

# SECTION 8

## Pharmacy

### Pharmacy Overview

As part of the continuing effort to control cost and monitor quality, MercyCare Health Plans (MCHP) periodically reviews pharmacy utilization. The review process is carried out through the MCHP Pharmacy & Therapeutics Committee. Members of the P & T Committee include physicians, pharmacists and MCHP staff. Activities of the Committee may include drug profile review, correspondence with physicians regarding drug utilization, and in some cases, correspondence with members related to medication use and formulary compliance.

In addition, MCHP publishes a "Drug Formulary" to assist physicians in selecting the most cost effective prescription medications for their patients.

### MercyCare Drug Formulary

The MCHP formulary has been designed to be comprehensive in addressing all therapeutic areas. Please indicate, "may substitute" on prescriptions that are available as a generic. Occasionally, formulary drug products may not meet the special needs of a patient because of allergies, therapeutic failure or specific clinical situations. In these situations, non-formulary drugs may be covered for the member with pre-authorization from MCHP. Medication requests are reviewed by the Medical Director using existing Prior Authorization Criteria, current medical literature and manufacturer drug information. Criteria for authorization are approved by the MercyCare Pharmacy and Therapeutics committee.

Non-formulary or Prior Authorization medications may be obtained for a patient by submitting the "Prior Authorization/Non-Formulary Request Forms" and faxing it to 608-758-7726. Prior Authorization medications have specific medical criteria that the MercyCare Medical Director uses to evaluate the request. You will be notified of formulary updates and deletions after every MercyCare Pharmacy and Therapeutics Committee meeting. Copies of the formulary book, "Prior Authorization/Non-Formulary Request Forms" and prior authorization criteria may be obtained by contacting your Provider Relations Representative at 1-800-752-3431.

### MercyCare Requests for Formulary Review

MCHP welcomes Physician input and participation. If you believe a drug should be included on the MCHP formulary, send a written request to the MCHP Medical Director c/o MCHP Quality Health Management Team. Requests for formulary changes are reviewed quarterly by the MCHP Pharmacy & Therapeutics Committee.

**Pharmacy Override Forms located at the end of this section.**



1300 WASHINGTON STREET  
 KANSAS CITY, MISSOURI  
 64105-1433  
 WWW.ARGUSHEALTH.COM

## PRESCRIPTION PROGRAM

## MERCYCARE HEALTH PLAN

On January 1, 2004, Argus Health Systems, Inc. will begin processing claims for **MercyCare** clients.

We are notifying providers to ensure that claims submissions for Mercy Care members are properly accepted at your pharmacy.

We will send announcements in the future to alert pharmacies of any new information as it occurs.

Please note that the following information is required for each claim submitted:

- BIN: 600428\*
- Processor Control Number (PCN): 02740000
- NCPDP Version 3.2 or higher
- Member ID (Format: 12345678)
- Pharmacy's Usual & Customary Price (U&C)
- Physician's DEA Number

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If you have any questions concerning enrollment into the pharmacy network, please access **Payer Sheets** at [www.argushealth.com](http://www.argushealth.com) or contact the Argus Help Desk at: **1.800.KC.ARGUS** (800) 522-7482

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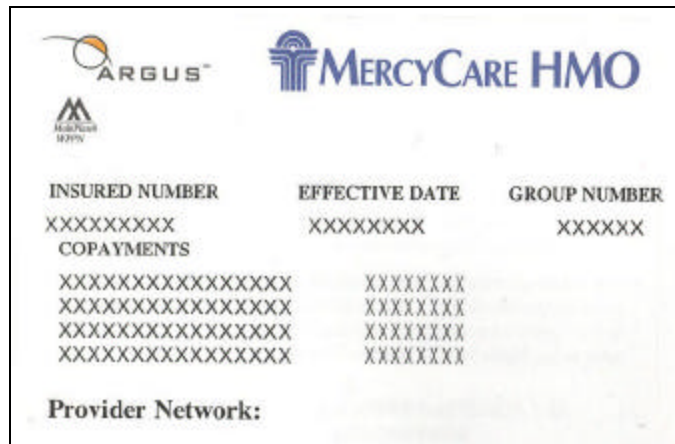


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**\*Note:** Pharmacies will need to contact their switching networks in order to update BINs

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### Card to look for:



( Other MercyCare cards may have a slightly different appearance.)



## MERCYCARE HEALTH PLANS' FORMULARY OPTIONS

MercyCare Health Plans (MCHP) offers two different formulary options to its members. Please note both options do have a prior authorization listing, which can be found on page 6 of MCHP's closed formulary booklet. MCHP's formulary options are as follows:

### Tier 2

The Tier 2 formulary option is a closed formulary requiring a co-pay for generic name drugs and a higher co-pay for brand name drugs. This is identified on the front of the member's insurance card. If there is a special circumstance where you feel a member would benefit from a drug not listed on the formulary, you must fill out a Drug Exception form for consideration.

### Tier 3

The Tier 3 formulary option is an open formulary with three different payment options. Tier 1 generic name drugs represents the most cost-effective option for the member, whereas tier 3 non-preferred brand name drugs represents the least cost-effective option for the member. This is identified on the front of the member's insurance card as "THREE TIER-GEN".

Enclosed in this section, you will find:

- ◆ Abbreviated Formulary
- ◆ Three Tier Drug Plan Summaries
  - ◆ \$7/20%-40%
  - ◆ \$10/20%-50%
  - ◆ \$20/\$40/\$60
- ◆ Covered Drugs
- ◆ Prior Approval Information
- ◆ Drug Exception Information
- ◆ Managed Drug Limitations
- ◆ Pill Splitting Information
- ◆ Specialty Pharmacy Information
- ◆ Oral Contraceptive Comparison
- ◆ Cytochrome P450 Drug Interactions Table
- ◆ Non-Formulary Request Form
- ◆ Prior Authorization Request Form
- ◆ Additional Prior Authorization Request Form
  - ◆ duloxetine (Cymbalta)
  - ◆ Psoriasis Immunomodulators
  - ◆ terbinafine (Lamisil)
  - ◆ Oxycontin & All Other Long-Acting Narcotics
  - ◆ atomoxetine hydrochloride (Strattera)
  - ◆ testosterone
  - ◆ topiramate (Topamax)
  - ◆ tegaserod (Zelnorm)
  - ◆ ondansetron (Zofran)

The 2005 MCHP Formulary was distributed in a booklet format in May of 2005. If you need additional copies of the 2005 MCHP Formulary, please contact your Provider Relations Representative by calling 1-800-752-3431.

Tracy Craker  
Provider Relations Representative

Angela Fox  
Provider Relations Representative

This is a summary by category of formulary alternatives and MercyCare reserves the right to change the formulary at any time. When an acceptable generic is available the generic product is considered the covered, formulary product – the brand is considered non-formulary. (Prior Authorization FAX # 608-758-7726 Customer Service 800-895-2421)

### TARGETED TABLET SPLITTING PROGRAM

Voluntary program offering reduced out of pocket expense for targeted medications. If members choose to split and take 1/2 tablet daily of a target medication #15 per 30 days supply, their coinsurance will be reduced or their copay will be reduced by one-half. (e.g. \$20 reduced to \$10).

**Abilify, Lexapro, Lipitor, Risperdal, Seroquel, Zocor, Zoloft, Zyprexa**

### TOBACCO CESSATION COVERAGE

Members must receive a written prescription of tobacco cessation therapy for 3 consecutive months per member per calendar year.

- *Prescriptions may be billed online at the pharmacy*
- *Products covered include Bupropion SR, Buproban, Nicotine Patches (OTC & Rx), Nicotine Nasal Spray, Nicotine Inhaler and Nicotine Gum.*
- *Lifetime limit of \$900 paid by MercyCare (usually two treatment courses).*

### OTC Formulary Alternatives

Tier 1 Prilosec-OTC

Tier 1 Loratadine-OTC, Loratadine-D OTC

\$0 Naphcon-A, Opcon-A

\$0 Niacin OTC

### Mercy Care PRIOR AUTHORIZATION MEDICATIONS & SPECIALTY PHARMACY MEDICATIONS

**PA indicates** that prior authorization criteria apply and require a prior authorization form to be faxed to 608-758-7726.

