

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.

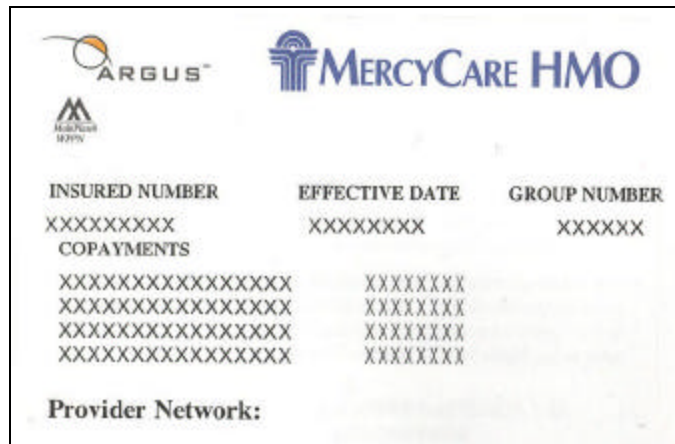
Please note that the following information is required for each claim submitted:

- 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

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

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

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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ALLERGY & ASTHMA										
Tier	Antihistamines	2	\$\$\$	Singular	1	\$	nystatin	\$	butalbital/APAP/Caff	
1	\$ clemastine	2	\$\$\$	Serevent	2	\$\$	Oxistat	1	\$\$ midrin - Generics	
1	\$ diphenhydramine	2	\$\$\$	Foradil	1	\$\$	lotrisone	2	\$\$\$ Migranal	
1	\$ hydroxyzine	2	\$\$\$	Tilade	1	\$\$	ketocoazole	2	\$\$\$\$ Depakote ER	
1	\$\$ deconamine SR	2	\$\$\$	Pulmicort	2	\$\$	Mycellex Tablets	2	\$\$\$\$\$ Maxalt/Maxalt MLT QL-12	
1	\$\$ bromfenex & PD	2	\$\$\$\$	Advair	2	\$\$	Nizoral Shampoo Rx	2	\$\$\$\$\$ Imitrex Tabs QL-9 , Inj QL-6	
1	\$\$ OTC loratadine Tabs & Syrup	2	\$\$\$\$\$	Pulmicort Respules AL < 8 years	1	\$\$	miconazole-3-Rx vag supp	3	\$\$\$\$\$ Axert QL-6	
1	\$\$ OTC loratadine-D	3	\$\$\$	Aerobid	3	\$\$	Terazol 3/7 Rx	3	\$\$\$\$\$ Amerge QL-9	
NC	\$\$ Loratadine Reditab	3	\$\$\$	Azmacort	MOTC	\$\$	Monistat	3	\$\$\$\$\$ Relpax QL-9	
2	\$\$\$\$ Rondec	PA-2	\$\$\$\$\$	Xolair	MOTC	\$\$	Clotrimazole	3	\$\$\$\$\$ Frova QL-9	
2	\$\$\$\$ Allegra & D	ANTI-INFECTIVES			MOTC	\$\$	Vagistat-1	3	\$\$\$\$\$ Zomig QL-6	
2	\$\$\$\$ Zyrtec & D	Tier		Cephalosporins	1	\$\$	econazole	Muscle Relaxants		
3	\$\$\$\$ Clarinex	1	\$	cephalexin	1	\$\$\$	fluconazole	1	\$ baclofen	
NC	\$\$\$\$ Claritin & D - Rx	1	\$\$\$	cefadroxil caps only	PA-2	\$\$\$\$\$	Lamisil	1	\$ cyclobenzaprine	
Nasal Sprays		1	\$\$\$	cefuroxime tabs only	PA-3	\$\$\$\$\$	Sporanox	1	\$\$ methocarbamol	
2	\$\$ Astelin	1	\$\$	cefaclor	PA-2	\$\$\$\$\$	Zyvox	1	\$\$\$\$ tizanidine	
