



**University of Arkansas  
October 2009**



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), or Step Therapy (ST) requirements according to Benefit Design.

Branded products with an available generic equivalent may be subject to the highest copayment<sup>1</sup> according to Benefit Design.

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*.

	Tier 1	Tier 2	Tier 3
<b>Anti-Infectives</b>			
Antibiotics - Cephalosporins	<i>cefaclor, cefadroxil, cefdinir, cefpodoxime, cefprozil, cefuroxime, cephalexin</i>		CEDAX, CEFTIN susp, CEFTIL, KEFLEX, OMNICEF, SPECTRACEF
Antibiotics - Macrolides	<i>azithromycin, clarithromycin, clarithromycin ext-rel, erythromycin delayed-rel, erythromycin ethylsuccinate, erythromycin stearate</i>	E-MYCIN, ERY-TAB	BIAXIN, BIAXIN XL, DYNABAC, E.E.S., ZITHROMAX
Antibiotics - Fluoroquinolones	<i>ciprofloxacin, ciprofloxacin ext-rel</i>	CIPRO susp, LEVAQUIN	AVELOX, CIPRO tabs, CIPRO XR, FLOXIN, NOROXIN, PROQUIN XR
Antibiotics - Penicillins	<i>amoxicillin, amoxicillin-clavulanate, dicloxacillin, penicillin VK</i>		AMOXIL, AUGMENTIN
Antibiotics - Other	<i>clindamycin HCl, doxycycline hyclate, minocycline, tetracycline</i>		CLEOCIN 75 mg caps, DYNACIN tabs, ZYVOX
Antifungals* (Prior Authorization) (Quantity Limit)	<i>fluconazole, itraconazole* (QL), ketoconazole, terbinafine tabs* (PA)</i>		DIFLUCAN* (QL), LAMISIL* (PA), NIZORAL, SPORANOX* (PA)
Antivirals - Influenza* (Quantity Limit)	<i>amantadine, rimantadine</i>	TAMIFLU* (QL)	RELENZA* (QL)
Antivirals - Herpes	<i>acyclovir, famciclovir</i>	VALTREX	FAMVIR, ZOVIRAX
Antivirals - Other - Interferons/Interferon Combinations	<i>ribasphere, ribavirin</i>	PEGASYS, PEGINTRON	COPEGUS, REBETOL
<b>Cardiovascular</b>			
Anti-Adrenergic Blockers - Peripherally Acting	<i>doxazosin, prazosin, terazosin</i>		CARDURA, CARDURA XL, HYTRIN, MINIPRESS
Anticoagulants/Antiplatelet Agents	<i>cilostazol, dipyridamole, warfarin</i>	AGGRENOX, PLAVIX	COUMADIN, PLETAL
Antihyperlipidemics - HMG (Statins)	<i>lovastatin, pravastatin, simvastatin</i>		ADVICOR, CRESTOR, LESCOL, LESCOL XL, LIPITOR, MEVACOR, PRAVACHOL, SIMCOR, VYTORIN, ZOCOR
Other Antihyperlipidemic Agents	<i>cholestyramine, colestipol, gemfibrozil</i>	LOVAZA, NIASPAN, TRICOR, WELCHOL	ANTARA, COLESTID, LOPID, TRIGLIDE, ZETIA
ACE Inhibitors and ACE Inhibitor Combinations	<i>captopril, captopril-hydrochlorothiazide, enalapril, fosinopril, fosinopril-hydrochlorothiazide, lisinopril, lisinopril-hydrochlorothiazide, quinapril, quinaprilhydrochlorothiazide, ramipril,trandolapril</i>		ACCUPRIL, ACCURETIC, ACEON, ALTACE, CAPOTEN, CAPOZIDE, MAVIK, MONOPRIL, MONOPRIL-HCT, PRINIVIL, PRINZIDE, VASOTEC, ZESTORETIC, ZESTRIL
Angiotensin II Receptor Antagonists* (Step Therapy)		ATACAND <sub>2</sub> * (ST), ATACAND HCT* (ST), AVALIDE* (ST), AVAPRO* (ST), DIOVAN* (ST), DIOVAN HCT* (ST)	BENICAR* (ST), BENICAR HCT* (ST), COZAAR* (ST), HYZAAR* (ST), MICARDIS* (ST), MICARDIS HCT* (ST), TEVETEN* (ST), TEVETEN HCT* (ST)

