Prescription Drug Formulary Template

All fields with an asterisk (*) a
Click the Create Formulary I
After creating Formulary IDs,
Select how many tiers a form
Enter all RXCUIs on the Drug

HIOS Issuer ID*	
Issuer State*	

Formulary ID*	Formulary URL*	Drug List ID*	Number of Tiers*
Required: Select the Formulary ID	**Required:** Enter the Formulary URL	**Required:** Select the Drug List ID (from Drug Lists sheet)	**Required:** Select the number of Tiers

are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize butto
Ds button (or Ctrl + Shift + C) to create Formulary IDs.
, select the ID from the drop down in Column A and 7 tiers will automatically be popoulated.
ɲulary uses from Number of Tiers and unused rows (tiers) will be greyed out.
g Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added pre

Drug Tier ID*	Drug Tier Type*	1 Month In Network Retail Pharmacy Cost Sharing Type*
Required: The template will populate a Drug Tier ID 1-10	**Required:** Select all the Drug Types included in this tier	**Required:** Select the Cost Sharing Type

All brands, All preferred brands, All non-preferred brands

All brands, All preferred brands, All non-preferred brands

n or Ctrl + Shift + F.

ss Delete Drug Lists (or Ctrl + Shift + D).

Copayment* **(Please enter a dollar amount)**	**Coinsurance***	**1 Month Out of Network Retail Pharmacy Benefit Offered?***	**1 Month Out of Network Retail Pharmacy Cost Sharing Type**
Required: Enter the Copayment for 1 Month In Network Retail Pharmacy	**Required:** Enter the Coinsurance for 1 Month In Network Retail Pharmacy	**Required:** Does this tier offer 1 Month Out of Network Retail Pharmacy benefits?	**Required if Offered:** Select the Cost Sharing Type

Copayment* **(Please enter a dollar amount)**	**Coinsurance**	**3 Month In Network Mail Order Pharmacy Benefit Offered?***	**3 Month In Network Mail Order Pharmacy Cost Sharing Type**
Required if Offered: Enter the Copayment for 1 Month Out of Network Retail Pharmacy	**Required if Offered:** Enter the Coinsurance for 1 Month Out of Network Retail Pharmacy	**Required:** Does this tier offer 3 Month In Network Mail Order Pharmacy benefits?	**Required if Offered:** Select the Cost Sharing Type

Copayment (Please enter a dollar amount)	Coinsurance	3 Month Out of Network Mail Order Pharmacy Benefit Offered?*	3 Month Out of Network Mail Order Pharmacy Cost Sharing Type
Required if Offered: Enter the Copayment for 3 Month In Network Mail Order	**Required if Offered:** Enter the Coinsurance for 3 Month In Network Mail Order	Required: Does this tier offer 3 Month Out of Network Mail Order benefits?	**Required if Offered:** Select the Cost Sharing Type

Copayment (Please enter a dollar amount)	Coinsurance
Required if Offered: Enter the Copayment for 3 Month Out of Network Mail Order	**Required if Offered:** Enter the Coinsurance for 3 Month Out of Network Mail Order

Drug Lists

	Drug List ID 1	
RXCUI*	**Tier Level***	**Prior Authorization Required**
Required: Enter the RXCUI	**Required:** Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	**Required if Tier Level is not NA:** Select "Yes" if Prior Authorization is Required

Step Therapy Required

Required if Tier Level is not NA:
Select "Yes" if Step Therapy is Required