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Strategic Pharmacy Planning:

Driving Better Health and Lower Costs

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Agenda

1. Inside the PBM Model
2. Critical Contract Elements
3. Beyond the Contract
4. The GLP-1 Outlook
5. Q&A

**PBM—Pharmacy Benefit Manager*

Inside the PBM Model

What PBMs Do

Four functions of a PBM in plan administration

THE BENEFITS

PBM administers complex plan rules during claim adjudication

PBM effectively communicates with large member populations.

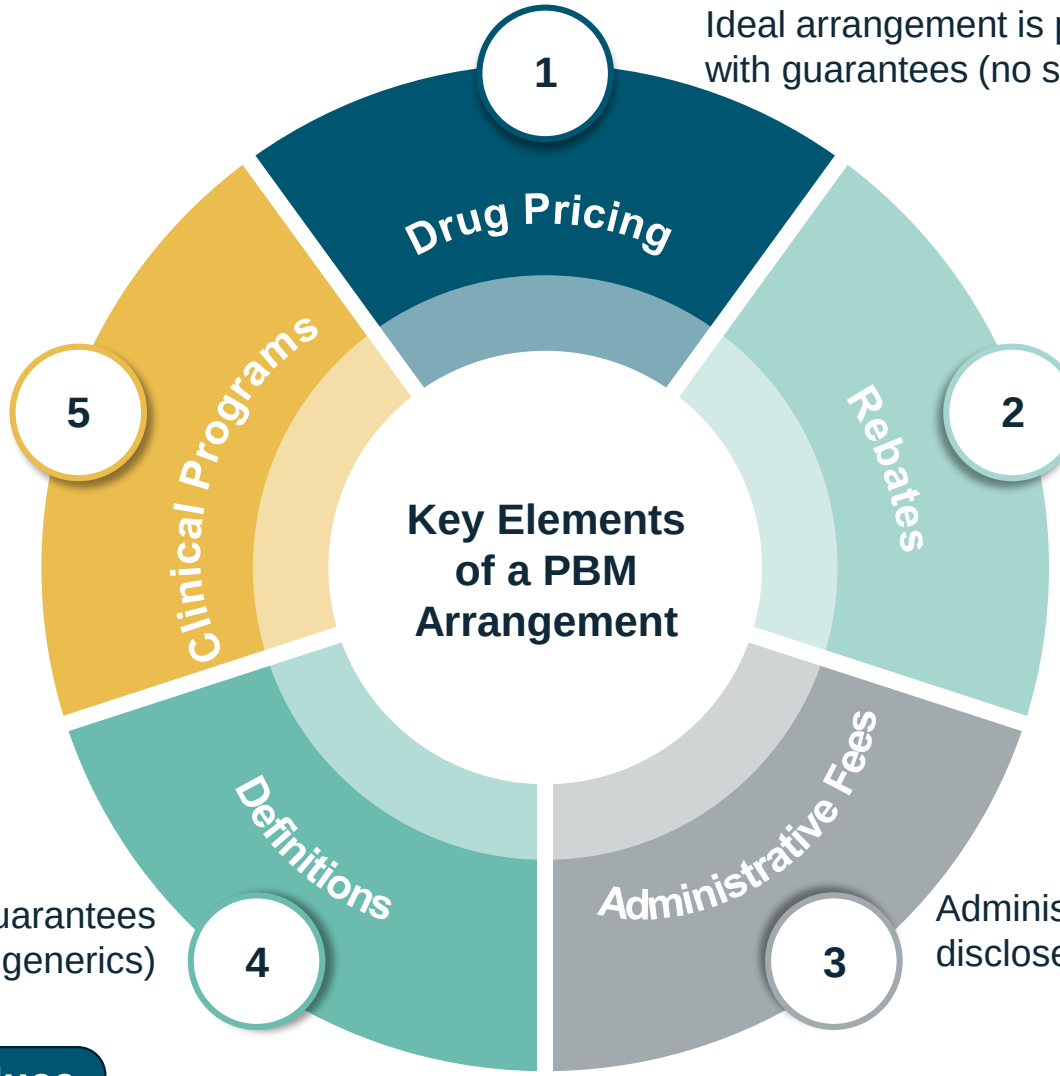
PBM implements programs resulting in decreased drug spend and may improve clinical outcomes.