If a PA request is denied or not obtained; members may pay 100% of the cost. If a PA-2 drug is approved, the member pays Tier-2. If a PA-3 drug is approved, the open formulary member obtains coverage at Tier-3.

**SP indicates a Specialty Pharmacy Medication** and may be mailed or obtained only from a designated specialty pharmacy after prior authorization has been approved.

Please call Customer Service (800) 895-2421 for a copy of the PA form, a list of approved Specialty Pharmacies, or any other questions.

|                      |                       |
|----------------------|-----------------------|
| Accutane (PA-2)      | Lupron (PA-2, SP)     |
| Anzemet (PA-2)       | Lotronex (PA-3)       |
| Apokyn (PA-2) QL-90  | Neulasta (PA-2, SP)   |
| Arava (PA-2)         | Neupogen (PA-2, SP)   |
| Avinza (PA-2)        | Nimotop (PA-2)        |
| Avonex (PA-2, SP)    | OxyContin (PA-2)      |
| Betaseron (PA-2, SP) | Pegasy (PA-2, SP)     |
| Bextra (PA-3)        | Peg-Intron (PA-2, SP) |
| Celebrex (PA-2)      | Procrit (PA-2, SP)    |
| Copaxone (PA-2, SP)  | Protopic (PA-2)       |
| Cymbalta (PA-3)      | Raptiva (PA-2, SP)    |
| Duragesic (PA-2)     | Rebetron (PA-2, SP)   |
| Elidel (PA-2)        | Rebif (PA-2, SP)      |
| Elmiron (PA-2)       | Regranex (PA-2)       |
| Enbrel (PA-2, SP)    | Remicade (PA-2, SP)   |
| Entocort EC (PA-2)   | Restatis (PA-2)       |
| Epogen (PA-2, SP)    | Rilutek (PA-2, SP)    |
| Famivir (PA-2)       | Roferon-A (PA-2, SP)  |
| Forteo (PA-2, SP)    | Spiriva (PA-2)        |
| Gleevec (PA-2, SP)   | Sporanox (PA-3)       |
| Humira (PA-2, SP)    | Strattera (PA-2)      |
| Infergen (PA-2, SP)  | Tazorac (PA-2)        |
| Intron-A (PA-2, SP)  | Tarceva (PA-2, SP)    |
| Iressa (PA-2, SP)    | Temodar (PA-2, SP)    |
| Kadian (PA-2)        | Tikosyn (PA-2)        |
| Ketek (PA-3)         | Tracleer (PA-2, SP)   |
| Kineret (PA-2, SP),  | Topamax (PA-2)        |
| Kytril (PA-3)        | Xolair (PA-2, SP)     |
| Lamisil (PA-2)       | Zelnorm (PA-3)        |
| Leukine (PA-2, SP)   | Zofran (PA-2)         |
| LidoDerm (PA-2)      | Zyvox (PA-2, SP)      |

### MercyCare Medicaid Formulary OTC Agents

Antacids  
Artificial tears  
Aspirin  
Acetaminophen  
Ibuprofen  
*(combination products including those which contain caffeine, or buffering agents are not covered)*  
Bismuth subsalicylate  
Capsaicin  
Contraceptive products  
Expectorants and/or cough suppressants  
Diphenhydramine  
Hydrocortisone topicals  
Insulins  
Iron supplements for pregnant women  
*(and for a 60 day period beyond delivery)*  
Lice control products  
Meclizine  
Ophthalmic lubricants  
Pyrantel pamoate  
Pyridoxine  
Pseudoephedrine  
Electrolyte replacement solutions  
Smoking Cessation Products  
Topical antibiotics  
Topical antifungals  
Vaginal antifungals

**KEY:** - Underline = best economic choice

- Tier \$0 = Zero dollar copay.
- Tier 1 = "**generic equivalent drug**" = bolded, lowercase indicates Tier-1 copay
- Tier 2 = "Brand Drug" = Not bolded, uppercase indicates Tier-2 copay
- Tier 3 = Not formulary, indicates Tier 3 copay
- \$ relative cost within drug class \$ = least expensive to \$\$\$\$\$ = most expensive

- AL=Age Limit; PA required > 40 years
- (PA) = Prior Authorization required for coverage. If PA approved covered at appropriate tier. **PA-3**= If PA approved, covered at Tier-3, **PA-2** If PA approved, covered at Tier-2
- QL = Quantity Limits (PA required for greater quantities)
  - QL-1 = 1 inhaler/copay
  - QL-45 = 45 tablets/month, use higher strength.
  - Maxalt 9 tabs/copay
  - Imitrex 9 tabs/copay
  - Imitrex nasal spray / Inj 6 devices/copay

- **OTC** = OTC Agents covered for Medicaid Members ONLY
- **INS** = Insulin Copay \$0, \$10, \$15, \$20 depending upon the benefit plan.

- **NC** = Not Covered. – Formulary equivalent is available.
- **NTI** = Narrow therapeutic index drug.
- **TS** = voluntary tab split: #15 / month reduces member coinsurance reduction or one-half copay reduction.
- **SP** = Specialty Pharmacy medication. After PA has been approved the medication must be obtained from a designated pharmacy.





