University of Arkansas
March 2017

Use of generic drugs can save both you and your health plan money. This list is not all-inclusive and is not a guarantee of coverage. Plan Benefit design is the final determinate of coverage.

Certain drugs (*) may be subject to Prior Authorization (PA), Quantity Limits (QL), Step Therapy (ST), or Reference Based Pricing (RBP) requirements according to Benefit Design. Unless noted, multisource brand drugs (brand drugs with generic equivalent) are covered at 100% copay.

If you have any questions about these requirements or other formulary questions, please contact a MedImpact Healthcare customer service representative at 800-788-2949.

This list represents brand products in CAPS, branded generics in upper- and lowercase Italics, and generic products in lowercase italics.

Drug Type	Tier 1	Tier 2	Tier 3
Anti-Infectives			
Antibiotics – Cephalosporins (Quantity Limit)	*cefaclor, cefadroxil, cefdinir, cefpodoxime, cefprozil, cefditoren,cefuroxime, cephalexin*		CEFTIN susp, SUPRAX 400mg only* (QL) Note: all other Suprax strengths are 100% copay
Antibiotics - Macrolides	*azithromycin, clarithromycin, clarithromycin ext-rel, erythromycin delayed-rel, erythromycin ethylsuccinate, erythromycin stearate*	ERY-TAB, PCE	ZMAX susp
Antibiotics - Fluoroquinolones	*ciprofloxacin, ciprofloxacin ext-rel, levofloxacin ,moxifloxacin*	FACTIVE	
Antibiotics - Penicillins	*amoxicillin, amoxicillin-clavulanate, dicloxacillin, penicillin VK*		
Antibiotics – Other* (Prior Authorization)	*clindamycin HCl, doxycycline hyclate, linezolid* (PA), minocycline, tetracycline*		ZYVOX susp*(PA)
Antifungals* (Prior Authorization) (Quantity Limit)	*fluconazole, itraconazole* (QL), ketoconazole, terbinafine tabs , voriconazole*		NOXAFIL
Antivirals - Influenza* (Quantity Limit)	*amantadine, rimantadine*	TAMIFLU	RELENZA* (QL)
Antivirals - Herpes	*acyclovir, famciclovir, valacyclovir, valganciclovir tab*		VALCYTE susp
Antivirals - Other - Interferons/Interferon Combinations (Prior Authorization)	*ribasphere, ribavirin*	EPCLUSA*(PA), PEGASYS* (PA), PEGINTRON* (PA), REBETOL susp, ZEPATIER*(PA)	DAKLINZA* (PA), TECHINIVIE* (PA)
Cardiovascular			
Anti-Adrenergic Blockers - Peripherally Acting	*doxazosin, prazosin, terazosin*		
Anticoagulants/Antiplatelet Agents (Quantity Limits)	*cilostazol, clopidogrel, dipyridamole, ticlopidine, warfarin*	AGGRENOX, ELIQUIS (QL), PRADAXA (QL), XARELTO (QL)	
Antihyperlipidemics - HMG (Statins) REFERENCE BASED PRICING PROGRAM (RBP)	*atorvastatin,lovastatin, pravastatin, simvastatin*	RBP: PLAN WILL PAY $0.50/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE ADVICOR, ALTOPREV, CRESTOR, LIVALO, SIMCOR, VYTORIN	

