How to Navigate Your Prescription Drug Insurance

Help to understand your prescription insurance plan for specialty drugs*

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This guide provides general information about prescription drug insurance plans. Specific details vary between plans and between states. To confirm your plan's specific policies, services, and coverage details always check with your insurance company or your employer's Benefits Manager.

*This guide is for people who have a commercial insurance plan through their employer. The information does not apply if you have another type of insurance plan (for example, Medicaid, Medicare, or other insurance provided by the state or federal government).

BIOMARIN Rare Connections™

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About Prescription Drug Insurance

Medical vs Prescription Drug Insurance

Many employer health insurance plans separate insurance into 2 parts—and some plans provide separate identification cards for your medical and prescription drug insurance.

- Medical health insurance, also known as the medical benefit, generally covers the costs of expenses such as office visits, hospital stays, and emergency room visits. Some specialty drugs, typically those that are infused, are also covered under the medical benefit
- Prescription drug insurance, also known as the pharmacy benefit, covers the costs of specialty prescription drugs or medicines that are oral or self-injectable

Have questions about what medical and pharmacy drug benefits your health insurance plan includes?

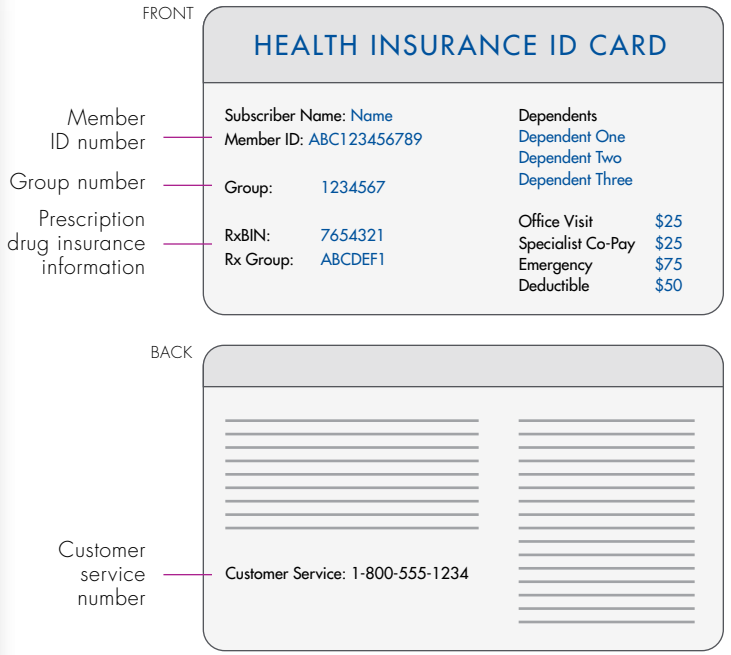
- Call the customer service phone number on your card(s)
- Talk to your employer's Benefits Manager, who usually works in the Human Resources department. The Benefits Manager is responsible for all the employee benefits a company offers, including medical and prescription drug insurance, and can advise you on your plan benefits, answer questions, and assist you with any concerns
- Visit your plan's website for information about coverage

Check your health insurance card(s) to see who provides your medical and prescription drug insurance

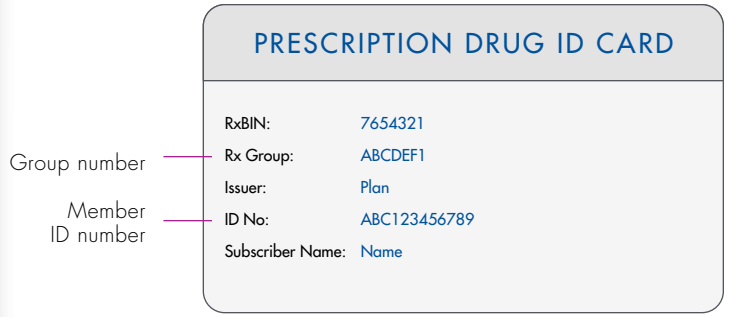
Examine both sides of your insurance card(s) for important information.

