Neuropathy Action Foundation

Awareness ▪ Education ▪ Empowerment

Getting the Medications and Treatments You Need

Understanding Your Rights in Arizona

As you search for a health insurance plan or coverage for your prescription medications, it is important to understand that insurance companies no longer pay for any and all drugs at any time you need them. Instead, they offer a number of different coverage options all with their own obstacles to navigate; some even have rules that may require you to pay more for the drugs that are actually best for you. (Your insurance company will give you an "Evidence of Coverage" document that explains the rules that apply to you.)

This brochure, developed by the Neuropathy Action Foundation (NAF), contains answers to general questions regarding how prescription drug insurance works and the rights patients have to access necessary medications. It also contains sample letters and useful contacts to help you advocate for and receive the services you are entitled to.*

Needing Urgent Help

If your dispute with your insurance company involves a serious threat to your health, make sure you take prompt action. Most insurance companies offer expedited review for such cases. At the end of this document you will find some contacts to use when seeking help, including the phone numbers of applicable insurance plan regulators. If you need urgent help, make sure you say so up front.

Types of Coverage

If my doctor prescribes a drug for me, does my insurance company have to pay for it?

No. With respect to drugs, the four major types of health insurance policies provide:

- No coverage for any medications, but access to discounts that the company gets with selected pharmacies.
- Generic-only coverage that pays for most of the generic drug, assuming one exists, that is close enough to the brand name drug your doctor prescribed for you. If you need a brand name drug, you can get the same discounts as discussed above.
- Formulary coverage that pays for drugs on the list created by the insurance company. Drugs not on the list are not covered.
- Preferred drug systems that pay different amounts for drugs, depending on whether, and how much, they are "preferred" or "recommended" by the insurance company. This is known as "tiered co-payments" or "preferred drug levels." Patients who need drugs that are not "preferred" have higher out-of-pocket costs with these plans.

Brand Name vs. Generic Drugs and Substitutions

What are brand name drugs?

Brand name drugs are the drugs sold by the manufacturer that, after years of research and clinical trials, developed them. Depending on how long the drugs have been on the market, they may no longer be protected by patent laws, which provide the right to be the only drug with the same active ingredients. Once the patent ends, generic drugs, which try to copy brand name ones, may be sold to patients.

Why is there a push toward generic drugs?

They are usually cheaper than brand name drugs, which is why insurance companies prefer them. Insurance companies promote the prescription of generic drugs by: 1) only covering them and not covering brand name drugs; 2) requiring that you pay higher copayments for brand name drugs; and 3) offering physicians a financial bonus if they meet a target generic prescribing rate.

I understand that generic drugs are cheaper, but are they the same as brand name drugs?

According to the federal Food and Drug Administration (FDA), a generic drug must have the same amount of the active ingredient of the brand name drug, but may differ in other respects, such as the way the drug is released into your system or the addition of fillers such as flavors and preservatives. Further, while the FDA approves generic drugs to assure they can be used in place of brand name ones, its standards do not require that the generic be exactly the same. This is most important in the area of "bioequivalency"—the rate and way the drug is absorbed by they body. The FDA allows a difference of up to 20% from the brand name drug.[1]

* Disclaimer: Please be aware that certain instances of the word "appeal" in this brochure may or may not refer to your legal right under Arizona law to appeal a health insurer's decision. Refer to your insurance or benefit documents to learn more about your rights to appeal denials.

[1] See U.S. Food and Drug Administration, Approved Drug Products with Therapeutic Equivalence Evaluations, (28th Ed. 2008).

Are generic drugs as good for me as brand name drugs?

They can be, but it is not always the case. Because of the differences between the brand name drug and its generic counterpart, there may be a medical reason why the generic version would not be as good for you.

Can the drug my physician recommends get substituted by another drug, such as a generic one?

Yes, it can. In Arizona, if a physician prescribes a brand name drug and does not indicate an intention to prevent substitution, a pharmacist may fill the prescription with a generic equivalent drug.[2] While a pharmacist is authorized to make a generic substitution, a prescription must be dispensed as written only if the physician writes or clearly displays "DAW," "dispense as written," "do not substitute," "medically necessary" or any statement that clearly indicates an intent to prevent substitution on the face of the prescription form. (Id.)

