AUGUST 2023

Prominence Health Plan

PHARMACY BENEFITS GUIDE

Program Overview

Prominence® Health Plan

PROMINENCE HEALTH PLAN | PHARMACY BENEFITS GUIDE

FORWARD

The following information is a summary of the Prominence Health Plan (the Plan) drug benefit. MedImpact, the Plan's Pharmacy Benefit Manager, can be contacted by calling 833-775-MEDS (6337) or by logging on at www.medimpact.com.

Once you are logged on to the MedImpact portal, you can compare copay prices; determine your financial responsibility for a drug based on your pharmacy benefit; order a refill for an existing, non-expired mail order prescription; find the location of an in-network pharmacy; conduct a proximity search based on ZIP code; determine potential drug-drug interactions; determine common side effects of a drug; and determine the availability of generic substitutes.

Both the Pharmacy Benefits Guide and a copy of the current Prominence Health Plan Formulary can be found by visiting www.prominencehealthplan.com. A current copy of these documents can also be obtained by calling Prominence Customer Service at 800-863-7515, Monday through Friday, 7:30 am to 5 pm, PT.

REFERENCE DOCUMENTS

The following reference sources are reviewed and approved by the Pharmacy and Therapeutics (P&T) Committee:

- **Pharmacy Benefits Guide (PBG)** – This is a summary of the plan's comprehensive pharmacy benefits. The Pharmacy Benefit Guide is updated annually or as needed.
- **Pharmacy Formulary –** The Pharmacy Formulary is available in both English and Spanish and is updated each month. It contains a comprehensive list of all covered drugs and is categorized by therapeutic class and pharmacy tier. Prior authorization, quantity limit and step therapy indicators are also included.

The Formulary is updated on a quarterly based on decisions made by the P&T Committee. These updates will occur on the first day of the quarter following each quarterly P&T Committee meeting, so for example, decisions from a January meeting would become effective on April 1.

FORMULARY

Introduction

Prominence Health Plan utilizes a Pharmacy and Therapeutics (P&T) Committee comprised of practicing physicians and pharmacists to help ensure that our formulary is medically sound and that it supports patient health. This committee reviews and evaluates medications on the formulary based on safety and efficacy to help maintain clinical integrity in all therapeutic categories.

Formulary Design

Prominence Health Plan has chosen an incentive-based formulary structure that organizes medication copays by the following tiers:

- Tier 0 - Essential Health Benefits (includes certain vaccines, contraceptives, smoking cessation medications and more)
- Tier 1 - Generic
- Tier 2 - Preferred Brand
- Tier 3 - Non-Preferred Brand
- Tier 4 - Specialty

The tiered copay is used to provide an incentive for members to become better informed about the cost of their medications; to more equitably share the cost of the medications between the health plan and its members; and to give providers and members a broad choice of medications.

The Formulary also uses utilization management functions to promote use of specific cost-effective agents. These utilization management functions include step therapy (ST), prior authorization (PA) and quantity limits (QL).

Prominence uses the Formulary to help manage the overall cost of providing prescription drug benefits. The Formulary offers a wide range of medications from which to choose. We realize that the Formulary may not include every drug from every manufacturer; however, choosing a Preferred drug when it is appropriate can provide access to the necessary medications to stay healthy, at a cost that is more affordable.

Formulary Organization

The Formulary is designed so that Essential Health Benefit medications (Tier 0) are listed first in each drug category. The Generic medications (Tier 1), Preferred Brand medications (Tier 2) are listed next, following by Non-Preferred Brand (Tier 3) and Specialty (Tier 4), respectively.

PLEASE NOTE: If a Preferred Brand product is listed in the “Preferred Brand” section and its corresponding Generic product is not listed in the “Generics” section, then a Generic version of the medication is not available.

Considering Preferred Alternatives

Prominence realizes that the medications on the Formulary may not always be appropriate for all patients. However, reference to the Formulary can help ensure the full advantage of the coverage provided by the prescription drug plan.

Although pharmacists are required by law to dispense a Generic when a Generic alternative to a Brand Name drug is available, pharmacists are not allowed to substitute a Preferred Brand drug without the prescriber's approval. Therefore, a pharmacist may contact the prescriber to obtain authorization to dispense an alternative preferred product when a non-preferred product is prescribed.