Other Antihyperlipidemic Agents	*cholestyramine, colestipol, gemfibrozil*	LIPOCHOL PLUS	WELCHOL
Drug Type	**Tier 1**	**Tier 2**	**Tier 3**
ACE Inhibitors and ACE Inhibitor Combinations	*captopril, captopril-HCTZ, enalapril, fosinopril, fosinopril-hydrochlorothiazide, lisinopril, lisinopril-HCTZ, quinapril, quinapril HCTZ, ramipril, trandolapril*		
Angiotensin II Receptor Antagonists* (Step Therapy)	*candesartan/-HCTZ (ST), eprosartan*(ST),irbesartan (ST)/-HCTZ (ST),losartan, losartan-HCTZ, telmisartan/-HCTZ, valsartan/-HCTZ*		BENICAR* (ST), BENICAR HCT* (ST), (ST), TEVETEN HCT* (ST)
Antihypertensive Combinations (Step Therapy)	*amlodipine-benazepril, amlodipine-valsartan(ST) ,nadolol-bendroflumethiazide, trandolapril/verapamil*		AZOR*(ST), TRIBENZOR*(ST), TEKAMLO*(ST)
Antihypertensive - Others	*eplerenone*		
Beta-blockers* (Quantity Limit)	*atenolol, carvedilol, carvedilol ext-rel, metoprolol, metoprolol ext-rel, propranolol, propranolol ext-rel*	LEVATOL	BYSTOLIC, COREG CR* (QL),
Calcium Channel Blockers	*amlodipine, diltiazem ext-rel, isradipine, nimodipine, nisoldipine, verapamil ext-rel*		
Chronic Angina* (Prior Authorization)			RANEXA* (PA)
Direct Renin Inhibitors/Combo* (Step Therapy)			AMTURNIDE*(ST),TEKTURNA* (ST), TEKTURNA HCT* (ST)
Diuretics	*furosemide, hydrochlorothiazide, metolazone, spironolactone/-HCTZ, triamterene-HCTZ, torsemide*		
Paroxysmal Nocturnal Hemoglobinuria Agents* (Prior Authorization)		SOLIRIS* (PA)	
Pulmonary Arterial Hypertension (Prior Authorization)	*sildenafil (PA)*		ADCIRCA* (PA), ADEMPAS* (PA), LETAIRIS, TRACLEER
Central Nervous System			
ADHD Medications* (Prior Authorization) (Quantity Limit) (Step Therapy) **EFFECTIVE 1/1/13** - Extended-Release ADHD medications will not be covered for members who are 26 years and older. Regular release ADHD drugs will continued to be covered at existing tiers.	*dexmethylphenidate, dexmethylphenidate ext-rel, dextroamphetamine, methylphenidate, methylphenidate ext-rel, modafinil (PA),* ADDERALL XR	STRATTERA	DAYTRANA* (ST), VYVANSE* (QL)
Alzheimer's Disease* (age edit)	*donepezil/-ODT*(age), galantamine,memantine* (age), rivastigmine*		
Analgesics - Narcotic* (Quantity Limit)(Prior Authorization)	*butalbital-APAP-caffeine, codeine-APAP, fentanyl transdermal/- buccal*(QL), hydrocodone-APAP, hydromorphone, morphine/-ER, morphine supp,*	KADIAN (200mg), OXYCONTIN* (QL),	ABSTRAL, , FENTORA* (QL), KADIAN (40mg,70mg, 130mg, 150mg), SUBOXONE* (PA)

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Drug Type	Tier 1	Tier 2	Tier 3
	oxycodone/APAP ER, oxycodone ibuprofen, propoxyphene, propoxyphene napsylate-APAP. Tramadol IR		
Analgesics - Anti-Inflammatory/ NSAIDs	*choline magnesium trisalicylate, diclofenac, etodolac, ibuprofen, indomethacin ext-rel, meloxicam, nabumetone, naproxen, naproxen sodium, oxaprozin, sulindac*		
Anticonvulsants (Prior Authorization)	*carbamazepine, clonazepam, clonazepam ODT, diazepam (rectal), divalproex sodium,ethosuximide, gabapentin, lamotrigine, levetiracetam/-XR, oxcarbazepine, phenobarbital, phenytoin, primidone, valproic acid, zonisamide*	CELONTIN, GABITRIL (12mg,16mg), STAVZOR	BANZEL* (PA), DEPAKENE, DEPAKOTE, DEPAKOTE ER, DILANTIN, FYCOMPA, LYRICA (PA), ONFI (PA), OXTELLAR XR VIMPAT
Antianxiety	*alprazolam/- ext-rel, buspirone, diazepam, lorazepam, oxazepam*		
Antidepressants - Other* (Quantity Limit)	*amitriptyline, bupropion/-ext-rel, clomipramine, desipramine, doxepin, mirtazapine, nortriptyline, trazodone*		EMSAM* (QL)
Antidepressants - SSRIs	*citalopram, escitalopram ,fluoxetine, paroxetine/-ER, sertraline*		
Antidepressants - SNRIs	*duloxetine, venlafaxine/-ER*		
Antiparkinsonian Agents	*amantadine, benztropine, bromocriptine, cabergoline, carbidopa-levodopa, carbidopa-levodopa ext-rel, entacapone, pramipexole, ropinirole/-XL, selegiline, tolcapone, trihexyphenidyl*		AZILECT, MIRAPEX ER, ZELAPAR
Antimanic Agents	*lithium carbonate*		
Antipsychotic Agents* (Prior Authorization)	*aripiprazole* (PA), chlorpromazine, clozapine, fluphenazine, haloperidol, olanzapine, perphenazine, paliperidone tabs, quetiapine (IR), risperidone, thioridazine, trifluoperazine,ziprasidone*	MOBAN, NAVANE 20mg only, SEROQUEL XR	
Migraine Products* (Quantity Limit)	*almotriptan* (QL), dihydroergotamine inj, ergotamine-caffeine tabs, naratriptan (QL), rizatriptan (QL), sumatriptan (QL), zolmitriptan (QL)*		CAFERGOT, RELPAX* (ST,QL), ZOMIG NS* (QL)
Multiple Sclerosis Drugs (Prior Authorizatiion)(Quantity Limit)	*Glatopa*	REBIF* (QL)	AVONEX, AUBAGIO (PA), BETASERON, GILENYA*(PA)(QL), PLEGRIDY* (PA), TECFIDERA (PA)
Sedative Hypnotics – Benzodiazepines (BZD)	*flurazepam, temazepam (except 7.5mg and 22.5mg), triazolam*		