Therapeutic substitution, on the other hand, occurs where less expensive drugs that are not chemically equivalent are substituted. Generally speaking, most states do not allow pharmacies to engage in this activity. It usually occurs where the prescribing physician is encouraged, through bonus pay or other incentives, to make the switch. As long as the decision to make the change is the prescriber's, this activity is usually legal, though Arizona law does prohibit a financial incentive plan that includes a specific payment made to or withheld from the healthcare professional as an inducement to deny, reduce, limit or delay medically necessary care.[3]

Drug Lists

How can I get a copy of my insurance company's formulary or preferred drug list?

The best way to get a current copy of your insurance company's drug list is to go to the company's website. If you are already a member, you can also call your company's member services department. (The phone number is usually on your insurance identification card.) For Medicare plans, you can use the Medicare Prescription Drug Plan or Formulary Finder tool at www.medicare.gov, or call the Medicare helpline at (800) MEDICARE, or (800) 633-4227, and ask a customer representative to let you know what drugs are covered and also compare plans.

If the drug I need is on the list, does that always mean the insurance company will pay for some of it?

Not necessarily. Again, insurance companies offer many different types of products that cover and exclude different drugs. Many drug lists explain that just because a drug is on the list does not mean that your policy will pay for it. So the best approach is to contact your employer's benefits manager, if you are getting your insurance through your employer, or the insurance company's member services department to be sure you understand which drugs are covered under your plan.

Changing or "Switching" Drugs on the List

Can my insurance company take drugs off the formulary or preferred drug list?

Yes, it can. Many insurers—even Medicare plans—do this.

What are my rights if I was covered for a drug and then the drug was removed from the list?

With respect to HMOs and hospital and medical service corporation plans, the law provides some protection. Plans that include prescription drug benefits must not limit or exclude coverage for at least sixty days after the healthcare services organization's or corporation's notice or the pharmacy's notice to the enrollee about the removal and need to contact a prescriber for a replacement drug, whichever occurs first, for a prescription drug for an enrollee to refill a previously prescribed drug. This prohibition applies if the prescription drug was previously approved for coverage under the drug formulary or pharmacy benefit plan for the enrollee's medical condition and the healthcare professional continues to prescribe the prescription drug for the same medical condition. The limitation or exclusion prohibited by this law applies if the prescription drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.[4]

Unfortunately, as for other types of health insurance such as PPOs, there is no protection under Arizona law if this occurs, although if the drug gets removed off the formulary, plans should give you the right to appeal for medical necessity reasons. See discussion below. If your plan tries to switch drugs, you can protest with a letter similar to the sample provided in **Model Letter 1** on page 6.

However, if a drug is switched to a more expensive tier (see discussion below under **Costs**), the cost of the drug may be too expensive. In that case, the switch could mean that you cannot get your drugs from a practical standpoint, unless the plan offers you a right to appeal.

[2] A.R.S. 32-1963.01.

[3] A.R.S. 20-833, 20-1061.

[4] A.R.S. 20-841.05, 20-1057.02.

Please let us know if this happens either by contacting us directly or using the **Help Form** on page 8. With this information, we may be able to help you get your drugs.

Medicare Part D plans have some useful protections. For example, prior to removing a covered Part D drug from its formulary, or making any change in the preferred or tiered cost-sharing status of a covered Part D drug, a plan must, among other things:

- Provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective; or
- At the time an affected enrollee requests a refill of the Part D drug, provide the enrollee with a 60-day supply of the Part D drug under the same terms as previously allowed, and provide written notice of the formulary change.[5]

Further, where there has been a drug switch in a Medicare plan, enrollees may seek an "exception," discussed below, to obtain the needed drug.

Costs

What types of out-of-pocket expenses will I likely have when getting my medications, assuming the drugs are "covered"?

Assuming your insurance company covers the drug (remember, if it doesn't, you are responsible to pay for the entire cost), there are three areas that you need to be aware of that will impact how much you will need to pay:

- **Annual benefit maximum.** Some insurance plans will only pay up to a certain dollar amount each year for your drugs. This amount differs from plan to plan. It is important to understand that once this amount is reached, the plan will no longer help you pay for your drugs during that year, and any unused amount will not be carried forward to the next year.
- **Deductible.** This is the amount you must pay for your drugs before your insurance company will help pay for any of them. For example, if your plan has a pharmacy deductible of $750, you will need to spend $750 toward your deductible before the plan begins covering the cost of your drugs. These deductibles are usually in addition to the deductible you have for your general healthcare expenses. Often, these deductibles apply only if you use brand name drugs.
- **Copayments.** This is the amount you need to pay each time you receive your medication. Again, plans have different rules and the copayment can be a flat dollar amount or it can be a percentage of the cost of the drug. Further, in preferred drug systems, the copayment increases depending on what "tier" (level of preference) your drug is placed in. The higher the "tier," the more you will need to pay, especially if you need a non-preferred, brand name drug.