Out-of-Pocket Cost Savings
The prescription drug plan determines the cost for Generic, Preferred Brand, and Non-Preferred Brand medications. Benefit providers often design prescription drug plans to encourage the use of Generic and Preferred Brand drugs. Choosing Non-Preferred drugs may mean paying higher out-of-pocket expenses (such as coinsurance, copays, and deductible amounts) or not receiving coverage at all. Patients may also pay less for Generic drugs, or they may be asked to pay the cost difference between Preferred Brand drugs and their Generic alternatives, which are preferred by the plan.

Consulting the prescriber's office when appropriate
When coverage for medications is provided based on use or quantity, MedImpact may contact your prescriber's office for additional information to determine whether coverage is available under your plan. Patients who are unsure whether these coverage rules apply for a particular medication can consult a MedImpact Member Services representative to determine specific coverage requirements.

Formulary Disclaimer: Coverage for some drugs may be limited to specific dosage forms and/or strengths. The benefit design determines what is covered and the applicable copay. The medications listed within the health plan Formulary are subject to change pursuant to the Formulary management by Prominence Health Plan. The presence of a medication on a formulary list does not guarantee coverage. To see the most up-to-date formulary, please visit www.prominencehealthplan.com. You may also call Prominence Customer Service at 800-863-7515, Monday through Friday, 6am to 5pm, PT to request a copy of the Formulary be mailed to you.

GENERIC DRUGS – FREQUENTLY ASKED QUESTIONS

As part of our ongoing efforts to help you manage your out-of-pocket pharmaceutical costs, we are distributing this information. Several frequently asked questions on generic drugs are listed below:

1. **Why do generics cost less than brand-name drugs?**
   Research and Advertising
   Drug manufacturers spend large sums of money on the research, development, marketing and advertising of brand-name drugs. These costs are built into the price you pay for the drug. Manufacturers of generic equivalents have much lower costs, and they pass the savings on to you.

2. **Are generics and brand-name drugs the same?**
   Same Active Ingredients, Different Package
   A generic drug contains the same active ingredients in the same dosage forms and strengths as the brand-name drug. Since they have the same active ingredients, generic drugs can be used by patients of all ages to achieve the same medical effects provided by brand-name drugs.

   Manufacturers do add small amounts of inactive ingredients for specific purposes, such as flavor and color. As a result, brand-name drugs and their generic equivalents often look different. These inactive ingredients

do not alter the effectiveness of the active ingredient(s). Talk with your doctor or pharmacist to determine if there is an appropriate generic drug for you. Although Prominence Health Plan does not require therapeutic interchange, members will often save on their prescription copayment when their doctors select a therapeutically equivalent generic drug.

3. **Why should you choose generics?**
   Cost-Effective
   Consumers who choose generic drugs when they fill their prescriptions realize annual savings in the billions of dollars. By choosing a generic medication, you:
   Often save on your prescription copayment
   Get the same quality and effectiveness as that of a brand-name drug
   Help keep medical care more affordable for everyone

4. **How do you know generics are safe?**
   FDA Approval
   The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs before they are marketed in the United States. The FDA requires that generic equivalent drugs contain the same active ingredients as brand-name drugs. Furthermore, the FDA requires that generic drugs be absorbed and used in the body in the same way as brand-name drugs. These requirements ensure that generic drugs will be as safe and effective as brand-name drugs.

You Have a Choice Between Generic and Preferred Brand-Name Drugs
When you get a prescription, find out whether a generic drug is available and whether it is appropriate for you. Discuss these questions with your doctor or pharmacist:

- Is there a generic drug that is appropriate for my condition?
- What is the potential for any side effects if I change medications?

If you have additional questions about generic medications, learn more direct from the FDA **here**.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

This document represents the efforts of the Prominence Pharmacy and Therapeutics (P&T) Committee to provide practitioners and pharmacists with a method to begin to evaluate the various drug products available. The medical treatment of patients is frequently relative to the practical application of drug therapy. Due to the vast availability of medication therapy and treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the Plan's Pharmacy Benefits Guide, Formulary, and Preferred Drug List is to enhance the practitioner's and pharmacist's abilities to provide optimal cost-effective drug therapy for patients. Practitioners are advised of this document's availability via the annual Provider Manual and periodic provider newsletters.

The Plan's P&T Committee meets quarterly and consists of the Plan's Medical Director, a multidisciplinary panel of Plan physicians representing various areas of practice, local pharmacists, the MedImpact Clinical Pharmacist, as well as other internal Plan personnel.

