

# Bluegrass Family Health

April 2003  
FORMULARY

## GENERAL DEFINITION OF TERMS

**1<sup>st</sup> Tier Medications** – Typically generic medications. A generic medication is called by its chemical name, a manufacturer assigns a brand name. Also, the price of the generic medication is usually lower than that of a brand name medication. Both generic and brand name products have the same *active* ingredients. Overall, the generic medication is just as safe and effective as the brand name medication.

**2<sup>nd</sup> Tier Medications** – Typically preferred brand medications. Preferred brand medications may have generic equivalents. Once a branded medication is available as a generic product, the branded medication will move to non-preferred status and the generic medication will become the preferred medication.

**3<sup>rd</sup> Tier Medications**– Typically branded medications, not listed on 1<sup>st</sup> or 2<sup>nd</sup> Tier. Non-preferred medications are usually available at the highest copay tier for members with tiered pharmacy benefits. For members with a closed formulary benefit, prior plan approval is required for all non-preferred medications.

**Prior Plan Approval (PPA) or Prior Authorization (PA)** – Due to the nature of some medications, prior plan approval may be required for the medication to be covered at any copay tier. Medications that require PPA do so because of their potential for misuse and/or abuse and will require that plan criteria be met. If a medication requires PPA, the ordering physician should contact the plan's pharmacy benefit administrator. Prescriptions exceeding plan limitations (QL), (ST), and (SE) will also require PPA. See Restricted Medication List – Medications Requiring Prior Plan Approval (PPA).

**Step Therapy (ST)** – Step therapy is an electronic PPA process that takes place at the time the pharmacist files the claim. For example, on medications that are considered “second-line” agents, the system will look at the member's claims history and if a claim(s) for the required “first-line” medication(s) is found, the system will approve the claim. If “first-line” medications are not found, the system will not approve the claim and will send a message back to the pharmacy advising that the step therapy protocol has not been met. At that time, the pharmacy may contact your physician and request that they contact the plan for PPA. See Restricted Medication List – Medications Requiring Step Therapy (ST).

**Specialty Edit (SE)** – In order to be considered for coverage, Bluegrass Family Health (BFH) may require that some medications be written by a specialty physician. Medications not meeting specialty edit will require (PPA). See Restricted Medication List – Medications Requiring Specialty Edit (SE).

**Quantity Limits (QL)** – Quantity limits have been placed on medications to be consistent with the maximum dosages that the Food and Medication Administration (FDA) has approved to be both safe and effective. Medications where the quantity exceeds the FDA's maximum daily dose will require PPA. Prescriptions exceeding plan limitations will require PPA. See Restricted Medication List – Medications with Quantity Limits (QL).