	Tier 1	Tier 2	Tier 3
<b>Cardiovascular (continued)</b>			
Antihypertensive Combinations	<i>amlodipine-benazepril, nadolol-bendroflumethiazide</i>	EXFORGE	AZOR, CORZIDE, LEXXEL, LOTREL, TARKA
Antihypertensive - Others	<i>eplerenone</i>		INSPRA
Beta-blockers* (Quantity Limit)	<i>atenolol, carvedilol, carvedilol ext-rel, metoprolol, metoprolol ext-rel, propranolol, propranolol ext-rel</i>		BYSTOLIC, COREG, COREG CR* (QL), INDERAL, INDERAL LA, INNOPRAN XL, LOPRESSOR, TENORETIC, TENORMIN, TOPROL XL
Calcium Channel Blockers	<i>amlodipine, diltiazem ext-rel, isradipine, nimodipine, verapamil ext-rel</i>		CALAN SR, CARDENE SR, CARDIZEM, CARDIZEM CD, CARDIZEM LA, COVERA-HS, DYNACIRC CR, NIMOTOP, NORVASC, PLENDIL, SULAR, TIAZAC, VERELAN PM
Chronic Angina* (Step Therapy)			RANEXA* (ST)
Direct Renin Inhibitors* (Step Therapy)			TEKTURNA* (ST), TEKTURNA HCT* (ST)
Diuretics	<i>furosemide, hydrochlorothiazide, metolazone, spironolactone, spironolactone-hydrochlorothiazide, triamterene-hydrochlorothiazide, torsemide</i>		ZAROXOLYN
Paroxysmal Nocturnal Hemoglobinuria Agents* (Prior Authorization)		SOLIRIS* (PA)	
Pulmonary Arterial Hypertension (Prior Authorization)			LETAIRIS (PA), REVATIO (PA), VENTAVIS (PA)
<b>Central Nervous System</b>			
ADHD Medications* (Prior Authorization) (Quantity Limit) (Step Therapy)	<i>dexmethylphenidate, dexmethylphenidate ext-rel, dextroamphetamine, dextroamphetamine ext-rel, methylphenidate, methylphenidate ext-rel</i>	ADDERALL XR, CONCERTA, METADATE CD, STRATTERA	DAYTRANA* (ST), DEXEDRINE, DEXTROSTAT, FOCALIN, METADATE ER, PROVIGIL* (PA), RITALIN, RITALIN LA, RITALIN SR, VYVANSE* (QL)
Alzheimer's Disease		ARICEPT, EXELON, NAMENDA	
Analgesics - Narcotic* (Quantity Limit)	<i>butalbital-acetaminophen-caffeine, butalbital-aspirin-caffeine, codeine-acetaminophen, fentanyl transdermal, hydrocodone-acetaminophen, hydromorphone, meperidine, morphine, morphine supp, morphine ext-rel, oxycodoneacetaminophen ext-rel, oxycodoneibuprofen, propoxyphene, propoxyphene napsylate-acetaminophen, tramadol</i>	OXYCONTIN	ACTIQ* (QL), ALCET, COMBUNOX, DARVOCET A500, DARVOCET N-100, DARVON, DEMEROL, DURAGESIC, FENTORA* (QL), FIORICET, FIORINAL, FIORINAL WITH CODEINE, LYNOX, PERCOCET, PERCODAN, TYLENOL WITH CODEINE, ULTRAM ER* (QL)
Analgesics - Anti-Inflammatory/ NSAIDs	<i>choline magnesium trisalcylate, diclofenac, etodolac, ibuprofen, indomethacin, indomethacin ext-rel, meloxicam, nabumetone, naproxen, naproxen sodium, oxaprozin, sulindac</i>		ANAPROX, ANAPROX DS, ARTHROTEC, CLINORIL, MOBIC, MOTRIN, NAPROSYN, PREVACID NAPRAPAC, VOLTAREN
Anticonvulsants (Prior Authorization)	<i>carbamazepine, clonazepam, clonazepam ODT, divalproex sodium delayed-rel, divalproex sodium ext-rel, ethosuximide, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, primidone, valproic acid, zonisamide</i>	GABITRIL, LAMICTAL chewable, TOPAMAX	DEPAKENE, DEPAKOTE, DEPAKOTE ER, DILANTIN, KEPPRA, LAMICTAL, LYRICA (PA), NEURONTIN, TEGRETOL, TRILEPTAL, ZONEGRAN
Antianxiety	<i>alprazolam, alprazolam ext-rel, buspirone, diazepam, lorazepam, oxazepam</i>		VALIUM, XANAX, XANAX XR
Antidepressants - Other* (Quantity Limit)	<i>amitriptyline, bupropion, bupropion ext-rel, clomipramine, desipramine, doxepin, imipramine, mirtazapine, nortriptyline, trazodone</i>		EMSAM* (QL), REMERON, REMERON SOLTAB, WELLBUTRIN, WELLBUTRIN SR, WELLBUTRIN XL
Antidepressants - SSRIs	<i>citalopram, fluoxetine, paroxetine, paroxetine ext-rel, sertraline</i>		CELEXA, LEXAPRO, PAXIL, PAXIL CR, PEVEVA, PROZAC, PROZAC WEEKLY, SARAFEM, ZOLOFT
Antidepressants - SNRIs* (Step Therapy)	<i>venlafaxine</i>		CYMBALTA, EFFEXOR, EFFEXOR XR* (ST)
Antiparkinsonian Agents	<i>benztropine, bromocriptine, cabergoline, carbidopa-levodopa, carbidopa-levodopa ext-rel, selegiline, trihexyphenidyl</i>	COMTAN, MIRAPEX	AZILECT, PARCOPA, SINEMET, SINEMET CR, STALEVO, ZELAPAR