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|                        |          |                                   |  |  |  |                 |                     |                                     |    |          |                          |  |  |   |          |                                     |
|------------------------|----------|-----------------------------------|--|--|--|-----------------|---------------------|-------------------------------------|----|----------|--------------------------|--|--|---|----------|-------------------------------------|
| 2                      | \$\$     | Temovate                          |  |  |  | 1               | \$\$                | dicyclomine                         | 2  | \$       | Prempro, Premphase       |  |  | 1   | \$\$\$   | Enpresse NC                         |
| 1                      | \$\$\$   | desoximetasone                    |  |  |  | 1               | \$\$\$              | levbid / levsinex                   | 2  | \$\$\$   | Miacalcin                |  |  | 1   | \$\$\$   | tri-levien                          |
| 1                      | \$\$\$   | diflorasone                       |  |  |  | 1               | \$\$\$              | golytely / nulytely                 | 2  | \$\$\$   | Fosamax                  |  |  | 2   | \$\$\$   | Nuvaring                            |
| 1                      | \$\$\$   | diprolene                         |  |  |  | 1               | \$\$\$              | dicyclomine                         | 2  | \$\$\$   | Actonel                  |  |  | 2   | \$\$\$   | Ortho Evra                          |
| 2                      | \$\$\$   | Ultravate                         |  |  |  | 1               | \$\$\$              | ortifoam                            | 2  | \$\$\$   | Estrace & Premarin Cream |  |  | NC  | \$\$\$   | nor-QD, Camila, Jolivette, Errin NC |
| PA-2                   | \$\$\$\$ | Elidel                            |  |  |  | 2               | \$\$\$              | Dipentum                            | 2  | \$\$\$   | Vagifem                  |  |  | 1   | \$\$\$   | ortho-micronor                      |
| PA-2                   | \$\$\$\$ | Protopic                          |  |  |  | 2               | \$\$\$\$            | Asacol                              | 2  | \$\$\$   | estratest & HS           |  |  | 1   | \$\$\$   | ortho-tri-cyclen                    |
| <b>EYE / EAR DROPS</b> |          |                                   |  |  |  | 2               | \$\$\$\$            | Rowasa                              | 2  | \$\$\$   | FemHRT                   |  |  | NC  | \$\$\$   | Trinessa, Tri-Sprintec NC           |
| Tier                   | Allergy  |                                   |  |  |  | 2               | \$\$\$\$            | Entocort EC                         | 1  | \$\$\$   | Prometrium               |  |  | 1   | \$\$\$   | generic climara patch               |
| \$0                    | \$       | <u>naphconA, Opcon-A</u>          |  |  |  | PA-3            | \$\$\$\$            | Zelnorm                             | 2  | \$\$\$   | generic climara patch    |  |  | 1   | \$\$\$   | estradiol patch                     |
| 2                      | \$\$\$   | Zaditor                           |  |  |  | PA-3            | \$\$\$\$            | Lotronex                            | 2  | \$\$\$   | Climara Pro              |  |  | 2   | \$\$\$   | Cyclessa                            |
| 2                      | \$\$\$   | Patanol                           |  |  |  | <b>HORMONES</b> |                     |                                     | 1  | \$\$\$   | estradiol patch          |  |  | 3   | \$\$\$   | Tri-Norinyl                         |
| 3                      | \$\$\$   | Optivar                           |  |  |  | Tier            | Antidiabetic Agents |                                     | 2  | \$\$\$   | Esclim                   |  |  | 2   | \$\$\$   | Yasmin                              |
|                        |          | <b>Anti-Infective &amp; Viral</b> |  |  |  | 1               | \$                  | glipizide MD                        | 2  | \$\$\$   | Vivelle, Dot             |  |  | 2   | \$\$\$   | Estrostep & Fe Lunelle              |
| 1                      | \$       | acetic acid OTIC                  |  |  |  | 1               | \$                  | <u>glyburide, non-micronized MD</u> | 1  | \$\$\$   | generic estraderm        |  |  | <b>Miscellaneous/ Specialty Medications</b> |          |                                     |
| 1                      | \$       | sulfacetamide 10%                 |  |  |  | 1               | \$\$\$              | <u>glipizide XL</u>                 | 2  | \$\$\$   | Alora                    |  |  | PA-2  | \$\$\$\$ | Epogen / Procrit                    |
| 1                      | \$       | gentamicin                        |  |  |  | 2               | \$\$\$              | Glucagon                            | 2  | \$\$\$   | Combipatch               |  |  | PA-2  | \$\$\$\$ | Neupogen                            |
| 1                      | \$       | tobramycin                        |  |  |  | 2               | \$\$\$              | Amaryl                              | 2  | \$\$\$   | Fosamax                  |  |  | PA-2  | \$\$\$\$ | Arava                               |
| 1                      | \$       | erythromycin                      |  |  |  | INS             | \$                  | Novolin Insulin QL-20mL             | 2  | \$\$\$   | Actonel                  |  |  | PA-2  | \$\$\$\$ | Apokyn QL-90 mL                     |
| 1                      | \$       | bacitracin                        |  |  |  | INS             | \$\$\$              | Novolog Insulin QL-20mL             | 2  | \$\$\$   | Estring (1 copay)        |  |  | PA-2  | \$\$\$\$ | Avonex                              |
| 1                      | \$       | domebro OTIC                      |  |  |  | INS             | \$                  | <u>Humulin Insulin QL-20mL</u>      | 2  | \$\$\$   | Evista                   |  |  | PA-2  | \$\$\$\$ | Copaxone                            |
| 1                      | \$\$\$   | neosporin                         |  |  |  | INS             | \$\$\$              | <u>Humalog Insulin QL-20mL</u>      | 2  | \$\$\$   | Menostar QL-4            |  |  | PA-2  | \$\$\$\$ | Enbrel                              |
| 2                      | \$\$\$\$ | Ciloxan                           |  |  |  | INS             | \$\$\$              | <u>Humalog Insulin QL-20mL</u>      | 3  | \$\$\$\$ | EstroGel                 |  |  | PA-2  | \$\$\$\$ | Raptiva                             |
| 2                      | \$\$\$\$ | Ocuflax                           |  |  |  | INS             | \$\$\$              | Lantus-Insulin QL-20mL              | 2  | \$\$\$   | Forteo                   |  |  | PA-2  | \$\$\$\$ | Kineret                             |
| 2                      | \$\$\$\$ | Floxin OTIC                       |  |  |  | 2               | \$\$\$              | Precose                             | 1  | \$\$\$   | Levora NC                |  |  | PA-2  | \$\$\$\$ | Humira                              |
| 2                      | \$\$\$\$ | Zymar                             |  |  |  | 2               | \$\$\$              | metformin                           | 1  | \$\$\$   | Levlen                   |  |  | PA-2  | \$\$\$\$ | Rilutek                             |
| 2                      | \$\$\$\$ | Vigamox                           |  |  |  | 1               | \$\$\$              | metformin XR                        | 1  | \$\$\$   | levlite                  |  |  | PA-2  | \$\$\$\$ | Betaseron                           |
| 2                      | \$\$\$\$ | Quixin                            |  |  |  | 2               | \$\$\$              | Glucovance                          | 1  | \$\$\$   | Aviane, Lessina NC       |  |  | PA-2  | \$\$\$\$ | Infergen                            |
| 2                      | \$\$\$\$ | Vira-A, Viroptic                  |  |  |  | 2               | \$\$\$              | Prandin                             | 1  | \$\$\$   | microgestin & FE         |  |  | PA-2  | \$\$\$\$ | Intron-A                            |
|                        |          | <b>Corticosteroid Combo</b>       |  |  |  | 2               | \$\$\$              | Starlix                             | NC | \$       | apri NC                  |  |  | PA-2  | \$\$\$\$ | Leukine                             |
| 1                      | \$       | neodecadron                       |  |  |  | 2               | \$\$\$              | Actos                               | 1  | \$\$\$   | ortho-cept               |  |  | PA-2  | \$\$\$\$ | LidoDerm                            |
| 1                      | \$\$\$   | cortisporin solution              |  |  |  | 2               | \$\$\$\$            | Avandia, Avandamet                  | NC | \$       | Necon NC                 |  |  | PA-2  | \$\$\$\$ | Lupron & Depot                      |
| 2                      | \$\$\$   | Blephamide                        |  |  |  | 2               | \$\$\$\$            | <b>HRT / Osteoporosis</b>           | 1  | \$       | ortho-Novum              |  |  | PA-2  | \$\$\$\$ | Neulasta                            |
| 2                      | \$\$\$   | Maxitrol / Maxidex                |  |  |  | 1               | \$                  | <u>estradiol</u>                    | 1  | \$       | modicon                  |  |  | PA-2  | \$\$\$\$ | Peg Intron                          |
| 2                      | \$\$\$   | Pred Mild / Forte                 |  |  |  | 2               | \$                  | Activella                           | 1  | \$\$\$   | low-ogestrel, cryselle   |  |  | PA-2  | \$\$\$\$ | Pegasys                             |
| 2                      | \$\$\$   | Tobradex                          |  |  |  | 1               | \$                  | estrogens, esterified               | NC | \$\$\$   | kariva NC                |  |  | PA-2  | \$\$\$\$ | Rebetron                            |
| 2                      | \$\$\$   | Cipro HC OTIC                     |  |  |  | 1               | \$                  | estropipate                         | 1  | \$\$\$   | mircette                 |  |  | PA-2  | \$\$\$\$ | Rebif                               |
| 3                      | \$\$\$\$ | Ciprodex                          |  |  |  | 1               | \$                  | medroxyprogesterone                 | NC | \$\$\$   | sprintec NC              |  |  | PA-2  | \$\$\$\$ | Regranex                            |
|                        |          | <b>Pain &amp; Miscellaneous</b>   |  |  |  | 2               | \$                  | Premarin                            | 1  | \$\$\$   | ortho-Cyclen             |  |  | PA-1  | \$\$\$\$ | Remicade                            |
| 1                      | \$       | auralgan OTIC                     |  |  |  | 2               | \$\$\$              |                                     | NC | \$\$\$   | Trivora, Triphasil,      |  |  | PA-2  | \$\$\$\$ | Ribavirin                           |
| 1                      | \$       | cerumenex OTIC                    |  |  |  |                 |                     |                                     | 1  | \$\$\$   |                          |  |  | PA-2  | \$\$\$\$ | Roferon-A                           |
| 2                      | \$\$\$\$ | Acular                            |  |  |  |                 |                     |                                     |    |          |                          |  |  |   |          |                                     |
| 2                      | \$\$\$\$ | Voltaren                          |  |  |  |                 |                     |                                     |    |          |                          |  |  |   |          |                                     |

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# THREE TIER DRUG PLAN

**\$7/20%/40%**

This is a Summary of Benefits only, and does not outline all the benefits and exclusions.

## **WHAT IS A THREE-TIERED DRUG PLAN?**

This three-tiered drug plan incorporates three levels of benefits.