2	\$\$ Flonase	1	\$	cephradine			Antivirals		3	\$\$\$ Skelaxin
2	\$\$ Nasonex	2	\$\$	cefprozil	1	\$	acyclovir	Narcotics		
2	\$\$ Beconase AQ	2	\$\$\$	Ceftin Susp.	1	\$	amantadine	1	\$ codeine	
3	\$\$ Nasarel	2	\$\$\$	Cefzil	1	\$\$\$	Tamiflu QL-10	1	\$ morphine	
3	\$\$ Rhinocort Aqua	2	\$\$\$	Omnicef	2	\$\$	Valtrex	1	\$ oxycodone	
Bronchodilators		2	\$\$\$	Suprax	PA-2	\$\$	Famvir	1	\$ tramadol	
1	\$ albuterol (Proventil)	1	\$\$	Fluoroquinolones	2	\$\$	Aldara, Condylox	3	\$ Ultracet	
1	\$ albuterol (Ventolin)	1	\$\$\$\$	ciprofloxacin	2	\$\$\$\$\$	All oral HIV medicines are formulary	1	\$ codeine/APAP	
1	\$ aminophylline	1	\$\$\$\$	ciprofloxacin suspension			Other		1	\$ hydrocodone/APAP
1	\$ theophylline (Slo-phyllin, Uniphyll)	3	\$\$\$\$	levofloxacin	1	\$	metronidazole	1	\$ propoxyphene/APAP	
2	\$\$ Maxair Autohaler ONLY	3	\$\$\$\$	Tequin	1	\$	bactrim SS/DS-generics	1	\$ oxycod 5 mg/APAP 325	
2	\$\$ Proventil HFA	1	\$	Macrolides & Ketolides	1	\$	tetracycline	1	\$\$\$ oxycod 7.5 mg/APAP 325	
2	\$\$\$\$ Atrovent	2	\$\$\$	erythromycin	1	\$\$\$	clindamycin	1	\$\$\$ oxycod 10 mg/APAP 325	
2	\$\$\$\$ Combivent	2	\$\$\$	Zithromax	1	\$\$	nitrofurantion	1	\$\$\$\$ morphine Sulfate SA (MS Contin)	
2	\$\$\$\$ Accuneb	2	\$\$\$	Biaxin, Biaxin XL	1	\$\$	doxycycline	PA-2	Oxycontin 10 mg QL-90 per month	
PA-2	\$\$\$\$\$ Spiriva	PA-3	\$\$\$	Ketek	1	\$\$\$	minocycline	PA-2	\$\$\$\$\$ Oxycontin 20 mg – 80 mg QL-60 per month	
NC	\$\$\$\$\$ Duoneb NC	1	\$	Penicillins	2	\$\$\$	Bactroban	PA-2	\$\$\$\$\$ Onc DEA pass	
	MC Preventative	1	\$	penicillin VK	2	\$\$\$	bacitracin MOTC	PA-2	\$\$\$\$\$ Onc DEA pass	
2	\$\$\$ Accolate	1	\$\$	amoxicillin 250,500 mg	3	\$\$\$\$	polysporin MOTC	PA-2	\$\$\$\$\$ Kadian QL-60 per month	
2	\$\$\$ Flovent	1	\$\$\$	dicloxacillin	3	\$\$\$\$	Tindamax			
2	\$\$\$ Intal	2	\$\$\$\$	amoxicillin/clavulanate	3	\$\$\$\$	Xifaxan			
2	\$\$\$ QVAR	2	\$\$\$	Augmentin ES & XR						
		2	\$	Antifungals						
				Exelderm						