## Preferred Drug List (PDL) - 1<sup>ST</sup> AND 2<sup>ND</sup> TIER MEDICATIONS

ACCOLATE	ALKERAN	ARIMIDEX	Benzocaine/Antipyrine Otic	Carisoprodol
Accu-Chek Active Glucometer	ALLEGRA	ASACOL	Benzonatate	CASODEX
Accu-Chek Advantage Glucometer	ALLEGRA D	Ascensia DEX2 Glucometer	Benzotropine Mesylate	CEENU
Accu-Chek Compact Glucometer	Allopurinol	Ascensia Elite Glucometer	Betamethasone Dipropionate	Cefaclor
ACCUPRIL	Alora	ASTELIN	Betamethasone Valerate	Cefadroxil
ACCURETIC	ALPHAGAN	Atenolol	Betaxolol	Cefuroxime
Acebutolol	Alprazolam	Atenolol/Chlorthalidone	Bethanechol	CEFZIL
Acetamin/Codeine ( <u>QL</u> )	ALTACE	Atropine	BETOPTIC S	CELEXA
Acetamin/Butalbital ( <u>QL</u> )	ALUPENT 650mcg	Atropine Sulfate	BILTRICIDE	Cephalexin
Acetamin/Hydrocodone ( <u>QL</u> )	Amantadine	ATROVENT INHALER	Bisoprolol	Cephadrine
Acetazolamide	AMARYL	AUGMENTIN 125, 250 only	Bisoprolol/HCTZ	Chloral Hydrate
Acetic Acid/ Hydrocort	Amidrine	AUGMENTIN ES	BRETHAIRE	Chlordiazepoxide
ACLOVATE	Amiloride/HCTZ	AUGMENTIN XR	Bromocriptine	CHLOROMYCETIN OPHTH.
ACTONEL	Amiodarone	Auroto	Bumetanide	Chloroquine Phosphate
Acyclovir - Oral	Amitriptyline	AVALIDE ( <u>ST</u> )	Bupropion	Chlorpromazine
ADALAT CC 90mg only	Amnesteem ( <u>QL</u> )	AVANDIA	Buspirone HCL	Chlorpropamide
ADDERALL 7.5, 12.5, 15mg only	Amoxicillin	AVANDAMET	Butalbital/APAP/Caffeine	Chlorthalidone
( <u>PPA over age 18</u> )	Amoxicillin, clavulanate	AVAPRO ( <u>ST</u> )	Butalbital/Aspirin/Caff - Tabs Only	Cholestyramine
ADDERALL XR ( <u>PPA over age 18</u> )	potassium 200, 400, 500, 875 only	Aviane	Butoconazole	Choline Mag. Trisal
ADVAIR DISKUS	Amphetamine Salt Combo 5, 10, 20, 30mg ( <u>PPA over age 18</u> )	Azathioprine	Butorphanol Tartrate ( <u>PPA</u> )	Cimetidine
AEROBID	Ampicillin	Aviane	( <u>QL</u> )	CIPRO
AEROBID M	Amylase/Lipase/Protease	AZOPT	CAFERGOT	CIPRO XR
AEROCHAMBER	Amylase/Lipase/Protease /Pancreatin	Bacitracin	Camila	Clemastine
AGENERASE	APAP/Dichlor/Isometh	Baclofen	Captopril	CLEOCIN VAGINAL CREAM
Albuterol	APPI	BACTROBAN	Captopril/HCTZ	CLEOCIN T LOTION
ALDARA		BECONASE	Carbachol	Clindamycin
		BECONASE AQ	Carbamazepine	Clindamycin Solution
		Belladonna/Phenobarb	Carbidopa/Levodopa	Clobetasol
		BENZAMYCIN		Clofibrate

**BOLD TYPEFACE** indicates product is available at the 1<sup>st</sup> tier copayment.  
CAPS indicates product is available at the 2<sup>nd</sup> tier copayment.

THE BLUEGRASS FAMILY HEALTH PREFERRED DRUG LIST HAS BEEN COMPILED TO RESPOND TO THE CONSTANTLY CHANGING NATURE OF MEDICATION THERAPY. THE LIST IS DYNAMIC AND IT IS SUBJECT TO CHANGE. YOU WILL BE NOTIFIED AT LEAST 30 DAYS IN ADVANCE OF ALL CHANGES. EVERY EFFORT HAS BEEN MADE TO INSURE THE ACCURACY OF THIS DOCUMENT. WE APOLOGIZE FOR ANY INCONVENIENCE ERRORS MAY CAUSE.