PBM has negotiating powers with pharmaceutical manufacturers.

Attributes of Ideal PBMs

- **TRANSPARENCY**
- **FLEXIBILITY**
- **CLINICAL PROGRAM SOLUTIONS**
- **HIGH-COST DRUG SOLUTIONS**

Five Key Elements of a PBM Arrangement



1. Ideal arrangement is pass-through with guarantees (no spread pricing)
2. Ideal arrangement is pass-through with minimum guarantees.
3. Administration fees should be disclosed.
4. Dictates value of guarantees (e.g., brand vs. generics)
5. Specialty Pharmacy, Clinical Edits, Formulary Management.

Effective pharmacy strategies can **reduce Rx spend by 20%-30%** (results vary by company)

The Spectrum of Pharmacy Models

EXPLORER TRADITIONAL MODEL

- Rx bundled with medical
- “Big 3” PBMs
- Spread pricing
- Limited or no rebate share
- Contract language favors PBMs
- Prescribed clinical protocols

INNOVATOR PASS-THROUGH MODEL

- Pass-through agreement
- Fully transparent
- No spread pricing
- 100% rebate share
- Contract language favors the plan sponsor
- More clinical edit choice

ADVANCED PASS-THROUGH STRATEGIES

- Manufacturer assistance programs
- Specialty alternative funding
- J-code drug management
- Site of care managed for infusion
- Drug importation

Critical Contract Elements

What Should Be Evaluated in Every PBM Contract

Six areas where hidden costs and weak contract language cost employers the most—and where oversight creates the greatest impact.

Drug Pricing

The risk: Spread pricing lets PBMs charge plans more than they reimburse pharmacies.

Gold standard: Pass-through pricing with contractual guarantees. No spread.

Rebates

The risk: Vague definitions allow PBMs to retain a portion before passing to the plan.

Gold standard: 100% pass-through with clear definitions and minimum guarantees.

Definitions

The risk: How "brand," "generic," and "specialty" are defined determines guarantee values.

Gold standard: Client-favorable definitions reviewed and negotiated by our PharmD.

Admin Fees

The risk: Undisclosed admin fees are a common source of hidden PBM or TPA or Broker revenue.

Gold standard: Full disclosure required. Every fee identified and benchmarked.

Clinical Programs

The risk: Formulary and specialty programs often designed around PBM revenue, not outcomes.

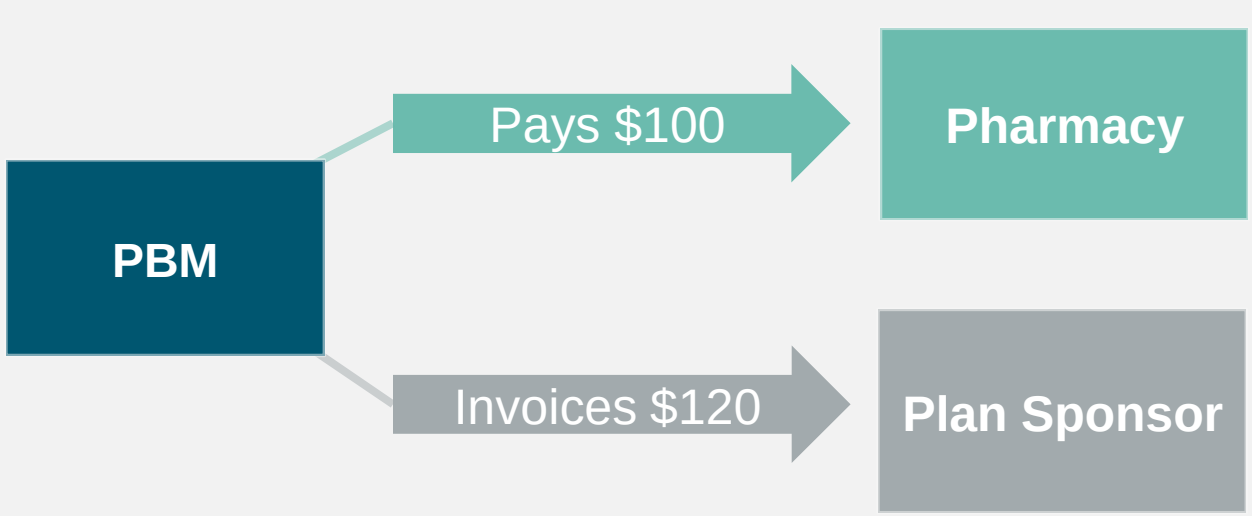
Gold standard: Independent clinical review ensures programs serve the plan and members.

