Formulary Design & Non-medical Switching:
The formulary is a list of drugs approved by a health plan, typically arranged into tiers. In a “closed” formulary, the health plan only provides coverage for a limited number of drugs; if a patient is prescribed a treatment not on the formulary, they must typically pay costs in full.

Drug cost is often what drives formulary decisions. Pharmacy benefit managers – also known as PBMs – negotiate rebates from drug manufacturers in exchange for preferred placement of a brand-name drug on their formulary. Rebates are a major source of revenue for many PBMs.

PBMs and insurers can change a drug’s tier or completely drop a drug from a formulary at any time during the year, for any reason. This can result in non-medical switching.

Non-medical switching:
When patients face a change in treatment for any reason that is NOT about improving care.

One day, I received a notice from my pharmacy as I was trying to refill the medication: it was no longer covered—not on the formulary. Imagine my panic.”

~ Patricia Goldsmith, Colorectal Cancer Survivor & CEO of CancerCare

Reasons for non-medical switching include:
→ Insurer completely eliminates coverage for a medication
→ Insurer moves a drug to a higher formulary tier that is unaffordable to the patient
→ Insurer offers patients or pharmacists a financial incentive to switch to a preferred drug

Employers can help by making adjustments to the formulary offered to their employees:
REQUIRING plans to offer an open formulary that covers prescriptions for all FDA-approved drugs when appropriate and medically necessary
PROHIBITING plans from changing the formulary mid-year
PREVENTING non-medical switching for patients who are stable on their current drugs.
MINIMIZING out-of-pocket costs for drugs used to treat chronic conditions to increase medication adherence and improve patient wellbeing

Scan the QR code to view a short video about formulary design.
Also available at BetterRxBenefits.org

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