide them to the member. Refer to [Generic Step Therapy Plans Drug List (025479)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=96fe40ec-f897-4f1d-a7ba-1459408a57a6). 3. Advise the member to consult with their doctor to determine which (if any) of the alternatives would be right for them.   **Note:** Test claims will determine the cost of the alternatives. Refer to [Compass - Test Claims (050041).](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe)   * If the client uses a customized version of HPGST, TGST or PGST, the differences will be noted on the CIF and will take precedence over the matrix.   **Note:** If the call becomes clinical in nature (side effects, efficacy, etcetera), warm transfer, refer to [Compass - Basic Call Handling (066076)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=18c64566-0ebb-4760-96fe-04da06185de0)  and [Clinical Care Services (004378)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f22eb77e-4033-4ad9-9afb-fc262f29faad). Ensure that all drug coverage/copay questions are addressed before completing the transfer. | | |
| **6** | Consult with the member on the ways to obtain a lower cost covered alternative, including how to obtain a new prescription for the alternative through Mail Service and/or at Retail.  Refer to [Compass - Obtaining a New Prescription (Rx) for the Member (New Rx Request) (054208)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a7684ce9-c2bc-4cbc-ab37-c1ffb7789706). | | |
| **7** | After consulting with the member on the covered alternatives, if the member still prefers to use the targeted medication:  Offer to start the ePA process, reference [Compass - Prior Authorization, Exceptions, Appeals Guide (063978) then select Compass - Initiating an ePA Request (055814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c)**.**   * If the member wants to speak to their prescriber before initiating the PA, advise the plan member to have their prescriber contact our Prior Authorization Team at 1-877-203-0003 to initiate a Clinical PA request.   1. Inform the member that if prior authorization is granted for the medication, it may then be covered under their benefit plan. If not, they may be responsible for the full cost of the medication if they continue to use it. Refer to the [Plan Member FAQs](#_Frequently_Asked_Questions) below for specific verbiage. | | |

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| Prior Authorization (PA) Requests |

GSTP Clinical PA requests will be handled by a designated team within the Prior Authorization Department. When this group receives a call from a physician regarding a targeted GSTP drug, they will engage the physician on the available alternatives for the targeted drug.

* If the physician agrees to prescribe an alternative and the plan member utilizes mail service, the PA Team offers to connect the physician with FastStart to obtain a new prescription.
* If the physician prefers that the plan member use the targeted drug, then the PA team begins the Clinical Prior Authorization process.

**PA Approved**

If the prior authorization is approved, the plan member will be able to bypass the Step Therapy requirement and obtain the targeted drug at the plan designated copay. The approval will be on file for two (2) years, after which the plan member will need to attempt to meet the step requirements by trying a generic, or have the prescriber initiate a renewal request for the prior authorization.

**PA Denied**

If prior authorization is not approved, the plan member has three options:

* Try one of the step drugs.
* Purchase the targeted drug at 100% of the cost.
* Initiate the Appeals process if allowed by the client’s plan design.

**Contacting the GSTP PA Team**

The designated toll-free number for the GSTP PA Team is **1-877-203-0003**.

* If you receive a call from a physician requesting approval for a targeted GSTP drug, warm transfer the physician to this number. Refer to

[Compass - Basic Call Handling – Opening the Call, Call Hold, Warm and Cold Transfer (066076)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=18c64566-0ebb-4760-96fe-04da06185de0)for proper introduction and release of caller.

* Do not transfer to the regular PA Team.

