Navigating Your Prescription Drug Insurance

A guide to help you understand how your prescription drug insurance plan[a] works

(Click to begin)

Table of Contents

[a] This guide is for people who have a commercial insurance plan through their employer. This information does not apply if you have another type of insurance plan (for example, Medicaid, Medicare, or other insurance provided by the state or federal government).

This guide provides general information about prescription drug insurance plans. Specific details vary from one plan to another, and from one state to another. To confirm your plan's specific policies or to determine what services or products they cover, always check with your insurance company or your employer's Benefits Manager.

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Table of Contents (Click a topic below)

ABOUT PRESCRIPTION DRUG INSURANCE

Medical vs prescription drug insurance 3

About pharmacy benefits managers (PBMs) 5

About specialty pharmaceuticals and specialty pharmacies 7

HOW SPECIALTY PHARMACEUTICAL DRUG CLAIMS ARE APPROVED OR DENIED

How a claim is processed 9

Once a claim is approved 12

Why a claim may be denied 13

What to do if a claim is denied 15

- Requesting a formulary exception 15
- Filing an internal appeal 16
- Requesting an external review 17
- Tips for calling your plan 18

GETTING APPEAL HELP

Where to look for additional help with appeals 19

GLOSSARY 21

EXAMPLE CALL RECORD 24

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Medical vs Prescription Drug Insurance

Your health insurance plan may include both medical and prescription drug insurance

Many people believe their employer offers **prescription drug insurance** directly through their health insurance plan. However, that is not always true. Many health plans separate insurance into 2 parts:

- **Medical health insurance**, which generally covers the costs of expenses other than prescription drugs—for example, **office visits**, **hospital stays**, and **trips to the emergency room**

- **Prescription drug insurance**, which covers the costs of prescription drugs or medicines. Many health insurance plans outsource prescription drug benefits to a type of company known as a **pharmacy benefits manager (PBM)**

Medical vs Prescription Drug Insurance (cont'd)

Check your health insurance card(s) to find out who provides your prescription drug insurance

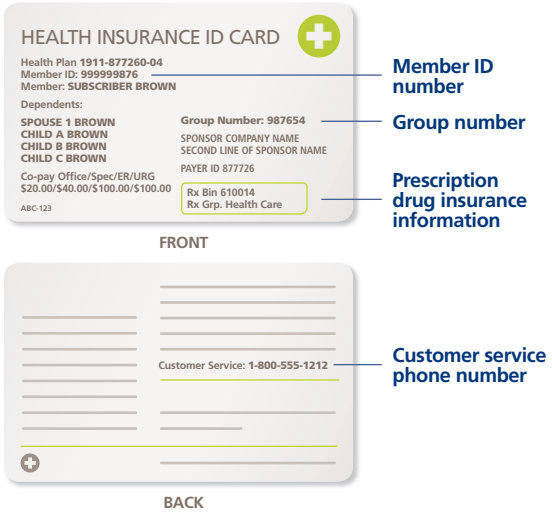
Some plans provide you with separate identification cards for your prescription and **medical insurance**.

If you have questions about your health insurance plan or the medical and prescription drug benefits it includes:

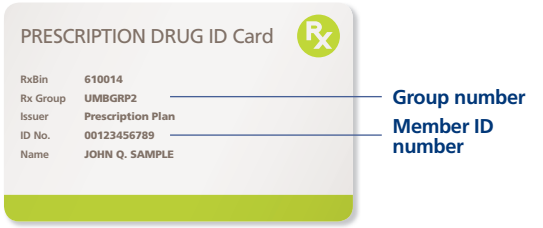
- **Call the customer service phone number** listed on your card(s). This phone number may appear on the back of your card, along with other information you may need to know
- **Talk to your employer's Benefits Manager**, who usually works in the Human Resources department. The Benefits Manager is responsible for all of the benefits a company offers its employees, including medical and prescription drug insurance. She or he can advise you on the benefits included in your employer's plan, answer questions, and assist you with any concerns or issues you may have

Single Health Insurance ID Card

Includes information about both your medical and prescription drug insurance.



Prescription Drug Insurance ID Card



Be sure to look at both sides of your insurance card(s) because there may be important information on the back.