- Tier 1 is for all generic drugs, which has the lowest co-payment.
- Tier 2 covers our preferred brand name drugs, and has the second lowest co-payment.
- Tier 3 represents all non-preferred brand name drugs and has the highest co-payment.

This drug plan is an open formulary, which means that all drugs are available to our members unless otherwise determined to be excluded. Our designated Pharmacy Benefit Manager and/or MercyCare determines the placement of drugs within each tier of this open formulary. Other changes may occur to this formulary as determined by MercyCare or our designated Pharmacy Benefit Manager.

## **PAYING FOR YOUR PRESCRIPTION**

### **Participating Pharmacy Benefits:**

#### ***Tier 1: All generic drugs:***

- \$7 co-pay per prescription drug order (30 day supply)

#### ***Tier 2: Preferred Brand Name Drugs:***

- \$15 minimum copay or 20% of total cost up to a maximum of \$40 copay per prescription drug order (30 day supply)

#### ***Tier 3: Non-Preferred Brand Name Drugs:***

- \$25 minimum copay or 40% of total cost up to a maximum \$75 copay per prescription drug order (30 day supply)

If the price of your prescription drug is less than your co-pay, you will pay the charged amount.

## **PRIOR APPROVAL**

Certain formulary drugs require prior approval from MercyCare before coverage is provided. If you are presently on a medication and would like to know if it requires a prior approval please call Customer Service.

## **NON-COVERED DRUGS**

- Fertility drugs.
- Any drug or medicine which is taken by or administered to you while you are a patient in a licensed hospital, rest home or sanitarium, extended care facility, convalescent hospital, skilled nursing facility or similar institution.
- Anti-obesity and anorexients.
- Prescription drugs, which the eligible person is entitled to receive without charge from any Worker's Compensation laws or any municipal state or federal program.
- Any drug when used for cosmetic treatment of the aging process.
- Any drug when used for treatment of hair loss.
- Any medication used to obtain, treat or enhance sexual performance and/or function. This includes dysfunction caused by organic diseases.
- Special formulations of covered drugs such as sustained release intended primarily for convenience of the patient, as deemed by MercyCare, are not covered.
- Special packaging of covered drugs intended primarily for convenience of the patient, as deemed by MercyCare, are not covered.
- Retin A, for members over the age of 25.

## **DEFINITIONS**

### **GENERIC**

A generic equivalent means a prescription drug available from more than one drug manufacturer that has the same active therapeutic ingredient as the brand or trade name prescription drug prescribed to you.

### **PREFERRED DRUG**

Branded drugs on our preferred drug list as determined by our designated Pharmacy Benefit Manager and MercyCare.

### **NON-PREFERRED DRUG**

All branded drugs not on our preferred drug list.



**MERCYCARE HEALTH PLANS**

MERCYCARE INSURANCE COMPANY • MERCYCARE HMO, INC.

P.O. BOX 2770, JANESVILLE, WI 53547-2770

# THREE TIER DRUG PLAN

**\$10/20%/50%**

This is a Summary of Benefits only, and does not outline all the benefits and exclusions.

## WHAT IS A THREE-TIERED DRUG PLAN?

This three-tiered drug plan incorporates three levels of benefits.

- Tier 1 is for all generic drugs, which has the lowest co-payment.
- Tier 2 covers our preferred brand name drugs, and has the second lowest co-payment.
- Tier 3 represents all non-preferred brand name drugs and has the highest co-payment.

This drug plan is an open formulary, which means that all drugs are available to our members unless otherwise determined to be excluded. Our designated Pharmacy Benefit Manager and/or MercyCare determines the placement of drugs within each tier of this open formulary. Other changes may occur to this formulary as determined by MercyCare or our designated Pharmacy Benefit Manager.

## PAYING FOR YOUR PRESCRIPTION

### **Participating Pharmacy Benefits:**

#### ***Tier 1: All generic drugs:***

- \$10 co-pay per prescription drug order (30 day supply)

#### ***Tier 2: Preferred Brand Name Drugs:***

- \$25 minimum copay or 20% of total cost up to a maximum of \$50 copay per prescription drug order (30 day supply)

#### ***Tier 3: Non-Preferred Brand Name Drugs:***

- \$50 minimum copay or 50% of total cost up to a maximum \$100 copay per prescription drug order (30 day supply)

If the price of your prescription drug is less than your co-pay, you will pay the charged amount.

## PRIOR APPROVAL

Certain formulary drugs require prior approval from MercyCare before coverage is provided. If you are presently on a medication and would like to know if it requires a prior approval please call Customer Service.

## NON-COVERED DRUGS

- Fertility drugs.
- Any drug or medicine which is taken by or administered to you while you are a patient in a licensed hospital, rest home or sanitarium, extended care facility, convalescent hospital, skilled nursing facility or similar institution.
- Anti-obesity and anorexients.
- Prescription drugs, which the eligible person is entitled to receive without charge from any Worker's Compensation laws or any municipal state or federal program.
- Any drug when used for cosmetic treatment of the aging process.
- Any drug when used for treatment of hair loss.
- Any medication used to obtain, treat or enhance sexual performance and/or function. This includes dysfunction caused by organic diseases.
- Special formulations of covered drugs such as sustained release intended primarily for convenience of the patient, as deemed by MercyCare, are not covered.
- Special packaging of covered drugs intended primarily for convenience of the patient, as deemed by MercyCare, are not covered.
- Retin A, for members over the age of 25.

## DEFINITIONS

### GENERIC

A generic equivalent means a prescription drug available from more than one drug manufacturer that has the same active therapeutic ingredient as the brand or trade name prescription drug prescribed to you.

### PREFERRED DRUG

Branded drugs on our preferred drug list as determined by our designated Pharmacy Benefit Manager and MercyCare.

### NON-PREFERRED DRUG

All branded drugs not on our preferred drug list.



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P.O. BOX 2770, JANESVILLE, WI 53547-2770

# THREE TIER DRUG PLAN

**\$20/\$40/\$60**

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This drug plan is an open formulary, which means that all drugs are available to our members unless otherwise determined to be excluded. Our designated Pharmacy Benefit Manager and/or MercyCare determines the placement of drugs within each tier of this open formulary. Other changes may occur to this formulary as determined by MercyCare or our designated Pharmacy Benefit Manager.

## PAYING FOR YOUR PRESCRIPTION

### **Participating Pharmacy Benefits:**

#### ***Tier 1: All generic drugs:***

- \$20 co-pay per prescription drug order (30 day supply)

#### ***Tier 2: Preferred Brand Name Drugs:***

- \$40 co-pay per prescription drug order (30 day supply)

#### ***Tier 3: Non-Preferred Brand Name Drugs:***

- \$60 co-pay per prescription drug order (30 day supply)

If the price of your prescription drug is less than your co-pay, you will pay the charged amount.

## PRIOR APPROVAL

Certain formulary drugs require prior approval from MercyCare before coverage is provided. If you are presently on a medication and would like to know if it requires a prior approval please call Customer Service.

## NON-COVERED DRUGS

- Fertility drugs.
- Any drug or medicine which is taken by or administered to you while you are a patient in a licensed hospital, rest home or sanitarium, extended care facility, convalescent hospital, skilled nursing facility or similar institution.
- Anti-obesity and anorexients.
- Prescription drugs, which the eligible person is entitled to receive without charge from any Worker's Compensation laws or any municipal state or federal program.
- Any drug when used for cosmetic treatment of the aging process.
- Any drug when used for treatment of hair loss.
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- Special packaging of covered drugs intended primarily for convenience of the patient, as deemed by MercyCare, are not covered.
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A generic equivalent means a prescription drug available from more than one drug manufacturer that has the same active therapeutic ingredient as the brand or trade name prescription drug prescribed to you.

### PREFERRED DRUG

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### NON-PREFERRED DRUG

All branded drugs not on our preferred drug list.



# MERCYCARE HEALTH PLANS DRUG FORMULARY

## COVERED DRUGS

This Prescription drug program provides coverage for drugs that satisfy the following criteria:

- Any prescription drug or insulin in the MercyCare Drug Formulary, or
- Insulin syringes, or
- Any medication compounded by the participating pharmacy that contains a covered prescription drug.