Clonazepam	Doxepin	Glipizide	LEXAPRO	Naproxen Sodium
Clonidine	<b>Doxycycline - Tabs, Caps Only</b>	GLUCAGON EMERGENCY KIT	<b>Lidocaine Viscous</b>	NARDIL
Clorazepate	DRITHOCREME	GLUCOVANCE	Lindane	NASACORT AQ
<b>Codeine/Aspirin (QL)</b>	DURAGESIC ( <b>PPA</b> )	Glyburide	LIPITOR	NATACYN
<b>Codeine/CPM/ PSE (QL)</b>	EFFEXOR	GOLYTELY	Lisinopril	NEBUPENT
Colchicine	EFFEXOR XR	GRIFULVIN V	<b>Lisinopril-HCTZ</b>	<b>Necon</b>
COLESTID	EFUDEX	Griseofulvin Ultramicrosize	Lithium Carbonate - All Forms	Nelova
COMBIVIR	ELIDEL ( <b>PPA over age 16</b> )	Guaifenesin	LIVOSTIN	Neomycin Sulfate
CONDYLOX	ELMIRON	Guaifenesin/Codeine	LOESTRIN (not FE)	Neomycin/Gram/Polymyx
COREG	ELOCON	Guaifenesin/Codeine/PSE	LOPRESSOR HCT	Neomycin/Polymyxin/HC
CORTEF 5, 10mg - NOT 20	EMCYT	Guaifenesin/PSE	Lorazepam	NEURONTIN
CORTENEMA	Enalapril	Guanabenz	LOTREL	NIASPAN
CORTISPORIN OPHTH.	Epinephrine	Guenfacine	LOTRISONE LOTION	<b>Nicardipine</b>
COTAZYM	Enpresse	Haloperidol	Lovastatin	NICLOCIDE
CORZIDE	EPIPIEN	HALOTESTIN	Low-Ogestrel	Nifedipine
CREON-5	EPIPIEN JR	HEXALEN	Loxapine	Nifedipine SR
CRIVIVAN	EPIVIR	HIVID	LYSODREN	NILANDRON
<b>Cromolyn Ophthalmic Solution</b>	EPIVIR HBV	Homatropine	MACROBID	<b>Nitrofurantoin</b>
<b>Cryselle</b>	ERGAMISOL	HUMALOG	Maprotiline	<b>Nitrofurantoin Macrocrystals</b>
CUPRIMINE	ERGOMAR	HUMULIN	MARINOL	Nitroglycerin Ointment
CUTIVATE	<b>Ergotamine Tartrate</b>	Hydralazine	MATULANE	Nitroglycerin Patches
CYCLESSA	<b>Ergotamine/Caff/Bella/ Pb</b>	Hydrochlorothiazide (HCTZ)	MAXAIR	Nitroglycerin Sublingual
<b>Cyclobenzaprine</b>	<b>Erlotamine/Caffeine</b>	Hydrocod/Acet ( <b>QL</b> )	Mebendazole	Nora-Be
CYCLOGYL 0.5%	Errin	Hydrocod/Homatropine ( <b>QL</b> )	Meclizine HCL	Nor QD
<b>Cyclopentolate</b>	Erythromycin	Hydrocortisone	Meclofenamate	Nortrel 7/7/7
<b>Cyclophosphamide</b>	ESCLIM	Hydrocortisone Rectal	Medrol	<b>Nortriptyline</b>
<b>Cyproheptadine</b>	<b>Esterified Estrogens</b>	Hydrocortisone/Pramox	Medroxyprogesterone	NORVIR
<b>Cyclosporin</b>	ESTRADERM	Hydromorphone	Megestrol	NOVOLIN
<b>Cyrcin</b>	Estradiol	Hydroxychloroquine	Menest	NOVOLOG
CYTOMEL	<b>Estradiol Patches</b>	Hydroxyurea	Meperidine	NULYTELY
CYTOTEC	ESTRATEST and HS	Hydroxyzine	Mephobarbital	NUVARING ( <b>QL</b> )
<b>Danazol</b>	<b>Estropiate</b>	Hyoscyamine Sulfate	MESTINON	<b>Nystatin - Oral Powder Not Covered</b>
DANTRIUM	ESTROSTEP	lbutrofen	METAPREL	OCUFLOX
DAPSONE	<b>Ethosuximide</b>	Imipramine	<b>Metaproterenol Oral</b>	OGEN VAGINAL CREAM
DARAPRIM	<b>Etodolac</b>	IMITREX tablets, nasal spray	Metformin	<b>Ogestrel</b>
DECLOMYCIN	EULEXIN	( <b>QL</b> )	<b>Methadone (QL)</b>	OPTICHAMBER