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About Pharmacy Benefits Managers (PBMs)

What you need to know about PBMs

A **pharmacy benefits manager (PBM)** is a company that manages the prescription drug benefits included in the health insurance plan your employer provides you. The PBM is responsible for helping you and your health insurance plan access prescription drugs at the lowest cost to your plan and to you.

PBMs create the drug formulary for your plan

One of the main services PBMs provide to prescription drug plans is to develop a **formulary**. A formulary is the list of drugs that the plan covers. Most formularies include certain drugs and exclude others.

Some common PBMs you may know by name are:

- Argus®
- CVS/caremark™
- EnvisionRxOptions
- ExpressScripts®

To find out if a prescription drug is on your plan's formulary, you can:

- **Call** the plan at the customer service phone number on your insurance card
- **Visit** the plan's website. Many plans offer online formularies that you can search (Note: If the drug is not listed in your plan's formulary, it is usually not covered)
- **Ask** your employer's Benefits Manager if he or she can provide you with your prescription drug plan's formulary

About Pharmacy Benefits Managers (PBMs) (cont'd)

PBMs develop co-payment tiers for the drugs in your plan's formulary

Within your plan's formulary, drugs are grouped into **co-payment** tiers, which are usually just called **tiers**. Most plans have 4 or 5 tiers, but the number varies from plan to plan. Prescription drugs in the lowest tiers (**Tiers 1 and 2**) usually have the lowest co-payment, and tend to be generic drugs; prescription drugs in the highest tiers (**Tiers 4 and 5**) usually have the highest co-payments and tend to be brand-name drugs.

PBMs contract the pharmacies in your plan's network

Another service PBMs provide is contracting with pharmacies to participate in your plan's network. In the same way that not all doctors participate in your **medical insurance** plan, not all pharmacies participate in your prescription drug plan. Before you fill any prescription, you may wish to confirm which pharmacies are in your plan's network. This applies to retail pharmacies (also known as neighborhood drugstores) as well as the types of pharmacies that mail prescription drugs to you, such as **specialty pharmacies**.

If you take a prescription to a pharmacy that is **not** in your network, you will be required to pay the **full cost** of the drug yourself.

We will refer to PBMs as your **"prescription drug insurance"** or **"prescription drug plan."**

About Specialty Pharmaceuticals and Specialty Pharmacies

What is a specialty pharmaceutical?

Specialty pharmaceuticals (also known as specialty drugs) are high-cost drugs prescribed to treat complex conditions and which usually have special handling requirements. In general, specialty pharmaceuticals:

- Are prescribed to treat complex, chronic, and/or rare conditions
- Have a high cost—often more than **$10,000** per year, and in some cases more than **$100,000** per year
- Have special storage, handling, and/or administration requirements
- Are available through certain pharmacies, known as **specialty pharmacies**

Specialty pharmaceuticals are usually shipped directly to you by a specialty pharmacy.

Because they are complex, specialty drugs may require that patients taking them receive ongoing monitoring and education. The specialty pharmacy that manages the drug usually provides these.

About Specialty Pharmaceuticals and Specialty Pharmacies (cont'd)

What is a specialty pharmacy?

A **specialty pharmacy** is one that manages specialty pharmaceuticals. Because these drugs require ongoing patient monitoring and education, specialty pharmacies provide additional services that traditional pharmacies do not provide. Specialty pharmacy services may include:

- Communicating directly with doctors and following up if needed
- Investigating a patient's health insurance benefits
- Assisting with prior authorization requests
- Dispensing and mailing specialty pharmaceuticals to patients
- Researching financial assistance and helping patients enroll in **patient assistance programs (PAPs)**
- Proactively notifying patients about prescription refills
- Educating patients about their medication and the potential side effects it may cause

Some common specialty pharmacies you may know by name are:

- Accredo®
- BriovaRx®
- CVS/caremark™
- Diplomat®
- Prime Therapeutics®

How a Claim Is Processed

Step 1

Doctor prescribes specialty drug

If your doctor determines that a specialty drug is right for your condition, she or he will prescribe it for you. Because specialty drugs can be expensive and may require special handling and monitoring, your **prescription drug insurance** plan may require that you and your doctor submit extra information before approving the **claim**.