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| Frequently Asked Questions and Answers |

Use as needed:

## Plan Member FAQs Applicable to All GSTP Types

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| **General** |
| **Q1: Why does my plan sponsor want me to use a generic first?** |
| **A1:** Generic drugs are a safe, effective and a low-cost option for treating many common conditions. Generic drugs cost an average of 30 to 80% less, than brand-name drugs, which can help you and your plan sponsor save money.  Association for Accessible Medications formerly Generic Pharmaceutical Association at <https://accessiblemeds.org/generic-medicines> |
| **Q2: What do I need to do to change to a generic medication?** |
| **A2:** Let your doctor or other health care provider know you prefer to use generic medications whenever possible. Ask your doctor to allow for generic substitution or to write a new prescription for a generic medication to treat your condition.  Your doctor will need to write a new prescription for a generic alternative available in the same drug class as your brand-name medication. |
| **Q3: What is step therapy?** |
| **A3:** Step therapy is a term used to describe the process of trying a generic drug first to treat your condition before trying a higher cost brand-name drug. Under your plan, trying a generic drug is a necessary first step in order to receive drug coverage. |
| **Drug/Condition Specific** |
| **Q4: Is <drug> covered under my plan?** |
| **A4:** I will be happy to check for you…  **CCR:** Complete a [Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe) to determine drug coverage. |
| **Q5: What drugs does my plan cover to treat <condition>?** |
| **A5:** Unfortunately, I cannot tell you what drugs may be used to treat <condition>. Your doctor is the best person to provide that information, and then we can check whether it is covered by your plan. |
| **Q6: How much can I save by changing from <brand-name drug> to a generic medicine?** |
| **A6:** I will be happy to check that for you…  **CCR:** Complete a [Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe) to determine savings. |
| **Q7: I already tried generic medication. Can you check for me?** |
| **A7:** Sure, I will be happy to check for you…  **CCR:** Access the plan member’s prescription history. If **6 months or one (1) year period**, depending on the drug class has passed since the member tried a generic medication in the same drug class as their current brand-name drug, educate member about requirement to try a generic again in order to receive coverage under their plan. |
| **Q8: I am concerned about using a generic drug.** |
| **A8:** According to the U.S. Food and Drug Administration (FDA), generic drugs are safe and effective.   * If you are concerned about using a generic, ask your doctor or other health care provider if a generic drug is right for you. |

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## Plan Member FAQs Specific to Traditional Generic Step Therapy