Information regarding the medications to be considered by the committee is prepared and presented by the MedImpact Clinical Pharmacist. The committee members are given summary documents describing the medications to be considered. The information in the summary documents includes indications, equivalent drugs already on the Preferred Drug List, pricing, clinical considerations and a discussion of the medication's place in therapy. A detailed monograph for each drug to be considered is also made available to committee members at the meeting. The detailed monograph includes information regarding the medication's pharmacology, pharmacokinetics, documented efficacy, warnings, drug interactions, and potential adverse events. The detailed monograph is fully referenced and includes the results of clinical trials.

The development, maintenance, and improvement of this process is ongoing and requires constant attention. This is accomplished by the Plan's P&T Committee. The Plan's P&T Committee is the policy recommending body to Prominence Health Plan. The Plan's Pharmacy Benefits Guide mirror the prevailing clinical opinion of the Plan's P&T Committee.

The Plan's P&T Committee reviews the Pharmacy Benefits Guide annually. The Plan reviews the Specialty Drug List quarterly and the Preferred Drug List annually.
The Plan's P&T Committee uses the following criteria in the evaluation of product selection:

- The drug product must demonstrate unequivocal safety for medical use, and be FDA approved for the indicated use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition.
- The drug product must demonstrate a therapeutic outcome.
- The drug product must be accepted for use by the medical community.
- The drug product must have an equitable cost ratio for the treatment of the medical condition.
- Drugs are not reviewed until they have been available to the public for at least six months.

MEMBER COPAYS

For copay information Prominence Health Plan members can refer to their schedule of benefits, call MedImpact Customer Service at 833-775-MEDS (6337) or contact the Prominence Health Plan Customer Service Department at 800-863-7515, Monday through Friday, 7:30 am to 5 pm, PT.

COMPOUNDED DRUGS

All compounded drugs are excluded from coverage.

EXPERIMENTAL DRUGS

The experimental nature or use of drug products will be determined by the Plan's P&T Committee using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage.

INJECTABLE DRUGS

All injectable drugs, with the exception of Insulin, Glucagon, Imitrex, and EpiPen products, require a prior authorization. In most cases, Prominence Customer Service will direct the member to a designated pharmacy to obtain the injectable drug. Self-injectable drugs may be subject to 20% copay or a deductible. For questions, contact Prominence Customer Service at 800-863-7515, Monday through Friday, 6am to 5pm, PT.

MAINTENANCE DRUGS

A member may purchase three (3) months of any 'Maintenance Medication' through the Plan's Prescription Mail Program. Maintenance medications are defined as drugs that are safe to be taken on a chronic basis and are taken for chronic disease states. Please call 844-282-5339 to inquire about specific medications.

DISPENSE AS WRITTEN (DAW) POLICY

Prescription drugs will always be dispensed as ordered by the physician and in compliance with applicable state and federal pharmacy regulations. Prominence Health Plan requires that the least expensive generic medication be dispensed. However, the prescribing physician or member may request that a brand-name drug be dispensed when a generic equivalent is available. If an equivalent generic is available, the member may be responsible for the cost difference between the generic and brand name, in addition to the generic copayment.

PARTIAL FILL (PF)

The Prominence Health Plan Partial Fill Program consists of a limit on the initial three months of selected medications to a 14- or 15-day supply. Specific specialty medications are targeted for the program due to high discontinuation rate, poor response, adverse effects, and/or noncompliance

Those drugs available for partial fill have an annotation of "PF" next to the drug name on the Formulary.

STEP THERAPY (ST)

Prominence Health Plan is committed to making the use of your prescription drug benefit easier, less complicated, and less expensive. Step Therapy is a clinical program designed to help and is a process for finding the best medication to help treat an ongoing condition such as arthritis, asthma, or high blood pressure. One drug must be tried before the next one. These are considered "steps" of therapy.

How does the Step Therapy Program work?

Step Therapy Programs require the use of one or more Step One medication(s) (often a more affordable generic medication) that has been proven effective for most people with your condition before you can get a similar, more expensive, brand-name drug covered. This means that Step Two drugs will not be covered until Step One prescription drugs are first tried unless your physician contacts Prominence to obtain a prior authorization.

Who decides the order of drugs to be taken?
The Prominence Pharmacy and Therapeutics Committee carefully reviews medical literature, manufacturer product information and recommendations of the medical community. This committee consists of medical experts including doctors and pharmacists.

What if I need to skip a step?
Your Provider may contact Prominence's Pharmacy Helpdesk to request this approval. **This is called prior authorization**. This is a review between your Provider and Prominence to determine the medical necessity of the request. To request authorization to skip a step, your Provider can call Prominence's Pharmacy Helpdesk at 833-775-MEDS (6337) and provide a justification for why alternative treatments are not appropriate for you.