Sedative Hypnotics* - Non-Benzodiazepine (Quantity Limit) REFERENCE BASED PRICING PROGRAM (RBP)	*zaleplon* (QL), zolpidem* (QL)*	RBP: PLAN WILL PAY $0.19/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *zolpidem tartrate ER** (QL,RBP), EDLUAR*(QL,RBP),eszopiclone (QL,RBP)INTERMEZZO*(RBP),ROZEREM* (QL,RBP), SILENOR*(QL,RBP), ZOLPIMIST*(RBP)	
Drug Type	**Tier 1**	**Tier 2**	**Tier 3**
Skeletal Muscle Relaxants REFERENCE BASED PRICING PROGRAM (RBP)	*baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, methocarbamol, tizanidine*	RBP: PLAN WILL PAY $0.09/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *orphenadrine* (RBP), *orphenadrine compound* (RBP), *metaxalone* (RBP), AMRIX (RBP),	
Dermatologicals			
Other Dermatologicals*(Prior Authorization)	*fluorouracil, spinosad*(PA)*		ALTABAX
Rectal Preparations	*lidocaine HC*		ANAMANTLE HC (0.5 %-3 %)
Endocrine			
Diabetes - Insulin		HUMALOG, HUMALOG MIX, HUMULIN, LANTUS/-SOLOSTAR	APIDRA, LEVEMIR
Diabetes - SGLT2 Inhibitors			JARDIANCE* (PA))
Diabetes - Insulin Sensitizing Agents*(Prior Authorization)	*metformin/-XR, pioglitazone*		
Diabetes - Insulin Secreting Agents	*chlorpropamide, glimepiride, glipizide, glipizide ext-rel, glyburide, tolazamide*		DIABETA
Diabetes - Combinations	*glyburide-metformin, glipizide-metformin, pioglitazone-metformin, metformin ext-rel, pioglitazone-glimepiride*	GLYSET	AVANDIA* (PA), AVANDAMET* (PA), AVANDARYL* (PA), JANUVIA, JANUMET/-XR, SYNJARDY* (PA
Diabetes - Other Medications (Step Therapy)	*acarbose*	GLYSET, GLUCAGON EMERGENCY KIT* (QL)	SYMLIN, VICTOZA* (PA)
Diabetic - Supplies	*$0 copay for ABBOTT and BAYER Test Strips, Lancets, Alcohol Swabs, Insulin Needles, and Syringes.*		GLUCOMETER**, HUMAPEN MEMOIR, LIFESCAN TEST STRIPS, ROCHE TEST STRIP and all other NON-ABBOTT/NON-BAYER Test strips
Thyroid Agents	*levothyroxine*		
Gastrointestinal/Urinary			
Antispasmodic/GI Motility	*belladonna alkaloids-phenobarbital, chlordiazepoxide-clidinium, dicyclomine, diphenoxylate-atropine, glycopyrrolate, hyoscyamine/-ext rel, loperamide,methscopolamine*		
Bowel Evacuants	*lactulose, peg 3350-electrolytes, polyethylene glycol*	KRISTALOSE	GOLYTELY, MOVIEPREP, SUPREP

