FIDUCIARY PHARMACY BENEFIT RISK MANAGEMENT SERVICES

OVERVIEW:

CURRENTLY MORE THAN 80% OF THE PHARMACY BENEFIT SPEND IS RELATED TO BRAND MEDICATIONS. THE BRAND MEDICATION SPEND IS MADE UP OF TWO PRIMARY COMPONENTS:

1. Maintenance Medications that are classified as non-specialty, for conditions such as asthma, diabetes, and HIV.
2. Specialty Medications for a variety of conditions including very rare diseases that can have exorbitant costs.

There are several factors that contribute to the continued trend of increased costs associated with brand medications:

1. PhRMA influence on prescribing habits through direct prescriber detailing, marketing events, and social media advertising.
2. Conflicts of interest within the Pharmacy Benefit Management (PBM) industry, in which the PBM dispenses the majority of the brand medications from their own pharmacies. PBM-owned pharmacy revenues and profits have grown to represent approximately 70% of the total revenue and profit for the PBMs.
3. Emphasis on rebates due to the current philosophy of predicting future costs by factoring previous claims by the new rates and deducting the rebates. While this sounds logical, it is never accurate due to the fact that higher rebates are associated with the higher cost of the medications. This is due to the fact that rebates are based on a percentage of the cost of the medication. The result is that high cost medications are prescribed and dispensed as first line agents when the national standards and best practices would classify these medications as third to fifth line agents due to a variety of reasons that include; efficacy, safety, and cost.

US-RX CARE'S SOLUTION

As a product of the "at-risk" health insurance plan industry, responsible for every dollar spent on pharmacy and medical, US-Rx Care informs prescribers about the national standards and best practices to ensure optimal therapy for members versus therapy simply based on marketing and profits. Health plans have controlled the utilization of medications for decades with an in-house pharmacy department instead of allowing their PBM to manage their medication utilization based on profits. US-Rx Care has simply brought the tools and expertise we have provided to the "at-risk" health insurance plan industry to the self-insured employer market.

US-Rx Care contractually must work in only the best interests of the plan sponsor and their members. The primary focus of US-Rx Care is to ensure that members are utilizing the optimal therapy based on national standards and contractually must work only in the best interests. US-Rx Care addresses the utilization management in two ways:

1. Retrospective utilization management for non-specialty medications
2. Prospective utilization management for specialty medications

The reason for these two separate processes is to avoid member disruptions while working within the current industry workflow with the providers and pharmacies to ensure optimal outcomes. US-Rx Care has named the combined programs as Right Rx®.

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US-Rx Care

RIGHT RX: RETROSPECTIVE UTILIZATION MANAGEMENT FOR NON-SPECIALTY MEDICATIONS

1. Claims filed from the previous month are analyzed for optimal therapy opportunities.

2. The Right Rx platform automatically sends communications to the prescribers identifying these opportunities with the appropriate therapy options.

3. The Right Rx platform tracks the responses from the prescribers as follows:

   a. The prescriber denied any changes - In this case the platform notes this preference for this prescriber and member and does not address this opportunity again.
   b. The prescriber accepts one of the options. In this case, the opportunity would progress to the next step in the process.
   c. The prescriber is non-responsive - In this case, a call is made to remind the prescriber of all outstanding opportunities that have not received a response.

4. The member is contacted to discuss the opportunities in which the prescriber accepted one of the options:

   a. The member accepts the prescriber's new prescription - In this case the opportunity would progress to the next step in the process.
   b. The member rejects the prescriber's new prescription - In this case, the platform would note the member's decision and remove the opportunity from future outreach.

5. The new prescription is sent to the pharmacy of the member's choice.

Prospective Utilization Management for Specialty Medications

1. The dispensing pharmacy receives a Prior Authorization (PA) Required message when attempting to process a specialty medication in the PBM adjudication system.

2. The dispensing pharmacy contacts US-Rx Care as instructed on the PA message.

3. US-Rx Care contacts the prescriber to obtain the patient's medical records (a legal document).

4. US-Rx Care reviews the patient's medical records for:

   a. Ensure the medication prescribed is appropriate for the diagnosis, lab values and other values.
   b. Validate the trial and failure of first line, second line, and other dtherapies.
   c. Use the information in the medical records to identify the best therapies based on national standards and best practices.

5. Approve the PA to the prescribed medication if appropriate.

6. Provide the recommended option(s) to the prescriber if the prescribed medication is inappropriate.

7. Provide a consult with a different clinical pharmacist or our medical director with the prescriber if they do not agree with the option(s) provided.

8. Provide an independent appeals process if the prescriber continues to refuse the option(s) provided.

CONCLUSION

The processes discussed above are processes utilized by the at-risk health insurance plan industry for decades. They are proven to be effective. They work within the established workflows and do not cause disruption for the member, prescriber or pharmacy. These programs are proven to result in savings of $15-25 or more per enrollee per month and typically see impressive savings growth.

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