How do I submit an Appeal if my request is still denied?
Your Provider must submit a request for an Appeal, in writing, outlining the reason for the Appeal, and including clinical or other information to Prominence within 180 calendar days after notification of Your denial notice. Send completed written Appeals to:

Prominence Health Plan
Attn: Appeals and Grievance Department
1510 Meadow Wood Lane
Reno, NV 89502

For an Expedited, Urgent Appeal, You or Your Provider must contact Prominence Health Plan's Customer Service by telephone or by fax: **Telephone:** 800-863-7515 **Fax:** 775-770-9365

Prominence will respond to standard request in no more than two (2) business days. For medically urgent requests, Prominence will respond within 24-hours after the request is made.

What treatments require Step Therapy?
Those drugs requiring step therapy have an annotation of "ST" next to the drug name on the formulary.

What if I have already gone through step therapy with my previous health insurance company?
Your Provider will submit a request for prior authorization, documenting which prescription drugs you have already tried, why it/they were ineffective, and if you are stable on the prescription drug selected by Your attending Provider for the medical condition under consideration.

Where can I get more help?
Please call Prominence Health Plan at 833-775-MEDS (6337). Representatives are available 24 hours a day, seven days a week.

PRIOR AUTHORIZATION (PA)

Prominence Health Plan and MedImpact, your pharmacy benefit manager, are committed to making the use of your prescription drug benefit easier, less complicated and less expensive. Prior Authorization (PA) is a clinical program designed to help.

What is Prior Authorization (PA)?
Prior Authorization means that approval must be given for certain drugs to be covered by your plan. MedImpact works with your doctor or provider to make sure coverage is appropriate for certain medication.

How does a Prior Authorization Program work?
MedImpact works with your doctor to ensure safe and effective use of select prescription drugs. Before your copay can be applied at the pharmacy, the drug must be approved by MedImpact with the help of your doctor.

Why do some drugs need Prior Authorization?
Some medications have a high possibility of misuse or being used outside the expert guidelines. In some cases, there are specific doses and quantities that should be used.

Who decides which drugs to include for Prior Authorization?
A team of independent, licensed doctors, pharmacists and other medical experts review and discuss the latest medical guidelines and research. They decide which drugs should be included in the Prior Authorization Program.

How do I know if my prescription needs a Prior Authorization?
Those drugs requiring prior authorization have an annotation of "PA" next to the drug name on the formulary and PDL.

What if the Prior Authorization request is not approved?
If the prior authorization is denied, you will be responsible for the full cost of your prescription at the pharmacy. You may fill your prescription, but your copay will not apply. You may also appeal any decision to Prominence.

Prior Authorization Forms may be requested by:

- Visit the secure member portal at ProminenceMember.com;
- Contacting the health plan Pharmacy Benefit Manager at 833-775-MEDS (6337) or by logging onto MedImpact's web site at www.medimpact.com; or
- Contacting Prominence Health Plan Customer Service team at 800-863-7515, Monday through Friday, 7:30 am to 5 pm, PT.

Each request will be reviewed on an individual patient basis. Approval will be granted based on documented medical need. It is the Plan's policy to issue a decision for those requests that do not require additional information, within 72 business hours after receipt of the request. In the event of a denial, the Practitioner and the member are both notified by letter, which will include the reason for denial and appeal rights.

Requests for prior authorizations should be faxed to MedImpact at 858-770-7100.

QUANTITY LIMITS (QL)

A number of drugs are available with certain restrictions, such as Quantity Limits (QL'S) and age restrictions.

Quantity Limits (QLs) are specific limits applied to medications, which help assure an appropriate quantity is dispensed as it relates to the days supply or length of therapy. The health plan may implement quantity

limitations for medications based upon FDA-approved dosages, safe use of medications, or recommendations of specialists. Some examples include:

1. Toxicities associated with chronic high-dose Acetaminophen – acetaminophen-containing (e.g. Lortab, Lorcet, or Vicodin) products are limited to allow a maximum of 4 grams of acetaminophen/day
2. Drugs limited to one tablet/capsule per day according to FDA-approved dosage and drug studies – e.g. Geodon, Lipitor
3. Drugs intended for short-term use only - e.g. Sleeping Aids, antibiotics, antifungal agents
4. Drug used to treat migraine headaches - e.g. Axert, Relpax, sumatriptan
5. Some antiemetics - e.g. Zofran, Kytrel
6. Some oncology drugs, e.g. Tarceva, Nexavar

Age Limits are specific age restrictions that are based on FDA recommendations to ensure the safe use of medications. Some examples include:

1. Paxil not covered for those less than 18 years of age.
2. Alinia 500mg tablets not covered for those less than 11 years of age.

