Exploring Drug Tiers and Formulary Exceptions

Drug Tier Basics

Drug tiers are the way health plans communicate to patients what they can expect a specific prescription will cost. The tier, or level, a medication is listed on is matched with the plan’s cost-sharing amounts and determines what you will have to pay at the pharmacy.

The part that can be confusing is that drug tiers are not standardized across insurance companies, and even plans offered by the same company are not the same. The number of tiers will vary by plan, typically ranging from 3 - 6 total tiers. Each plan also decides what they want to name their tiers, making it harder to compare plan to plan. Plans and insurers treat medications differently, and it is very common to see the same drugs on different tiers, or different versions of the same medicine on different tiers.

Here is an example of a common structure for a 4-tier formulary.

Tier 1 holds the cheapest prescription drugs available to you, typically limited to generic drugs. Generic drugs are just as safe as brand-name drugs. The only difference between the two is the name and the cost savings. Some plans may also include some cheaper brand-name drugs under Tier 1.

More expensive generic drugs and preferred brand-name drugs occupy this tier. If you must take a brand-name medication, try to work with your doctor to choose an appropriate one from Tier 2, as they are the most affordable.

Non-preferred and expensive brand-name drugs are typically in this tier. Your plan may include drugs in this tier that are new to the market. There may be assistance available to help pay for these, especially if they are new. Try to check with your doctor or pharmacist.

This is the most expensive tier, usually occupied by brand-name and specialty drugs. These drugs typically do not have specific copays; instead you’ll pay a percentage of the total cost negotiated between the health plan and the manufacturer of the medication.

Anything not on the formulary, is considered “off-formulary”, and not covered by your insurance at all. You should expect to pay 100% of the costs of these medications. Uncovered medications do not count towards your deductible or out-of-pocket max.
Your doctor is your ally when it comes to your health. Many plans require that your doctor submit a formulary exception on your behalf. The doctor will need to send paperwork, or online forms, indicating the reason that you cannot take the preferred medications and must be approved for one that is not currently on the formulary.

The documentation should describe how preferred medication(s) on lower tiers are better for you. Include specific reasons like the fact that it would not be as effective as the requested drug for treating your condition, you might have a bad reaction to the preferred medication, or both.

Once submitted, your doctor should hear back about your plan’s decision within a couple days after the request. If approved, your medication will be covered at cost-sharing that applies in the lower tier.

If your doctor feels that not having the medication could put you in serious harm, an “urgent” or expedited request can be filed, and a decision would be made by your health plan within 24 hours.

Scenarios Where Formulary Exceptions Are Common

- You have an allergy or had a bad reaction to medications on the formulary
- You already tried formulary medications and they did not work with your condition
- Your doctor has decided the medication choices available in the formulary are not appropriate for you and insists that the one that was prescribed is medically necessary
- Your doctor believes the use of a formulary medication may escalate an underlying medical condition
- The medication is actually on the formulary but has restrictions such as a quantity limit or a dosage limit that your doctor believes should not apply to you

If your formulary exception is denied by your health plan, you may have the right to appeal and ask for a reconsideration. You will be sent a letter by your insurer of the final decision. Call your health plan regarding the denial and find out if you have appeal rights, and if so, what the timeline and requirements are for submission.

A Note About New Medications

Medications that just became available will most likely not be added to your plan’s formulary immediately after their FDA approval. Plans regularly review new medications and do adjust the formulary throughout the plan year, but it may still be some time before a medication is considered.

If your doctor feels that a brand new drug is the best treatment, you will likely have to submit for prior-authorization and then submit a formulary exception as well in order to access the medication.

Patient Empowerment Series

For additional topics surrounding common insurance challenges and healthcare issues, visit patientadvocate.org