What is a prescription drug formulary?
A prescription drug formulary is a list of the prescription medications covered by a health plan. Health plans typically decide what prescription drugs to cover on their formularies based on plan-sponsored reviews of the medical efficacy, safety, and cost-effectiveness of particular drugs.

Why do health plans use formularies?
Prescription drug formularies are a way for health insurance plans to control costs and encourage the use of lower cost medications. Formulary design often encourages the use of generic medications, which cost less than the equivalent name-brand medications. Health plans also use formularies to encourage the use of lower-cost brand drugs over higher-cost brand drugs with similar effectiveness, and to discourage the use of less effective drugs.

What is a formulary tier?
Prescription drug coverage is often divided into three or four categories or tiers: generics, preferred brands, non-preferred brands, and specialty drugs (the specialty drug tier is not used in 3-tier formularies). Each tier has different cost-sharing requirements for the plan participant, with lower cost-sharing applying to generic drugs, which are the least expensive. Whether a brand-name drug is preferred or non-preferred varies by plan and is often based on the drug's cost-effectiveness and negotiations between health plans or pharmacy benefit managers and prescription drug manufacturers. The table below illustrates common tier designs:

	2 Tier Formulary	**3 Tier Formulary**	**4 Tier Formulary**	**5 Tier Formulary**
Tier 1	Generics	Generics	Generics	Preferred Generics
Tier 2	Brands	Preferred Brands	Preferred Brands	Non-Preferred Generics
Tier 3		Non-preferred brands	Non-Preferred Brands	Preferred Brands
Tier 4			Specialty Medications	Non-Preferred Brands
Tier 5				Specialty Medications

In the new Health Insurance Marketplace, most health plans have a four- or five-tier prescription drug formulary. In plans with four tiers, the highest tier with the most cost-sharing is reserved for specialty medications, which are often high-cost drugs such as biologics. This tier is often referred to as a "specialty" tier. The five-tier plans typically divide generic drugs into two categories: preferred and non-preferred generics.

Why would a formulary exclude an FDA-approved drug?
Health plans may choose not to cover particular prescription drugs on their formulary. These are sometimes called non-formulary or non-covered drugs. Exclusion of particular drugs occurs frequently if a generic version of the drug is available, even if no generic is available for certain dosages or time-release formats of the drug. In addition, the plan's review process may lead to the exclusion of drugs that have been determined to be less effective for the average patient than other drugs to treat the same condition, or are equally effective but cost significantly more.

In addition, some plans have very narrow formularies but generous policies allowing physicians to prescribe non-formulary drugs when medically necessary. This approach allows plans to strongly encourage the use of generic and low-cost medications while preserving patient access to more expensive drugs when medically necessary.

What happens if a patient needs a drug that isn't covered on the formulary?
In non-grandfathered individual and small group market plans, health insurance companies are required to have a process that allows patients to appeal to get access to drugs that are not covered by the plan (grandfathered plans and large group health plans may also have an appeals process, though none is required). The Department of Health and Human Services has offered little guidance on this issue, however, so the process will vary by health plan. Patients, their physicians, or their pharmacists should contact health plans directly to request coverage of non-formulary drugs. There is no requirement for an appeals process to lower the out-of-pocket cost for covered drugs.