Broker Compensation

The risk: Some brokers collect $4+ per script in undisclosed PBM commissions.

Gold standard: Fixed disclosed fee. No PBM commissions. No percentage of savings.

How Spread Pricing Works



PBM keeps $20[1]

Traditional Contract Example

[1]*This is an example for illustrative purposes. The actual spread is not disclosed and can range from 5-12% of plan spend.*

Contract Provisions That Preserve Leverage

Six provisions where weak language erodes plan leverage.

Termination Language

The risk: Long notice periods, “for cause only” language, and termination fees lock plans into underperforming arrangements with no leverage to walk.

Our standard: Termination for convenience with reasonable notice. No early-out penalties. Clearly defined breach triggers.

Carve-Out Fees

The risk: PBMs penalize plans for routing specialty, mail, or other categories to specialized vendors—eroding the savings that drove the carve-out.

Our standard: No carve-out penalties. Plan retains the right to direct any drug class without financial consequence.

PBM Audits

The risk: PBMs limit audit scope, frequency, sample size, and third-party access—making it nearly impossible to verify that guarantees were actually met.

Our standard: Annual claims-level audit rights. Independent auditor of the plan’s choice. Full data access without restriction.

Performance Guarantees

The risk: Guarantees with capped or token penalties (e.g., a fraction of admin fees) create no real accountability when targets are missed.

Our standard: Meaningful dollars at risk on AWP discounts, dispensing fees, rebates, and service metrics—with defined reconciliation timelines.

Implementation Allowances

The risk: Implementation credits are often undocumented, restricted in use, or subject to clawback if the plan terminates before contract end.

Our standard: Clearly defined allowances with no clawback on for-cause termination. Use restrictions transparent and reasonable.

Market Check Capabilities

The risk: Without a market check provision, plans cannot reset pricing mid-term—even when AWP discounts and rebate yields have moved meaningfully.

Our standard: Mid-term market check (typically year 2 or 3) with a defined methodology and the right to renegotiate or terminate based on findings.

If these elements aren’t in your contract…

A practical path to closing the gap that requires specialized expertise.

1

Audit & Identify

- Map your current contract language against best-in-class standards.
- Quantify the financial, operational, and audit exposure of each gap.
- Prioritize by dollar impact and likelihood of negotiation success.

2

Negotiate Directly

- Most provisions are negotiable—especially at renewal or contract true-up.
- Lead with data: claims-level analysis, market benchmarks, peer-tested language.
- Insist on red-lined edits in writing; verbal assurances are not contract terms.

3

Engage Expertise

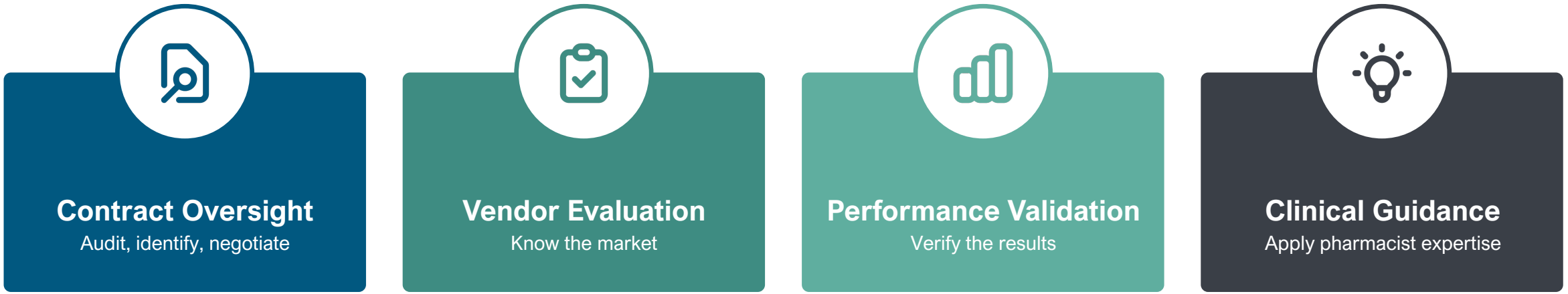
- PBMs are sophisticated counterparties with a significant information advantage.
- Independent advisors bring contract benchmarks, redline libraries, and pharmacist-level fluency.
- The biggest leverage comes when negotiations stall on “standard language.”