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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%

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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.

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MERCYCARE HEALTH PLANS

MERCYCARE INSURANCE COMPANY • MERCYCARE HMO, INC.

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

THREE TIER DRUG PLAN

\$20/\$40/\$60

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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.

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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 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.

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.

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 2 course per lifetime (max \$900)
Tamiflu	1 course 10 tabs or 75 ml susp per copay, 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

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 (3 Tier Open Formulary)	Member CoPay Portion (2 Tier Closed Formulary)
Lipitor 20 mg tablet daily (#30 for 30 day supply)	\$19.80	\$20
Lipitor 40 mg ½ tablet daily (#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
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MONOPHASICS SORTED BY PROGESTIN & ESTROGEN STRENGTH							
Label Name	(mcg) ESTROGEN	(mg) PROGESTIN	Progenicity	Availability	NEW COPAY TIERS		
MOST ANDROGENIC PROGESTINS							
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
Zovia 1/50	50	Ethinyl Estradiol	1	Ethinodiol	+++	Generic	Tier 1
Demulen 1/35	35	Ethinyl Estradiol	1	Ethinodiol	+++	Brand	Tier 3
Zovia1/35	35	Ethinyl Estradiol	1	Ethinodiol	+++	Generic	Tier 1
LoOvral 21 & 28	30	Ethinyl Estradiol	0.3	Norgestrel	+++	Brand	Tier 3
Low-Ogestrel, Cryselle	30	Ethinyl Estradiol	0.3	Norgestrel	+++	Generic	Tier 1
Levlen	30	Ethinyl Estradiol	0.15	Levonorgestrel	+++	Brand	Tier 1
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
Levlite	20	Ethinyl Estradiol	0.1	Levonorgestrel	+++	Generic	Tier 1
MODERATE ANDROGENIC PROGESTINS							
Genora 1/50, Necon 1/50	50	Mestranol	1	Norethindrone	+	Generic	Not Covered
Norinyl 1+50	50	Mestranol	1	Norethindrone	+	Brand	Not Covered
Ortho-Novum 1/50	50	Mestranol	1	Norethindrone	+	Brand	Tier 1
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
Ortho-Novum 1/35	35	Ethinyl Estradiol	1	Norethindrone	+	Brand	Tier 1
Brevicon	35	Ethinyl Estradiol	0.5	Norethindrone	+	Brand	Not Covered
Genora 0.5/35	35	Ethinyl Estradiol	0.5	Norethindrone	+	Generic	Not Covered
Modicon	35	Ethinyl Estradiol	0.5	Norethindrone	+	Brand	Tier 1
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
Microgestin & Junel 1.5/30	30	Ethinyl Estradiol	1.5	Norethindrone	+	Generic	Tier 1
Loestrin & Fe 1/20	20	Ethinyl Estradiol	1	Norethindrone	+	Brand	Tier 3
Microgestin & Junel 1/20	20	Ethinyl Estradiol	1	Norethindrone	+	Generic	Tier 1
LEAST ANDROGENIC PROGESTINS							
Ortho-Cyclen	35	Ethinyl Estradiol	0.25	Norgestimate	+++	Brand	Tier 1
Sprintec, Mononessa	35	Ethinyl Estradiol	0.25	Norgestimate	+++	Generic	Not Covered
Previfem	35	Ethinyl Estradiol	0.25	Norgestimate	+++	Generic	Not Covered
Yasmin	30	Ethinyl Estradiol	3	Drospirenone	+	Brand	Tier 2
APRI	30	Ethinyl Estradiol	0.15	Desogestrel	+++	Generic	Not Covered
Desogen	30	Ethinyl Estradiol	0.15	Desogestrel	+++	Brand	Not Covered
Ortho-Cept	30	Ethinyl Estradiol	0.15	Desogestrel	+++	Brand	Tier 1

MONOPHASIC

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	<i>Not Covered</i>
		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	<i>Not Covered</i>	
	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	<i>Not Covered</i>
		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	<i>Not Covered</i>
		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	<i>Tier 3</i>
		9 tabs	35	Ethinyl Estradiol	1	Norethindrone			
		5 tabs	35	Ethinyl Estradiol	0.5	Norethindrone			
	Estrostep Fe <i>Estrostep 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	<i>Not Covered</i>	
	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	<i>Not Covered</i>
	Ovrette				0.075	Norgestrel	+++	Brand	<i>Tier 3</i>
	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	<i>Tier 3</i>
	Preven (Includes Pregnancy Test)		50	Ethinyl Estradiol	0.25	Levonorgestrel	+++	Brand	<i>Tier 3</i>

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.