Step 2

Doctor performs benefits investigation to determine coverage

Once you have been prescribed a specialty drug, your doctor will perform a complete **benefits investigation (BI)** to confirm the benefits your prescription drug insurance plan offers. Some pharmaceutical companies and specialty pharmacies can assist doctors with BIs. You may be required to provide some information, too.

(Click to move to specific step)

1 Doctor prescribes specialty drug
2 Doctor performs benefits investigation to determine coverage
3 Doctor prepares claim, including request for prior authorization
4 Plan receives and reviews claim
5 Claim decision

How a Claim Is Processed (cont'd)

Step 3

Doctor prepares claim, including request for prior authorization

The investigation will help determine whether your plan will cover the prescribed specialty drug, how much it will cost you, and whether the plan requires **prior authorization (PA)** for that drug. PA means that a drug must be preapproved by your prescription drug plan before the plan will cover the cost of the drug. Many plans require PA for **specialty pharmaceuticals**.

As part of this step, the doctor may also be required to submit other information as part of the claim, such as:

- The results of any tests or procedures that confirm your diagnosis
- Proof that you have tried other therapies
- A **letter of medical necessity** that explains why you need the specialty drug prescribed

(Click to move to specific step)

1 Doctor prescribes specialty drug

2 Doctor performs benefits investigation to determine coverage

3 Doctor prepares claim, including request for prior authorization

4 Plan receives and reviews claim

5 Claim decision

How a Claim Is Processed (cont'd)

Step 4

Plan receives and reviews claim

When your plan receives a claim for a specialty drug, it reviews the claim to confirm that:

- You (or the person for whom the drug is prescribed) are a member of the plan
- The drug is covered by your plan's **formulary**
- The supporting information the plan requires has been provided by you, your doctor, or the **specialty pharmacy**

Step 5

Claim decision

After confirming the information in Step 3, the plan approves the claim or denies it.

- **If the specialty drug claim is approved**, the plan informs the specialty pharmacy and communicates what your share of the payment will be
- **If the prescription claim is denied**, the plan informs the specialty pharmacy, the doctor, or you and explains why

(Click to move to specific step)

1 Doctor prescribes specialty drug

2 Doctor performs benefits investigation to determine coverage

3 Doctor prepares claim, including request for prior authorization

4 Plan receives and reviews claim

5 Claim decision

Once a Claim Is Approved

Step 1

Upon approval, the specialty pharmacy fills the prescription

Once the claim has been approved, the specialty pharmacy collects your share of the drug cost, fills the prescription, and ships it to you.

Step 2

You receive the prescription

The staff at the specialty pharmacy will tell you when the drug will arrive, and they may call to confirm that you have received it. They may also tell you more about the drug or its possible side effects. In addition, they may call you from time to time to ensure you are taking the drug regularly, as your doctor prescribed.

Why a Claim May Be Denied

There are a number of reasons a prescription drug insurer may deny (refuse to pay for) your claim. Here are some common reasons for denials, and what you can do when a claim is denied.

Inaccurate information was provided

Your doctor or pharmacist may have entered information incorrectly. They may have entered your birth date or insurance information incorrectly, or provided the wrong drug code that the insurer requires. If you recently changed insurance plans, the pharmacy may still be submitting claims to your old plan.

Actions you can take:

Your doctor or pharmacist can usually correct these types of errors in your records or in the claim form before the pharmacy resubmits the claim.

An administrative error occurred

The insurer may not have entered you in their system yet, or they may have entered the wrong information and do not recognize you (yet) as one of their members.

Call the insurance company to confirm membership before the pharmacy resubmits the claim.

Incomplete information

The plan needs additional information about your diagnosis or the reasons your doctor has prescribed the drug before it will approve the claim.

Your doctor may need to submit additional information (for example, test results) before the pharmacy resubmits the claim.

Why a Claim May Be Denied (cont'd)

Medical necessity

The plan does not consider the prescribed drug to be **medically necessary** for you, or requires that you demonstrate **medical necessity**.

Actions you can take:

Your doctor may need to write a letter of medical necessity to explain to the plan why the drug is necessary for you. The plan will review the letter before determining if it will cover the drug prescribed.

Prior authorization

The plan requires that you apply for approval in advance (receive prior authorization) before it will cover the cost of the drug.