<b>Deltasone</b>	EURAX LOTION	Indapamide	<b>Methadose (QL)</b>	OPTIHALER
DEPAKOTE	EVISTA	INDERAL LA	Methazolamide	OPTIPRANOLOL
DEPAKOTE ER	EZ-SPACER	INDERIDE LA	Methimazole	<b>Oramorph SR (PPA) (QL)</b>
<b>Desipramine</b>	<b>Famotidine</b>	<b>Indomethacin</b>	Methocarbamol	Orphenadrine Citrate
<b>Desmopressin Nasal Spray</b>	FANSIDAR	Indomethacin SR	Methotrexate	Orphenadrine/ASA/Caff
<b>Dexamethasone</b>	FARESTON	INSPIREASE	Methylidopa	ORTHO-CYCLEN
<b>Dexamethasone/Neomyc</b>	FEMARA	INSULINS – ALL	<b>Methylphenidate (PPA over age 18)</b>	ORTHO EVRA ( <b>QL</b> )
<b>Dexameth/Poly/Neomycin</b>	<b>Fenoprofen</b>	INTAL INHALER	<b>Methylprednisolone</b>	ORTHO TRI-CYCLEN
<b>Dexchlorpheniramine</b>	FIV-ASA	INVIRASE	<b>Methyltestosterone</b>	OTIOTIBIC
<b>Dextroamphetamine (PPA over age 18)</b>	<b>Florinef Acetate</b>	Isoniazid	Metoclopramide	OVCON
<b>Diabetic Lancets - All</b>	FLOVENT	ISOPTO CARBACHOL, not 3%	Metoprolol Tartrate	OVRETTE
DIABETIC TEST STRIPS – ALL	<b>Fludrocortisone Acetate</b>	Isosorbide Dinitrate	METROCREAM	<b>Oxazepam</b>
<b>Diazepam</b>	Flunisolide	Isosorbide Mononitrate	METROGEL	<b>Oxaprozin</b>
DIBENZYLINE	Fluocinolone	JENEST	<b>Metronidazole</b>	OXISTAT
<b>Diclofenac Sodium</b>	<b>Fluocinolone Acetonide</b>	Kariva	MEXITIL	OXSORALEN
Dicloxacillin	Fluocinonide	Ketoconazole	Microgestin FE	<b>Oxybutynin</b>
Dicyclomine	Fluoride/Polyvit; /FE	Ketoprofen	MICRONOR	<b>Oxycodone/Acetamin (QL)</b>
DIFLUCAN ( <b>150mg QL</b> )	Fluoride/Vit A, D, C; /FE	Ketorolac Tromethamine	MIGRANAL ( <b>QL</b> )	<b>Oxycodone/Aspirin (QL)</b>
Diflunisal	Fluorometholone	Labetalol	<b>Minocycline - Susp. Not Covered at Generic Tier</b>	Papavarine CR
Digoxin	Fluoxetine HCL	Lactulose	Minoxidil	PARNATE
Diltiazem	Fluphenazine	LAMICTAL	MINTEZOL	PAXIL
Diltiazem SA Caps	Flurazepam	LANTUS	<b>Mirtazapine</b>	<b>Pemoline (PPA over age 18)</b>
Diltiazem SR	<b>Flurbiprofen Sodium</b>	LARIAM ( <b>QL</b> )	<b>Morphine (PPA) (QL)</b>	Penicillin VK
DIOVAN ( <b>ST</b> )	FML FORTE	LARODOPA	MYAMBUTOL	PENTASA
DIOVAN HCT ( <b>ST</b> )	Folic Acid	LESCOL XL	MYCELEX TROCHE	Pentoxifylline
Diphenoxylate/Atropine	FORADIL	Lessina	MYCOBUTIN	<b>Perphenazine</b>
<b>Dipivefrin</b>	FORTOVASE	Leucovorin	MYLERAN	Phenazopyridine
DIPROLENE GEL, LOTION	FULVICIN U/F	LEUKERAN	MYLOCEL	PHENERGAN 12.5MG, 25MG SUPP
DIPROLENE AF	Furosemide	LEVATOL	Nabumetone	<b>Phenobarbital</b>
<b>Dipyridamole</b>	FUROXONE	Levlen	Nadolol	Phenyleph/Pyril
<b>Disopyramide</b>	Gemfibrozil	Levobunolol	Naphazoline	Phenylephrine
<b>Disopyramide CR</b>	Gentamicin	Levora	Naproxen	
<b>Doxazosin Mesylate</b>	Gentamicin Sulfate	Levothyroxine		
	GLEEVEC ( <b>PPA</b> )	Levoxyl		

