



Prescription Drug Benefits Under the University of Arkansas Prescription Drug Program Summary of Benefits

MedImpact Healthcare Systems, Inc. is the prescription benefit manager of this plan.

Effective November 1, 2010

Retail Days' Supply Limitations:

Up to 90-day supply
*One retail copay applies for each 30-day supply purchased.

Mail Service Days' Supply Limitations:

Up to 90-day supply on maintenance medicines (members must fill a 60-day supply within a one year period in order to use mail service).
*One retail copay applies for each 30-day supply purchased.

Standard Copay Amounts:

Retail (up to 30-day supply)		Mail Service (up to 90-day supply)	
Generic (Tier 1)	\$10	Generic (Tier 1)	\$30
Formulary Brand (Tier 2)	\$35	Formulary Brand (Tier 2)	\$105
Non-Formulary Brand (Tier 3)	\$70	Non-Formulary Brand (Tier 3)	\$210

***EXAMPLE:** Formulary brand medicines purchased for up to a 30-day supply = \$35. For up to a 60-day supply = \$70. For up to 90-day supply = \$105. This **stepped copay** applies to both mail service and retail purchases of generic, formulary brand and non-formulary brand medicines.

Mail Service Pharmacy:

MedVantx

Formulary Type:

3-Tier Primary/Preferred Drug List

Dependent Age Limitations:

Dependents are covered up to their 26th birthday.

Prescription Benefit Drug Card Produced By:

MedImpact Healthcare Systems, Inc. (Two cards issued to primary plan participant, additional cards can be requested online at www.medimpact.com or by contacting MedImpact Customer Service toll-free at 1-800-788-2949).

Refill Restrictions:

Plan participant must use 50 percent of medicine before refill permitted at retail (60 percent if refilled through mail service or Choice90).

Paper Claim Reimbursement for Plan Participants:

If plan participant fails to use prescription drug card at a retail pharmacy and submits a paper claim to MedImpact Healthcare Systems for reimbursement, the claim will be paid at the same rate the pharmacy would have been paid, less the applicable copay. There is also a \$1.50 processing fee withheld from plan participant reimbursement. Paper claim forms available online at www.medimpact.com.

Pharmacy Network:

Full pharmacy network; most pharmacies in Arkansas are included. For a complete list of participating pharmacies, please log in as a member at www.medimpact.com.

Compounded Drug Reimbursement Policy:

It is the policy of the University of Arkansas to place all compounded drugs at third tier (\$70 copay) under the prescription drug program. A compounded drug is considered to be any drug that is combined with another drug outside of the manufacturer's setting. This policy includes the compounding of one or more generic drugs.

Brand Drug Status When Generic is Available:

It is the policy of the University of Arkansas to place brand-name drugs to third tier (\$70 copay) when its generic equivalent becomes available on the market.

Moreover, if a plan participant chooses the brand product over the generic when available, there may be a generic incentive applied in addition to the third tier (\$70) copay. If the physician does not allow generic substitution, then no generic incentive is applied to the claim. The generic incentive is the difference in cost between the available generic medication and the selected brand product.

Example: Brand-name product costs \$185 dollars. The available generic costs \$75. The difference in cost between brand and generic is \$110. If the plan participant chooses brand instead of the available generic, the generic incentive (\$110) will be added to the T3 copay (\$70) for a total plan participant cost of \$180.

The University of Arkansas Pharmacy Advisory Committee comprised of physicians, pharmacists and benefit specialists makes all formulary, quantity and days' supply limitations decisions after careful consideration based upon published evidence-based medical data.

Please note that the University of Arkansas Preferred Drug List, administered by MedImpact Healthcare Systems, is not intended to be inclusive or exclusive of all drugs on the market, but reflects the more commonly used drugs. Be sure to verify coverage per plan programs and limitations. You may call MedImpact Customer Service toll-free at 1-800-788-2949 or log in as a member at www.medimpact.com.

COVERED PRESCRIPTIONS

Covered drugs include the following:

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| <ul style="list-style-type: none"> • Insulin • Diabetes Supplies* • (QL) Blood Glucose Monitor** • Oral Contraceptives • Nuvaring and Contraceptive Patches • Glucagon • Most Injectable Medications • Cough Syrup with Codeine • Prescription Vitamins and Pediatric Vitamins • Pre-Natal Vitamins • HIV Treatments | <ul style="list-style-type: none"> • (QL) Compounded Medications • (QL) Smoking Cessation Products • Acne Medications • (QL) Retinoid Acne Products • (QL) Sedatives/Hypnotics/Insomnia Agents • (QL) Migraine Therapies • Allergic Emergency Injectables • (ST) Singulair/Accolate/Zyflo | <ul style="list-style-type: none"> • (RBP) Proton Pump Inhibitors (Ulcer meds) • (ST) ARBs (Hypertension) • (ST) Daytrana • (QL) Ultram Extended Release • (QL) Emsam Patch • (QL) Actiq/Fentora • (ST) Effexor XR • (QL) Zostavax vaccine • (QL) Liquadd |
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(QL) = Quantity or Age Limits (ST) = Step Therapy

***Note:** Diabetes supplies (test strips, lancets, alcohol swabs, insulin needles/syringes) are \$0 when purchased with a doctor's prescription.