Your doctor (and possibly you) will need to submit information to receive authorization. Some plans provide unique prior authorization forms that must be completed and submitted for approval. A plan reviews this form before determining if it will cover the drug prescribed.

Step therapy

Your plan requires that you start and fail on a less expensive drug before the plan will cover the cost of a more expensive drug.

Your doctor will need to provide your plan with information about your treatment as part of a formal request for coverage of the drug prescribed.

There are other reasons a plan may deny coverage of a drug. If you have questions about a denial, you should call the customer service phone number on your health insurance card to find out more about why the claim was denied.

What to Do if a Claim Is Denied

When a health insurer denies a prescription drug claim, many plans are required to explain why and they must tell you how you can dispute their decision. Depending on the reason the claim was denied, you may be able to ask your plan to reconsider their decision. You may be able to get support from:

- Your doctor's office
- The **specialty pharmacy**
- Support programs (that are sometimes offered by the companies that make the drug you have been prescribed)
- Your employer's Benefits Manager

3 steps you can take to have the plan reconsider a decision to deny your claim are:

- Asking your plan for a formulary exception
- Filing an internal appeal
- Requesting an external review

Requesting a formulary exception

If your doctor prescribes a drug that your prescription plan does not cover, you may request a **formulary exception** (usually referred to as "an exception"). The process for requesting an exception can vary from plan to plan, and the requirements may vary as well. If you would like to request an exception, call your plan to find out what you or your doctor needs to do.

The plan may require that your doctor submit additional information or complete a form in order to:

- Confirm that the drug is appropriate for your medical condition
- Explain that other drugs the plan covers for your condition have not been effective, or will not be as effective as the one requested, or may cause side effects that may be harmful to you

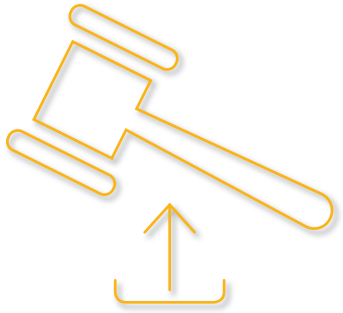
What to Do if a Claim Is Denied (cont'd)

Filing an internal appeal

When you file an **internal appeal**, you are formally requesting that the plan review its decision to deny your claim. The plan will be required to make a full review, which may be conducted by employees of the plan who were not involved in the original decision.

You, your doctor, and/or pharmacist may need to submit more information about your claim, and many plans require that you complete an **appeal** form as part of your request. Appeal forms vary from plan to plan, but in general you may be asked to provide information such as:

- Member's name (if it's not you)
- Member's ID number
- Member's group number
- Name of the drug
- Name of the prescribing doctor, and her or his address and phone number
- Reason the member is appealing the decision



Always confirm any time limits for submitting an internal appeal when you speak with the customer service representative at your plan.

See questions you may wish to ask your plan about your denial

What to Do if a Claim Is Denied (cont'd)

Requesting an external review

If the plan reviews your **internal appeal** and still denies your request that they cover a drug, you can then request an **external review**. This review will be conducted by an independent third party—people who do not work for your insurance company. If the external reviewer reverses your **prescription drug insurance** plan's denial, the plan must pay for the claim you have appealed.

The process of requesting an external appeal can vary. To find out how, start with your plan:

- **If it rejected your internal appeal**, it must explain the reason for the rejection. Some plans are required to provide a formal denial notice after an internal appeal, and this notice must explain how you can request an external review if you disagree with their decision. As with internal appeals, you may be required to make your request within a defined number of days or months
- **After you gather the information** you need from your prescription drug plan, call the independent reviewer to confirm what you must do to submit your request, what the time limit to file your request will be, and whether there are any requirements you must follow

If you need help requesting an external review, check to see if your state has a consumer assistance program that can help you with your request.

Some older plans are not required to provide appeals; your right to appeal may also depend on the state where you live and the type of plan you have. To find out more, check with your health insurance company or your employer's Benefits Manager.