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Phenyl/Hydrocod/CPM	Propranolol	SINGULAIR	Timolol	VANCERIL DS
Phenylephrine/Prometh	Propranolol LA	SLO-BID	Tizanadine	Veetids
Phenytoin	Propranolol/HCTZ	Sodium Chloride	TOBRADEX	VELOSULIN
PHOSLO	Propylthiouracil	Sodium Polystyrene Sulfonate	Tobramycin Drops	VEPESID
PHOSPHOLINE IODIDE	PROTONIX <u>(ST)</u>	SORIATANE	TOBREX OINTMENT	Verapamil
Pilocarpine	PROVENTIL REPETABS	Sotalol	Tolazamide	Verapamil LA Tablets
Pindolol	PSE/Carbinox.	Spiroolactone	Tolbutamide	VESANOID
Piroxicam	PSE/DM	Spiroolactone/HCTZ	Tolmetin	VIDEX
PLENDIL	P-tiox/Phenir/Pyril	Sprintec	TONOCARD	VIRA A
POLYCITRA	PULMICORT RESPULES	STARLIX	TOPROL XL	VIRACEPT
Polymixin B Sulfate/TMP	PURINETHOL	STILPHOSTROL	Toresemide	VIRAMUNE
Polymyxin B/Bacitracin	Pyrazinamide	Sucrafate tablets	Trazodone	VIVELLE
Portia	Quinidine Gluconate	SULAR	Tramadol <u>(ST)</u>	VIVELLE DOT
Potassium Chloride 10mEq	Quinidine Sulfate	Sulfacetamide/Pred	Tretinoin- Limited to Acne	VOLMAX
Potassium Iodide	Quinidine Sulfate SR	SMZ/TMP	Only <u>(PPA over age 25)</u>	Warfarin Sodium
Pramoxine /Hydrocort	QVAR	Sulfasalazine	Triamcinolone	WELLBUTRIN SR <u>(PPA)</u>
Prazosin	Ranitidine	Sulfisoxazole	Triamcinolone/Nystatin	WIGRAINE
Prednisolone	RELION	Sulfonyleureas	Triamterene/HCTZ	XALATAN
Prednisolone Acetate	RESCRIPTOR	Sulindac	Triazolam	XELODA
Prednisolone Sodium	RETROVIR	SUSTIVA	Trifluoperazine	YASMIN
Phosphate	RHINOCORT	SYNTHROID	Trifluridine	YODOXIN
PREMARIN	RHINOCORT AQUA	SYNTOCINON	Trihexyphenidyl	YUTOPAR
PREMPHASE	RIDAURA	TAMBOCOR	Tri-Levlen	ZAROXOLYN
PREMPRO	Rifampin	Tamoxifen Citrate	Trimethobenzamide	ZERIT
PREVPAC <u>(QL)</u>	Rimantadine HCL	Temazepam	Trimethoprim	ZIAGEN
PRIMAQUINE	RISPERDAL <u>(SE)</u>	Terazosin	Trimox	ZOFRAN <u>(QL)</u>
Primidone	ROWASA	Terbutaline Sulfate	TRINALIN REPETABS	Zovia
Probenecid	SALAGEN	TESLAC	TRI-NASAL	ZOVIRAX OINTMENT
Procainamide	Salsalate	Tetracycline	TRI-NORINYL	ZYPREXA (SE and age 12 and
Procainamide SR	SANDIMMUNE 100mg/ml	Theophylline	Triple Sulfa Vaginal	over)
Prochlorperazine Maleate	Solution	Theophylline SR	Trivora	ZYPREXA ZYDIS (SE and
Promethazine	SANSERT	Thiethylperazine	Tropicamide	age 12 and over)
Promethazine/Codeine	SEBIZON	THIOGUANINE	UNIPHYL	Zyrtec Syrup
Promethazine DM	Selegiline	Thioridazine	UNIRETIC	
Prometh/Codeine/PE	Selenium Sulfide 2.5%	Thiothixene	UNIVASC	
Propafenone	SEREVENT	Thyroid, Desiccated	UROCIT-K	
Propoxyphene	SEREVENT DISKUS	TIAZAC	Ursodiol	
Propoxyphene-N/APAP <u>(QL)</u>	Silver Sulfadiazine	Ticlopidine	Valproic Acid	
Propoxy/ASA/Caffeine	SINEMET CR	TILADE INHALER	VANCERIL	