	Tier 1	Tier 2	Tier 3
<b>Central Nervous System (continued)</b>			
Antimanic Agents	<i>lithium carbonate</i>		LITHOBID
Antipsychotic Agents	<i>chlorpromazine, clozapine, fluphenazine, haloperidol, perphenazine, risperidone, thioridazine, thiothixene, trifluoperazine</i>	SEROQUEL, SEROQUEL XR, ZYPREXA, ZYPREXA ZYDIS	CLOZARIL, INVEGA, RISPERDAL
Migraine Products* (Quantity Limit)	<i>dihydroergotamine inj, ergotamine-caffeine tabs, sumatriptan</i>	AXERT* (QL), MAXALT* (QL), MAXALT MLT* (QL)	AMERGE* (QL), FROVA* (QL), IMITREX* (QL), RELPAX* (QL), ZOMIG* (QL), ZOMIG ZMT* (QL)
Multiple Sclerosis Drugs		AVONEX, BETASERON, COPAXONE, REBIF	
Sedative Hypnotics* (Quantity Limit)	<i>flurazepam, temazepam, triazolam, zaleplon, zolpidem* (QL)</i>		AMBIEN* (QL), AMBIEN CR* (QL), DALMANE, HALCION, LUNESTA* (QL), RESTORIL, ROZEREM* (QL), SONATA* (QL)
Skeletal Muscle Relaxants	<i>baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, dantrolene, diazepam, methocarbamol, orphenadrine-aspirin-caffeine, tizanidine</i>	SKELAXIN	FLEXERIL, SOMA, ZANAFLEX
<b>Dermatologicals</b>			
Keratolytics			NEOBENZ
Other Dermatologicals			ALTABAX, EFUDEX
Rectal Preparations	<i>lidocaine HC</i>		ANAMANTLE HC
<b>Endocrine</b>			
Diabetes - Insulin		HUMALOG, HUMALOG MIX, HUMULIN, LANTUS, NOVOLIN, NOVOLOG, RELION	APIDRA, LEVEMIR
Diabetes - Insulin Sensitizing Agents	<i>metformin</i>	ACTOS	AVANDIA, GLUCOPHAGE, GLUCOPHAGE XR, GLUMETZA
Diabetes - Insulin Secreting Agents	<i>chlorpropamide, glimepiride, glipizide, glipizide ext-rel, glyburide, tolazamide</i>		AMARYL, DIABETA, DIABINESE, GLUCOTROL, GLUCOTROL XL, MICRONASE, PRANDIN, STARLIX
Diabetes - Combinations	<i>glyburide-metformin, glipizide-metformin, metformin ext-rel</i>	ACTOPLUS MET, DUETACT	AVANDAMET, AVANDARYL, GLUCOVANCE, JANUMET, METAGLIP
Diabetes - Other Medications	<i>acarbose</i>	GLUCAGON EMERGENCY KIT	BYETTA, JANUVIA, PRECOSE
Diabetic - Supplies (**To receive a free glucometer from LifeScan, please call 1-888-427-8335)	\$0 copay for Glucose Test Strips, Lancets, Alcohol Swabs, Insulin Needles, and Syringes.		GLUCOMETER**, HUMAPEN MEMOIR
Thyroid Agents	<i>levothyroxine, LevoxyI</i>		SYNTHROID
<b>Gastrointestinal/Urinary</b>			
Antispasmodic/GI Motility	<i>belladonna alkaloids-phenobarbital, chlordiazepoxide-clidinium, dicyclomine, diphenoxylate-atropine, glycopyrrolate, hyoscyamine, hyoscyamine ext-rel, loperamide</i>		PAMINE, PAMINE FORTE
Bowel Evacuants	<i>peg 3350-electrolytes, polyethylene glycol</i>	OSMOPREP	
Digestive Aids	<i>pancrelipase</i>	CREON, ULTRASE, VIOKASE	
Gallstone Solubilizing Agents	<i>ursodiol</i>	URSO	
H <sub>2</sub> -Antagonists	<i>cimetidine, famotidine, nizatidine, ranitidine</i>		AXID, PEPCID, TAGAMET, ZANTAC
Proton Pump Inhibitors* (Step Therapy)	<i>omeprazole, pantoprazole, Prilosec OTC</i>		ACIPHEX* (ST), PREVACID* (ST), PRILOSEC* (ST), PROTONIX* (ST), ZEGERID* (ST)
Genitourinary Medications	<i>bethanechol, oxybutynin chloride, oxybutynin ext-rel, phenazopyridine, potassium citrate</i>	DETROL, DETROL LA	DITROPAN XL, OXYTROL
Inflammatory Bowel	<i>balsalazide, mesalamine, sulfasalazine, sulfasalazine delayed-rel</i>	ASACOL, CANASA, ENTOCORT EC	COLAZAL, LIALDA
<b>Immunosuppressive Agents</b>			
Immunosuppressive	<i>azathioprine, cyclosporine, cyclosporine modified, Gengraf</i>	CELLCEPT tabs, PROGRAF	CELLCEPT caps, MYFORTIC, NEORAL, SANDIMMUNE