Single Health Insurance ID Card

Includes information about both your medical and prescription drug insurance.



Prescription Drug Insurance ID Card



About Prescription Drug Insurance (cont.)

About Your Prescription Drug Insurance Plan's Formulary

Understanding your health plan's formulary is an important part of understanding your overall benefits. Your formulary tells you (1) what drugs are covered by your plan and (2) the co-pay tier for each drug.

What is a formulary?

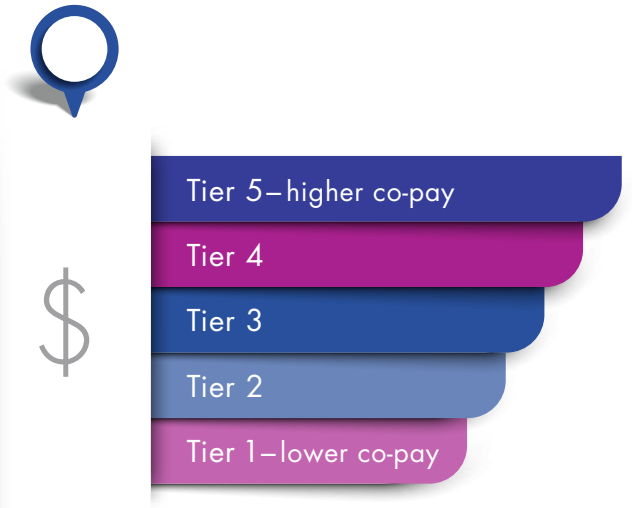
Each prescription drug plan—even plans from the same company—has a formulary, which is a list of prescription drugs the plan covers. Most formularies include certain drugs and exclude others. In some cases, a drug may not be on the formulary but may still be covered.

Health plans update their formularies every year, but they also make changes throughout the year. These changes may occur when a new drug becomes available.

Depending on the drug listed, you may be asked to share the cost with an out-of-pocket co-pay or coinsurance payment. Co-pays and coinsurance payments can vary according to the drug's "tier."

Tiers

In your plan's formulary, drugs are grouped in tiers. The number of tiers varies by plan. Prescription drugs in the lowest tiers (tiers 1 and 2) usually have the lowest co-pay and tend to be generic drugs. Prescription drugs in the higher tiers may often require coinsurance.



While new drugs may not be on your plan's pharmacy formulary, you may be able to get the drug covered through the medical/formulary exception process.

About Prescription Drug Insurance (cont.)

About Your Prescription Drug Insurance Plan's Formulary (cont.)

The difference between co-pay and coinsurance

A co-pay is the flat amount you pay for a prescription drug that is covered by your plan.

Coinsurance is usually a percentage of the cost of the drug. For example, if your coinsurance is 20%, you pay 20% of the cost and your plan pays the remaining 80%.

Want to find out if a prescription drug is on your formulary?

Call the plan at the customer service phone number on your insurance card.

Visit the plan website and search for an online formulary. (Note: If the drug is not listed in your plan formulary, it (1) could be covered on the medical benefit or (2) may not be covered.

Ask your employer's Benefits Manager to provide you with your prescription drug plan formulary.

About Prescription Drug Insurance (cont.)

About Specialty Pharmaceuticals and Specialty Pharmacies

Specialty pharmaceuticals (specialty drugs) generally differ from traditional drugs used to treat general health and chronic conditions because they:

- Are prescribed to treat complex, chronic, and/or rare conditions
- Have a high cost
- Have special storage, handling, and/or administration requirements
- Are available through certain pharmacies, known as specialty pharmacies

A specialty pharmacy manages specialty pharmaceuticals and may provide services that traditional pharmacies do not, such as:

- Communicating directly with doctors and following up if needed
- Investigating a patient's health insurance benefits
- Assisting with prior authorization requests
- Dispensing and delivering specialty pharmaceuticals directly to patients
- Researching financial assistance and helping patients enroll in patient assistance programs (PAPs)
- Proactively notifying patients about prescription refills
- Educating patients about their medication and potential side effects

Most prescription drug plans will have a preferred specialty pharmacy so be sure to ask which specialty pharmacy is in your prescription plan's network.