****Receive a No Cost Blood Glucose Monitoring System**

If you'd like to switch to a LifeScan OneTouch blood glucose monitoring system *and receive a 90 day supply of test strips by mail*, please call MedVantx toll free 1-866-744-0621 and choose option 3 to speak with a Customer Service Representative while supplies last. *MedVantx will work with your physician to obtain the details for processing your request.*

PRIOR AUTHORIZATION REQUIRED (PA): Contact MedImpact Customer Service toll-free at 1-800-788-2949 with questions and to begin the prior authorization process. **Other medications not listed below may also require prior authorization.**

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| <ul style="list-style-type: none"> • Growth Hormones • Hemophilia Medications • Erectile Dysfunction Agents (QL apply) • Forteo • Lamisil and Sporanox (Oral Antifungals) • Gleevec • Xolair (Asthma) • Antineoplastics* | <ul style="list-style-type: none"> • Osteoporosis Injectables • Nutritional Supplements for PKU • Injectables (except Insulin) • Nexavar • Revlimid • Botox • Ranexa • Sutent | <ul style="list-style-type: none"> • Orencia • Somatuline • Kuvan • Intelence • Syprine • Selzentry • Lyrica • Provigil |
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* Antineoplastic agents may be covered without prior authorization if prescribed by a physician specializing in oncology or neurology.

IMPORTANT INFORMATION ON THE PRIOR AUTHORIZATION PROCESS: MedImpact Healthcare Systems will provide the necessary paperwork to the prescriber for medications that require prior authorization. Plan participant or prescriber must contact MedImpact Customer Service toll-free at 1-800-788-2949 to begin the prior authorization process. Prescriptions listed as **excluded** will not be authorized under any circumstances. Authorizations for changes to copays will not be permitted under any circumstances, except for Lipitor 80 mg. In the event a request for prior authorization is denied, plan participants are to contact MedImpact Healthcare Systems toll-free at 1-800-788-2949 if they wish to make an appeal.

Drugs may be added to the exclusion list at any time. Please be sure to verify coverage per plan programs and limitations. You may call MedImpact Customer Service toll-free at 1-800-788-2949 or log in as a member at www.medimpact.com. The majority of exclusions will be allowed to process, however the member will be responsible for 100% of the cost of the medication. The University of Arkansas System will not share in the cost.

New specialty medications released to the market will be excluded from coverage pending review by the University of Arkansas Pharmacy Advisory Committee.

EXCLUSIONS: This is an exclusion list by drug category. To see if a particular medication is considered a plan exclusion, you may call MedImpact Customer Service toll-free at 1-800-788-2949 or log in as a member at www.medimpact.com.

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| <ul style="list-style-type: none"> • ***Diaphragms, IUDs and Misc. Contraceptives • Emergency Contraceptives • Fertility Medications • ***Implantable Contraceptives • Cosmetic Alteration Drugs • Hair Loss • Weight Loss • Topical Dental Fluorides • *****Immunizations • Misc. Medical Supplies • Misc. Syringes • Infant Formulas or Liquid Nutritional Supplements | <ul style="list-style-type: none"> • ****Over-the-Counter (OTC) Medications • Cough/Cold/Allergy Medications with OTC Equivalents • Cream/Ointment/Lotion with OTC Equivalents • H2 Antagonists with OTC Equivalents (Ulcer Meds) • Acne Medications/Products with OTC Equivalents • "Me Too" drugs (new drugs that do not provide substantial improvements over existing drugs in the same class) | <ul style="list-style-type: none"> • Smoking Deterrents – OTC (patches are included, all other OTC smoking cessation products are excluded) • Vitamins – OTC • Xopenex • Magnacet • Cox II Inhibitors (Celebrex) • Non-Sedating Antihistamines (NSAs), OTC and prescription, brand and generic (Allegra, Zyrtec/D OTC, Clarinex, Claritin/D OTC, and Xyzal) • Treximet |
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***Certain contraceptives not covered under the prescription drug program, such as IUDs and implantable contraceptives, are covered under the health plan benefit. Please consult the QualChoice Summary Plan Description (SPD) for additional coverage details.