My plan limits my out-of-pocket expenses. Do my drug costs count toward that limit?

Usually not. Again, you should know the rules of your plan.

Limitations and Prior Approval

Other than costs, what types of rules can my insurer impose before I can get my drugs?

There are a number of things insurance companies do to help reduce their costs and/or control your medications. These can include:

- **Prior authorization.** Some insurers may require that certain drugs, even those on your insurance company's drug list, require your insurer's approval before it will agree to help pay for them. If that is the case, your doctor will need to explain to the insurer why the drug is medically necessary for you. While most doctors find it difficult to do "battle" with insurance companies, it is important for you to work with your doctor to make sure that he or she advocates on your behalf. This process may take time, so you may need to pay the entire cost of the drug until a decision is made.
- **Step-therapy.** Some insurers may require that you try certain less expensive drugs before they will cover the one your doctor initially recommended. If, however, it is medically necessary for you to use the "first-line" drug before trying the cheaper alternatives, again, your physician should be able to get a medical exception for you from the plan. If you are not given the exception, we urge you to contact the NAF so that we can help you. You can either call us or use the **Help Form** on page 8.
- **Quantity restrictions.** Most insurers also set quantity limits on some of the drugs that they will help pay for. Nonetheless, if your doctor believes that you need more medications than the limit, the plan should have a process in place to allow your doctor to ask for a medical exception. If not, please use the **Help Form** on page 8 so that we can help you.

[5] 42 C.F.R. Section 423.120.

- **Mail order.** Some plans may require that you use their preferred mail order pharmacies in order to get your drugs. Arizona, however prohibits plans from requiring that enrollees use mail order pharmacies.[6]
- **Off-label.** Some plans may deny coverage if the drug has not been specifically approved by the FDA to treat your condition.

Appeals

What can I do if I cannot get my medication because my medication is not on the drug list, is in too expensive a "tier" or there is some other rule that prevents me from getting it?

There are a number of things that you can do:

- **Prior authorization and request for medical exemption.** First, all that may be needed is for your doctor to fill out a request for either prior authorization or medical exemption. These forms are generally on the plan's website and can be easily accessed. Your doctor will need to provide specific information about your case and explain why you need a certain drug.
- **Ask your employer for help.** You may wish to seek the help of your employee benefits manager or whoever else in your company works with your health plan in securing coverage. Many employers have worked with plans to reduce or eliminate copayments to "take not the cheapest medications, but the ones they need the most."[7] Purchasers of health coverage are increasingly realizing that getting the right care early on saves money in the long run.
- **Appeal.** First, if the best drug for your condition is placed in a tier that is too expensive for you, or there are other hurdles you need to go through before you can get it, you may be able to appeal to have this drug placed in a lower, less-expensive tier or have the restriction removed. Medicare Part D plans allow you to do this. Some plans will also allow you to do this under their general appeals process for medical necessity denials, even if it is not explicitly stated in their rules.

  An HMO or Medical or Hospital Corporation with a prescription drug benefit that uses a drug formulary as a component of the evidence of coverage must, among other things:

  1. Develop and maintain a process by which healthcare professionals may request authorization for a medically necessary formulary or non-formulary prescription drug during nonbusiness hours. If the HMO or Corporation does not maintain that process, the entity must reimburse an enrollee for the enrollee's out-of-pocket expense minus any deductible or copayment for a prescription drug that was purchased by the enrollee without preauthorization but that was later approved.
  2. Develop and maintain a process by which healthcare professionals may request authorization for medically necessary non-formulary prescription drugs. The entity must approve an alternative prescription drug when either of the following conditions is met:
     - The equivalent prescription drug on the formulary has been ineffective in the treatment of the enrollee's disease or condition.
     - The equivalent prescription drug on the formulary has caused an adverse or harmful reaction in the enrollee.[8]

  If the enrollee's treating healthcare professional makes a determination that the subscriber meets any of the conditions described above, any denial to cover the nonformulary prescription drug by the entity shall be made in writing by a licensed pharmacist or medical director. The written denial shall contain an explanation of the denial, including the medical or pharmacological reasons why the authorization was denied, and the licensed pharmacist or medical director who made the denial shall sign it. (Id.)

  Arizona law does not provide a specific appeal right for non-formulary drugs for insurers, though insurers should provide you with a general right to appeal decisions that prevent you from accessing your drug. If they don't, we urge that you use the **Help Form** on page 8 so that we can help you.