Some common specialty pharmacies you may know by name:

- **Accredo®**
- **Optum®/Optum Frontier Therapies Specialty Pharmacy**
- **CVS Caremark® Specialty Pharmacy**
- **AllianceRx Walgreens Prime Specialty Pharmacy**

How Specialty Pharmaceutical Drug Requests Are Approved

How a Drug Request Is Processed

Step 1

Doctor prescribes specialty drug and submits forms to initiate request for coverage

Your doctor's office may work with the pharmaceutical company's patient services hub or specialty pharmacy to seek coverage. Your insurance plan may require you and your doctor to complete and submit extra information or forms.

Step 2

Completion of your benefits investigation to determine coverage

The pharmaceutical company's patient services hub or the specialty pharmacy may perform a complete benefits investigation (BI) to confirm the benefits your insurance plan offers. You may be required to provide information during this process as well.

The BioMarin patient services hub is known as BioMarin RareConnections™.
For information visit BioMarin-RareConnections.com or call 1-866-906-6100.

CLICK NUMBER TO MOVE TO STEP

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

How a Drug Request Is Processed (cont.)

Step 3

The pharmaceutical company's patient services hub or specialty pharmacy collects information on behalf of the patient, including determining whether a prior authorization is required

The benefits investigation (BI) will help determine if your plan will cover the prescribed specialty drug, how much it will cost you, and if the plan requires prior authorization (PA) for the drug.

PA means that a drug must be preapproved by your prescription drug plan before the plan will cover the cost of the drug. Many plans require PAs for specialty pharmaceuticals. The doctor will complete a PA form if required and may also be required to submit other information as part of the PA, such as:

- Results of any tests or procedures that confirm the diagnosis; this could include genetic testing
- Proof that other therapies have been tried (eg, for patients with phenylketonuria [PKU])
- A letter explaining to the insurance company why the specialty drug prescribed is needed. Insurance companies refer to this as the "letter of medical necessity"

CLICK NUMBER TO MOVE TO STEP

1 Doctor prescribes specialty drug and submits forms to initiate request for coverage

2 Completion of your benefits investigation to determine coverage

3 Collection of information, including determination for prior authorization

4 Plan receives and reviews drug request

5 Drug request decision

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

How a Drug Request Is Processed (cont.)

Step 4

Plan receives and reviews drug request

Your plan reviews the drug request for the specialty drug to confirm that:

- The person being prescribed the drug is a member of the plan
- The drug is covered

The required supporting information has been provided by you, your doctor, or the specialty pharmacy

Step 5

Drug request decision

After confirming the information in Step 4, the plan approves or denies the drug request.

- If the specialty drug request is approved, the plan informs the specialty pharmacy and the doctor or patient and communicates what your share of the payment will be
- If the specialty drug request is denied, the plan informs the specialty pharmacy, the doctor, or the patient with an explanation. The drug request decision process may take some time to resolve while the patient services hub or specialty pharmacy works with the doctor's office for additional information to appeal the decision on behalf of the patient

CLICK NUMBER TO MOVE TO STEP

1 Doctor prescribes specialty drug and submits forms to initiate request for coverage

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3 Collection of information, including determination for prior authorization

4 Plan receives and reviews drug request

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How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

Once a Drug Request Is Approved

Step 1

Upon approval, the specialty pharmacy fills the prescription

The specialty pharmacy collects your share of the drug cost, fills the prescription, and will contact you to arrange shipment.

Step 2

You receive the prescription

The specialty pharmacy will tell you when the drug will arrive and may call to confirm that you have received it. You may also be told more about the drug or possible side effects, and you may be contacted from time to time to ensure you are taking the drug regularly, as your doctor prescribed.