	Tier 1	Tier 2	Tier 3
<b>Men's Health</b>			
Erectile Dysfunction* (Prior Authorization) (Quantity Limit)		MUSE* (PA) (QL), VIAGRA* (PA) (QL)	CIALIS* (PA) (QL), LEVITRA* (PA) (QL)
Hormone Replacement		ANDRODERM, ANDROGEL, TESTIM	STRIANT
Prostate Health	<i>finasteride</i>	FLOMAX	AVODART, PROSCAR, UROXATRAL
<b>Ophthalmics</b>			
Anti-Allergic Agents	<i>cromolyn, ketotifen</i>	OPTIVAR	ACULAR, ALAMAST, ALOCRIL, ALOMIDE, CROLOM, ELESTAT, EMADINE, PATADAY, PATANOL
Anti-Infective/Antiviral Agents	<i>bacitracin, ciprofloxacin, erythromycin, ganciclovir capsule, gentamicin, neomycin-polymyxin B-gramicidin, ofloxacin, polymyxin B-bacitracin, polymyxin B-trimethoprim, sulfacetamide, tobramycin, trifluridine</i>		AZASITE, BLEPH-10, CILOXAN, OCUFLOX, VIGAMOX, VIROPTIC, ZYMAR
Anti-Glaucoma Agents/ Beta-blockers	<i>betaxolol, brimonidine, dipivefrin, levobunolol, metipranolol, pilocarpine, timolol, Carboptic</i>	XALATAN	BETIMOL, COMBIGAN, PROPINE, TIMOPTIC, TIMOPTIC-XE
Anti-Inflammatory Agents	<i>dexamethasone, diclofenac sodium, fluorometholone, prednisolone acetate, prednisolone phosphate</i>		ALREX, LOTEMAX, OMNIPRED, VOLTAREN
<b>Respiratory</b>			
Nasal Products* (Quantity Limit)	<i>flunisolide, fluticasone* (QL)</i>	ASTELIN* (QL), NASONEX* (QL), RHINOCORT AQUA* (QL)	ASTEPRO* (QL), BECONASE AQ* (QL), FLONASE* (QL), NASACORT AQ* (QL), NASAREL* (QL)
Asthma -Leukotriene Modulators* (Step Therapy)			ACCOLATE* (ST), SINGULAIR* (ST), ZYFLO CR* (ST)
Asthma - Steroid Inhalants		FLOVENT, FLOVENT HFA, PULMICORT, QVAR	AEROBID, AEROBID-M, AZMACORT, FLOVENT DISKUS
Asthma - Beta Agonists - Short Acting	<i>albuterol ext-rel, albuterol inhalation soln, terbutaline</i>	MAXAIR, PROAIR HFA, PROVENTIL HFA	BRETHINE
Asthma - Beta Agonists - Long Acting		FORADIL, SEREVENT	BROVANA
Asthma - Other* (Prior Authorization)	<i>ipratropium soln</i>	ADVAIR, ADVAIR HFA, ATROVENT HFA, COMBIVENT, TILADE, UNIPHYL	PRELONE, SYMBICORT, XOLAIR* (PA)
<b>Topical</b>			
Ears	<i>acetic acid, acetic acid-aluminum acetate, acetic acid-hydrocortisone, neomycin-polymyxin B-hydrocortisone, ofloxacin otic</i>		CIPRODEX, DERMOTIC, FLOXIN OTIC
Miscellaneous	<i>ciclopirox soln</i>		PENLAC* (QL)
Skin - All	<i>betamethasone dipropionate augmented, calcipotriene soln, clobetasol propionate, clotrimazole-betamethasone, mometasone furoate</i>	ELIDEL, LIDODERM	CLOBEX spray, DIPROLENE AF, DOVONEX soln, ELOCON, FINACEA, LOTRISONE lotion, OLUX, SYNALAR, ZODERM
Skin - Acne	<i>benzoyl peroxide, clindamycin, sulfacetamide-sulfur, tretinoin</i>	BENZACLIN, BENZAMYCIN, DUAC CS, NORITATE, ROSAC WASH	ACCUTANE, ATRALIN, CLEOCIN T, KLARON, RETIN-A
<b>Women's Health</b>			
Antineoplastic - Hormonal Agents	<i>tamoxifen</i>	SOLTAMOX	
Contraceptives* (All Contraceptives subject to Quantity Limit)	<i>ethinyl estradiol-drospirenone, medroxyprogesterone acetate, Apri, Aviane, Jolessa, Kariva, Levora, Low-Ogestrel, Necon 7/7/7, Nortrel, Quasense, Sprintec, Tri-Previfem, Trinessa, Trivora, NECON 10/11</i>	ORTHO-EVRA, ORTHO TRI-CYCLEN LO, YAZ	BREVICON, CYCLESSA, DEPO-PROVERA, DEMULEN, DESOGEN, ESTROSTEP FE, LO/OVRAL, LOESTRIN, LYBREL, MIRCETTE, NORDETTA, NORINYL, ORTHO-CYCLEN, ORTHO-NOVUM, ORTHO TRI-CYCLEN, OVCON, SEASONALE, SEASONIQUE, TRI-NORINYL, TRIPHASIL, YASMIN
Combination HRT	<i>estradiol-norethindrone</i>	CLIMARA PRO, COMBIPATCH, FEMHRT, PREFEST, PREMPHASE, PREMPRO, PREMPRO LOW DOSE	ACTIVEVILLA, ANGELIQ