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| **General** |
| **Q1: I received a letter about a change to my prescription benefit but do not understand what it means. Can you please explain it to me?** |
| **A1:** Sure. According to your plan, in order to have coverage for prescription drugs in certain drug classes, you must try a generic drug first to treat your condition. If you try (or have tried) a generic drug and it does not work for you, then you may receive coverage for a brand-name drug that your doctor prescribes.  The amount you pay for your prescription will be lower when you choose a generic drug. However, if you choose to use a brand-name drug without trying a generic first or without getting prior approval, coverage may be denied, and you may have to pay the full cost of the brand-name drug. |
| **Q2: Why has my prescription benefit plan changed?** |
| **A2:** Your plan sponsor is always looking for ways to offer you choice and help you save money on your prescriptions. Your plan is designed to help you and your employer maintain affordable prescription drug coverage and save on prescription costs by encouraging the use of lower-cost generic drugs.  Keep in mind that your plan provides coverage for generic drugs without restriction. These drugs are safe, effective and will save you money. |
| **Q3: What if I want to stay with my current brand-name drug?** |
| **A3:** You may choose to stay with your current brand-name drug. However, if you have not tried a generic to treat your condition within the last 24 months, and your doctor has not received prior approval for the brand-name drug, coverage may be denied, and you may have to pay the full cost of the brand-name drug.  If your doctor receives prior approval, your brand-name drug may be covered under your plan.  **Mail service users:** Some brand-name drugs may not be available through Mail Order, even if you pay the full cost. I will be happy to check on this for you…  **CCR:** Review the CIF for plan-specific information. |
| **Plan Member Disruption** |
| **Q4: When I got my prescription refilled, I had to pay the full cost of the medicine. Can you tell me why?** |
| **A4:** According to your plan, if you use a brand-name drug without trying a generic first or without your doctor getting prior approval for brand, then coverage may be denied, and you may have to pay the full cost of the brand-name drug. |
| **Q5: Why isn’t my prescription medicine covered anymore? It was prior to now.** |
| **A5:** **Plan design changed:** As of <date>, your prescription benefit plan changed. According to your new plan, brand-name drugs in certain drug classes are not covered. In order to have coverage for drugs in these drug classes, your plan requires that you choose a lower-cost generic drug first.  **Formulary changed:** The list of drugs your plan covers recently changed. According to your plan, your drug will no longer be covered unless you try a generic drug first to treat your condition. |
| **Q6: What if I already tried a generic?** |
| **A6:** If our records show that you have tried a generic drug to treat your condition within the last 24 months, then your brand-name drug may be covered.  If more than 24 months have passed since you tried a generic drug to treat your condition, your plan requires you to try a generic again. It is possible that new generics may now be available to treat your condition.  If you would like, I can check your drug history for you to see when you tried the generic… |
| **Q7: What if there is no generic available to treat my condition?** |
| **A7:** Generics are available in most drug classes. However, if there is no generic available within a certain drug class, you may choose a brand-name drug to treat your condition. |
| **Q8: What if I cannot take the generic?** |
| **A8:** If you cannot take a certain generic drug due to allergy or other medical reasons, your doctor may consider prescribing a different generic drug to treat your condition. Your plan covers generic drugs without restriction at a lower copay/coinsurance than brand-name drugs.  If no other generic alternative is available, your doctor may contact us to obtain prior approval so you may receive coverage for a brand-name drug. Without prior approval, coverage of the brand-name drug may be denied, and you may have to pay the full cost of the drug. |
| **Q9: Have you contacted my doctor about changing my prescription?** |
| **A9:** **Member uses Mail Order:** From the **Member Snapshot,** in the **Quick Actions** panel, click **Communication** hyperlinkto view all communications for an outbound call to the doctor or in the **Order Details** screen, review order level alerts to determine whether the member’s doctor has been contacted.  **Member uses retail:** No. We have not contacted your doctor about changing your prescription. Your retail pharmacist may already have or be able to do that for you. |
| **Q10: My doctor does not want me to change to another drug. What should I do?** |
| **A10:** If you are taking a brand-name drug to treat your condition, ask your doctor to contact us to obtain prior approval so you may receive coverage for your drug. Without prior approval, coverage of the brand-name drug may be denied, and you may have to pay the full cost of the drug.   * If you are taking a generic drug, you may continue to do so. Generics are covered under your plan and available at a lower cost to you. |
| **Q11: If my doctor gets prior approval, will my brand-name drug be covered?** |
| **A11:** Your prescription benefit plan requires that specific criteria be met in order for brand-name drugs to be covered. If your doctor obtains prior approval for your brand-name drug, your plan may provide coverage for it.   * If you are taking a brand name drug, have not tried a generic within the last 24 months and your doctor has not received prior approval for the brand-name drug, then your drug may not be covered under your plan. |
| **Q12: I received a letter that said my drug will not be covered unless I receive prior approval. Can you please tell me what I need to do to get prior approval?** |
| **A12:** Ask your doctor to call us to obtain prior approval from us for you to use a non-preferred brand drug and receive coverage by your plan. Your doctor can call the physician line provided in communications we have sent. |
| **Q13: What if the plan member becomes upset about the step therapy requirement for brand-name drugs?** |
| **A13:** I understand your concerns. Please keep in mind that your plan is designed to help you and your employer maintain affordable prescription drug coverage and save on prescription costs by encouraging the use of lower cost drugs that are safe and effective. Your plan provides generous coverage of generic drugs without any restrictions.  Is there anything else I can help you with today? |

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## Plan Member FAQs Specific to Performance Generic Step Therapy

