Paydhealth

Select Drugs and Products℠ Program

Group Health Plans partner with Paydhealth to offer the Select Drugs and Product℠ Program for their Plan participants who are taking certain specialty drugs. The Select Drugs and Products Program includes financial case management services that focus on the economic needs of Plan participants while leveraging clinical services already included through the Plan's prescription drug benefit. The Program reduces costs for Plan participants, with minimal impact on treatment time.

Key things to know:

Enrollment in the Plan's Select Drugs and Products Program provides an opportunity to substantially reduce a Plan participant's specialty drug out-of-pocket cost — in some cases, to no cost at all.

A Plan participant must complete prior authorization and enroll in the Program to meet Plan coverage criteria. Otherwise, the specialty drug prescription cost will not be paid by the Plan, and the Plan participants will pay the full cost of the specialty drug charged by the pharmacy.

All specialty drugs on the Plan's Select Drugs and Products℠ list require clinical and administrative review, they must be medically necessary, and must be processed through the Program before a benefit will be payable.

Here are answers to a few frequently asked questions (FAQs) about your Select Drugs and Products Program.

How does the Plan case coordinator advocate for Plan Participants?

Prescription drug savings and marketing cards are examples of funding that help Plan participants afford otherwise high-cost medications. Funding sources could also include other financial resources available through private foundations (often sponsored by pharmaceutical companies), public foundations and endowments, county, and/or municipal programs, and state specialty access programs.

Throughout the year, a Plan participant may be required to provide information for multiple funding sources depending on their funding needs.

What type of information will a Plan participant need to provide to the Program or other funding sources?

Funding programs typically require that applicants meet certain eligibility criteria. Generally, funding programs require the Plan participant to meet a complex level of requirements, although most programs are available to the general public.

In some cases, an funding program may ask to confirm information in order to determine the Plan participant's eligibility for a Program identified program. The Program will screen the Plan participant's information as part of identifying funding programs that may be right for them.

Some of the questions a Plan participant may be asked include:

- What is the reason the Plan participant is taking a medication (also known as the indication)?
- What medication has been used in the past?
- Is the Plan participant eligible for any federal healthcare benefits (e.g., Medicare, Medicaid, etc.)?
- What state, county or municipality does the Plan participant reside in?
- Is the Plan participant a U.S. Citizen or legally documented person?
- How large is the household?
- What is the approximate income of the household?

In all cases where funding is obtained, Plan participant responses are kept in confidence between the Plan participant, the Program, and any funding program that has been identified by the Program on the Plan participant's behalf. When funding is obtained by the Plan participant, the Plan does not use this information in any way to determine coverage under the Plan.

Is funding *only* for people with no healthcare coverage?

No. Many funding programs have been offered in the market for more than twenty years and the market has steadily grown year over year. Many of these programs are specifically designed for individuals who have healthcare coverage. Funding includes any form of funding provided to a Plan participant outside of a health and welfare plan.

How will this impact me? What should I expect?

Most Plan participants will see little or no out-of-pocket cost for specialty drugs when they receive funding. When a specialty drug claim is processed under the prescription drug benefit of a Plan, it is automatically subject to prior authorization review. This is a standard procedure that assures the specialty drug is appropriately used and is meeting the medical necessity requirements of the Plan. When this clinical review is completed, a near simultaneous administrative review of the funding market is completed.

The Program is a “chaperone” service. A Plan case coordinator will initially contact the Plan participant to begin the administrative review. This initial call takes about 10 minutes where a case coordinator will review funding with the Plan participant and the requirements of identified programs. Some funding programs require that the Plan participant attest to the accuracy of the information submitted. The case coordinator will notify the Plan participants if such an attestation is required. The process routinely takes less than 72 hours when all information is gathered.

How is the Program informed about Plan participants using Specialty Drugs?

The Program is notified of a Plan participant who may qualify for the Select Drugs and Product℠ Program through an identification code that is associated with a specialty drug claim. This notification happens in near real-time and will initiate outreach to the Plan participants by the Plan Program's case coordination team. The Plan participants will usually hear from the Program within 24 hours of the pharmacy submitting a claim for a medication on the Plan's Select Drug and Products List. During this period, the Pharmacy and the Plan participant’s healthcare provider/prescriber will attempt to confirm the medical necessity for the prescription under the Plan.

Will my provider need to provide any information to the Program?

The Plan participant's provider office may need to provide information to the Program and to any funding programs identified by the Program on the Plan participant's behalf. The Program will also work with the Plan participant's provider office to facilitate any new prescription requests at the Plan participant's direction. The Plan participant's provider may be asked by an funding program to confirm the Plan participant's diagnosis.

Will I experience a disruption in receiving my specialty drug?

No. The Program is specifically designed to ensure that the Plan participant will not experience a delay or disruption in treatment. To avoid disruptions, a member's active and timely participation is required when working with the Plan's case coordinators. Members should plan ahead and communicate frequently with their case coordinator, who is their personal advocate.