Digestive Aids	*pancrelipase*	VIOKASE	CREON, PANCREAZE, ULTRESA, ZENPEP (EXCEPT ZENPEP 5K-17K-27K CAPS)
Gallstone Solubilizing Agents	*ursodiol*		
H_2-Antagonists	*cimetidine, famotidine, nizatidine, ranitidine*		
Drug Type	**Tier 1**	**Tier 2**	**Tier 3**
Genitourinary Medications REFERENCE BASED PRICING PROGRAM (RBP)	*bethanechol, oxybutynin chloride, phenazopyridine, potassium citrate* ***oxybutynin ext-rel (2nd Tier Copay)***	RBP: PLAN WILL PAY $0.30/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *tolterodine/-XL (RBP), trospium* (RBP), GELNIQUE (RBP), MYRBETRIQ (RBP), OXYTROL (RPB), TOVIAZ (RBP), VESICARE (RBP)	
Inflammatory Bowel* (Quantity Limit) (Step Therapy)	*balsalazide, budesonide, mesalamine, sulfasalazine, sulfasalazine delayed-rel*	APRISO*(QL), DELZICOL*(QL),	CANASA, , ENTOCORT EC, GIAZO, LIALDA, PENTASA, UCERIS* (ST)
Immunosuppressive Agents			
Immunosuppressive* (Prior Authorization)	*azathioprine, cyclosporine, cyclosporine modified, Gengraf,mycophenolate (caps/tabs), tacrolimus caps*		AZASAN, RAPAMUNE, ZORTRESS*(PA)
Men's Health			
Erectile Dysfunction* (Prior Authorization) (Quantity Limit)		MUSE* (PA) (QL), VIAGRA* (PA) (QL)	CIALIS* (PA) (QL), LEVITRA* (PA) (QL), STENDRA*(PA), STAXYN* (PA)
Hormone Replacement * (Prior Authorization)	*testosterone cyprionate, testosterone enanthate*	EFFECTIVE ON 1/1/15 – TOPICAL TESTOSTERONES ARE COVERED AT 100% COPAY	
Prostate Health	*alfluzosin, dutasteride, finasteride, tamsulosin*		RAPAFLO
Ophthalmics			
Anti-Allergic Agents	*azelastine,cromolyn, epinastine*		ALAMAST, ALOCRIL, ALOMIDE, EMADINE, LASTACAFT, PATADAY
Anti-Infective/Antiviral Agents	*bacitracin, ciprofloxacin, erythromycin, gentamicin, neomycin-polymyxin B-gramicidin, ofloxacin, levofloxacin, polymyxin B-bacitracin, polymyxin B-trimethoprim, sulfacetamide, tobramycin, trifluridine*	NATACYN	AZASITE, VIGAMOX
Anti-Glaucoma Agents/ Beta-blockers (Quantity Limit)	*betaxolol, brimonidine, dipivefrin, latanoprost, levobunolol, metipranolol, pilocarpine, timolol, Carboptic*	AZOPT	ALPHAGAN P (0.10%), BETIMOL, BETOPTIC S, COMBIGAN, COSOPT PF,LUMIGAN (0.01%), RESCULA
Anti-Inflammatory Agents	*bromfenac, dexamethasone, diclofenac sodium, fluorometholone, ketotifen,ketorolac, prednisolone acetate, prednisolone phosphate*	FLAREX, FML FORTE, FML S.O.P., MAXIDEX, NEVANAC, VEXOL, XIBROM	ACUVAIL, ALREX, LOTEMAX