When the answer becomes “that’s just our standard language,” that’s the signal to bring in independent expertise—advisors who do this every day, with the contract benchmarks and leverage to turn boilerplate back into negotiation.

Beyond the Contract

Core Functions of Pharmacy Benefit Oversight

Four pillars of an effective program—each requires distinct expertise and ongoing attention.



The Pharmacy Benefit Management Lifecycle

Effective oversight is continuous, not episodic—distinct expertise is required at each phase.

01

Evaluate

02

Recommend

03

Implement

04

Monitor

Hallmarks of a High-Quality Pharmacy Program

Use these as evaluation criteria for any consultant, broker, or in-house program—including your current arrangement.

01

Continuous Clinical Pharmacist Oversight

02

Independent Claims Validation

03

Pass-Through Pricing Standards

04

Aligned Compensation Structure

The GLP-1 Outlook

GLP-1 Medications: Diabetes vs. Weight Loss

Coverage and benefit design implications for self-funded employers

GLP-1 for Diabetes

COVERED DRUGS

Ozempic, Ozempic oral, Mounjaro, Rybelsus, Trulicity, Victoza, liraglutide

INDICATION

Glycemic control in T2DM; CV & renal risk reduction

BENEFIT CHANNEL

Pharmacy benefit—generally covered by commercial plans

PRIOR AUTH BURDEN

Minimal—confirmed T2DM diagnosis typically sufficient

vs

GLP-1 for Weight Loss

COVERED DRUGS

Wegovy, Zepbound, Saxenda, Foundayo, Wegovy pill, liraglutide

INDICATION

Chronic weight management; BMI ≥30, or ≥27 + comorbidity; OSA; MASH; CV risk reduction