And also must be:

- Medically necessary for patients medical condition and appropriate given patients medical history; and
- Prescribed in a manner consistent with its FDA approval and manufacturer recommendations; and
- Prescribed in its most cost-effective dosing regimen; and
- Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by MercyCare.

Prescription drug coverage applies to drugs provided to ambulatory patients and dispensed by the MercyCare network of retail pharmacies. The pharmacy benefit plan is managed internally. Copayment amounts vary, depending on the plan selected by the employer group. Each member's MercyCare Identification Card indicates the copayment amount required for each prescription.

Limited additional coverage exists under the medical benefit for drugs administered on an outpatient basis in the physician's office. Drugs administered to hospitalized patients are covered directly in MercyCare's payment to the hospital, and are also excluded from the prescription drug coverage.

Drug coverage and exclusions for MercyCare are:

- Most Members can receive a supply of medication not exceeding 30 days for one copay. For certain groups the supply can be up to 34 days for one copay. Some members have an enhanced benefit allowing them to receive up to a 90-day supply of certain medications for three copays. The MercyCare Customer Service Department can verify if the member has the enhanced benefit, and identify the drugs, which can be prescribed in the larger supply.
- Covered drugs are only those available on a prescription basis; exclusions include most over-the-counter (OTC) medications. A limited list of OTCs are available on the abbreviated formulary in this section or at: [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com) or in the 2005 Formulary booklet.
- Insulin, diabetes monitoring products, and associated syringes and needles are covered. Selected diabetic monitoring products are available at no copay through a special program, contact Customer Service for further details.
- Generally, there is no coverage for other injectable medications unless it is included under the prior authorization process.
- Investigational drugs, which bear the label "Caution: New Drug-Limited by Federal (or United States) law to investigational use", are not covered.

## **PRIOR APPROVAL (PA)**

Drugs indicated with a PA are not covered unless they have been prior authorized by MercyCare Health Plans. The physician must apply for prior approval for a specific patient and a specific drug and dose. The request must fulfill PA criteria. This ensures that these drugs are used in a manner consistent with all of the criteria cited in the section COVERED DRUGS. Please call MercyCare Health Plans at 1-800-752-3431 and ask for a Provider Relations Representative if you need a copy of the Prior Approval or Non-Formulary request forms or go to our website: [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com).

The following information will be needed when requesting prior approval:

1. patient name, member number, and date of birth
2. physician name, phone number and fax number
3. drug, strength and dosage form
4. duration of therapy
5. documentation of medical necessity

A Prior Approval or Non-Formulary request form must be faxed to 608-758-7726.

MCHP's Quality Health Management Pharmacist will contact the physician if other information is needed, such as lab data or diagnosis.

If approved, patient information is updated electronically to allow the patient to obtain the drug from any participating pharmacy. If the request is denied, the physician will be contacted by phone and the member will also be notified in writing of the denial and appeal rights.

## **DRUG EXCEPTION**

**This section does not apply to non-covered drugs.**

If the physician believes that a drug not found on the MercyCare formulary is necessary for the patient then they must apply for the DRUG EXCEPTION.

### **Drug exception criteria:**

1. Patient previously treated with the drug **AND** it would be dangerous to the patient's health or unreasonably difficult to switch patient to formulary alternatives, or
2. The requested drug is medically necessary and ALL formulary alternatives (including drugs from other drug classes) are inappropriate for the patient, or have failed.

### **In addition the drug must be:**

1. Medically necessary for patients medical condition, and appropriate given the patients medical history; and
2. Prescribed in a manner consistent with its FDA approved indication(s) and manufacturer recommendations; and
3. Prescribed in its most cost-effective dosing regimen; and
4. Used in a manner consistent with any and all guidelines and criteria developed, adopted, or researched by MercyCare.
5. Not listed as an exclusion in the member's drug rider.

All exceptions are subject to approval from the Plan. Please call MercyCare Health Plans at 1-800-752-3431 and ask for a Provider Relations Representative if you need a copy of the Prior Approval or Non-Formulary request form or visit our website: [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com).

## MANAGED DRUG LIMITATIONS

The following drugs have limitations on quantity or strength, which can be prescribed.

| Brand Name           | Limitation  |
|----------------------|---|
| Ambien               | 10 tablets per copay per month                                    |
| Amerge, Frova        | 9 tablets per copay per month                                     |
| Axert                | 6 tablets per copay per month                                     |
| Bextra 10 mg         | 30 tablets per copay per month                                    |
| Celebrex 200 mg      | 30 capsules per copay per month                                   |
| Dalmane              | 10 capsules per copay per month                                   |
| DDAVP                | 2-2.5 ml spray bottles per copay per month                        |
| Duragesic Patches    | 10 patches per copay per month                                    |
| Ear & Eye Drops      | 30-day supply or 2 containers per month                           |
| Glucagon Kit         | One kit per copay   |
| Halcion              | 10 tablets per copay per month                                    |
| Imitrex Injection    | 6 syringes per copay per month                                    |
| Imitrex Spray        | 6 spray devices per copay   |
| Imitrex Tablets      | 9 tablets per copay per month                                     |
| MDI Inhalers         | 1 inhaler or one month supply/copay                               |
| Lipitor              | 30 tablets per copay per month                                    |
| Lovenox              | 60 syringes per copay   |
| Maxalt               | 12 tablets per copay per month                                    |
| Maxalt MLT           | 12 tablets per copay per month                                    |
| Oxycontin 10 mg      | 90 tablets per month per copay                                    |
| Oxycontin 20mg-80 mg | 60 tablets per copay, per month                                   |
| Regranex             | One copay per 15 gram tube  |
| Relpax, Zomig        | 6 tablets per copay, per month                                    |
| Restoril             | 10 capsules per copay per month                                   |
| Smoking Cessation    | 1 course of 90 days per year<br>2 course per lifetime (max \$900) |
| Tamiflu              | 1 course 10 tabs or 75 ml susp per copay,<br>2 courses per year   |
| Toradol              | 20 tablets per copay per month                                    |
| Zocor                | 30 tablets per copay per month                                    |
| Zofran               | 9 tablets per copay per month                                     |



# MERCYCARE HEALTH PLANS

## PRIOR AUTHORIZATION FAX REQUEST FORM - FAX to 608-758-7726 FOR FORMULARY DRUGS THAT REQUIRE PRIOR APPROVAL

|               |     |
|---------------|-----|
| Name          | DOB |
| MercyCare ID# |     |

FOR MERCYCARE USE ONLY Tier 2 3

MCHP Group Name:#

MCHP Group #:

Effective date:

GNRC's:

Transaction #

Entered by:

**NOTICE: This form is to be used for ON formulary drugs that require prior approval**

|  |  |  |   |
|--|--|--|---|
| Drug Name  | Strength                               | Dosing   | Quantity  |
| Diagnosis Pertinent To Request   |  | Duration of Therapy Anticipated  |   |
| <input type="checkbox"/> New therapy   | <input type="checkbox"/> Samples given | <input type="checkbox"/> Continuation of previously approved MCIC override | <input type="checkbox"/> Continuation of therapy authorized by previous insurance |
| Criteria for Coverage of any drug on the MercyCare Formulary:  |  |  |   |
| 1. Medically necessary for the patient's medical condition and appropriate given their medical history.              |  |  |   |
| 2. Prescribed in a manner consistent with its FDA approval and manufacturer recommendations.                         |  |  |   |
| 3. Prescribed in its most cost-effective dosing regimen.   |  |  |   |
| 4. Use is consistent with any and all guidelines and criteria developed, adopted or researched by MercyCare Ins. Co. |  |  |   |
| Physician Signature  |  | Date   | Phone #   |
| Physician Name (Please Print)  |  | Specialty  | Location  |
| Fax #  |  |  |   |

### FOR MERCYCARE USE ONLY

Approved thru:

/ /

3—6—9—12 months

**Denied**

**Records Requested**

**Rx History**

**Redirect**

Medical Director Signature: \_\_\_\_\_ / /



# MERCYCARE HEALTH PLANS

## DRUG EXCEPTION FAX REQUEST FORM FAX to 608-758-7726 FOR NON-FORMULARY DRUGS

|               |     |
|---------------|-----|
| Name          | DOB |
| MercyCare ID# |     |