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Respiratory			
Nasal Products* (Quantity Limit) REFERENCE BASED PRICING PROGRAM (RBP)	*azelastine*(QL), flunisolide, fluticasone* (QL)*	RBP: PLAN WILL PAY $22.42/inhaler; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *budesonide spray/pump (QL,RBP), triamcinolone** (QL,RBP), BECONASE AQ* (QL,RBP), DYMISTA (RBP), NASONEX* (QL,RBP), OMNARIS* (QL,RBP), QNASL* (RBP), VERAMYST* (QL,RBP), ZETONNA (RBP)	
Drug Type	**Tier 1**	**Tier 2**	**Tier 3**
Asthma -Leukotriene Modulators* (Step Therapy)	montelukast, zafirlukast* (ST)		
Asthma - Steroid Inhalants	*budesonide neb soln*	FLOVENT DISKUS/-HFA QVAR	AEROBID, AEROBID-M, ALVESCO, ASMANEX, AZMACORT, DULERA
Asthma - Beta Agonists Short Acting	*Albuterol/-ER albuterol inhalation soln, metaproterenol, terbutaline*	PROAIR HFA, PROVENTIL HFA VENTOLIN HFA	VOSPIRE ER
Asthma - Beta Agonists - Long Acting		FORADIL, SEREVENT	BROVANA, PERFOROMIST
Asthma - Other* (Prior Authorization)	*ipratropium soln, theophylline anhydrous*	ADVAIR DISKUS, ADVAIR HFA, ANORO ELLIPTA, ATROVENT HFA, COMBIVENT, SPIRIVA/-RESPIMAT	BREO ELLIPTA, DALIRESP* (PA), STRIVERDI RESPIMAT, SYMBICORT,TUDORZA, XOLAIR* (PA)
Topical			
Ears	*acetic acid, acetic acid-aluminum acetate, acetic acid-hydrocortisone, ciprofloxacin, fluocinolone, neomycin-polymyxin B-hydrocortisone, ofloxacin otic*	CIPRODEX, COLY-MYCIN S, CORTISPORIN-TC	CIPRO HC
Miscellaneous	*ciclopirox soln*		
Skin - All	*betamethasone dipropionate 0.05% gel/oint/cream/lotion, betamethasone valerate 0.1% lot/cream/oint, calcipotriene soln, clobetasol 0.05% sol/cream, , clotrimazole-betamethasone, fluocinolone, lidocaine, mometasone furoate, triamcinolone 0.1%, 0.25% cream/oint/lotion or 0.5% cream/oint*	ELIDEL, CORTISPORIN	CORDRAN, FINACEA (15%) gel , fluocinolone scalp oil, triamcinolone spray
Skin – Acne* (Prior Authorization)	*adapalene, benzoyl peroxide, clindamycin, metronidazole, sulfacetamide-sulfur, isotretinoin*(PA), tretinoin*	ALA-QUIN, AZELEX	NORITATE
Women's Health			
Antineoplastic - Hormonal Agents	*tamoxifen*		
Contraceptives* (All Contraceptives subject to Quantity Limit)	*$0 copay for contraceptives nclude: generic oral contraceptives such as ethinyl estradiol-drospirenone, medroxyprogesterone acetate, Apri, Kariva, Levora, Low-Ogestrel, Necon Sprintec, Trinessa,* ORTHO-EVRA patch, NUVARING		

Combination HRT	*estradiol-norethindrone*	CLIMARA PRO, COMBIPATCH, PREFEST, PREMPHASE, PREMPRO, PREMPRO LOW DOSE	ANGELIQ
Hormone Replacement Therapy (HRT) *NOTE: If a product may be used to treat infertility prior authorization will be required.*	*estradiol,estradiol patches estropipate,progesterone micronized*(PA)*	ALORA, CENESTIN, MENEST, MENOSTAR, MINIVELLE, PREMARIN	CLIMARA PRO, DIVIGEL, ELESTRIN, ENJUVIA, ESTRACE vaginal cream, ESTRING, FEMRING, FEMTRACE
Drug Type	**Tier 1**	**Tier 2**	**Tier 3**
Osteoporosis REFERENCE BASED PRICING PROGRAM (RBP)	*alendronate*	RBP: PLAN WILL PAY $0.26/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE ACTONEL (RBP), ATELVIA (RBP), ibandronate 150mg (RBP)	
Osteoporosis	*etidronate, Fortical,raloxifene,zoledronic acid*		
Prenatal Vitamins	*generics*		
Vaginal Products* (Quantity Limit)	*clindamycin, clotrimazole, fluconazole* (QL on 150mg), metronidazole, terconazole*		,
Miscellaneous			
Antiemetics* (Quantity Limit)	*granisetron* (QL), ondansetron* (QL), trimethobenzamide caps*	EMEND caps* (QL)	ANZEMET* (QL), CESAMET* (PA), SANCUSO* (QL),
Antineoplastic Enzyme Inhibitors* (Prior Authorization)		NEXAVAR* (PA), SPRYCEL* (PA), SUTENT* (PA)	
Antineoplastic Immunomodulator Agents* (Prior Authorization)			REVLIMID* (PA)
Antineoplastic Monoclonal Antibodies * (Prior Authorization)			LARTRUVO* (PA)
Growth Hormone (Prior Authorization)		GENOTROPIN* (PA), NORDITROPIN* (PA), NUTROPIN* (PA), NUTROPIN AQ* (PA)	HUMATROPE* (PA), OMNITROPE* (PA), SAIZEN* (PA), SEROSTIM* (PA), TEV-TROPIN * (PA)
Hematopoietic Growth Factors		ARANESP * (PA), EPOGEN* (PA), PROCRIT* (PA)	
Insulin-Like Growth Factors* (Prior Authorization)			INCRELEX* (PA)
Miscellaneous	*cevimeline*		CUVPOSA,NASCOBAL, NARCAN
Neurological Disease, misc (Prior Authorization)			NUEDEXTA*(PA),TYSABRI*(PA)
Rheumatoid Arthritis (Prior Authorization)	*methotrexate*	HUMIRA* (PA), ENBREL* (PA), TREXALL	ACTEMRA SC* (PA), ORENCIA* (PA), INFLECTRA* (PA), SIMPONI* (PA)
Smoking Cessation	*bupropion ext-rel, nicotine transdermal*	CHANTIX, NICOTROL INHALER	