BENEFIT CHANNEL

Pharmacy benefit—coverage varies widely; many plans exclude

PRIOR AUTH BURDEN

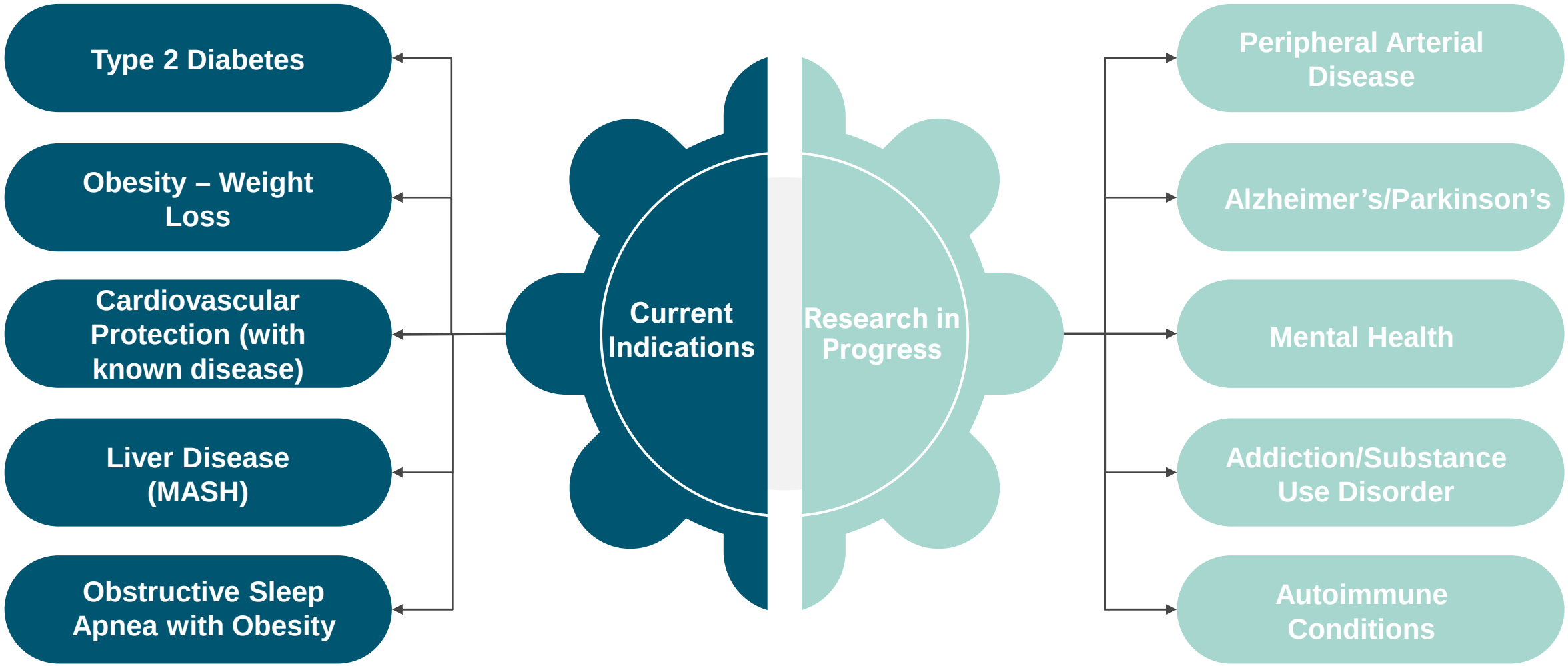
Heavy, variable—BMI thresholds, step therapy, behavioral requirements

You cannot carve out GLP-1 utilization for diabetes. GLP-1s prescribed for T2DM are medically necessary, standard-of-care treatments. Restricting them may expose plans to ADA non-discrimination claims, ERISA fiduciary liability, and legal challenge. The diabetes indication is not discretionary.

Same molecule, different obligation: Semaglutide as **Ozempic** (T2DM) = covered, low UM. Semaglutide as **Wegovy** (obesity) = optional, high UM, employer discretion. The label determines the obligation.

** T2DM = Type 2 Diabetes Mellitus | OSA = Obstructive Sleep Apnea (Zepbound) | MASH = Metabolic Dysfunction-Associated Steatohepatitis (Wegovy) | CV risk reduction (Wegovy)*

GLP-1 Uses – Current vs. Pipeline



Among many others…

Distribution Channels

GLP-1s for Weight Loss (Wegovy, Zepbound, Foundayo, Saxenda) | *Diabetes-indicated GLP-1s (Ozempic, Mounjaro, Rybelsus) flow through the standard pharmacy benefit*

STANDARD PLAN COVERAGE

PBM-mediated coverage

- Medical carrier
- PBM
- TPA
- Plan-contracted specialty vendors (Omada, Virta, Calibrate, etc.)

PLAN INTEGRATION

Tracks to deductible / OOP max
Plan sponsor receives manufacturer rebates
Plan dictates plan/member cost share

DIRECT TO EMPLOYER

Launched March 2026

Lilly Employer Connect[5]

- 15+ admins: GoodRx, Cost Plus Drugs, Teladoc, Calibrate, Transcarent, 9amHealth, Waltz, Ilant, Goodpath
- Zepbound KwikPen: $449/mo, all doses
- Dispensing via HealthDyne / CenterWell Pharmacies only

Novo Nordisk[6]

- Employer program announced Dec 2025

PLAN INTEGRATION

Does **NOT** track to deductible / OOP max
No plan-level rebates
Member pays up to 100%; plan may subsidize outside of plan benefit