*FOR MERCYCARE USE ONLY*      Tier      2      3

MCHP Group Name:

MCHP Group #

Effective date:

GNRC's:

Transaction #

Entered by:

**NOTICE:** This form is to be used for requesting a DRUG EXCEPTION for an OFF formulary drug

|  |          |                                  |          |
|--|----------|----------------------------------|----------|
| Drug Name  | Strength | Dosing                           | Quantity |
| Diagnosis Pertinent To Request   |          | Duration of Therapy Anticipated: |          |
| <input type="checkbox"/> New therapy <input type="checkbox"/> Samples given <input type="checkbox"/> Continuation of previously approved MCIC override <input type="checkbox"/> Continuation of therapy authorized by previous insurance |          |                                  |          |
| You must provide information with this DRUG EXCEPTION REQUEST that supports either of the following:   |          |                                  |          |
| 1. Your patient has been previously treated with this drug while covered by another health plan AND it would be dangerous to their health or unreasonably difficult to switch them to formulary alternatives. OR                         |          |                                  |          |
| 2. The requested drug is medically necessary and ALL formulary alternatives including drugs of other drug classes are not appropriate for your patient and have failed.  |          |                                  |          |
|  |          |                                  |          |
|  |          |                                  |          |
|  |          |                                  |          |
|  |          |                                  |          |
| Physician Signature  |          | Date                             | Phone #  |
| Physician Name (Please Print)  |          | Specialty                        | Location |
|  |          |                                  | Fax #    |

**FOR MERCYCARE USE ONLY**

Approved thru:

/ /

**3—6—9—12 months**

**Denied**

**Records Requested**

**Rx History**

**Redirect**

Medical Director Signature: \_\_\_\_\_ / /



# MERCYCARE HEALTH PLANS

PRIOR AUTHORIZATION FAX REQUEST FORM - FAX to 608-758-7726

FOR **duloxetine (Cymbalta)**

|               |     |
|---------------|-----|
| Name          | DOB |
| MercyCare ID# |     |

**FOR MERCYCARE USE ONLY**

MCHP Group Name:#

MCHP Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

**NOTICE: This form is to be used for:  
Prior Approval of duloxetine**

|                             |          |                      |           |
|-----------------------------|----------|----------------------|-----------|
| Drug Name <b>duloxetine</b> | Strength | Dosing:              | Quantity: |
|                             |          | Duration of Therapy: |           |

Patients will be approved for duloxetine if they meet the following criteria. **Please check the appropriate box and send supporting documentation.** Usage compatible with its FDA approval. Duloxetine is indicated for the treatment of major depressive disorder and neuropathic pain associated with diabetic peripheral neuropathy. Duloxetine may elevate serum transaminases. Hepatic toxicity has been reported with patients who have substantial alcohol consumption.

**Major Depressive Disorder**

Provider has determined patient has treatment resistant depression and single agents or augmentation strategies have been ineffective:

- Failure of at least 2 first line agents (SSRI)
- Failure of at least one second line agent (SNRI, bupropion, mirtazapine)
- Provider has consulted with a behavior health specialist
- No alcohol abuse nor history of liver disease

**Neuropathic Pain**

- Diagnosis of diabetic neuropathy
- Failure of a 12 week trial of at least 2 first line agents (amitryptline, imipramine, gabapentin, carbamazepine)

|                               |           |          |       |
|-------------------------------|-----------|----------|-------|
| Physician Signature:          | Date      | Phone #  | Fax # |
| Physician Name (Please Print) | Specialty | Location |       |

Approved thru:  /  /

**3—6—9—12 months**

**Denied**

**Records Requested**

**Rx History**

**Redirect**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Director Signature:** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_



# MERCYCARE HEALTH PLANS

PRIOR AUTHORIZATION FAX REQUEST FORM - **FAX to 608-758-7726**

FOR **atomoxetine hydrochloride (Strattera)**

|               |     |
|---------------|-----|
| Name          | DOB |
| MercyCare ID# |     |

**FOR MERCYCARE USE ONLY**

MCHP Group Name:#

MCHP Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

**NOTICE: This form is to be used for:  
Prior Approval of Strattera**

|                     |          |                      |           |
|---------------------|----------|----------------------|-----------|
| Drug Name Strattera | Strength | Dosing:              | Quantity: |
|                     |          | Duration of Therapy: |           |

Patients will be approved for Strattera if they are  $\leq 18$  years of age and meet the following criteria.

**Please check the appropriate box and send supporting documentation.** Usage compatible with its FDA approval.

Must have failed two different medications to treat ADHD (one containing dexedrine and one containing methylphenidate) Please list medications that were tried and when:

\_\_\_\_\_  
\_\_\_\_\_

*Or*

Documented adverse side effects necessitating a change in medication (please send supporting documentation)

|                               |           |          |       |
|-------------------------------|-----------|----------|-------|
| Physician Signature:          | Date      | Phone #  | Fax # |
| Physician Name (Please Print) | Specialty | Location |       |

Approved thru:

**3—6—9—12 months**

**Denied**

**Records Requested**

**Rx History**

**Redirect**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Director Signature:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



# MERCYCARE HEALTH PLANS

PRIOR AUTHORIZATION FAX REQUEST FORM - FAX to 608-758-7726

FOR **Topamax**

|               |     |
|---------------|-----|
| Name          | DOB |
| MercyCare ID# |     |

**FOR MERCYCARE USE ONLY**

MCHP Group Name:#

MCHP Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

**NOTICE: This form is to be used for:  
Prior Approval of Topamax**

|                          |          |                                 |          |
|--------------------------|----------|---------------------------------|----------|
| Drug Name <b>Topamax</b> | Strength | Dosing                          | Quantity |
|                          |          | Duration of Therapy Anticipated |          |

Patients will be approved for Topamax if they meet **ONE** of the following criteria. **Please check the appropriate box and send supporting documentation.**

- As adjunctive therapy for adults and pediatric patients with partial onset seizures, or primary generalized catatonic chronic seizures.** Patients must be on at least one other epileptic drug to justify Topamax.
- As a first line agent for adults and pediatric patients with partial onset seizures, or primary generalized catatonic chronic seizures** when requested by the attending physician as a first line agent and other agents are not appropriate.
- In vascular headaches when numerous first-line agents have tried and failed.** Approval will be limited to a three-month trial and subsequent approval will only occur if the trial has been successful by the following criteria:
  - o The use of Topamax has clearly resulted in
    - Fewer health care contacts for acute migraines AND
    - Reduced use of narcotics or other rescue medications
- As an adjunct following inpatient alcohol detoxification of patients who have been unable to stay sober in the past due to impulsive drinking.** Approval will be limited to 180 days.

|                               |           |          |       |
|-------------------------------|-----------|----------|-------|
| Physician Signature:          | Date      | Phone #  | Fax # |
| Physician Name (Please Print) | Specialty | Location |       |

**Approved thru:**  /  /   
**3—6—9—12 months**

**Denied**

**Records Requested**

**Rx History**

**Redirect**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Director Signature:** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_



# MERCYCARE HEALTH PLANS

MCHP has a pill splitting program in place that currently targets the following medications:

Lipitor

(20mg, 40mg, 80mg)

Lexapro

(20mg)

Risperdal

(0.5mg, 1mg, 2mg, 4mg)

Seroquel

(100mg, 200mg, 300mg)

Zocor

(10mg, 20mg, 40mg, 80mg)

Zoloft

(50mg, 100mg)

Abilify

(20mg, 30mg)

Zyprexa

(5mg, 10mg, 15mg, 20mg)

MCHP's pill splitting program is designed to decrease cost to all members who participate in it by reducing their co-pays by approximately 40-50%.