FOR YOUR INFORMATION: Generics should be considered the first line of prescribing. This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage. Specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document. The plan participant's prescription benefit plan may have a different copay for specific products on the list. Unless specifically indicated, drug list products will include all dosage forms. This list represents brand products in CAPS, branded generics in upper- and lowercase Italics, and generic products in lowercase italics. Generics listed in therapeutic categories are for representational purposes only. This is not an all-inclusive list. Listed products may be available generically in certain

strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed. Log in to **www.medimpact.com** to check coverage and copay information for a specific medicine.

[1] Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

[2] Atacand should be reserved for plan participants who meet CHARM (Candesartan in Heart Failure – Assessment of Reduction in Mortality and Morbidity) trial criteria.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber.

Prescription Drug Benefits Under the University of Arkansas Prescription Drug Program

Summary of Benefits

Effective January 2016

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

Retail Day's 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)** Tier 1 $ 15 — Tier 1 $45 Tier 2 $ 50 — Tier 2 $150 Tier 3 $ 80 — Tier 3 $240 Note: High cost generics may have non-tier 1 copays.
Out of Pocket Maximum	**Individual** $1,600 / **Family** $3,200
Pharmacy Benefit Manager	MedImpact Healthcare Systems, Inc. https://mp.medimpact.com/uas Customer Service: 800-788-2949
Mail Service Pharmacy:	MedVantx Pharmacy Services http://www.medvantx.com Tel: 866-744-0621 Fax: 605-978-3999
Formulary Type:	3-Tier Primary/Preferred Drug List
Dependent Age Limitations:	Children may be covered until the end of the month in which they turn age 26.
Prescription Benefit Drug Card Produced By:	To order a new a new ID card, call UMR at 1-888-438-6105.
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 $3.00 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 https://mp.medimpact.com/uas.
Compounded Drug Reimbursement Policy:	It is the policy of the University of Arkansas to place all compounded drugs at third tier ($80 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:	If the brand drug has a generic equivalent, the member will be responsible for 100% of the brand drug cost.
Brand Drugs with Generic Copay	Due to manufacture pricing, Adderall XR brand name will be available for a generic copay. The generic version will not be covered by the University of Arkansas (subject to change).
Generic Drugs with Brand Copay	Some high cost generics may have non-tier 1 copays. Please consult your PDL for more information or call MedImpact Healthcare Systems, Inc. at 800-788-2949.

Blood Glucose Monitors	One per calendar year. Bayer and Abbott brands preferred. All other manufacturers will return a non-formulary copay.
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.

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 (PDL), 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 https://mp.medimpact.com/uas.

(QL) = Quantity or Age Limits (ST) = Step Therapy

*NOTE: Only Bayer and Abbott testing supplies (test strips, lancets) are $0 when purchased with a doctor's prescription. All other brands are considered tier 3, $80 copay.