DIRECT TO CONSUMER

Cash-pay; outside the plan

Manufacturer DTC

- LillyDirect (Zepbound $349–$499)
- LillyDirect (Foundayo $149-$299) * NEW
- NovoCare Pharmacy (Wegovy $499)
- Wegovy Subscription[6]: $249/mo (12-mo) via Ro, WeightWatchers, LifeMD, Hims & Hers, Sesame

TrumpRx (launched Feb 2026)[7]

- Federal cash-pay portal; members forfeit insurance reimbursement & deductible credit

PLAN INTEGRATION

Does **NOT** track to deductible / OOP max
No plan-level rebates
Member pays 100%

NOTE: *Post-FDA shortage resolution and April 2026 enforcement, most compounded GLP-1s (including B12 combinations) are no longer permitted; narrow, medically-justified exceptions remain.[8]*

[1-4] Full citations on Reference slide

Designing Coverage for the Whole-Person Approach

The drug is one pillar—coverage design should reflect how these therapies actually work.

1

A multidimensional decision

Coverage spans cost, clinical impact, and employee well-being—not just pharmacy spend.

2

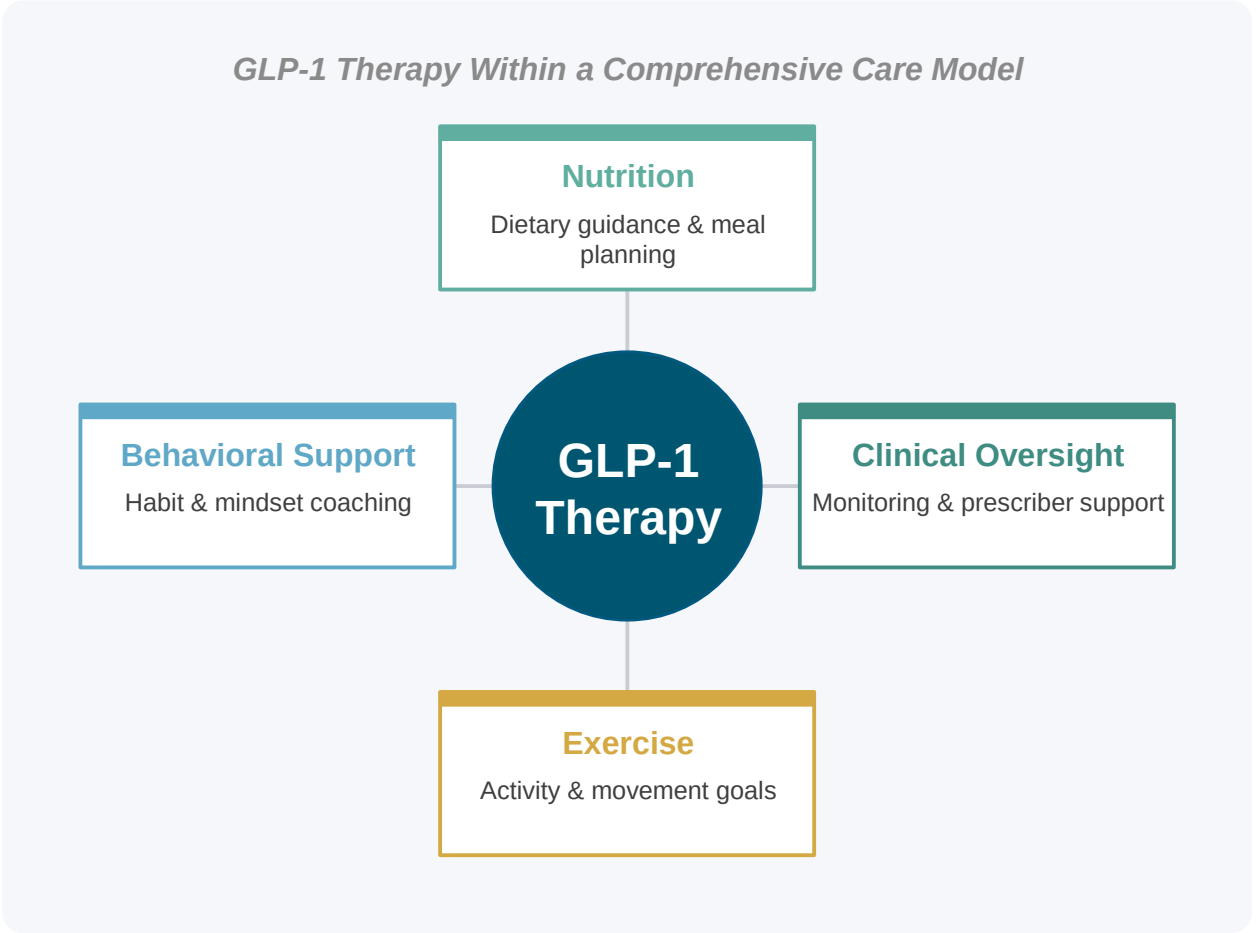
Outcomes follow program design

Drug therapy paired with nutrition, behavioral, and clinical support consistently outperforms drug-only access.

3

Strategy requires alignment

Carrier, PBM, and point-solution vendors should coordinate around the same comprehensive model—not operate in silos.



What to Watch in 2026 + Beyond

GLP-1 trends shaping plan strategy in the year ahead

CLINICAL EXPANSION

- Continued uptick in demand
- Expanded clinical indications
- Oral GLP-1 formulations becoming available

MARKET DYNAMICS

- Novo Nordisk price reductions
- Direct-to-employer purchasing programs
- PBM strategic shifts in response

EVIDENCE & OUTLOOK

- Long-term outcomes data emerging
- ROI evidence becoming available

Thank you!

For more information about Hylant,
please visit us at ***hylant.com.***

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References

Citations supporting content presented in this discussion

SLIDE21 · DISTRIBUTION CHANNELS

1. Eli Lilly and Company. Lilly Employer Connect platform launches with over fifteen independent program administrators. PR Newswire, March 5, 2026.