### 3<sup>rd</sup> TIER MEDICATIONS\*

All other medications, for which a prescription is written, and medications that under Federal law may only be dispensed by prescription and are FDA approved for the treatment of a covered diagnosis, are available at the 3<sup>rd</sup> tier copayment. Plan limitations and restrictions will still apply.

Drugs used to treat diagnoses that are excluded from the benefit will not be covered at any copayment tier.\*\*

\* All restrictions apply. See Restricted Medication List for specific details.

\*\* Examples include, but are not limited to, medications used for smoking cessation, weight loss, sexual dysfunction and cosmetic purposes.

**COMPOUNDED MEDICATIONS THAT ARE PREPARED BY A PHARMACIST AND ARE NOT FDA APPROVED IN THEIR FINAL FORM WILL NOT BE COVERED AT ANY COPAYMENT TIER.**

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# Bluegrass Family Health

## RESTRICTED MEDICATION LIST April 2003

### MEDICATIONS REQUIRING PRIOR PLAN APPROVAL (PPA)

**Prior Plan Approval (PPA) or Prior Authorization (PA)** – Due to the nature of some medications, prior plan approval may be required for the medication to be covered at any copay tier. Medications that require PPA do so because of their potential for misuse and/or abuse and will require that plan criteria be met. If a medication requires PPA, the ordering physician should contact the plan's pharmacy benefit administrator. Prescriptions exceeding plan limitations (QL), (ST), and (SE) will also require PPA.

Actiq	Dextrostat (over age 18)	Orfadin	Sarafem
Adderall (over age 18)	Differin (over age 25)	<b>Oxycodone – all products (not including acetaminophen or aspirin combinations)</b>	Soboxone
ADDERALL XR (over age 18)	DURAGESIC	OxyContin	Sporanox
<b>Amphetamine Salt Combo (over age 18)</b>	ELIDEL (over age 16)	OxyDose	Sporanox PulsePak
Androderm	GLEEVEC	OxyFast	Stadol Nasal Spray
Androgel	Kadian	<b>Pemoline (over age 18)</b>	Strattera
Avita	Lamisil	Provigil	Testoderm
Azelex	Mesnex	Rebetol	<b>Tretinoin (over age 25)</b>
<b>Butorphanol tartrate</b>	Metadate CD (over age 18)	Regranex	WELLBUTRIN SR
Concerta (over age 18)	<b>Methylphenidate (over age 18)</b>	Renova	Xyrem
Copegus	<b>Morphine</b>	Retin-A (over age 25)	Zelnorm
Cylert (over age 18)	MS Contin	Ritalin Brand (over age 18)	Zithromax 600mg
Dexedrine Brand (over age 18)	MSIR		Zyvox
<b>Dextroamphetamine (over age 18)</b>	<b>Oramorph SR</b>		

ALL INJECTABLE MEDICATIONS DISPENSED AT A RETAIL PHARMACY (NOT INCLUDING INSULIN PRODUCTS, IMITREX, RHOGAM, DEPO PROVERA, LUNELLE AND EPIPENS) REQUIRE PRIOR PLAN APPROVAL.

ALL MEDICATIONS USED IN THE TREATMENT OF INFERTILITY REQUIRE PRIOR PLAN APPROVAL. \*\*

\*\* Not all plans provide coverage for the treatment of infertility. Plans provided for the Commonwealth of Kentucky, as well as some other Bluegrass Family Health plans, do not cover infertility. Please refer to your Schedule of Benefits or contact Bluegrass Family Health Customer Service Department at (877) 205-6308 or (859) 335-3755.

### MEDICATIONS REQUIRING STEP THERAPY (ST)

**Step Therapy (ST)** – Step therapy is an electronic PPA process that takes place at the time the pharmacist files the claim. For example, on medications that are considered “second-line” agents, the system will look at the member’s claims history and if a claim(s) for the required “first-line” medication(s) is found, the system will approve the claim. If “first-line” medications are not found, the system will not approve the claim and will send a message back to the pharmacy advising that the step therapy protocol has not been met. At that time, the pharmacy may contact your physician and request that they contact the plan for PPA.

Aciphex	Cozaar	Nexium	<b>Tramadol</b>
Atacand	DIOVAN	Omeprazole	Ultracet
AVALIDE	DIOVAN HCT	Prevacid	Ultram
AVAPRO	Entocort EC	Prilosec	Valtrex
Benicar	Famvir	PROTONIX	Vioxx
Bextra	Hyzaar	Tevetan	Zetia
Celebrex	Micardis	Tevetan HCT	

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## MEDICATIONS REQUIRING SPECIALTY EDIT (SE)

**Specialty Edit (SE)** – In order to be considered for coverage, Bluegrass Family Health (BFH) may require that some medications be written by a specialty physician. Medications not meeting specialty edit will require (PPA).

