

Coverages/Exclusions at Retail and Mail							
Client Name:		HealthComp					
Parent Group Name (if applicable):		Nasomah Health Group					
Benefit Plan Name:							
Benefit Plan ID (add when assigned by operations):		2176AQA1					
Drug Coverage Values and Definitions							
C	Covered: Medication will be covered under the plan.						
E	Excluded: Medication will be excluded. Message at pharmacy will be "Drug Not Covered".						
A	Prior Authorization: Client managed option of entering a standard prior authorization for a group of medications, or entering a standard prior authorization after the limits are met (i.e. age, quantity etc.). Message at pharmacy will be "PA required call 1-800-755-7247".						
P	Clinical Prior Authorization: WHI will handle the clinical prior authorization for a group of medications or a CPA after the limits are met (i.e. age, quantity etc.). Message at pharmacy will be "PA required, call 1-877-665-6609". Medication management routing sheet is required. CPA is only for limited drug categories and includes a charge per review.						
S	Step Care Therapy: WHI will handle the step care therapy for a group of medications which requires one or more prerequisite medications must be tried before a "step therapy" medication will be covered, unless medical exception authorization is received. Message at pharmacy will be "PA required, call 1-877-665-6609" plus prerequisite medication noted. Medication management routing sheet is required. SCT is only for limited drug categories and includes a charge per review.						
D	Discounted: Excluded drugs processed at 100% copay.						
Drug Category	Drug Coverage		Limits				
	Retail	Mail	Retail		Mail		
			Units	Days/Age	Units	Days/Age	
COSMETIC DRUGS							
Hair Treatments (e.g. Propecia, Rogaine, Vaniqa)	E	E					
Pigmenting/De-pigmenting (e.g. Eldoquin, Oxsoralen, Solage, Solaquin, Solaquin Forte)	E	E					
Anti-Wrinkle (e.g. Renova)	E	E					
DIABETIC SUPPLIES							
Blood Glucose Testing Machines	C	C					
Blood Sugar Diagnostics (e.g. blood test strips)	C	C					
Insulin	C	C					
Insulin Syringes/Needles	C	C					
Lancets	C	C					
Urine Tests	C	C					
INJECTABLES							
Outpatient Injectables (e.g. Ana-Guard, Ana-Kit, D.H.E. 45, Epipen, Fuzeon, Glucagon, Methotrexate)	C	C					
Syringes (non-Insulin)	C	C					
Miscellaneous Injectables (e.g. antibiotics)	E	E					
ALL OTHER							
Biologicals (e.g. allergens, serums, vaccines) <i>If you elect to cover flu & pneumonia vaccines through the Walgreens Flu and Pneumonia program, then Biologicals should be Excluded under the Rx Benefit. Covering these vaccines within the Biologicals category may lead to members being charged an administration fee by the pharmacy in addition to the applicable copay.</i>	E	E					
Compounds with legend ingredients (meds mixed using at least one ingredient that requires a prescription)	C	C					
Contraceptives – Abortive (e.g. Mifeprex)	C	C					
Contraceptives – Emergency (e.g. PlanB, Preven)	C	C					
Contraceptives – Implantable (e.g. Implanon)	C	C					
Diaphragms and IUD's	C	C					
Diflucan 150mg	C	C	2	Per 25 days	6	Per 25 days	
Flu Medications- Recommend 5 days supply per 25 days. Exclude at mail (<i>Tamiflu 10 capsules for 45mg & 75mg & 20 capsules for 30mg, Relenza 1 package per 25 days</i>)	C	E	10	Per 25 days			