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| **General** |
| **Q1: I received a letter about a change to my prescription benefit but do not understand what it means. Can you please explain it to me?** |
| **A1:** Sure. According to your plan, in order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a non-preferred brand-name medication that your doctor prescribes.  The amount you pay for your prescription will be lower when you choose generic medication. If no generic is available or if it is not right for you or your plan provides coverage for preferred brand medications†, which may also save you money.\*  However, if you choose to use a non-preferred brand medication without trying a generic first or without getting prior approval, coverage may be denied, and you may have to pay the full cost of the non-preferred brand medication.  †Preferred brand medications are those your plan provides that can save you money. Preferred brands are safe, effective, and usually available at a lower cost than non-preferred drugs.  \*The amount of your savings will be based on your benefit plan. |
| **Q2: Why has my prescription benefit plan changed?** |
| **A2:** Your plan sponsor is always looking for ways to offer you choice and help you save money on your prescriptions. Your plan is designed to help you and your employer maintain affordable prescription drug coverage and save on prescription costs by encouraging the use of lower-cost generic and preferred brand medications.†  Keep in mind that your plan provides coverage for generic and preferred brand medications without restriction. These drugs are safe, effective and will save you money.\*  †Preferred brand medications are those your plan provides that can save you money. Preferred brands are safe, effective, and usually available at a lower cost than non-preferred drugs.  \*The amount of your savings will be based on your benefit plan. |
| **Q3: What if I want to stay with my current (non-preferred) brand drug?** |
| **A3:** You may choose to stay with your current non-preferred brand drug. However, if you have not tried a generic to treat your condition within the last 24 months, and your doctor has not received prior approval for the non-preferred brand, coverage may be denied, and you may have to pay the full cost of the non-preferred brand medication.  If you try (or have tried) a generic drug first (within the last 24 months) to treat your condition, you may receive coverage for the non-preferred brand drug. The doctor would need to receive prior approval for your non-preferred brand drug to possibly be covered under your plan.  Do you use mail service to get your non-preferred brand drugs?  **For mail service users:** Some non-preferred drugs may not be available through mail service, even if you pay the full cost. I will be happy to check on this for you…  **Note to CCR:** Check the CIF for plan-specific information. |
| **Q4: What happens if I change to a preferred brand drug but later it becomes non-preferred?** |
| **A4:** If your plan drug list changes and your drug becomes non-preferred, you should receive a letter listing your options or you can ask your doctor to prescribe a generic or preferred brand drug† in the same drug class to save you money.\*  Keep in mind that generics are a lower cost option that is always covered under your plan without restriction. Generic drugs will never become non-preferred under your current prescription benefit plan.  †Preferred brand drugs are those your plan provides that can save you money. Preferred brands are safe, effective and usually available at a lower cost than non-preferred drugs.  \*The amount of your savings will be based on your benefit plan. |
| **Q5: I am concerned about using generic medication.** |
| **A5:** According to the U.S. Food and Drug Administration (FDA), generic medications are just as safe and effective as brand-name medications.  If you are concerned about using a generic, ask your doctor or other health care provider if a generic medication is right for you. |
| **Plan Member Disruption** |
| **Q6: When I got my prescription refilled, I had to pay the full cost of the medicine. Can you tell me why?** |
| **A6:** According to your plan, if you use a non-preferred brand drug without trying a generic first or without your doctor getting prior approval for the non-preferred brand, then coverage may be denied and you may have to pay the full cost of the non-preferred brand medication. |
| **Q7: Why isn’t my prescription medicine covered anymore? It was prior to now.** |
| **A7:** **Plan design changed:**  As of <date>, your prescription benefit plan changed. According to your new plan, non-preferred brand medications in certain drug classes are not covered. In order to have coverage for medications in these drug classes, your plan requires that you choose a lower cost generic or preferred brand medication† first.  †Preferred brand medications are those your plan provides that can save you money. Preferred brands are safe, effective, and usually available at a lower cost than non-preferred drugs.  **Formulary changed:** The list of drugs your plan covers recently changed. According to your plan, your drug will no longer be covered unless you try a generic medication first to treat your condition. |
| **Q8: What if I already tried a generic?** |
