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PRESCRIPTION DRUGS, Explained

You're at the pharmacy to fill a prescription. Your pharmacist is unable to provide a generic drug because your doctor marked the script "Dispense as Written". Do you know what this means? How about the difference between a preferred and non-preferred drug?

Pharmacy jargon can be a little confusing — especially when you're sick — so familiarize yourself with these common terms to help save a little time and money in the checkout line.

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty

- Generic Drugs – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- Preferred Drugs – Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- Preventive Drugs – Certain medications may be available to you at $0 cost share or before satisfying your deductible if your plan has a Preventive Drug List. Drugs on this list will vary from plan to plan, so this may not apply to you.
- Non-Preferred Drugs – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- Specialty Drugs – Prescription medications used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Because of the high cost of these specialty drugs, many insurers require that specific criteria be met before a drug is covered. These requirements often include:
  - ✓ Performing a prior authorization to request coverage of the medication
  - ✓ Having a specific disease that the drug is FDA-approved to treat
  - ✓ Having a history of trying and failing cheaper medications
  - ✓ Restricting what pharmacy can dispense these medications

Direct Member Reimbursement (DMR) – Direct member reimbursement is a paper claim submitted directly by a patient. This method of reimbursement is used when a patient has to pay full price for a drug or does not have their drug identification card with them at the pharmacy store. Usually forms require the original prescription label receipt — cash register and credit card receipts alone are will not be acceptable as proof of purchase.

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Dispense as Written (DAW) – While many states mandate that pharmacists deliver a generic version whenever available to reduce medical costs, Dispense as Written overrides the mandate, requiring that the prescription be filled with the specific name-brand drug that the doctor is prescribing.

While many researchers report that most DAW prescriptions are the result of a distrust of generic drugs, many doctors simply write a DAW script out of habit and name recognition of a name-brand drug. As there is a direct line between opting for generic drugs and saving money, many jurisdictions are moving to limit the DAW override in favor of the consumer.

Home Infusion – A drug that is administered intravenously, or through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Home infusion typically involves the administration or medication through a needle or catheter. Diseases commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics, cancer, dehydration, hemophilia, and multiple sclerosis. Infusible medications may also be filled in the doctor's office, outpatient hospital setting or clinic.

Because of the severity of condition and/or administration of the drugs, Prior Authorization is often required before the initiation of Home Infusion Therapy. Patients may also experience limited access to Home Infusion therapy. For example, many rural patients may not have access to the necessary services, supplies and equipment needed, due to location or gaps in coverage. Overall, Home Infusion Therapy is much more cost-effective, averaging between $150 and $200 per day, while hospitalization may average $1,500 to $2,500 per day.

Over-the-Counter (OTC) Medications – Medications made available without a prescription. A prescription for OTC medication is required for purchase through a Flexible Spending Account, while OTC health care items such as bandages, crutches and catheters are eligible.

Prior Authorization – A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you. Prior Authorization is a technique for minimizing costs, as the benefits are only paid if the medical care has been pre-approved by your insurance company. Without Prior Authorization, your insurance may not pay for your medication. Drugs that are subject to Prior Authorization may include, but are not limited to:

- ✓ Name-brand medicines that are available in a generic form
- ✓ Expensive medicines, such as those needed for psoriasis or rheumatoid arthritis
- ✓ Cosmetic drugs and drugs used to treat a non-life threatening condition (hair growth, specialty skincare, erectile dysfunction, etc.)
- ✓ Drugs not usually covered by the insurance company, but said to be medically necessary by the prescriber. Many different drugs can be used to treat the same condition. If a patient requires a particular medicine, the doctor must inform the insurance company that there are no other medicines that would be effective for the patient.
- ✓ Drugs that are usually covered by the insurance company but are being used at doses higher than normal
- ✓ Drugs that require some sort of generic test

The patient is responsible for checking with the pharmacy to ensure that the Prior Authorization is approved. A Prior Authorization may not be approved if not enough time is given to the doctor and insurance company to complete the necessary steps, the doctor's office fails to contact the insurance company, or improper pharmacy billing due to an incorrect PA code. Also, keep in mine that approval may only be valid for a limited time, and the process may need to repeat once expired.

Step Therapy – The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.