Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work.

Prescription Drug Program
Occupational Training Center
01/01/2022 - 12/31/2022

The Prescription Drug Program covers FDA approved legend drugs. A prescription order from a physician is required for drugs to be eligible. Prescriptions may be refilled within one year of the original prescription date, when authorized by the physician and permitted by law. Any limitations that apply to an original prescription also apply to the refills.

The Horizon Prescription Formulary is a list of prescription medications developed by an independent Pharmacy and Therapeutics (P&T) Committee comprised of practicing physicians and pharmacists in New Jersey. The Horizon P&T Committee determines which drugs will be placed into preferred and non-preferred status within our open formulary. The priority consideration is clinical efficacy and safety, followed by other considerations such as second line therapies, and availability of commonly used and safe generics. At least two drugs from each therapeutic class are placed in the preferred status on the formulary. Once a quality review has determined that two or more drugs are equal to other therapeutic alternatives, the P&T Committee may place the most cost effective drug(s) into preferred status.

Type of Program	Preferred Generic Drugs	Preferred Brand Name Drugs	Non-Preferred Drugs
Three Tier Copayment Plan:			
Retail: Up to a 90 day supply (1 retail copay applies per 30-day supply)	$10	$40	$75
Mail Order: Up to 90 day supply (1 mail order copay applies for the 90-day supply)	$25	$100	$200
Front End Deductible (applies to retail and mail): Amount excluding copayments/co-insurance, which must be incurred per member in a benefit period before benefits are paid.	Not Applicable		
Benefit Period Maximum:	Unlimited		
Plan includes:	• Contraceptive (self-administered or injectible) drugs & devices obtained at a pharmacy • Diabetic Supplies • Fertility Drugs • DAW1 Program (Dispense as Written) - If **prescriber** requests brand drug when generic equivalent is available, prior authorization will be required and the non-preferred copay is charged. • DAW2 Program - If **member** requests brand drug when generic equivalent is available, the generic copay PLUS the cost difference between the brand and generic will be assessed. • Prior Authorization and Advantage Formulary Program - Certain medications that have medical utility for only a select group of patients require PA before coverage is approved. Specific guidelines, developed and approved by physicians and pharmacists, have to be met for these drugs to be approved and covered under your prescription drug benefits. See Horizon BCBSNJ's website for the PA drug list.		
Specialty Pharmacy Program: Certain specialty pharmaceuticals must be obtained from one of the contracted pharmacies. Specialty pharmaceuticals are typically used to treat conditions such as: Adenosine Deaminase Deficiency, Allergic Asthma, Alpha-1 Proteinase Inhibitor Deficiency, Anemia, Crohn's Disease, Cytomegalovirus, Fabry's Disease, Gaucher Disease, Hypercalcemia of Malignancy, Neutropenia, Prostate Cancer, Psoriasis, Pulmonary Hypertension, Respiratory Synctial Virus, and Rheumatoid Arthritis.	• Personal attention from a pharmacist-led team that provides condition-specific education, medication administration instruction and expert advice to help manage therapy. • Claims assistance to help determine individual coverage and file the necessary paperwork. • Easy access to pharmacists and other health experts 24 hours a day, seven days a week. • Single, reliable source for specialty medication needs. • Easy ordering with a dedicated toll-free number. • Confidential and convenient delivery to the location of choice (i.e., home, physician's office.) • Helpful follow-up care calls to remind when it's time to refill a prescription, check on therapy progress and answer any questions. • NOTE: Specialty pharmacies are considered "retail" pharmacies and are always subject to the retail copayment levels, even if the specialty pharmaceutical is obtained through the mail.		
Exclusions:	Anti-Obesity Drugs Over The Counter Vitamins & Minerals Growth Hormones (unless prior authorized) Drugs for Cosmetic Purposes Immunization Agents and Allergy Serum Lifestyle Drugs		

Dependent children, including full-time students, are covered until the end of the calendar year in which they reach the age of 26. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to the age of 26. Under certain conditions, coverage may be extended for qualified dependents up to age 31.

For more information about your prescription drug plan, please refer to our website at www.HorizonBlue.com under Member Information. Should you have any additional questions, please feel free to contact Member Services at the phone number listed on your identification card.