What to Do if a Claim Is Denied (cont'd)

Tips for calling your plan

Before you call

- Write down everything you know about the denial:
  - Name of the drug
  - Date the claim was denied
  - Prescribing doctor's name and address
  - Pharmacy's name and phone number
  - Reason the original claim was denied (if you know)
- If the insurer has sent a written denial, have the form with you. There may be a claim number or other information on the form that the customer service representative will ask you to provide
- Have your insurance card available. The customer service representative may ask for information on the card

During your call

- Write down all of the following information:
  - Date and time you call the plan
  - Full name, job title, and phone number or extension number of the customer service representative who answers your questions
  - Any information the representative provides you about the reason the claim was denied
  - What the representative suggests you do next to appeal the denied claim

By recording all of this information:

- You create a record you can share with the prescribing doctor or his/her office staff if you need to
- You can refer to this record if you need to call the plan again later. If you do call again, ask if you can speak to the same customer service representative you spoke with previously

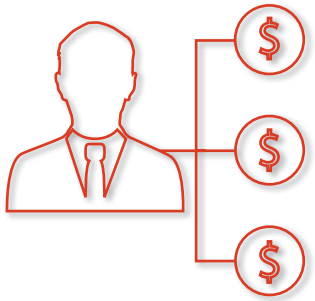
Questions you may wish to ask about your denial

Below are some questions you may wish to ask the customer service representative who talks to you about your denied claim:

- Why was this claim denied?
- What can I do next?
- Can I appeal this denial?
- How do I appeal?
- What information do I need to provide as part of this appeal?
- What information do you need my doctor to provide as part of this appeal?
- Are there any forms I need to complete as part of my appeal? If there are, how can I obtain them?
- Is there a time limit for filing this appeal?
- How long will it take for your company to make a decision about this appeal?

Where to Look for Additional Help With Appeals

Contacting your health plan and your doctor may be your first steps in getting help with an **appeal**, but there are other sources that may be able to help you, as well. Below are a few suggestions:



Your employer's Benefits Manager

Depending on the circumstances, the Benefits Manager might be able to send a letter or call the plan and explain why your **claim** is valid. This could persuade the insurance plan to reverse its decision and pay your claim.

Employee support programs

Some employers include health care advocate services as part of their employee support program. The services vary—some provide over-the-phone advice only, while other programs have care managers who can meet in person with you and your health care provider.

Specialty pharmacies

If the drug prescribed is a specialty pharmaceutical, the **specialty pharmacy** that distributes it may offer help in submitting prior authorization requests or appeals.

Where to Look for Additional Help With Appeals (cont'd)

Links provided as a public service and for informational purposes only. No endorsement is made or implied.

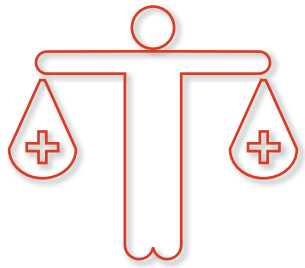
Your state's Consumer Assistance Program

Some states sponsor Consumer Assistance Programs that can help you file an appeal or request an **external review** if your plan does not cover a drug your doctor prescribes for you. Visit **LocalHelp.HealthCare.gov** to learn about help that may be available in your area.

Nonprofit organizations

Some nonprofit organizations dedicated to a specific health condition offer information or resources to help you navigate health insurance appeals. For example:

- **The MAGIC Foundation** at **1-800-362-4423** or visit **https://www.magicfoundation.org/Financial-Assistance/**
- **Good Days from CDF** at **1-877-968-7233** or visit **http://www.mygooddays.org**
- **American Diabetes Association** at **1-800-342-2383** or visit **http://www.diabetes.org/living-with-diabetes/health-insurance/prescription-assistance.html**



Patient advocates

A patient advocate is someone who helps you with a broad range of health care issues, which can include health insurance issues. The Patient Advocate Foundation is an organization that advocates for patients, and can offer help with appeals and prior authorizations. Visit **http://www.patientadvocate.org/patient_services.php?p=757**.

Appeal: A request that your medical or prescription drug insurance plan review a decision they made in which they denied coverage or payment of a medical service or prescription drug.

Benefits investigation (BI): A process used to determine the benefits your prescription drug plan provides, whether a specific drug is covered, and what your share of the cost of a drug is.

Claim: A request for payment that you or your health care provider submits to your insurance company for a prescription drug or medical service.