Substrates

1A2	2B6	2C8	2C19	2C9	2D6	2E1	3A4,5,7
amitriptyline caffeine clomipramine clozapine cyclobenzaprine (Flexeril®) estradiol flovoxamine haloperidol imipramineN-DeMe mexiletine naproxen olanzapine ondansetron phenacetin=>acetaminophen =>NAPQI propranolol riluzole ropivacaine tacrine theophylline verapamil (R)warfarin zileuton zolmitriptan	bupropion cyclophosphamide efavirenz ifosfamide methadone	paclitaxel torsemide amodiaquine cerivastatin repaglinide	Proton Pump Inhibitors: omeprazole lansoprazole pantoprazole E-3810	NSAIDs: diclofenac ibuprofen meloxicam S-naproxen=>Nor piroxicam suprofen	Beta Blockers: carvedilol S-metoprolol propafenone timolol	Anesthetics: enflurane halothane isoflurane methoxyflurane sevoflurane	Macrolide Antibiotics: clarithromycin erythromycin (not 3A5) NOT azithromycin Anti-arrhythmics: quinidine=>3-OH (not 3A5)
			Oral Hypoglycemic Agents: tolbutamide glipizide	Antidepressants: amitriptyline clomipramine desipramine imipramine paroxetine	Benzodiazepines: alprazolam diazepam=>3OH midazolam triazolam		
			Anti-epileptics: diazepam=>Nor phenytoin(O) S-mephenytoin phenobarbitone	Angiotensin II Blockers: irbesartan losartan Sulfonylureas: Glyburide Glibenclamide Glipizide Glimepiride tolbutamide	Antipsychotics: haloperidol perphanazine risperidone=>9OH thioridazine		Acetaminophen =>NAPQI aniline benzene chlorzoxazone ethanol N,N-dimethyl Formamide theophylline=>8-OH
amipriptyline carisoprodol citalopram clomipramine cyclophosphamide hexobarbital imipramine N-DeMe indomethacin R-mephobarbital moclobemide nelfinavir nilutamide primidone progesterone proguanil propranolol teniposide R-warfarin=>8-OH	amitriptyline celecoxib fluoxetine fluvastatin glyburide nateglinide phenytoin=>4-OH rosiglitazone tamoxifen torsemide S-warfarin	alprenolol amphetamine atomoxetine bufuralol chlorpheniramine chlorpromazine codeine (=>O-desMe) debrisoquine dexfenfluramine dextromethorphan ecainide flecainide fluoxetine fluvoxamine lidocaine metoclopramide methoxyamphetamine mexiletine nortriptyline minaprine ondansetron perhexiline	HIV Antivirals: indinavir nelfinavir ritonavir saquinavir Prokinetic: cisapride Antihistamines: astemizole chlorpheniramine terfenidine Calcium Channel Blockers: amlodipine diltiazem felodipine lercanidipine nifedipine nisoldipine nitrendipine verapamil				

Substrates Continued

1A2	2B6	2C8	2C19	2C9	2D6	2E1	3A4,5,7
					phenacetin phenformin propranolol(=>4OH) sparteine tamoxifen tramadol venlafaxine		HMG CoA Reductase Inhibitors atorvastatin cerivastatin lovastatin NOT pravastatin simvastatin
							Steroid 6beta-OH estradiol hydrocortisone progesterone testosterone
							Miscellaneous alfentanyl buspirone cafergot caffiene=>TMU cocaine dapson codeine-N demethylation dextromethophan eplerenone fentanyl finasteride gleevec haloperidol irinotecan LAAM lidocaine methadone nateglinide odanestron pimozide propranolol quinie Not rosuvastatin salmeterol sildenafil sirolimus tamoxifen taxol terfenadine trazodone vincristine zaleplon zolpidem

Inhibitors

1A2	2B6	2C8	2C19	2C9	2D6	2E1	3A4,5,7
amiodarone cimetidine fluoroquinolones fluvoxamine furafylline interferon? methoxsalen mibefradil ticlopidine	thiotepa	trimethoprim quercetin glitazones gemfibrozil	cimetidine felbamate fluoxetine fluvoxamine indomethacin ketoconazole lansoprazole modafinil omeprazole paroxetine probenicid ticlopidine topiramate	amiodarone fluconazole fluvastatin fluvoxamine isoniazid lovastatin paroxetine phenylbutazone probenicid sertraline sulfamethoxazole sulfaphenazole teniposide trimethoprim zafirlukast	amiodarone bupropion celecoxib chlorpromazine chlorpheniramine cimetidine clomipramine cocaine doxorubicin fluoxetine halofantrine red-haloperidol levomepromazine metoclopramide methadone mibefradil moclobemide paroxetine quinidine ranitidine ritonavir sertraline terbinafine histamine H1 receptor antagonists diphenhydramine chlorpheniramine demastine perphenazine hydroxyzine tripeleennamine	diethyl-dithiocarbamate disulfiram	HIV Antivirals: delaviridine indinavir nelfinavir ritonavir saquinavir amiodarone NOT azithromycin chloramphenicol cimetidine ciprofloxacin clarithromycin diethyl-dithiocarbamate diltiazem erythromycin fluconazole fluvoxamine gestodene grapefruit juice itraconazole ketoconazole mifepristone nefazodone norfloxacin norfluoxetine mibefradil star fruit verapamil