	Tier 1	Tier 2	Tier 3
<b>Women's Health (continued)</b>			
Hormone Replacement Therapy (HRT)	<i>estradiol, estropipate</i>	CENESTIN, ESTRADERM, MENEST, PREMARIN, PROMETRIUM, VIVELLE-DOT	CLIMARA, ELESTRIN, ESTRACE, ESTRING, FEMRING
Osteoporosis - Calcium Regulators* (Prior Authorization)	<i>alendronate, Fortical</i>	ACTONEL, ACTONEL WITH CALCIUM, FORTEO* (PA)	BONIVA, DIDRONEL, FOSAMAX, MIACALCIN
Osteoporosis - Hormone Receptor Modulators		EVISTA	
Prenatal Vitamins	<i>generics</i>	PRECARE, PREMESIS RX, PRIMACARE	PRIMACARE ONE, VITAFOL-OB
Vaginal Products* (Quantity Limit)	<i>clindamycin, clotrimazole, fluconazole, metronidazole, terconazole</i>	GYNAZOLE-1	DIFLUCAN 150 mg* (QL), ESTRACE vaginal cream, METROGEL VAGINAL, TERAZOL
<b>Miscellaneous</b>			
Antiemetics* (Quantity Limit)	<i>granisetron* (QL), ondansetron* (QL), trimethobenzamide caps</i>	EMEND* (QL)	ANZEMET* (QL), CESAMET* (PA), KYTRIL* (QL), SANCUSO* (QL), TIGAN caps* (QL), ZOFRAN* (QL)
Antineoplastic Enzyme Inhibitors* (Prior Authorization)		NEXAVAR* (PA), SPRYCEL* (PA), SUTENT* (PA)	
Antineoplastic Immunomodulator Agents* (Prior Authorization)			REVLIMID* (PA)
Antipsoriatics			AMEVIVE
Growth Hormone		GENOTROPIN, NORDITROPIN, NUTROPIN, NUTROPIN AQ	HUMATROPE, OMNITROPE, SAIZEN, SEROSTIM, TEV-TROPIN
Hematopoietic Growth Factors		ARANESP	
Insulin-Like Growth Factors* (Prior Authorization)			INCRELEX* (PA)
Miscellaneous Nutritional Substances			DEPLIN, NASCOBAL
Rheumatoid Arthritis	<i>methotrexate</i>	TREXALL	ORENCIA* (PA), REMICADE
Saliva Stimulants		EVOXAC	
Smoking Cessation (*Limited to 90-day supply maximum per lifetime, **Generic patches have a limit of 180-day supply per lifetime)	<i>bupropion ext-rel*, nicotine transdermal**</i>	CHANTIX*, NICOTROL INHALER*	NICODERM CQ*, WELLBUTRIN SR*, WELLBUTRIN XL*, ZYBAN*