Abilify (Psychiatry)  
Arava (Rheumatology)  
Enbrel (Rheumatology; Dermatology)  
Geodon (Psychiatry)

Humira (Rheumatology)  
Kineret (Rheumatology)  
RISPERDAL (Psychiatry)  
Seroquel (Psychiatry)

Tracleer (Cardiology/Pulmonary)  
ZYPREXA (Psychiatry)  
ZYPREXA ZYDIS (Psychiatry)

## MEDICATIONS WITH QUANTITY LIMITS (QL)

**Quantity Limits (QL)** – Quantity limits have been placed on medications to be consistent with the maximum dosages that the Food and Medication Administration (FDA) has approved to be both safe and effective. Medications where the quantity exceeds the FDA's maximum daily dose will require PPA. Prescriptions exceeding plan limitations will require PPA.

ACCUTANE  
**Acetaminophen w/codeine, butalbital, or hydrocodone**  
All hydrocodone products  
All meperidine products  
All methadone products  
All morphine products  
All oxycodone products  
Ambien  
Amerge – 9 per rx/ month  
**Amnesteem**  
Anzemet  
Arixtra  
**Butorphanol Tartrate - 4 per rx/month (PPA required)**  
Darvocet N-100  
DIFLUCAN 150mg – 1 per rx

Estring – 1 every 3 months  
Flonase - One Unit (16)  
Fragmin  
Helidac -1 rx per year  
IMITREX 50mg Tablets – 9 per rx/month  
IMITREX Nasal Spray – 6 Units per rx/month  
Imitrex Injection - 2 kits (4 Injections) per rx/month  
Kytril  
LARIAM - 12 per 3 months  
Lovenox  
Maxalt - 6 per rx/month  
MIGRANAL - 4 units per rx/month  
MS Contin (**PPA required**)  
NUVARING  
**Oramorph SR (PPA required)**  
ORTHO EVRA  
Oxycontin

Oxyfast (**PPA required**)  
Oxyir (**PPA required**)  
PREVPAC - 1 rx per year  
**Propoxyphene Napsylate w/Apap**  
Prozac Weekly  
Relenza - 1 unit per year  
Relpax  
Sarafem 20mg – 14 (**PPA required**)  
Stadol Nasal Spray – 4 per rx/month(**PPA required**)  
Sonata  
Tamiflu - 10 caps per year  
Toradol  
Tritec - 1 rx per year  
Zithromax 600mg (**PPA required**)  
ZOFRAN  
Zomig – 6 per rx/month

**BOLD TYPEFACE** indicates product is available at the 1<sup>st</sup> tier copayment.  
CAPS indicates product is available at the 2<sup>nd</sup> tier copayment.

*THE BLUEGRASS FAMILY HEALTH PREFERRED DRUG LIST HAS BEEN COMPILED TO RESPOND TO THE CONSTANTLY CHANGING NATURE OF MEDICATION THERAPY. THE LIST IS DYNAMIC AND IT IS SUBJECT TO CHANGE. YOU WILL BE NOTIFIED AT LEAST 30 DAYS IN ADVANCE OF ALL CHANGES. EVERY EFFORT HAS BEEN MADE TO INSURE THE ACCURACY OF THIS DOCUMENT. WE APOLOGIZE FOR ANY INCONVENIENCE ERRORS MAY CAUSE.*

# BluegrassFamily Health

- ✓ **APPROPRIATE USE PROGRAM** - Bluegrass Family Health's pharmacy benefit is based on an Appropriate Use Program. The goal of Appropriate Use is to provide high quality, safe and effective prescription medication therapy in collaboration with physicians and pharmacists. Under the Appropriate Use Program prescribed medications are monitored for correct dosing, quantity, length of therapy, inappropriate use, duplicated therapy, and medication interactions. Medications prescribed appropriately can provide one of the most effective means of therapy. However, the inappropriate use of medications may result in costly adverse events due to medication interactions or misuse.
- ✓ **PHARMACY BENEFITS** – For **HMO/EPO members, and POS/PPO members using the in-network pharmacy benefits**, you must use a participating pharmacy (except in an urgent or emergent situation) to access your Bluegrass Family Health pharmacy benefits. Presenting a valid ID card to the pharmacist is vital! To be eligible, medications must be processed online by your pharmacist; claims not filed online by a participating pharmacy may not be eligible for reimbursement. For **POS/PPO members using the out-of-network pharmacy benefits**, you must submit a detailed pharmacy receipt to Bluegrass Family Health for reimbursement. ALL requests for reimbursement must be accompanied by a written statement of why the claim was not filed by the pharmacy, and a pharmacy receipt that includes the name of the medication, the name of the pharmacy where the medication was purchased, the quantity dispensed, the days supply, and the amount the pharmacy charged. You will be reimbursed based on your benefits and the applicable copayment will be deducted from your reimbursement.