| **A8:** If our records show that you have tried a generic medication to treat your condition within the last 24 months, then your non-preferred brand drug may be covered.  If more than 24 months have passed since you tried a generic medication to treat your condition, your plan requires you to try a generic again. It is possible that new generics may now be available to treat your condition.  As an alternative, you may choose to use a preferred brand medication. Preferred brands are covered by your plan and available at a lower cost to you than non-preferred brands. Your copay/coinsurance will be slightly higher for a preferred brand than for a generic.  If you would like, I can check your drug history for you to see when you tried the generic… |
| **Q9: What if I take a preferred brand drug but did not try a generic first?** |
| **A9:** According to your plan, if you are currently taking a preferred brand drug and would like to continue receiving it, you may do so and continue to receive coverage. You do not need to change to a generic to receive coverage for your medication. However, you may decide to change to a generic to save money\*. Your copay/coinsurance will be lower when you use a generic.  Please keep in mind that if you and your doctor decide to change from a preferred brand drug to a non-preferred brand later, your plan requires that you try a generic drug first in order to get coverage. Use of a preferred brand does not allow coverage for a non-preferred brand.  \*The amount of your savings will be based on your benefit plan. |
| **Q10: What if I take a preferred brand drug but want to change to a non-preferred brand instead?** |
| **A10:** In order to receive coverage for non-preferred brand medications, your plan requires that you try a lower cost generic medication first. If you choose to use a non-preferred brand medication without trying a generic first or without getting prior approval, coverage may be denied, and you may have to pay the full cost of the non-preferred brand medication. |
| **Q11: What if there is no generic available to treat my condition?** |
| **A11:** If there is no generic available, you may choose a preferred brand medication† to treat your condition. Preferred brands are covered by your plan and available at a lower cost to you than non-preferred brands.  †Preferred brand medications are those your plan provides that can save you money. Preferred brands are safe, effective, and usually available at a lower cost than non-preferred drugs. |
| **Q12: What if I cannot take the generic?** |
| **A12:** If you cannot take a certain generic medication due to allergy or other medical reason, your doctor may consider prescribing a different generic or a preferred brand medication†, which may also save you money.\* Your plan covers generic and preferred brand medications without restriction at a lower copay/coinsurance than non-preferred brand medications.  †Preferred brand medications are those your plan provides that can save you money. Preferred brands are safe, effective, and usually available at a lower cost than non-preferred drugs.  \*The amount of your savings will be based on your benefit plan. |
| **Q13: Have you contacted my doctor about changing my prescription?** |
| **A13:** **Member uses Mail Order service:** From the **Member Snapshot,** in the **Quick Actions** panel, click **Communication** hyperlinkto view all communications for an outbound call to the doctor or in the **Order Details** screen, review order level alerts to determine whether the member’s doctor has been contacted.  **Member uses retail:** No. We have not contacted your doctor about changing your prescription. Your retail pharmacist may be able to do that for you. |
| **Q14: My doctor does not want me to change to another medication. What should I do?** |
| **A14:** If you are taking a non-preferred brand medication to treat your condition, ask your doctor to contact us to obtain prior approval so you may receive coverage for your medication. Without prior approval, coverage of the non-preferred brand drug may be denied, and you may have to pay the full cost of the medication.  If you are taking a generic or preferred brand medication†, you may continue to do so. Generic and preferred brand medications are covered under your plan and available at a lower cost to you.  †Preferred brand medications are those your plan provides that can save you money. Preferred brands are safe, effective, and usually available at a lower cost than non-preferred drugs. |
| **Q15: If my doctor gets prior approval/authorization, will my non-preferred brand drug be covered?** |
| **A15:** Your prescription benefit plan requires that specific criteria be met in order for non-preferred brand medications to be covered. If your doctor obtains prior approval or authorization for your non-preferred brand drug, your plan may provide coverage for it.  If you have not tried a generic within the last 24 months and your doctor has not received prior approval for the non-preferred brand, then your drug may not be covered under your plan. |
| **Q16: I received a letter that says my medication will not be covered unless I receive prior approval. Can you please tell me what I need to do to get prior approval?** |
| **A16:** Ask your doctor to call us to obtain prior approval for you to use a non-preferred brand drug and receive coverage by your plan. |
| **Q17: What if the plan member becomes upset about step therapy requirement for non-preferred brands?** |
| **A17:** I understand your concerns. Please keep in mind that your plan is designed to help you and your employer maintain affordable prescription drug coverage. It saves on prescription costs by encouraging the use of lower cost medications that are just as safe and effective as non-preferred brands. Your plan provides generous coverage of generic and preferred brand drugs without any restrictions.  Is there anything else I can help you with today? |