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

Why a Drug Request May Be Denied

Here are some common reasons why a prescription drug insurer may deny (refuse to pay for) your drug request, and actions you may take when a drug request is denied.

Inaccurate information was provided

Your doctor or specialty pharmacist may have entered information incorrectly, such as a birth date or insurance information, or provided the wrong drug code. Or if you recently changed insurance plans, the pharmacy may have submitted a claim to your old plan.

Your doctor or specialty pharmacist can usually correct these types of errors in your records or in the drug request form before the clinic or specialty pharmacy resubmits the drug request.

An administrative error occurred

Your health insurer may not have entered you in their system yet, or they may have entered the wrong information and do not recognize you (yet) as one of their members.

Call your health insurance plan to confirm membership before the clinic or specialty pharmacy resubmits the drug request.

Incomplete information

The plan needs additional information about your diagnosis or the reasons your doctor has prescribed the drug before it will approve the drug request. Most new drugs will require the doctor to complete a generic PA form indicating specifics about your condition.

Check with your doctor to see if additional information needs to be submitted (for example, test results) before the clinic or specialty pharmacy resubmits the drug request.

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

Why a Drug Request May Be Denied (cont.)

Medical necessity

The plan does not consider the prescribed drug to be medically necessary for you, or it requires that you demonstrate medical necessity.

Insurance companies may require a letter from your doctor explaining why the prescribed drug is needed, or a letter of medical necessity. Check with your doctor to see if a letter of medical necessity may be written to explain why the drug is necessary for you. Then call or write your own letter to your insurance company to tell them why the treatment is necessary. The plan will review the letter before determining if it will cover the drug prescribed.

Step therapy (eg, for patients with phenylketonuria [PKU])

Your plan requires that you start and fail on a less-expensive drug before the plan will cover the cost of a more-expensive drug.

Your doctor will need to provide your plan with information about your treatment as part of a formal request for coverage of the drug prescribed.

There are other reasons a plan may deny coverage of a drug.

If you have questions about a denial, call the customer service phone number on your health insurance card to learn more about why the drug request was denied.

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

What to Do if a Drug Request Is Denied

When a health insurer denies a prescription drug request, the specialty pharmacy or patient services hub will be notified of the decision and may be able to take action on your behalf to learn why the request was denied and how to dispute the decision. Depending on the reason the request was denied, you may be able to ask your plan to reconsider the decision. For support in this process, reach out to:

- Your doctor's office
- The specialty pharmacy
- BioMarin RareConnections™
- Your employer's Benefits Manager

Two steps you can take to have the prescription drug plan reconsider a decision to deny your drug request

Step 1 Request a formulary exception

If your doctor prescribes a drug that your prescription plan does not cover, you may request a medical or formulary exception (usually referred to as an "exception"). The process and requirements for requesting an exception can vary by plan. If you want to request an exception, call your plan to find out what action you or your doctor needs to take.

For BioMarin product support, contact BioMarin RareConnections by visiting BioMarin-RareConnections.com, or by calling 1-866-906-6100.

The prescription drug plan may require that your doctor submit additional information or complete a form to:

- Confirm that the drug is appropriate for the medical condition.
- Explain that no other drugs are available for the condition or (eg, for patients with phenylketonuria [PKU]) that the other drugs the plan covers for the condition have not been effective or will not be as effective as the one requested.

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

What to Do if a Drug Request Is Denied (cont.)

Step 2 File an internal appeal

When you file an internal appeal, you are formally requesting that the prescription drug plan review its decision to deny your drug request. The plan will be required to make a full review, which may be conducted by employees of the plan who were not involved in the original decision.

You, your doctor, and/or specialty pharmacist may need to submit more information about your drug request, and many plans require that you complete an appeal form as part of your request. Appeal forms vary from plan to plan, but in general you may be asked to provide information such as:

- Member's name
- Member's ID number
- Member's group number
- Name of the drug
- The prescribing doctor's name, address, and phone number
- Reason for appealing the decision

It may be helpful to include your own letter or a letter from your child, if they are the patient, explaining why the drug is important.