Coinsurance: The amount of money you pay for a covered medical service after you have paid your plan's deductible. With coinsurance, the amount you must pay is usually a percentage of the cost. For example, if your coinsurance is 20%, that means you pay 20% of the cost and your plan pays the remaining 80%.

Commercial insurance plan: A health insurance plan that is paid for by someone other than the government. Usually, commercial health insurance is paid for by an employer or union, but some people may buy their own individual plan, as well.

Co-pay (sometimes called co-payment): The amount of money you pay for a medical service or prescription drug that is covered by your plan.

Deductible: The amount of money you pay for covered services or drugs before your plan starts to pay. For example, if you have a $1,000 deductible per year, you must pay the first $1,000 in covered services and drugs yourself before your plan starts to pay. After you have paid your deductible for the year, you usually pay only co-payments or coinsurance for services and drugs; your plan pays the rest.

External review: A process in which an independent third party reviews your plan's decision to deny a claim as part of an internal appeal. The third party that performs the review has the authority to either uphold or overturn your plan's decision to deny the claim.

Formulary: The list of drugs that are covered by a prescription drug plan.

Formulary exception: A request to make a nonformulary prescription drug available to a patient as a formulary drug.

Internal appeal: A formal request that your plan conduct a full and fair review of its decision to deny a claim you have submitted.

Letter of medical necessity: A letter a doctor must write explaining why a prescribed drug or medical service is necessary for the patient.

Medical insurance: The part of your health insurance that covers the costs of expenses other than prescription drugs (for example, office visits, hospital stays, and trips to the emergency room).

Medical necessity: See Medically necessary drugs/services below.

Medically necessary drugs/services: Procedures, treatments, drugs, or services that a health care provider would provide to prevent, evaluate, diagnose, or treat a patient's illness, injury or disease, or symptoms, according to generally accepted medical standards. Many health insurance plans cover only services they deem to be medically necessary.

Patient assistance programs (PAPs): Programs offered by pharmaceutical companies to provide free or low-cost prescription drugs to individuals who qualify.

Pharmacy benefits manager (PBM): A company that manages the prescription drug benefits included in the health plan your employer provides you.

Prescription drug insurance: The part of your health insurance that covers the costs of prescription drugs.

Primary insurance plan: For people who are covered under more than one health insurance plan, the primary plan is the one that pays expenses first. If you have insurance through your employer, this plan is usually considered your primary insurance plan. For more information, see the definition of secondary insurance plan.

Prior authorization (PA): A type of preapproval your prescription plan requires before it will cover the cost of a drug.

Quantity limits: Limits on the amount of a prescribed drug you can receive in a defined period. For example, a once-a-day pill may have a quantity limit of 30 pills for 30 days. The limits are usually based on a drug's approved dosing and usage guidelines, and are intended to help prevent waste and inappropriate use.

Secondary insurance plan: For people who are covered under more than one health insurance plan, the secondary plan is the one that pays second. If your primary insurance plan does not cover an expense, or only partly covers it, you can submit the unpaid part of the claim to your secondary plan.

Specialty pharmaceutical: A high-cost drug that usually has special storage, handling, or administration requirements and is prescribed to treat a complex, chronic, or rare condition.

Specialty pharmacy: A pharmacy that manages specialty pharmaceuticals and provides additional services that traditional pharmacies do not provide.

Step therapy: The practice of requiring patients to start drug therapy for a medical condition using a less expensive drug—and proving that it does not work for the patient—before an insurance plan will cover the cost of a more expensive drug for the condition.

Tiers (or co-payment tiers): A method of grouping drugs within a formulary based on the amount of co-payment charged.

Use this page to write down important information about your conversation with your prescription drug plan's customer service representative. You may wish to photocopy this page or print it again in case you need to call the plan again later. You should keep a record like the one below each time you call your plan.

Date of call: _____ Time of call: _____

Customer service representative's name: _____

Customer service representative's title: _____

Phone: _____ Email: _____

Important topics you discussed during the call: _____

_____

_____

Why your claim was denied: _____

_____

Documents you have sent, or will send (if any): _____

_____

Date sent: _____

Documents you have received, or will receive (if any): _____

_____

_____

Identification number for this call (if you are given one): _____

Next steps you need to take: _____

_____

_____

Time limit (if there is one): _____

Notes:

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