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## Plan Member FAQs Specific to High Performance Generic Step Therapy

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| **General** |
| **Q1: I received a letter about a change to my prescription benefit but do not understand what it means. Can you please explain it to me?** |
| **A1:** Sure. According to your plan, in order to have coverage for some prescription medications in certain drug classes, you first must try a generic drug to treat your condition. If you try (or have tried) a generic drug and it does not work for you, then you may receive coverage for a non-selected brand drug that your doctor prescribes.  The amount you pay for your prescription will be lower when you choose a generic drug. If no generic is available or if it is not right for you or your plan provides coverage for selected brand drugs†, which may also save you money.\*  However, if you choose to use a non-selected brand drug without trying a generic first or without getting prior authorization, coverage may be denied, and you may have to pay the full cost of the brand drug. |
| **Q2: Why has my prescription benefit plan changed?** |
| **A2:** Your plan sponsor is always looking for ways to offer you choice and help you save money on your prescriptions. Your plan is designed to help you and your employer maintain affordable prescription drug coverage and save on prescription costs by encouraging the use of lower-cost generic and selected brand drugs.†  Keep in mind that your plan provides coverage for generic and selected brand drugs without restriction. These drugs are safe, effective and will help you save money.\*  †Selected brand drugs are covered by your plan, usually available at a lower cost than non-selected brands and can help you save money.  \*The amount of your savings will vary based on your benefit plan. |
| **Q3: What if I want to stay with my current (non-selected) brand drug?** |
| **A3:** You may choose to stay with your current non-selected brand drug. However, if you have not tried a generic to treat your condition within the last 24 months, and your doctor has not received prior authorization for this drug, you may have to pay the full cost of the drug.  If your doctor obtains prior authorization, your non-selected brand drug may be covered under your plan.  Keep in mind that your plan may provide coverage for a selected brand drug within a drug class without restriction. Selected brand drugs are safe, effective and will save you money.\*  †Selected brand drugs are usually available at a lower cost than non-selected drugs.  \*The amount of your savings will vary based on your benefit plan.  Do you use mail service to get your brand drugs?  **Mail Order service users:** Some non-selected brand drugs may not be available through mail service, even if you pay the full cost. I will be happy to check on this for you…  **Note to CCR:** Check the CIF for plan-specific information. |
| **Plan Member Disruption** |
| **Q4: When I got my prescription refilled, I had to pay the full cost of the medicine. Can you tell me why?** |
| **A4:** According to your plan, if you use a non-selected brand drug without trying a generic first, or without your doctor getting prior authorization for the non-selected brand, then you may have to pay the full cost of the brand name drug. |
| **Q5: Why isn’t my prescription medicine covered anymore? It was prior to now.** |
| **A5:** **Plan design changed:** As of <date>, your prescription benefit plan changed. According to your new plan, some brand medications in certain drug classes will not be covered unless you have tried a generic drug first. In order to have coverage for medications in these drug classes, your plan requires that you choose a lower cost generic or selected brand drug.  †Selected brand drugs are covered by your plan, usually available at a lower cost than non-selected brands and can help you save money.  **Formulary changed:** The list of drugs your plan covers recently changed. According to your plan, your non-selected brand drug will no longer be covered unless you try a generic drug first to treat your condition. |
| **Q6: What if I already tried a generic?** |
| **A6:** If our records show that you have tried a generic drug to treat your condition within the last 24 months, then your non-selected brand medication in the same drug class may be covered.  If more than 24 months have passed since you tried a generic drug, your plan requires you to try a generic again. It is possible that new generics may now be available to treat your condition.  As an alternative, you may choose to use the selected brand medication in the same drug class. Selected brands are covered by your plan and available at a lower cost to you than non-selected brands. Your copay/coinsurance may be slightly higher for a selected brand than for a generic.  If you would like, I can check your drug history for you to see when you tried the generic… |