Please see the example below:

|   | Member Co-Pay Portion<br>(3 Tier Open Formulary) | Member CoPay Portion<br>(2 Tier Closed Formulary) |
|---|--|---|
| Lipitor 20 mg tablet daily<br>(#30 for 30 day supply)   | \$19.80  | \$20  |
| Lipitor 40 mg ½ tablet daily<br>(#15 for 30 day supply) | \$10.12  | \$10  |

## Key Points About the Pill Splitting Program:

- **Co-pay Reduction**-Participating members pay 40-50% less of their usual co-pay. Non-participating members pay their usual copay.
- **Physicians receive a one-time** reimbursement of \$15 per patient switched to a split pill regiment.
- **A new prescription order from the member's physician is required.** Only prescriptions ordered as: *half tablet daily (#15 for a 30 day supply, or #30 for a 60 day supply)*, qualify for a lower co-pay.
- **Please call Customer Services at 800-895-2421 if you have any questions, or would like additional pill splitters for your patients.**



## MERCYCARE HEALTH PLANS

MCHP will begin to use Mercy Health System as the designated Specialty Pharmacies. Only the Specialty pharmacies will be used to dispense selected biological medications. The select list of medications requires prior authorization.

After the request has been approved members will select a Mercy Health System pharmacy to obtain the prescribed medication. If there is not a Mercy Health System pharmacy that is geographically convenient, mail order or delivery service will be coordinated.

|          |                     |             |
|----------|---------------------|-------------|
| Avonex   | Lupron              | Remicade    |
| Cellcept | Neupogen, Neulasta  | Rilutek     |
| Copaxone | Peg-Intron, Pegasys | Roferon-A   |
| Enbrel   | Procrit, Epogen     | Sandostatin |
| Forteo   | Prograf             | Thalomid    |
| Gleevec  | Pulmozyme           | Tobi        |
| Humira   | Rebetol             | Tracleer    |
| Kineret  | Rebetron            | Zyvox       |
| Leukine  | Rebif               |             |

Please call Marc Dinnel, R.Ph., MBA, MercyCare Health Plans Managed Care Pharmacist at 608-758-7702, if you have any questions.



# Oral Contraceptive Comparison

Effective  
9/04

| MONOPHASICS SORTED BY PROGESTIN & ESTROGEN STRENGTH |                |                   |             |                |                 |         |               |
|---|----------------|-------------------|-------------|----------------|-----------------|---------|---------------|
| Label Name  | (mcg) ESTROGEN | (mg) PROGESTIN    | Progenicity | Availability   | NEW COPAY TIERS |         |               |
| <b>MOST ANDROGENIC PROGESTINS</b>                   |                |                   |             |                |                 |         |               |
| Ogestrel  | 50             | Ethinyl Estradiol | 0.5         | Norgestrel     | +++             | Generic | Tier 3        |
| Ovral   | 50             | Ethinyl Estradiol | 0.5         | Norgestrel     | +++             | Brand   | Tier 3        |
| Demulen 1/50  | 50             | Ethinyl Estradiol | 1           | Ethinodiol     | +++             | Brand   | Tier 3        |
| <b>Zovia 1/50</b>                                   | 50             | Ethinyl Estradiol | 1           | Ethinodiol     | +++             | Generic | <b>Tier 1</b> |
| Demulen 1/35  | 35             | Ethinyl Estradiol | 1           | Ethinodiol     | +++             | Brand   | Tier 3        |
| <b>Zovia1/35</b>                                    | 35             | Ethinyl Estradiol | 1           | Ethinodiol     | +++             | Generic | <b>Tier 1</b> |
| LoOvral 21 & 28                                     | 30             | Ethinyl Estradiol | 0.3         | Norgestrel     | +++             | Brand   | Tier 3        |
| <b>Low-Ogestrel, Cryselle</b>                       | 30             | Ethinyl Estradiol | 0.3         | Norgestrel     | +++             | Generic | <b>Tier 1</b> |
| <b>Levlen</b>                                       | 30             | Ethinyl Estradiol | 0.15        | Levonorgestrel | +++             | Brand   | <b>Tier 1</b> |
| Levora 0.15/30                                      | 30             | Ethinyl Estradiol | 0.15        | Levonorgestrel | +++             | Generic | Not Covered   |
| Nordette  | 30             | Ethinyl Estradiol | 0.15        | Levonorgestrel | +++             | Brand   | Not Covered   |
| Portia  | 30             | Ethinyl Estradiol | 0.15        | Levonorgestrel | +++             | Generic | Not Covered   |
| Seasonale #91 per 90 days sply                      | 30             | Ethinyl Estradiol | 0.15        | Levonorgestrel | +++             | Brand   | Tier 3        |
| Alesse  | 20             | Ethinyl Estradiol | 0.1         | Levonorgestrel | +++             | Brand   | Not Covered   |
| Aviane  | 20             | Ethinyl Estradiol | 0.1         | Levonorgestrel | +++             | Generic | Not Covered   |
| Lessina   | 20             | Ethinyl Estradiol | 0.1         | Levonorgestrel | +++             | Generic | Not Covered   |
| <b>Levlite</b>                                      | 20             | Ethinyl Estradiol | 0.1         | Levonorgestrel | +++             | Generic | <b>Tier 1</b> |
| <b>MODERATE ANDROGENIC PROGESTINS</b>               |                |                   |             |                |                 |         |               |
| Genora 1/50, Necon 1/50                             | 50             | Mestranol         | 1           | Norethindrone  | +               | Generic | Not Covered   |
| Norinyl 1+50  | 50             | Mestranol         | 1           | Norethindrone  | +               | Brand   | Not Covered   |
| <b>Ortho-Novum 1/50</b>                             | 50             | Mestranol         | 1           | Norethindrone  | +               | Brand   | <b>Tier 1</b> |
| Ovcon-50  | 50             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Brand   | Tier 3        |
| Necon 1/35  | 35             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Generic | Not Covered   |
| Nelova 1/35, Norcept 1/35                           | 35             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Brand   | Not Covered   |
| Norethin 1/35, Norinyl 1/35                         | 35             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Generic | Not Covered   |
| Nortrel 1/35, Genora 1/35                           | 35             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Generic | Not Covered   |
| <b>Ortho-Novum 1/35</b>                             | 35             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Brand   | <b>Tier 1</b> |
| Brevicon  | 35             | Ethinyl Estradiol | 0.5         | Norethindrone  | +               | Brand   | Not Covered   |
| Genora 0.5/35                                       | 35             | Ethinyl Estradiol | 0.5         | Norethindrone  | +               | Generic | Not Covered   |
| <b>Modicon</b>                                      | 35             | Ethinyl Estradiol | 0.5         | Norethindrone  | +               | Brand   | <b>Tier 1</b> |
| Necon 0.5/35  | 35             | Ethinyl Estradiol | 0.5         | Norethindrone  | +               | Generic | Not Covered   |
| Nortrel 0.5/35                                      | 35             | Ethinyl Estradiol | 0.5         | Norethindrone  | +               | Generic | Not Covered   |
| Ovcon-35  | 35             | Ethinyl Estradiol | 0.4         | Norethindrone  | +               | Brand   | Tier 3        |
| Loestrin & Fe 1.5/30                                | 30             | Ethinyl Estradiol | 1.5         | Norethindrone  | +               | Brand   | Tier 3        |
| <b>Microgestin &amp; Junel 1.5/30</b>               | 30             | Ethinyl Estradiol | 1.5         | Norethindrone  | +               | Generic | <b>Tier 1</b> |
| Loestrin & Fe 1/20                                  | 20             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Brand   | Tier 3        |
| <b>Microgestin &amp; Junel 1/20</b>                 | 20             | Ethinyl Estradiol | 1           | Norethindrone  | +               | Generic | <b>Tier 1</b> |
| <b>LEAST ANDROGENIC PROGESTINS</b>                  |                |                   |             |                |                 |         |               |
| <b>Ortho-Cyclen</b>                                 | 35             | Ethinyl Estradiol | 0.25        | Norgestimate   | +++             | Brand   | <b>Tier 1</b> |
| Sprintec, Mononessa                                 | 35             | Ethinyl Estradiol | 0.25        | Norgestimate   | +++             | Generic | Not Covered   |
| Previfem  | 35             | Ethinyl Estradiol | 0.25        | Norgestimate   | +++             | Generic | Not Covered   |
| <b>Yasmin</b>                                       | 30             | Ethinyl Estradiol | 3           | Drospirenone   | +               | Brand   | <b>Tier 2</b> |
| APRI  | 30             | Ethinyl Estradiol | 0.15        | Desogestrel    | +++             | Generic | Not Covered   |
| Desogen   | 30             | Ethinyl Estradiol | 0.15        | Desogestrel    | +++             | Brand   | Not Covered   |
| <b>Ortho-Cept</b>                                   | 30             | Ethinyl Estradiol | 0.15        | Desogestrel    | +++             | Brand   | <b>Tier 1</b> |

**KEY:**

Most Androgenicity: Levonorgestrel

Moderate Androgenicity: Norethindrone

Less Androgenicity: Norgestimate < Desogestrel

Least/no Androgenicity: Drospirenone

Tier 1 = Formulary Generic Copay.