What are the typical qualification criteria?

- While each funding program sets its own unique qualification criteria, typically the following areas of interest are used in determining a member's eligibility for funding:
- Household Characteristics, including the size and income of the household;
- US citizenship status and the state/county or municipality in which the Plan participant resides;
- Medical condition confirmation;
- That there is no "off-label" use, in other words, that the specialty drug is being used in accordance with the FDA-approved use.

What information is shared with the Plan?

All information shared by members with the Program and funding programs is confidential to those parties. The only exception is that information required to adjudicate Plan payments may be shared with the Plan. The Plan does not receive any other Plan participant information shared with the Program or funding programs and does not use any shared Plan participant information in determining coverage of a specialty drug.

Will specialty drugs be excluded from Plan coverage?

The decision to include or exclude a specialty drug is only available to the Plan Administrator the Program does not determine coverage for a specialty drugs under the Plan. If funding is available for eligible Plan participants, the Plan case coordinator works closely with the Plan participant to access it. If it is not available, the Plan provides options to have a case reconsidered under the Plan's appeal process where a Plan participant will be required to meet Plan criteria.

Will I have to change pharmacies to get my specialty medication?

The Plan's Select Drugs and Products Program coordinates the funding of the member's specialty prescriptions. The dispensing pharmacy will determine the funding based on the funding program(s) available. In most cases, the current specialty pharmacy will continue to dispense the member's specialty medications whenever possible. However, certain prescriptions are only available through specific pharmacies chosen by an funding program and those distribution options may be limited.

How often is the Select Drugs and Products List updated?

The Program drug list is updated every three months, using a rolling update model. Only brand-name specialty drugs are included in the Program. Therefore, if the product becomes available generically, the generic specialty drug benefit will apply.

What about non-compliant members?

Our experience indicates that very few Plan participants will be non-compliant. In these instances, communication and disclosure is key. Plan case coordinators make every effort to engage non-compliant Plan participants, and if unsuccessful, the Program will reach out to the Plan's contact(s) for assistance in communicating with a non-compliant Plan participants.

Does the Select Drugs and Products Program include all specialty drugs?

While the Program includes the vast majority of specialty drugs, certain categories are not included in the Program. These categories include specialty drugs used in an urgent or emergency care setting that are typically administered in a healthcare facility. Example categories are allergens and toxins, visco supplements, infertility drugs, IUDs, and blood thinners. Also, generic an most multi-source drugs are not included in the Program.

Does the Select Drugs and Products℠ Program include personal importation (Canadian Pharmacy) or pharmacy tourism?

No. The Program includes only U.S. pharmacy-supplied specialty drugs. The Program is designed to manage the funding of specialty drug prescriptions and it does not provide advocacy services for prescriptions dispensed by pharmacies or healthcare practitioners located outside of the United States of America or its territories.

Will I be billed for services, and are there fees associated with the Select Drugs and Products℠ Program program?

The only charges that a Plan participant may experience are related to their published out-of-pocket expense payable to the pharmacy or an funding service charge. The Program is designed to assist the Plan participant in securing enough funding to off-set the Plan participant's out-of-pocket costs. The Program will never charge a Plan participants directly, and all Program fees are paid by the Group Health Plan.

Is there a deductible or maximum out-of-pocket for specialty drugs?

Yes. Specialty drugs paid by the Plan are subject to a deductible and accumulate toward the maximum out-of-pocket (MOOP). For more detail, refer to the benefit summary. Funding contributions to a Plan participant do not accumulate toward a deductible or MOOP, unless required by regulations.

What about members who don't qualify for funding?

Most Plan participants will receive some amount of funding. A significant percentage of Plan participants will be eligible for funding that addresses the full cost of a specialty drug prescription. A Plan participant's claim that is not eligible for full funding through an funding program is automatically submitted on the Plan participant's behalf for a benefit reconsideration under the appeals policy of the Plan. If approved, the Plan will pay the drug claim, subject to any deductible, coinsurance, or co-pay paid prior to satisfaction of the out-of-pocket maximum.

What if the appeal for benefit reconsideration is denied?

A Plan participant's claim that is not eligible for full funding, through an funding program, is automatically submitted on the member's behalf for a benefit reconsideration under the appeals policy of the Plan. In the event that the benefit reconsideration claim is denied, the Plan participants may appeal that decision under the Plan's claim procedure. If the appeal is approved, the Plan will pay the drug claim, subject to any deductible, coinsurance, or co-pay prior to satisfaction of the out-of-pocket maximum.

Who do I call with questions about my specialty drug funding options?

If the Plan participant has any questions regarding this Program or the Plan participant's specialty drug benefit and funding, please call Paydhealth's Specialty Contact Center at 877.422.1776 (Monday thru Friday - 9:00 a.m. – 9:00 p.m. ET / 8:00 a.m. – 8:00 p.m. CT).