Always confirm any time limits for submitting an internal appeal when you speak with the customer service representative at your plan.

See questions you may wish to ask your plan about your denial.

Some older prescription drug plans are not required to provide appeals. Your right to appeal may also depend on the state where you live and the type of plan you have. To learn more, check with your health insurance company or your employer's Benefits Manager.

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

What to Do if a Drug Request Is Denied (cont.)

Tips for calling your prescription drug plan about a denial

Before you call

- Write down everything you know about the denial:
  - Name of the drug
  - Date the drug request was denied
  - Prescribing doctor's name and address
  - Pharmacy's name and phone number
  - Reason the drug request was denied (if you know)
- If the prescription drug insurer has sent a written denial, have the form with you. There may be a drug request number or other information on the form that the customer service representative will ask you to provide
- Have your insurance card available. The customer service representative may ask for information on the card

During your call

- Write down all of the following information:
  - Date and time of the call
  - Full name, job title, and phone number or extension number of the customer service representative who answers your questions
  - Any information the representative provides about the reason the drug request was denied
  - What the representative suggests you do next to appeal the denied request
- Be sure to ask the representative for the reference number for the call

By documenting all of this information:

You create a record to share with the prescribing doctor or his/her office staff, if needed.

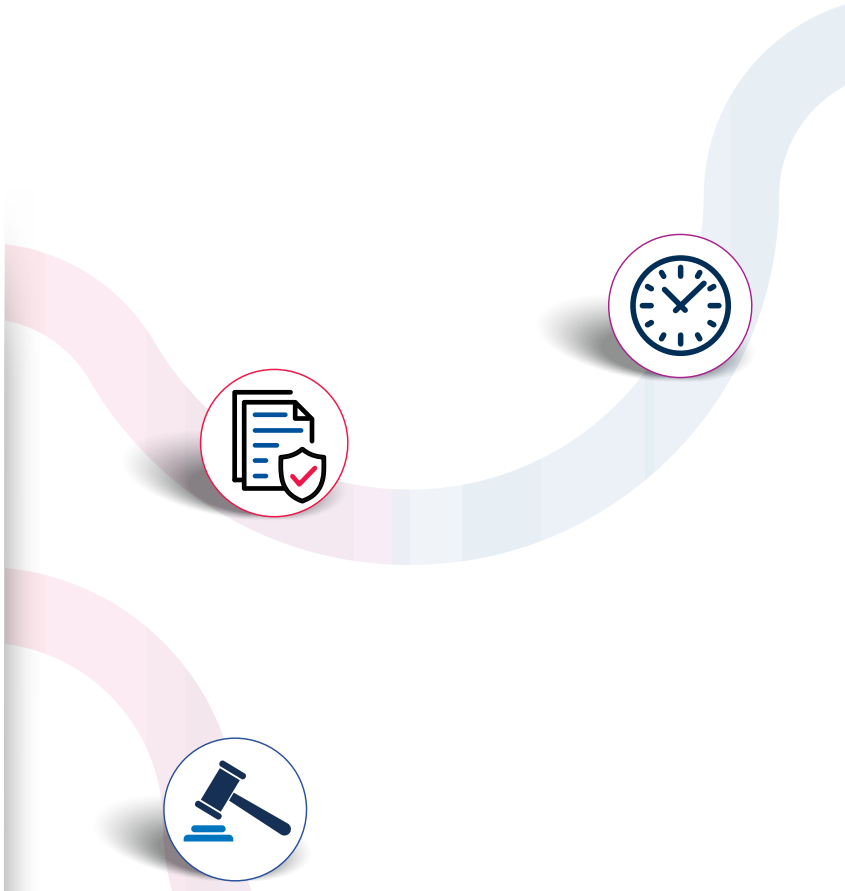
You can refer to this record if you need to call the plan again later. If you do call again, ask if you can speak to the customer service representative you spoke with previously.

How Specialty Pharmaceutical Drug Requests Are Approved (cont.)