| **Q7: What if I take a selected brand drug but did not try a generic first?** |
| **A7:** According to your plan, if you are currently taking a selected brand drug and would like to continue receiving it, you may do so and continue to receive coverage. You do not need to change to a generic. However, you may decide to change to a generic to save money.\* Your copay/coinsurance will be lower when you use a generic.  Please keep in mind that if you and your doctor later decide to change from the selected brand medication to a non-selected brand medication in the same drug class, your plan requires that you try a generic drug first. Use of a selected brand does not allow coverage for a non-selected brand drug.  \*The amount of your savings will be based on your benefit plan. |
| **Q8: What if I take a selected brand drug but want to change to a non-selected brand instead?** |
| **A8:** In order to receive coverage for a non-selected brand medication in the same drug class, your plan requires that you try a lower cost generic medication first. If you choose to use a non-selected brand medication without trying a generic first or without getting prior authorization, you may have to pay the full cost of the drug. |
| **Q9: What if there is no generic available to treat my condition?** |
| **A9:** If there is no generic available, you may choose to use a selected brand drug† to treat your condition. Selected brands are covered by your plan and available at a lower cost to you than non-selected brand name drugs.  †Selected brand drugs are covered by your plan, usually available at a lower cost than non-selected brands and can help you save money. |
| **Q10: What if I cannot take the generic?** |
| **A10:** If you cannot take a certain generic drug due to allergy or other medical reason, your doctor may consider prescribing a different generic or a selected brand drug†, which may also save you money.\* Your plan covers generic and selected brand drugs without restriction at a lower copay/coinsurance than non-selected brand drugs.  †Selected brand drugs are covered by your plan, usually available at a lower cost than non-selected brands and can help you save money.  \*The amount of your savings will vary based on your benefit plan. |
| **Q11: Have you contacted my doctor about changing my prescription?** |
| **A11:** **Member uses mail order service:** From the **Member Snapshot,** in the **Quick Actions** panel, click **Communication** hyperlinkto view all communications for an outbound call to the doctor or in the **Order Details** screen, review order level alerts to determine whether the member’s doctor has been contacted.  **Member uses retail:** No. We have not contacted your doctor about changing your prescription. Your retail pharmacist may be able to do that for you. |
| **Q12: My doctor does not want me to change to another drug. What should I do?** |
| **A12:** If you are taking a non-selected brand drug to treat your condition, ask your doctor to call us to obtain prior authorization so you may receive coverage for your drug. Without prior authorization, you may have to pay the full cost of the non-selected brand drug.  If you are taking a generic or selected brand drug†, you may continue to do so. Generic and selected brand drugs are covered under your plan and available at a lower cost to you.  †Selected brand drugs are covered by your plan, usually available at a lower cost than non-selected brands and can help you save money. |
| **Q13: If my doctor gets prior authorization, will my non-selected brand drug be covered?** |
| **A13:** Your prescription benefit plan requires that specific criteria be met in order for a non-selected brand drug to be covered. If your doctor obtains prior authorization for your brand drug, your plan may provide coverage for it.  If you have not tried a generic within the last 24 months and your doctor has not received prior authorization for the non-selected brand drug, then your drug may not be covered under your plan. |
| **Q14: I received a letter that says my medication will not be covered unless I receive prior authorization. Can you please tell me what I need to do to get prior authorization?** |
| **A14:** Ask your doctor to call us to obtain prior authorization for you to use certain brand name drugs and receive coverage by your plan. Your doctor can call the physician line provided in communications we have sent. |
| **Q15: What if the plan member becomes upset about step therapy requirement for non-selected brands?** |
| **A15:** I understand your concerns. Please keep in mind that your plan is designed to help you and your employer maintain affordable prescription drug coverage. This saves on prescription costs by encouraging the use of lower-cost drugs that are safe and effective. Your plan provides generous coverage of generic and selected brand drugs without any restrictions.  Is there anything else I can help you with today? |

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