2. Novo Nordisk. Wegovy subscription program launch, March 31, 2026. / HR Brew. Eli Lilly, Novo Nordisk launch direct-to-employer models. December 19, 2025.
3. Kaiser Family Foundation. TrumpRx: What's the Value for Customers? February 2026.
4. U.S. Food and Drug Administration. FDA clarifies policies for compounders as national GLP-1 supply begins to stabilize. April 1, 2026.

SLIDE 22 · A STRUCTURED APPROACH

5. Eli Lilly. *Zepbound® (tirzepatide) Prescribing Information* (Study 1 & 2 design), 2024. / Novo Nordisk. *Wegovy® (semaglutide) Prescribing Information* (STEP trial design), 2025.
6. Wegovy / Zepbound FDA Prescribing Information — weight-loss response criteria for continuation. / AACE/ACE Clinical Practice Guidelines for Comprehensive Medical Care of Patients with Obesity.

A Structured Approach for Weight-Loss Coverage

Plan-design components aligned with the clinical evidence base

COMPONENTS FOR SUSTAINABLE OUTCOMES

*Pivotal Zepbound and Wegovy trials demonstrated efficacy **on top of** a reduced-calorie diet and 150 min/week of physical activity — in **both** treatment and placebo arms.*

*Lifestyle intervention is **foundational to the evidence base** — not an add-on. A durable plan strategy mirrors that structure.*

1

Clinical eligibility & prior authorization

Evidence-based criteria aligned with FDA labeling — BMI ≥30, or ≥27 with a weight-related comorbidity; documented prior weight-loss attempts.

2

Lifestyle integration as a condition of coverage[10]

Pair medication with enrollment in a plan-contracted weight-management program (e.g., Omada, Virta, Wondr). Mirrors the design that produced the trial results.

3

Response-based continuation criteria[11]

Documented weight-loss milestone (≥5% at 16–20 weeks per FDA labeling) to continue coverage. Aligns reimbursement with clinical response.

4

Thoughtful member cost-share design

Copay structure that supports adherence in responders while balancing overall plan utilization and long-term affordability.

NOTE: *Not all PBM vendors support custom plan design — including response-based continuation criteria, lifestyle participation requirements, or duration limits. Confirm administration capability early in vendor evaluation.*

[5-6] Full citations on Reference slide


Questions?