EXPRESS SCRIPTS®

PRIOR AUTHORIZATION

Making sure your medicine is right for you.

At Express Scripts, we make the use of prescription medicines safer and more affordable. That's why, when you're prescribed certain medicines, your pharmacist may tell you it requires prior authorization. That means we need more information to make sure the prescribed medicine will work well for you and your condition and that it's covered by your pharmacy benefit. Only your physician can provide this information and request a prior authorization for this medicine.

Please see other side

What are my options if my doctor isn't available or prior authorization is denied?

1. **Here's the first option:**
   If the pharmacist can't reach your doctor, and you need your prescription right away, you can ask your pharmacist about filling a small supply of your prescription until your doctor can be consulted. You may have to pay full price for this small supply.

2. **Here's the second option:**
   If your plan doesn't cover the medicine that was originally prescribed, ask your doctor about getting another prescription for a medicine that is covered. You'll get that medicine for your plan's copayment or coinsurance.

3. **Here's the third option:**
   You can fill the original prescription at full price.

Here's how prior authorization works

Express Scripts pharmacists regularly review the most current research on newly approved medicines and existing medicines and consult with independent licensed doctors and pharmacists to determine which medicines have been proven to be effective. The prior authorization program includes medicines with a variety of different uses. Your plan determines which medicines are covered.

The first time you try to fill a prescription that needs prior authorization (at a retail pharmacy or the Express Scripts Pharmacy℠), your pharmacist should explain that more information is needed from your doctor to determine whether the medicine is covered by your plan. The pharmacist will ask your doctor to call the Express Scripts Prior Authorization department to find out if the medicine is covered. Prior authorization phone lines are open 24/7 – so a determination can be made right away.

If you have questions about prior authorization, or about anything else in your prescription plan, we're here to help. Just call the number on your member ID card, log in at express-scripts.com or download the Express Scripts mobile app.

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DRUG QUANTITY MANAGEMENT

The right medicine in the right amount.

At Express Scripts, we make the use of prescription medicines safer and more affordable. That's why, when you're prescribed certain medicines that are a part of a drug quantity management (DQM) program, we make sure you get it in the amount – or quantity – considered safe and effective by the U.S. Food & Drug Administration (FDA). So you get the right medicine in the right amounts for good health and the health of your family.

Please see other side

DQM can save you money

Let's say your doctor decides to increase the dosage of your medicine from **one** to **two 10mg pills per day**. That means you'd need to buy two supplies of pills per month and pay two copayments*. Instead, with your doctor's approval, you could take just **one 20mg pill**, and you would only need to buy just one supply per month.

= 2 copayments

= 1 copayment

Here's how Drug Quantity Management works

The FDA, medical researchers and medicine manufacturers look at individual medicines to determine a recommended maximum quantity considered safe. This is especially important for medicines that are challenging to take in the proper dose such as inhalers or nose sprays. These medicines are then added to a DQM program. Your plan decides which of these medicines are covered.

My prescription is in a DQM program. Do I need to do anything differently?

No. When you submit a prescription for a medicine in a DQM program, you'll get the recommended amount – which should last until it's time for a refill.

NOTE: Sometimes, doctors may write a prescription for a quantity larger than your plan covers. In this case, your pharmacist can contact your doctor and discuss changing your prescription to a higher strength, if one is available.

If you run out of medicine before your refill date, it could mean you're using too much and you should talk to your doctor.

If you have questions about drug quantity management, or about anything else in your prescription plan, we're here to help. Just call the number on your member ID card, log in at express-scripts.com or download the Express Scripts mobile app.

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*Some plans may have coinsurance

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STEP THERAPY

Finding the most effective medicine for your health and your money.

Step therapy simply means making sure you get safe and proven-effective medicine for your condition – at the lowest possible cost to you and your plan sponsor.

In other words, it's how you can avoid paying more for the medicine you need.

Here's how step therapy works

A panel of independent licensed physicians, pharmacists and other medical experts work with Express Scripts to recommend medicines for the step therapy program. Together, they review the most current research on thousands of prescription medicines tested and approved by the Food and Drug Administration (FDA). Then they determine the most appropriate medicines to include in the program. Medicines are then grouped in categories, or "steps."

First-line medicines – These are the first step and are typically generic and lower-cost brand-name medicines. They are proven to be safe and effective, as well as affordable. In most cases, they provide the same health benefit as more expensive medicines, but at a lower cost.

Second-line medicines – These are the second and third steps and are typically brand-name medicines. They are best suited for the few patients who don't respond to first-line medicines. They're also the most expensive options.

On average, the cost of a generic drug is

80-85%

lower than the brand-name product.[1]

Please see other side

Here's how to start step therapy

Step 1

The next time your doctor writes you a prescription, or if your current medicine qualifies, ask if a first-line generic medicine is right for you. Often, generic medicines have the same chemical makeup as their brand-name counterparts, and the same effect in the body, so the only real difference is cost.

Step 2

Plans often cover second-line (more expensive) medicines if:

- You've tried the first-line medicine covered by your step therapy program, and you and your doctor feel that the medicine doesn't treat your condition effectively, OR
- You can't take a first-line medicine (for example, because of an allergy), OR
- Your doctor decides that you need a second-line medicine for medical reasons

How do you find out if a first-line medicine is right for you?

Only your doctor can make that decision. Log in to your account at express-scripts.com or call Express Scripts at the number on your member ID card to find out if step therapy applies to the medicine your doctor prescribed. If it does, you can see a list of first-line alternatives. You can give that list to your doctor to choose the medicine your plan covers that best treats your condition.

What happens if your doctor gives you a prescription that's not on the first-line list for your plan?

The first time you try to fill the prescription, whether it's in person or submitted to the Express Scripts Pharmacy℠ to be delivered, your pharmacist should explain that step therapy requires you to try a first-line medicine before a second-line medicine is covered. Since only your doctor can change your current prescription, either you or your pharmacist need to speak with your doctor to request a first-line medicine that's covered by your plan. If you need your prescription right away, you may ask your pharmacist to fill a small supply until you can consult your doctor. NOTE: You might have to pay full price for this small supply.

If you have questions about step therapy, or about anything else in your prescription plan, we're here to help. Just call the number on your member ID card, log in at express-scripts.com or download the Express Scripts mobile app.

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[1]U.S. Food and Drug Administration, 2016

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How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a pharmacist, physician, or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	**Patient** Automated call (and letter, if call unsuccessful)	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days				
Urgent*	72 hours	**Patient** Automated call and letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Live call and letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

External review

When and how to request an external review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to Express Scripts.

Express Scripts
Attn: External Appeals Department
PO Box 66588
St. Louis, MO 63166-6588

800.753.2851

877.852.4070

The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

How an external review is processed

Standard external review

Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an independent review organization and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO.

The IRO will notify the claimant in writing that it has received the request for an external review, and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration.

The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent external review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO and the claimant will be notified of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.