Which drugs have quantity limits applied?
Those drugs with quantity limitations applied have an annotation of "QL" next to the drug name on the formulary and PDL.

OPIATE NÄIVE

A member is designated as Opiate Naïve if they have not had a prescription filled within the last 60 days. If a member is Opiate Naïve, they can receive up to a seven-day medication supply for the first prescription filled. After the initial fill, the member can receive up to a 30-day supply.

It is common for new Prominence members who have opiate medications regularly prescribed and filled to flag as Opiate Naïve because Prominence does not have the prescription history from the previous health carrier. Because of this, new members will receive up to a seven-day medication supply for the first prescription filled and then up to a 30-day supply for subsequent prescriptions.

COVERAGE LIMITATIONS/EXCLUSIONS

The Formulary and Preferred Drug List may not provide information regarding the specific coverage and limitations an individual member may have. Many members have specific exclusions, copays or a lack of coverage that is not reflected in this list. Refer to the schedule of benefits for specific coverage and limitations.

The following general exclusions pertain to all covered individuals:

1. Cosmetic and Aging of the Skin products: Cosmetic products, health and beauty aids, all products used to retard or reverse the effects of aging of the skin, whether prescription or non-prescription, and any drugs/products for the treatment of hair loss.
2. Dietary Aids and Appetite Suppressants: Dietary or nutritional products, including prescription or non-prescription vitamins (except those prescribed pre-natal vitamins listed on the Prominence Preferred Drug List), appetite suppressants, and diet pills used for weight reduction.
3. Experimental or Investigational drugs: Any drug labeled "Caution: Limited by Federal Law to

Investigational Use," as well as drugs either not approved by the Federal Drug Administration as "safe and effective" as of the date this rider is issued to the group or, if so approved, which are intended to treat a condition for which the U.S. Food and Drug Administration (FDA) has not approved its use, whether used on an inpatient or outpatient basis.

4. Fertility drugs: Drugs/Products used for the treatment of impotence or infertility.
5. Sexual Dysfunction drugs
6. Nail Fungal Medications and/or Preparations
7. Non-Approved drugs: Drugs determined by the Prominence Pharmacy and Therapeutics Committee as ineffective, duplicative, or as having preferred formulary alternatives.
8. Non-Covered Service: Any Prescription Drug prescribed in connection with a Non-Covered Service.
9. Non-Plan Pharmacies: Any Prescription Drug purchased at a Non-Plan Pharmacy except for covered out-of-area emergency situations.
10. Over the counter drugs: Over-the-counter drugs and other items which do not require a prescription even if ordered by a Prominence plan practitioner by a prescription, or drugs administered in a practitioner's office. Any Drug which becomes available over the counter will not be covered either in its Brand or Generic form.
11. Compound medications
12. Any other drug or product as determined by the Plan's Pharmacy and Therapeutics Committee.

MEMBER COMMUNICATION

Members will be notified by letter when a drug they have taken within the last two months is being removed from the Preferred Drug List or will no longer be covered by the Plan. The communication will usually include information regarding similar drugs available on the Preferred Drug List. Members will also be notified by letter when a drug they have taken within the last three months has been removed from the market by the FDA.

PHARMACIST AND PHYSICIAN COMMUNICATION

The Plan's Formulary is a tool to promote effective prescription drug use. The Plan's P&T Committee has made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. The Plan welcomes the participation of practitioners, pharmacists, and ancillary medical providers, in this dynamic process. Practitioners and pharmacists are highly encouraged to direct any suggestions, comments or preferred drug additions to the Plan at the following address:

Prominence Health Plan Medical Director
c/o Pharmacy & Therapeutics Committee
1510 Meadow Wood Lane
Reno, Nevada 89502

Appropriate practitioners will be notified by letter when a drug that they have prescribed for a Plan member within the last two months has been removed from the market by the FDA. A list of those members affected will be provided with this letter.

Pharmacists will be notified at the point of service by the Plan's Pharmacy Benefit Manager of drug interactions

at the time the prescription claim is filed electronically. The types of interactions that Pharmacists are notified of include:

- drug-to-drug
- drug age
- drug allergy and;
- drug under-/over-utilization.

The pharmacist will be notified of the potential severity of each interaction when they meet the organization's severity threshold, but it will be left to their professional discretion as to how the interaction is resolved.