**** Receive a No Cost Blood Glucose Monitoring System**
Blood glucose monitoring systems from Abbott and/or Bayer Healthcare are available by calling Abbot at (866) 224-8892 or Bayer at (888) 832-1039 (code BDC-MI). These are the preferred manufacturers for diabetic testing supplies for the University of Arkansas and are available at zero copayment. All other brands are considered tier 3, $80 copay.

PRIOR AUTHORIZATION REQUIRED (PA):

A process that evaluates the drug's prescribed use against a predetermined set of criteria to determine whether your employer will cover the medication. In most cases, if the physician does not submit a prior authorization prior to you presenting your prescription at the pharmacy, the claim will be denied at point of service. Contact MedImpact Customer Service toll-free at 1-800-788-2949 with questions and to begin the prior authorization process.

To obtain a list of drugs that requires a Prior Authorization please consult your PDL or Medimpact's member website.

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. **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. All appeals information can be sent to MedImpact Healthcare Systems, P.O. Box 509098, San Diego, CA 92150-9098 or fax to: 858-790-6060.**

QUANTITY LIMITS (QL):

A quantity limitation refers to the maximum days' supply or quantity of a medication that you can obtain at one time under your prescription benefits (example up to a 30 day supply or 100 unit dose). Sometimes general therapeutic categories, specific drug classes or individual medications may have additional quantity limitation restrictions. Please consult your PDL or MedImpact's member website to see if your drug has a quantity limit associated with it.

EXCLUSIONS:

Most drugs that are excluded under the University of Arkansas will be allowed to process but the member will be responsible for 100% of the drug cost.
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 https://mp.medimpact.com/uas. 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.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. Newly approved drugs are subject to review by the Pharmacy Advisory Committee before being covered or may be excluded altogether. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed.

REFERENCE BASED PRICING (RBP):

Drugs to Treat Insomnia	Generic and Branded insomnia drugs will be covered up to $0.19 per pill. Any additional cost will be applied to the copay. (Examples include: Ambien, Ambien CR, Edluar, Lunesta, Rozerem, Sonata). Zolpidem (generic Ambien) will continue to be available at the standard copay rates.
Overactive Bladder Drugs	Generic and Branded overactive bladder drugs will be covered up to $0.30 per pill. Any additional cost will be applied to the copay. (Examples include: Detrol, Detrol LA, Ditropan XL, Enablex, Sanctura, Vesicare, and Oxytrol Patches). Oxybutynin Immediat release (generic Ditropan) will continue to be available at the standard copay rates, and Oxybutynin Extended Release (generic Ditropan XL) will be available at a tier 2 copay.
Skeletal Muscle Relaxants	Generic and Branded skeletal muscle relaxants (oral formulations) will be covered up to $0.09 per pill. Any additional cost will be applied to the copay. (Examples include: Amrix, Fexmid, Norflex, Skelaxin, Soma, and Zanaflex). Baclofen, carisoprodol, cyclobenzaprine, methocarbamol, tizandine,and chlorzoxazone will continue to be available at the standard copay rates.
Nasal Steroids	Generic and Branded nasal steroids will be covered up to $22.42 per device. Any additional cost will be applied to the copay. (Examples include: Beconase AQ, Flonase, Nasacort AQ, Nasalide, Nasarel, Nasonex, Omnaris, Rhinocort AQ, and Veramyst). Fluticasone (generic Flonase) and flunisolide (generic Nasalide) will continue to be available at the standard copay rates.
Osteoporosis Drugs	Generic and Branded osteoporosis drugs will be covered up to $0.26 per pill. Any additional cost will be applied to the copay. (Examples include: Actonel, Actone w/ Calcium, Atelvia, Boniva, Fosamax, and Fosamax-D). Alendronate (generic Fosamax) will continue to be available at the standard copay rates.
'Statin' Drugs to Treat Cholesterol	Branded statin drugs and statin combos will be covered up to $0.50 per pill. Any additional costs will be applied to the copay. (Examples include: Advicor, Alotprev, Crestor, Lescol/-XL, Lipitor, Livalo, Simcor, Vytorin). Generic atorvastatin, lovastatin, pravastatin and simvastatin will continue to be available at the standard copay rates.

DRUGS TO TREAT ADHD:

Extended Release (ER) ADHD Drugs	Extended release formulations (Examples include: Adderall XR, Concerta, Vyvanse) of drugs used to treat ADHD are covered for individuals 25 years of age and younger. Non-ER ADHD medications are available at the applicable benefit with no age restrictions.