What to Do if a Drug Request Is Denied (cont.)

Questions you may wish to ask about your denial

- Why was this drug request denied?
- What can I do next?
- Can I appeal this denial?
- How do I appeal?
- What information do I need to provide as part of this appeal?
- What information do you need my doctor to provide as part of this appeal?
- Are there any forms I need to complete as part of my appeal? If there are, how can I get them?
- Is there a time limit for filing this appeal?
- How long will it take for your company to make a decision about this appeal?



Who to Ask for Appeal Help

Your employer's Benefits Manager

Depending on the circumstances, the Benefits Manager may be able to send a letter or call the plan to explain why your drug request is valid. This could persuade the insurance plan to reverse its decision and pay for your drug.

Employee support programs

Some employers include healthcare advocate services as part of their employee support program. Services may offer over-the-phone advice or have care managers who can meet in person with you and your healthcare provider.

Specialty pharmacies

The specialty pharmacy that distributes the drug may offer help in submitting prior authorization requests or appeals.

Patient services hub

Drug manufacturer patient services hub can be helpful. For BioMarin products, contact BioMarin RareConnections™ by visiting BioMarin-RareConnections.com, or by calling 1-866-906-6100.

For BioMarin product support, contact BioMarin RareConnections™ by visiting BioMarin-RareConnections.com, or by calling 1-866-906-6100.

Who to Ask for Appeal Help (cont.)

Your state's Consumer Assistance Program

Some states sponsor Consumer Assistance Programs that can help you file an appeal or request an **external review** if your plan does not cover a drug that your doctor prescribes for you. Visit LocalHelp.HealthCare.gov to learn about help that may be available in your area.

Advocacy organizations

Some nonprofit/advocacy organizations dedicated to a specific health condition offer information or resources to help you navigate health insurance appeals. For example:

- Global Genes, globalgenes.org
- HealthWell Foundation, healthwellfoundation.org
- National Organization for Rare Disorders (NORD), rarediseases.org
- National PKU Alliance, npkua.org
- National MPS Society, mpssociety.org
- Batten Disease Support and Research Association, bdsra.org
- The MAGIC Foundation, magicfoundation.org/insurance-appeals/

Patient advocates

A patient advocate is someone who helps you with a broad range of healthcare issues, which can include health insurance issues. The Patient Advocate Foundation is an organization that advocates for patients and can offer help with appeals and prior authorizations.

- Visit patientadvocate.org

Links are provided for informational purposes only. No endorsement is made or implied.

Glossary

Appeal: A request made to your medical or prescription drug insurance plan to review a decision to deny coverage or payment for a medical service or prescription drug.

Benefits investigation (BI): A process used to determine the benefits your prescription drug plan provides, if a specific drug is covered, and what your share of the cost of a drug is.

Benefits Manager: The Benefits Manager is responsible for all the benefits a company offers its employees, including medical and prescription drug insurance, and can advise you on the benefits included in your employer's plan, answer questions, and assist you with any concerns or issues.

Drug request: Also known as a claim. A request for payment that you or your healthcare provider submits to your insurance company for a prescription drug or medical service.

Coinsurance: The amount of money you pay for a covered prescription drug or medical service after you have paid your plan's deductible. With coinsurance, the amount you must pay is usually a percentage of the cost. For example, if your coinsurance is 20%, you pay 20% of the cost and your plan pays the remaining 80%.

Commercial insurance plan: A health insurance plan that is paid for by someone other than the government. Usually, commercial health insurance is paid for by an employer or union, but some people may buy their own individual plan.

Co-pay (sometimes called co-payment): A flat amount of money you pay for a medical service or prescription drug that is covered by your plan.

Deductible: The amount of money you pay for covered services or drugs before your plan starts to pay. For example, if you have a $1,000 deductible per year, you must pay the first $1,000 in covered services and drugs yourself before your plan starts to pay. After you have paid your deductible for the year, you usually pay only co-payments or coinsurance for services and drugs and your plan pays the rest.

Glossary (cont.)