**** OTC Prilosec is covered with a prescription under the University of Arkansas prescription plan, with 1 retail copay for up to a 42 days supply.

*****Zostavax (QL) is a covered immunization/vaccine under the University of Arkansas prescription plan.

STEP PROGRAMS (ST):

Singulair Step Therapy

Singulair/Accolate/Zyflo not covered for allergic rhinitis. Prior authorization required for treatment of asthma. Plan participant must currently be on a beta-2 agonist (albuterol, etc.) and an inhaled corticosteroid (e.g., Pulmicort, Qvar), or Advair (which is a combination of beta-2 agonist and corticosteroid) to qualify for coverage.

ARB Step Therapy

Plan participant must try a 30-day supply of an ACE Inhibitor (Angiotensin II Converting Enzyme) before Angiotensin Receptor Blocker (ARB) is covered, or have serious ACE Inhibitor adverse affect. For these conditions, a prior authorization is required. (ARB Examples: Diovan, Avalide, Benicar, Cozaar, Hyzaar, etc.)

Daytrana Step Therapy

Plan participant must try a 30-day supply of an oral ADD/ADHD medication before Daytrana patch is covered.

Byetta Step Therapy	Concurrent use with insulin is not allowed. To obtain Byetta, plan participant must be on concomitant therapy of one or more of the following diabetic drugs: a sulfonylurea, metformin, or thiazolidinedione or any combination of these products. (Examples of these drugs include generic metformin, chlorpropamide, glyburide, glipizide, Actos and Avandia.)
Lexapro Step Therapy	Plan participant must try a 30 day trial of a generic SSRI antidepressant before Lexapro is covered. (Examples of generic SSRIs: fluoxetine, citalopram, paroxetine or sertraline)

QUANTITY LIMITATIONS (QL):

Proton Pump Inhibitor (PPI) Limitations	Doses greater than one-per-day require a prior authorization. (Applicable PPIs include Prevacid, Aciphex, Protonix, Nexium and Zegerid).
Migraine Therapies	All migraine therapy products are subject to manufacturer recommended quantity limits. (Migraine therapy examples: Imitrex, Amerge, Relpax, Zomig, Zomig ZMT, Axert, Frova, Maxalt and Maxalt MLT.)
Smoking Cessation	Covered for 90-day length of therapy per lifetime. Generic nicotine patches, only, will be covered for an additional 90-day therapy per lifetime. Chantix (varenicline tartrate) is covered for 180-day supply per year. Covered employees and dependents who wish to participate in the Kick the Nick Smoking Cessation program are eligible for copay waivers for Chantix and two Primary Care Provider visits with officially enrolled in the program. Call 1-888-795-6810 to enroll.
Tretinoin (Retin-A, Atralin), Retinoids	Covered to age 25, then prior authorization required for non-cosmetic use.
Ambien/-CR, Lunesta and Rozerem	Limited to 15 units per fill and only 15 units per rolling 30-day period. Copay applies for each 15-day supply.
Lovenox/enoxaparin	Covered for a maximum of 10 days therapy per fill with a maximum of 2 syringes per day.
Lipitor	Covered with a maximum dose of 2 tablets per day.
Actiq/Fentora	Quantities greater than 6 units per 30 days require a prior authorization.
Blood Glucose Monitors	One per calendar year.
Compounded Medications	Covered up to \$200 per fill. All compound medications are third tier.
Dose Optimization	For drugs where FDA approval is once-daily dosing and different strengths are available at similar costs, quantity limits are set at 1 pill per day for the lower strengths in order to decrease costs and increase compliance. For example, if a member is taking two 20mg strength per day and the drug is available in a 40mg strength, a switch to the higher unit dose may be required. The dose optimization program includes but is not limited to , the following drugs (brand and generics): Coreg CR, Cymbalta, Effexor XR, Mirapex ER, Toprol XL, Ultram ER and Vyvanse.

REFERENCE BASED PRICING (RBP):

Proton Pump Inhibitor (PPI) drugs	Effective November 1, 2010, generic and Branded PPI drugs will be covered up to \$0.64 per pill. Any additional cost will be applied to the copay. (Examples include: pantoprazole, lansoprazole, Aciphex, Dexilant, Nexium, Prevacid, Protonix and Zegerid). Prescription/OTC omeprazole and Prilosec OTC (when presented with a valid prescription) will continue to be available at the standard copay rates. Other OTC PPI drugs will remain excluded.
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