**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](http://www.medimpact.com) to check coverage and copay information for a specific medicine.

<sup>1</sup> 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.

<sup>2</sup> 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

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

**Effective October 1, 2009**

**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  
\*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)
	<b>Generic (Tier 1)</b>	<b>Generic (Tier 1)</b>
	\$10	\$30
	<b>Formulary Brand (Tier 2)</b>	<b>Formulary Brand (Tier 2)</b>
	\$35	\$105
	<b>Non-Formulary Brand (Tier 3)</b>	<b>Non-Formulary Brand (Tier 3)</b>
	\$70	\$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:** Ameripharma, Inc. Pharmacy

**Formulary Type:** 3-Tier Primary/Preferred Drug List

**Dependent Age Limitations:** Dependents covered up to their 19<sup>th</sup> birthday. Dependents who are full-time students are covered up to their 25<sup>th</sup> 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](http://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 (60 percent if refilled through mail service).

**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](http://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](http://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](http://www.medimpact.com).

**COVERED PRESCRIPTIONS**

Covered drugs include the following:

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

**\*\*Note:** Free blood glucose monitors(One Touch Mini and One Touch Ultra) made by LifeScan are available by calling AmeriPharm at 1-866-744-0621. AmeriPharm will contact your physician on your behalf to get a prescription for diabetic testing strips to go with your new glucometer.

**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"> <li>• Growth Hormones</li> <li>• Hemophilia Medications</li> <li>• Erectile Dysfunction Agents (QL apply)</li> <li>• Forteo</li> <li>• Lamisil and Sporanox (Oral Antifungals)</li> <li>• Gleevec</li> <li>• Xolair (Asthma)</li> <li>• Antineoplastics</li> </ul> | <ul style="list-style-type: none"> <li>• Osteoporosis Injectables</li> <li>• Nutritional Supplements for PKU</li> <li>• Injectables (except Insulin)</li> <li>• Nexavar</li> <li>• Revlimid</li> <li>• Botox</li> <li>• Ranexa</li> <li>• Sutent</li> <li>• Orencia</li> </ul> | <ul style="list-style-type: none"> <li>• Somatuline</li> <li>• Kuvan</li> <li>• Intelence</li> <li>• Syprine</li> <li>• Selzentry</li> <li>• Lyrica</li> <li>• Provigil</li> </ul> |
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**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](http://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](http://www.medimpact.com).

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

\*\*\*\*\*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.

**Proton Pump Inhibitor (PPI) Program**

All proton pump inhibitors will require a 3rd tier copay except for Prilosec OTC and omeprazole (ST). Prilosec OTC is covered at the generic copay when a valid prescription is presented to the pharmacy. (PPIs include Prilosec, omeprazole, Prevacid, Aciphex, Protonix and Zegerid. Nexium is not covered.) A 30-day trial of OTC Prilosec must be tried prior to brand-name PPIs being covered.

**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.

**Effexor XR Step Therapy**

Plan participant must try two generic selective serotonin reuptake inhibitor (SSRI) agents prior to coverage of Effexor XR.

**QUANTITY LIMITATIONS (QL):**

**Proton Pump Inhibitor (PPI) Limitations**

Doses greater than one-per-day require a prior authorization. (PPIs include Prilosec, Prilosec OTC, omeprazole, Prevacid, Aciphex, Protonix and Zegerid. Nexium is not covered.)

**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.

**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.