  With respect to Medicare Part D plans, an easy process has been set up for enrollees and/or their physicians. It is called the "exception process." Enrollees can use this process for virtually any plan decision that restricts access to necessary drugs, such as requests for non-formulary drugs, requests for lower copayments and requests to be relieved from quantity limits.

  Regardless of whether your coverage is with Medicare or a private insurance company, you need to make

[6] ASR 20-1410.

[7] See *New Tack on Copays: Cutting Them*, Wall Street Journal, May 8, 2007.

[8] A.R.S. 20-841.05, 1057.02.

sure that the matter is appealed; while your doctor should help you with this, you need to take charge of the appeal and be sure to present facts. Your physician may be able to help you get to sources of medical information that will support your appeal. You can use **Model Letter 2** on page 7 as a guide.

Blood Plasma Protein Therapies

Many of the same premises described in this brochure also apply to blood plasma protein therapies, including immuno globulins such as IVIG, blood clotting factors and alpha 1 proteinase inhibitors. However, please keep in mind there are no generic versions of blood plasma protein therapies. Many insurers will cover each brand of therapy (including Medicare and Medicaid) but some insurers may require prior authorization or step-therapy.

Each brand of a blood plasma therapy is therapeutically different, thus, it is not a "one size fits all" approach. For example, different brands of IVIG have different indications and vary clinically. Therefore, you should work with your physician and insurer, if necessary, to ensure coverage of the brand of therapy that works best for you.

In addition to the therapy that works best, the same holds true for site of service. Many insurers may place restrictions on where your therapy may be administered. You may need to work with your physician and insurer to ensure your therapy is administered in the most clinically appropriate site of service regarding your individual care.

Lastly, you will need to determine where the better coverage benefits reside, either under the insurance plan's major medical benefit or the pharmacy benefit. These two coverage benefits do not communicate across the insurance plan. For example, copays incurred under the pharmacy benefit are not credited towards the maximum annual out of pocket caps of the insurance plan. You should request a complete benefits investigation before determining who will provide therapy and in which site of service. The payer can provide this information or the you can speak directly with the payer's customer service representative.

Contact the Neuropathy Action Foundation

The Neuropathy Action Foundation is your healthcare advocate. Contact us using the information below, or by completing the **Help Form** on page 8.

☎ (877) 512-7262 (Toll-free)
✉ info@neuropathyaction.org
🖱 www.neuropathyaction.org

Additional Contacts

In addition to the NAF, there are organizations that can help you if you are having a problem and are not getting the coverage you are entitled to.

Consumer Affairs Division of the Arizona Department of Insurance

Regulates insurers, HMOs and medical and hospital corporations.

☎ (800) 325-2548; (602) 364-2499
✉ consumers@azinsurance.gov
🖱 www.id.state.az.us

Department of Labor (DOL)

For assistance with ERISA plans.

☎ (866) 444-EBSA (3272)

Health Insurance Counseling and Advocacy Program

For assistnace with Medicare plans in Arizona.

☎ (800) 432-4040

Additional Consumer Assistance

There are a number of programs that help patients, particularly low-income patients, with their coverage problems. These include:

Patient Advocate Foundation

☎ (800) 532-5274
🖱 www.patientadvocate.org

Patient Services Incorporated

☎ (800) 366-7741
🖱 www.uneedpsi.org

Model Letter 1:
Protest Drug Being Changed on or Switched from Drug List

[Today's Date]

Re: **[Your Name]**
[Your Insurance Carrier / Health Plan / IPA Name]
Insurance ID Number: **[Your Insurance ID Number]**
Request for Continuation in Drug Coverage

Dear **[Medical Director's Name]**,

I have been prescribed **[Name of Drug] [continuously / intermittently]** for the past **[timeframe that you have been taking the drug]** for **[name of your medical condition]**. Up until recently, I have received appropriate coverage from your insurance company for this important medication for me. However, I was recently informed that the drug **[has been taken off your formulary / has been moved to a more expensive copayment tier]**. This change as a practical matter makes it impossible for me to get this medication.

This new formulary limitation impairs my ability to receive medications important to treating my medical condition. When a non-formulary alternative is medically necessary and appropriate, I should be entitled to an exception.