Tier 2 = Tier 2 Formulary Brand Copay.

Tier 3 = Not on the Formulary and Tier 3 Copay.

Not Covered = Must use formulary alternative.



# Oral Contraceptive Comparison

Effective  
9/04

| MULTIPHASICS SORTED BY PROGESTIN & ESTROGEN STRENGTH |  |                |                   |                   |              |                |              |                 |             |
|--|--|----------------|-------------------|-------------------|--------------|----------------|--------------|-----------------|-------------|
| Label Name   |  | (mcg) ESTROGEN |                   | (mg) PROGESTIN    |              | Progenicity    | Availability | NEW COPAY TIERS |             |
| BIPHASIC   | Ortho-Novum 10/11  | 10 tabs        | 35                | Ethinyl Estradiol | 0.5          | Norethindrone  | +            | Brand           | Tier 1      |
|  |  | 11 tabs        | 35                | Ethinyl Estradiol | 1            | Norethindrone  |              |                 |             |
|  | Necon, Nelova 10/11  | 10 tabs        | 35                | Ethinyl Estradiol | 0.5          | Norethindrone  | +            | Generic         | Not Covered |
|  |  | 11 tabs        | 35                | Ethinyl Estradiol | 1            | Norethindrone  |              |                 |             |
|  | Mircette   | 21 tabs        | 20                | Ethinyl Estradiol | 0.15         | Desogestrel    | +++          | Brand           | Tier 1      |
|  |  | 5 tabs         | 10                | Ethinyl Estradiol |              |                |              |                 |             |
|  | Kariva   | 21 tabs        | 20                | Ethinyl Estradiol | 0.15         | Desogestrel    | +++          | Generic         | Not Covered |
|  |  | 5 tabs         | 10                | Ethinyl Estradiol |              |                |              |                 |             |
| TRIPHASIC  | Tri-Levlen   | 6 tabs         | 30                | Ethinyl Estradiol | 0.05         | Levonorgestrel | +++          | Brand           | Tier 1      |
|  |  | 5 tabs         | 40                | Ethinyl Estradiol | 0.075        | Levonorgestrel |              |                 |             |
|  |  | 10 tabs        | 30                | Ethinyl Estradiol | 0.125        | Levonorgestrel |              |                 |             |
|  | Triphasil, Trivora 28, Enpresse                                | 6 tabs         | 30                | Ethinyl Estradiol | 0.05         | Levonorgestrel | +++          | Generic         | Not Covered |
|  |  | 5 tabs         | 40                | Ethinyl Estradiol | 0.075        | Levonorgestrel |              |                 |             |
|  |  | 10 tabs        | 30                | Ethinyl Estradiol | 0.125        | Levonorgestrel |              |                 |             |
|  | Ortho-Novum 7/7/7  | 7 tabs         | 35                | Ethinyl Estradiol | 0.5          | Norethindrone  | +            | Brand           | Tier 1      |
|  |  | 7 tabs         | 35                | Ethinyl Estradiol | 0.75         | Norethindrone  |              |                 |             |
|  |  | 7 tabs         | 35                | Ethinyl Estradiol | 1            | Norethindrone  |              |                 |             |
|  | Necon 777, Nortrel   | 7 tabs         | 35                | Ethinyl Estradiol | 0.5          | Norethindrone  | +            | Generic         | Not Covered |
|  |  | 7 tabs         | 35                | Ethinyl Estradiol | 0.75         | Norethindrone  |              |                 |             |
|  |  | 7 tabs         | 35                | Ethinyl Estradiol | 1            | Norethindrone  |              |                 |             |
|  | Tri-Norinyl  | 7 tabs         | 35                | Ethinyl Estradiol | 0.5          | Norethindrone  | +            | Brand           | Tier 3      |
|  |  | 9 tabs         | 35                | Ethinyl Estradiol | 1            | Norethindrone  |              |                 |             |
|  |  | 5 tabs         | 35                | Ethinyl Estradiol | 0.5          | Norethindrone  |              |                 |             |
|  | Ethrostep Fe<br><i>Ethrostep Fe with 5 mg Ferrous Fumarate</i> | 5 tabs         | 20                | Ethinyl Estradiol | 1            | Norethindrone  | +            | Brand           | Tier 2      |
|  |  | 7 tabs         | 30                | Ethinyl Estradiol | 1            | Norethindrone  |              |                 |             |
|  |  | 9 tabs         | 35                | Ethinyl Estradiol | 1            | Norethindrone  |              |                 |             |
|  | Cyclessa 777   | 7 tabs         | 25                | Ethinyl Estradiol | 0.1          | Desogestrel    | +++          | Brand           | Tier 2      |
|  |  | 7 tabs         | 25                | Ethinyl Estradiol | 0.125        | Desogestrel    |              |                 |             |
| 7 tabs   |  | 25             | Ethinyl Estradiol | 0.15              | Desogestrel  |                |              |                 |             |
| Ortho-Tri-Cyclen Lo                                  | 7 tabs   | 25             | Ethinyl Estradiol | 0.18              | Norgestimate | +++            | Brand        | Tier 2          |             |
|  | 7 tabs   | 25             | Ethinyl Estradiol | 0.215             | Norgestimate |                |              |                 |             |
|  | 7 tabs   | 25             | Ethinyl Estradiol | 0.25              | Norgestimate |                |              |                 |             |
| Ortho-Tri-Cyclen                                     | 7 tabs   | 35             | Ethinyl Estradiol | 0.18              | Norgestimate | +++            | Brand        | Tier 1          |             |
|  | 7 tabs   | 35             | Ethinyl Estradiol | 0.215             | Norgestimate |                |              |                 |             |
|  | 7 tabs   | 35             | Ethinyl Estradiol | 0.25              | Norgestimate |                |              |                 |             |
| Trinessa, Tri-Sprintec, Tri-Previfem                 | 7 tabs   | 35             | Ethinyl Estradiol | 0.18              | Norgestimate | +++            | Generic      | Not Covered     |             |
|  | 7 tabs   | 35             | Ethinyl Estradiol | 0.215             | Norgestimate |                |              |                 |             |
|  | 7 tabs   | 35             | Ethinyl Estradiol | 0.25              | Norgestimate |                |              |                 |             |
| OTHER  | Micronor   |                |                   |                   | 0.35         | Norethindrone  | +            | Brand           | Tier 1      |
|  | Camila, Jolivette, Errin, Nor-Q.D.                             |                |                   |                   | 0.35         | Norethindrone  | +            | Generic         | Not Covered |
|  | Ovrette  |                |                   |                   | 0.075        | Norgestrel     | +++          | Brand           | Tier 3      |
|  | NuvaRing (Approx Daily Dose)                                   | 15             |                   | Ethinyl Estradiol | 0.12         | Etonogestrel   | +++          | Brand           | Tier 2      |
|  | Ortho Evra Patch (Approx Daily Dose)                           | 20             |                   | Ethinyl Estradiol | 0.15         | Norelgestromin | +++          | Brand           | Tier 2      |
|  | Plan B   |                |                   |                   | 0.75         | Levonorgestrel | +++          | Brand           | Tier 3      |
|  | Preven (Includes Pregnancy Test)                               |                | 50                | Ethinyl Estradiol | 0.25         | Levonorgestrel | +++          | Brand           | Tier 3      |

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