**If you are at the pharmacy and you do not have your Bluegrass Family Health identification card, or if the pharmacist is having trouble filing the claim online, please instruct the pharmacist to contact the Bluegrass Family Health Pharmacy Services Department at (877) 205-6308 or (859) 335-3755.**
- ✓ **BENEFIT EXCLUSIONS** — Bluegrass Family Health will not cover, at any copayment tier, any medications prescribed for the treatment of diagnoses excluded from coverage. The list of 1<sup>st</sup> and 2<sup>nd</sup> tier medications does not provide information regarding the specific coverage and limitations an individual member may have. Many members have specific exclusions and copays which are not reflected in this list. The list applies only to outpatient medications provided to members and does not apply to medications used in inpatient settings. If a member has any specific questions regarding their coverage, they should contact BFH. The following general exclusions pertain to all covered individuals:
  - A. Over the Counter (OTC) medications or their equivalents are not covered, unless otherwise specified in the list of 1<sup>st</sup> and 2<sup>nd</sup> tier medications.
  - B. Nicotine Smoking Cessation products (i.e., transdermal nicotine, nicotine gum) are not covered.
  - C. Medication Products specifically listed as not covered.
  - D. Any medication products used for cosmetic purposes, including hair loss, are not covered.
  - E. Experimental medication products or any medication product used in an experimental manner, or for conditions not approved by the FDA, are not covered.
  - F. Replacement of lost, stolen or spilled medication is not covered.
  - G. Medications on the Prior Plan Approval (**PPA**) List that do not meet the medical necessity criteria are not covered.
  - H. Weight loss medications are not covered.
  - I. Medications for the treatment of sexual dysfunction are not covered unless specified in plan documentation.
  - J. Compounded medications that are prepared by a pharmacist and are not FDA-approved in their final form are not covered.
  - K. Medications not approved by the FDA.
- ✓ **URGENT AND EMERGENT SITUATIONS** – If you are out of the area and need to have a prescription filled for an urgent or emergent condition, for your convenience you may take the prescription and your Bluegrass Family Health identification card to a participating chain pharmacy such as Wal-Mart, Rite-Aid, K-Mart, or Walgreens and pay just your copayment. If the pharmacist has difficulty processing the claim, he or she may contact the Pharmacy Help Desk at (877) 205-6308 . If you do not have access to a participating pharmacy you may take the prescription to a non-participating pharmacy and file the pharmacy receipt for reimbursement.
- ✓ **REFUNDS** – If you pay out-of-pocket for a prescription at a participating pharmacy, you may return to the pharmacy within 30 days, have the claim processed online and be reimbursed the eligible out-of-pocket expenses. If you are reimbursed by Bluegrass Family Health for an eligible out-of-pocket prescription expense, you may be paid based on the Bluegrass Family Health's contracted pharmacy rates. These contracted rates are usually less than the pharmacy's retail charges, resulting in a net cost to you greater than your usual copayment. Requests for out-of-pocket prescription reimbursement received more than six months after the prescription was filled will not be eligible for reimbursement.
- ✓ **DISPENSE AS WRITTEN (DAW)** – State law requires that when there is a generic medication available for a branded medication that the pharmacist dispense the generic product unless otherwise stated by the physician to dispense as written, or it is requested by the patient. If a member specifically requests a brand name medication, the member will be subject to their 3<sup>rd</sup> tier copayment and may be responsible for any difference in price between the generic medication and the brand name medication.
- ✓ **REPLACEMENT MEDICATIONS** – Bluegrass Family Health does not cover the replacement of medications that are lost, stolen or spilled.
- ✓ **PHARMACY SERVICES DEPARTMENT** – Bluegrass Family Health has a team of employees that is dedicated to assisting you with any questions or concerns you have regarding your prescription drug benefits. You may contact Pharmacy Services at (877) 205-6308 or (859) 335-3755

*For additional information please see the Bluegrass Family Health Preferred drug list at*

[www.bluegrassfamilyhealth.com](http://www.bluegrassfamilyhealth.com).

**BOLD TYPEFACE** indicates product is available at the preferred generic copayment tier.  
**CAPS** indicates product is available at the preferred brand copayment tier.

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