Inducers

1A2	2B6	2C8	2C19	2C9	2D6	2E1	3A4,5,7
broccoli brussel sprouts char-grilled meat insulin methly cholanthrene modafinil nafcillin? beta- naphthoflavone omeprazole tobacco	phenobarbital rifampin	rifampin	carbamazepine norethindrone NOT pentobarbital prednisone rifampin	rifampin secobarbital	dexamethasone rifampin?	ethanol isoniazid	HIV Antivirals: efavirenz nevirapine barbiturates carbamazepine glucocorticoids modafinil phenobarbital phenytoin rifampin St. John's wort troglitazone pioglitazone rifabutin



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

MCIC Group Name:

MCIC 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
<p>You must provide information with this DRUG EXCEPTION REQUEST that supports either of the following:</p> <ol style="list-style-type: none"> 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

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 FORMULARY DRUGS THAT REQUIRE PRIOR APPROVAL

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY Tier 2 3

MCIC Group Name:#

MCIC 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

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

FOR **duloxetine (Cymbalta)**

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY

MCIC Group Name:#

MCIC 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 duloxetine	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 Psoriasis Immunomodulators

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY

MCIC Group Name:#

MCIC Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

**NOTICE: This form is to be used for:
Prior Approval of etanercept
(Enbrel) or efalizumab (Raptiva)**

Drug Name	Strength	Dosing:	Quantity:
		Duration of Therapy:	

Patients will be approved for if they meet the following criteria. Please check the appropriate box and send supporting documentation of failure and/or contraindication to first line agents.

- Usage compatible with its FDA approval. Moderate to Severe Plaque Psoriasis (Photographs sent to document >10% BSA involvement)**
- Prescribed by a Dermatologist or dermatology dictation is submitted
- Required failure or contraindication to therapies in each category of topical, suppressive and remitting agents:

Topical Agents (Failure or contraindicated of at least 2 agents)

- Topical corticosteroids
- Topical tazarotene (Tazorac)
- Topical calcipotriene (Dovonex)

Suppressive Agents (Failure or contraindicated of at least 2 agents)

- Acitretin
- Cyclosporine
- Methotrexate

Remitting Agents (Failure or contraindicated of at least 2 agents)

- PUVA
- UVB

		Phone #	Fax #
Physician Name (Please Print)	Specialty	Location	

Approved thru:

3—6—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 **terbinafine (Lamisil)**

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY

MCIC Group Name:#

MCIC Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

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

Drug Name terbinafine	Strength: 250 mg	Dosing: Daily	Quantity: see below
Please check all appropriate boxes and complete the form		6 weeks Quantity #21 x 2	12 weeks Quantity #28 x 3

Approvals will be limited to 6 weeks for fingernails and 12 weeks for toenails

Mandatory pretreatment history and diagnostics

- No history of hepatitis **AND** pretreatment Serum Liver Transaminases confirmed to be normal
- No prior history of lamisil treatment (*speciality consultation is required for retreatment*)

Medical Necessity

- Diabetes Mellitus
- Peripheral Vascular Disease
- Severe immunodeficiency - please specify: _____
- Number of fingernails involved _____ *isolated involvement of one or two toenails is generally most reliably treated with permanent avulsion and we will consider a penlac exception for involvement of one or two fingernails*
- Number of toenails involved: _____ *penlac exception for involvement of one or two fingernails*

Documentation : Please attach relevant office notes.

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

Approved thru:

6 weeks 12 weeks

Denied

Records Requested

Rx History

Redirect

Medical Director Signature: _____ / ____ / ____



MERCYCARE HEALTH PLANS

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

FOR Oxycontin & All Other Long-Acting Narcotics

Name _____	DOB ____/____/____
MercyCare ID# _____	

FOR MERCYCARE USE ONLY

MCIC Group Name:# _____

MCIC Group #: _____ Effective date: _____

Tier 2 3 _____

GNRC's: _____ Transaction # _____

Entered by: _____

**NOTICE: This form is to be used for:
Prior Approval of Oxycontin & All Other Long-Acting Narcotics**

Drug Name: _____	Strength: _____	Dosing: _____	Quantity: _____
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Consultations obtained: (The requesting physician must provide these records as proof of their coordination of care with other specialties.)