External review: A process by which an independent third party reviews your plan's decision to deny a drug request. The third party has the authority to uphold or overturn your plan's decision to deny the drug request.

Formulary: The list of drugs that are covered by a prescription drug plan.

Formulary exception: A request to make a nonformulary prescription drug available to a patient as a formulary drug.

Internal appeal: A formal request that your plan conduct a full and fair review of its decision to deny a drug request you have submitted.

Letter of medical necessity: A letter written by a doctor to explain why a prescribed drug or medical service is necessary for the patient.

Medical insurance, also known as the medical benefit: The part of your health insurance that covers the costs of expenses other than prescription drugs, such as office visits, hospital stays, and emergency room visits. Some specialty drugs, typically those that are infused, are also covered under the medical benefit.

Medical necessity: See "Medically necessary drugs/services" below.

Medically necessary drugs/services: Procedures, treatments, drugs, or services that, according to generally accepted medical standards, a healthcare provider would use to prevent, evaluate, diagnose, or treat a patient's illness, injury or disease, or symptoms. Many health insurance plans cover only services deemed to be medically necessary.

Patient assistance programs (PAPs): Programs offered by pharmaceutical companies to provide free or low-cost prescription drugs to individuals who qualify.

Patient services hub: An operation that serves as a go-between for manufacturers and specialty pharmacies to assist patients in obtaining care.

Prescription drug insurance, also known as the pharmacy benefit: The part of your health insurance that covers the costs of prescription drugs or medicines that are oral or self-injectable.

The BioMarin patient services hub is known as BioMarin RareConnections™.

For information visit BioMarin-RareConnections.com or call 1-866-906-6100.

Glossary (cont.)

Primary insurance plan: For people who are covered under more than one health insurance plan, the primary plan is the one that pays expenses first. If you have insurance through your employer, this plan is usually considered your primary insurance plan. For more information, see "Secondary insurance plan."

Prior authorization (PA): A type of preapproval your prescription drug plan requires before it will cover the cost of a drug.

Quantity limits: Limits on the amount of a prescribed drug you can receive in a defined period. For example, a once-daily pill may have a quantity limit of 30 pills for 30 days. The limits are usually based on a drug's approved dosing and usage guidelines and are intended to help prevent waste and inappropriate use.

Secondary insurance plan: For people who are covered under more than one health insurance plan, the secondary plan is the one that pays second. If your primary insurance plan does not cover an expense, or only partly covers it, you can submit the unpaid part of the drug request to your secondary plan.

Specialty drug/pharmaceutical: A high-cost drug that usually has special storage, handling, or administration requirements and is prescribed to treat a complex, chronic, or rare condition.

Specialty pharmacy: A pharmacy that manages specialty pharmaceuticals and provides additional services that traditional pharmacies do not.

Step therapy (eg, for patients with phenylketonuria [PKU]): The practice of requiring patients to start drug therapy for a medical condition using a less-expensive drug—and proving that it does not work for the patient—before an insurance plan will cover the cost of a more-expensive drug for the condition.

Tiers (or co-payment tiers): A method of grouping drugs within a formulary based on the amount of co-payment charged.

Call Record Worksheet

Use this page to write down important information about your conversation with your prescription drug plan's customer service representative. You should keep a record like the one below each time you call your plan.

Date of call _____ Time of call _____

Customer service representative's name _____

Customer service representative's title _____

Phone _____ Email _____

Important topics you discussed during the call _____

_____

_____

Why your drug request was denied _____

_____

Documents you have sent, or will send (if any) _____

_____

Date sent _____

Documents you have received, or will receive (if any) _____

_____

_____

Identification number for this call (if you are given one) _____

Next steps you need to take _____

_____

_____

Time limit (if there is one) _____

Notes

BioMarin RareConnections™ is the BioMarin patient services hub.

Contact us for help to navigate the insurance process or identify assistance options you may be eligible for to start and continue on treatment.

Visit BioMarin-RareConnections.com or call 1-866-906-6100.

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