(For HMOs and Hospital and Medical Corporations) Plans that include prescription drug benefits must not limit or exclude coverage for at least sixty days after the healthcare services organization's or corporation's notice or the pharmacy's notice to the enrollee about the removal and need to contact a prescriber for a replacement drug, whichever occurs first, for a prescription drug for an enrollee to refill a previously prescribed drug. This prohibition applies if the prescription drug was previously approved for coverage under the drug formulary or pharmacy benefit plan for the enrollee's medical condition and the healthcare professional continues to prescribe the drug for the same medical condition. The limitation or exclusion prohibited by this law applies if the prescription drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. (A.R.S. 20-841.05, 20-1057.02.)

[Name of Drug] is medically necessary in this case because it is the best and most effective medication for my condition. Indeed, a number of studies have recommended this particular drug, including **[study names]**. Further, the pharmacology of the drug your company is requesting that I take is potentially harmful for me. I have little tolerance for any changes in my medications and indeed, I have experienced **[list negative effects]** due to changes in drug regimens. Other harmful effects include **[list other negative effects]**.

In addition, covering this medication would be in your company's economic interest because **[discuss any potential cost savings, e.g., the drug should make me healthier quicker or reduce the likelihood of hospitalizations]**.

My prescribing doctor clearly feels that my taking **[name of medication]** is in my medical best interest. My physician's name is **[Your Physician's Name]** and **[he / she]** she can be reached at **[your physician's telephone number]**.

Under these circumstances, I am entitled to a continuation of my former coverage for this drug. Please contact me to confirm this fact. I can be reached at **[your phone number]**.

Thank you very much for your attention to this important matter.

Sincerely,

[Your Signature]
[Your Name]

cc: **[Your Physician's Name]**

Model Letter 2:
Appeal of Coverage Decision Regarding a Specific Drug

[Today's Date]

Re: **[Your Name]**
[Your Insurance Carrier / Health Plan / IPA Name]
Insurance ID Number: **[Your Insurance ID Number]**
Appeal of **[ ]** Determination Regarding Drug

Dear **[Medical Director's Name]**,

For the reasons discussed below, my physician believes it is medically necessary that I take **[name of medication]**. Unfortunately, I cannot access this medication because of your company's decision to **[action taken, e.g.: not include it on your drug list / place it on an expensive tier / require that I take other medications first]**. I am writing to you to appeal this decision.

[Name of medication] is medically necessary in this case because it is the best and most effective medication for my condition. Indeed, a number of studies have recommended this particular drug, including **[names of studies]**. Further, the pharmacology of the drug your company is requesting that I take is potentially harmful for me. I have little tolerance for any changes in my medications and indeed, I have experienced **[list negative effects]** due to changes in drug regimens. Other harmful effects include **[list other negative effects]**.

In addition, covering this medication now would be in your company's economic interest because **[discuss any potential cost savings, e.g., the the drug should make me healthier quicker / reduce the likelihood of hospitalizations]**.

My prescribing doctor clearly feels that my taking [name of medication] is in my medical best interest. My physician's name is **[Your Physician's Name]** and **[he / she]** she can be reached at **[your physician's telephone number]**.

Thank you for your reconsideration and prompt attention to this matter. Please let me know if there are any additional steps I should take for this appeal.

Sincerely,

[Your Signature]
[Your Name]

cc: **[Your Physician's Name]**

Help Form

If you are having trouble getting your medications, please use this form to let the Neuropathy Action Foundation know about your experience. Completing the form can benefit you in two ways. First, the NAF can help you work with your insurance company to get the medications and therapies you are entitled to. Second, the NAF will keep track of the problems patients face, identify patterns and work to improve the system for everyone.

Just cut off this form on the dashed line, fill it out and call us toll-free at (877) 512-7262 to find out where to mail it.

1. Patient's name: _____
2. Patient's telephone number: (___) _____
3. Name of person asking for help (if not the patient): _____
4. Phone number of person asking for help (if not the patient): (___) _____
5. Insurance company name: _____
6. Insurance company member services telephone number (see your ID card): (___) _____
7. Patient's insurance identification number: _____
8. Name of drug that you are having trouble getting: _____
9. Diagnosis for which drug was prescribed: _____
10. Please explain fully the facts of your problem. Why are you having a problem? Did you appeal? Please attach photocopies of any letters from your insurance company and any other materials you believe are important.

    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____

11. AUTHORIZATION: I, _____, hereby authorize the Neuropathy Action Foundation to have possession of the above medical information and other information necessary to assist me with my dispute.

_____ _____

Signature Date

Neuropathy Action Foundation

Awareness ▪ Education ▪ Empowerment

Toll free: (877) 512-7262
info@neuropathyaction.org
www.neuropathyaction.org