Please check the appropriate box and send supporting documentation.

- Pain Management Date: ____/____/____ Physician: _____ Records Attached
- Surgical Date: ____/____/____ Physician: _____ Records Attached
- Medical Date: ____/____/____ Physician: _____ Records Attached
- Rehabilitation Medicine Date: ____/____/____ Physician: _____ Records Attached
- Psychiatry* Date: ____/____/____ Physician: _____ Records Attached
- Psychology* Date: ____/____/____ Counselor: _____ Records Attached

*Ongoing consultation with Psychiatry and/or Psychologist and Counselors is mandatory in patients who carry a psychiatric diagnosis.

- Addictions Medicine** Date: ____/____/____ Physician: _____ Records Attached

**Required if history of drug abuse or dependency, or if patient is showing drug seeking behaviors.

Diagnosis and Diagnostic Studies and Findings:

Current Short-Acting Narcotics Per Month: _____ # per Month _____

Plan To Be Reduced To: _____ # per Month _____

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

Approved thru:
2—3—6—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

MCIC Group Name:#

MCIC 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 ≤ 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 **testosterone**

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY

MCIC Group Name:#

MCIC Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

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

Drug Name	Strength	Dosing	Quantity
		Duration of Therapy Anticipated	

Anabolic steroids and the use of testosterone for sexual enhancement are an excluded pharmacy benefit.

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

- Used for hormone replacement therapy in males, for conditions associated with a deficiency or absence of endogenous testosterone
- Attach Testosterone level

Patients with primary hypogonadism will generally have elevated gonadotropin level (FSH or LH). Patients with hypogonadotropic hypogonadism such as idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation, may have low testosterone levels but normal or low range gonadotropin levels.

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

MCIC Group Name:#

MCIC 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 Topamax	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 #
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Physician Name (Please Print)	Specialty	Location
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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 **tegaserod (Zelnorm)**

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY

MCIC Group Name:#

MCIC Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

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

Drug Name tegaserod	Strength	Dosing: Twice Daily Before Meals	Quantity: (See Below), tegaserod is indicated for 4-6 weeks may repeat x 1
		Duration of Therapy: 12 weeks Quantity #60 x 3	

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

- Usage compatible with its FDA approval.** Tegaserod is indicated for the SHORT term treatment of women with IBS whose primary bowel symptom is constipation. Consideration will be given for continuous therapy when indicated
- The Patient has IBS diagnosis consistent with ROME II criteria: Abdominal discomfort or pain with a specified relationship to defecation or changes in stool frequency and consistency
- Serious attempts at symptomatic relief over 6 months with appropriate combinations of the following agents have clearly failed to give the patient relief: Bulking agents specifically Ispaghula husk, tricyclics, and laxatives.
- Evaluation and screened for psychological co-morbidities. (The primary literature has demonstrated that 54-90% of IBS patients meet criteria for an Axis I psychological disorder.)

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

Approved thru:

 / /

12 weeks

Denied

Records Requested

Rx History

Redirect

Medical Director Signature: _____ / ____ / ____



MERCYCARE HEALTH PLANS

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

FOR **Zofran**

Name	DOB
MercyCare ID#	

FOR MERCYCARE USE ONLY

MCIC Group Name:#

MCIC Group #:

Effective date:

Tier 2 3

GNRC's:

Transaction #

Entered by:

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

Drug Name	Zofran	Strength	Dosing	Quantity
			Duration of Therapy Anticipated	

The following guideline was taken from ACOG, February 2004 Practice Guidelines.

Patients will be approved for Zofran after they have tried and failed ALL the following agents and IV hydration has already been medically necessary. Please not agents are ADDED not tried sequentially.

Please fill in the following information and provide the supporting documentation.

- Dates done: Vitamin B₆, 10-25 mg, 3 or 4 times per day **AND** Doxylamine, 12.5 mg, 3 or 4 times per day.
- Dates done: **Added** Promethazine, 12.5-25mg every 4 hours, orally or rectally, **OR** Dimenhydrinate, 50-100mg every 4-6 hours, orally or rectally (*not to exceed 400 mg per day; not to exceed 200mg per day if patient also taking doxylamine*).
- Dates done: IV hydration has been necessary.
- Dates done: **Added** Metoclopramide, 5-10 mg every 8 hours.

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: _____ / ____ / ____