Fluoride Preps (oral fluoride – e.g. Fluorotab, Karidium, Luride, Lozi-tabs, Phos-Flur)	E	E				
Infertility Non-Injectable (e.g. Clomid)	E	E				
Miscellaneous Medical Supplies – Legend (Ostomy drainage bags, splints, graftskin, ointment dressings)	E	E				
Over-the-Counter Medications	E	E				
Prenatal Prescription Vitamins (e.g. Natafort)	C	C				
Schedule V Drugs (e.g. Phenergan with codeine, Robitussin A-C, Tussi-Organidin-S, Lomotil)	C	C				
Toradol <i>Recommend 5 days supply per Rx. Exclude at mail.</i>	C	E	5	DS/25 days		
Vitamins Legend – Non-Prenatal (e.g. Niacin, Cyanocobalamin)	E	E				
Zyvox <i>Recommend 14 days supply per Rx. Exclude at mail.</i>	C	E	14	DS/Rx		
30-DAY SUPPLY CATEGORIES (Excluded at mail)						
Acne – Oral (e.g. Accutane, Amnesteem) <i>Limited to 30-day supply only through the retail pharmacy. Excluded at mail.</i>	C	E				
MEDICATION MANAGEMENT PROGRAMS						
Footnotes:						
‡ Requires minimum of four months of prescription history.						
* Denotes contract implications may apply. Please refer to Rebate Routing Sheet for details.						
§ Medication Management programs are maintained and updated as medications are FDA approved within a defined therapeutic class. Clinical criteria may be updated periodically or as necessary based on new clinical data from guidelines or published literature to reflect current clinical practice.						
ADHD						
ADHD/Narcolepsy (e.g. Dexedrine, Ritalin) <i>Recommended to cover through age 19, then CPA</i>	C	C	Cover thru age 19		Cover thru age 19	
Strattera‡	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
Allergy						
Leukotrienes*‡ (e.g. Singulair, Accolate, Zylflo)	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
OTC Non-Sedating Antihistamines (NSA) <i>Choose one of the following:</i>	E	E	<input type="checkbox"/> OTC NSA Step Care Therapy (Start Date _____) <input type="checkbox"/> OTC/Rx Generic NSA Step Care Therapy (Start Date _____)			
Anabolic Steroids						
Anabolic Steroids – Injectable (e.g. Deca-Durabolin, Virilon IM) <i>Recommend CPA</i>	A	A				
Anabolic Steroids – Oral (e.g. Anadrol-50, Android Testred, Oxandrin, Winstrol) <i>Recommend CPA</i>	A	A				
Anabolic Steroids – Topical (e.g. Androderm, Androgel, Testoderm) <i>Recommend CPA</i>	A	A				
Antiasthmatics and COPD						
Long Acting β -Agonists*‡ (e.g. Serevent, Foradil, Advair)	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
Antidepressants						
Antidepressant*‡ (e.g. Prozac, Paxil, Zoloft)	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
Wellbutrin SR/XL‡	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
Antiemetics						
Antiemetics – (e.g. Kytril, Zofran) <i>Recommend quantity limit 7 days supply per 25 days, 21 days supply per 75 days, then CPA.</i>	C	C	7	Per 25 days	21	Per 75 days
Antifungal						
Lamisil/Sporanox <i>Recommend CPA.</i>	C	C				

Penlac <i>Recommend CPA.</i>	E	E	
Atopic Dermatitis			
Atopic Dermatitis (e.g. Elidel, Protopic) <i>Recommend CPA.</i>	C	C	
Cardiovascular			
Generic Statins* (e.g. Lipitor, Pravachol, Crestor, Vytorin, Zocor)	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)
Ranexa <i>Recommend CPA followed by a DACON limitation.</i>	C	C	<input type="checkbox"/> CPA - Followed by a DACON limitation
Diabetes			
Byetta* <i>Recommend CPA followed by a quantity limitation.</i>	C	C	<input type="checkbox"/> CPA - Followed by a Quantity Limit (1 pre-filled Pen per 25 days)
Diabetic Wound Healing Agents (e.g. Regranex) <i>Recommend CPA</i>	C	C	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors** (e.g. Januvia)	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)
Symlin <i>Recommend CPA followed by a quantity limitation.</i>	C	C	<input type="checkbox"/> CPA - Followed by a Quantity Limit (Type 1 Diabetes - 3 vials per 25 days, Type 2 Diabetes - 4 vials per 25 days)
Gastrointestinal			
Proton Pump Inhibitors (e.g. Prevacid, Aciphex, Nexium) <i>Choose one of the following:</i>	C	C	<input type="checkbox"/> OTC Prilosec** Step Care Therapy (Start Date _____) <input type="checkbox"/> OTC/Rx Generic PPI*‡ Step Care Therapy (Start Date _____) <input type="checkbox"/> Preferred First PPI Step Care Therapy (Start Date _____)
Infertility			
Crinone 8% <i>Recommend CPA.</i>	A	A	
Insomnia			
Insomnia* (e.g. Ambien, Restoril, Sonata) <i>Choose one or both of the following:</i>	C	C	<input checked="" type="checkbox"/> Quantity limit with CPA Limit 90 per 144 DS, then CPA
	C	C	<input checked="" type="checkbox"/> Daily average limit of 1
Non-Benzodiazepine Insomnia Agents** (e.g. Ambien, Rozerem, Lunesta)	C	C	<input type="checkbox"/> Step Care Therapy followed by a DACON limitation (Start Date _____)
Lifestyle			
Acne – Topical (e.g. Retin-A, Avita, Differin) <i>Age edit with CPA. Recommended to cover through age 24, then CPA.</i>	C	C	
Botulinum Toxins (e.g. Myobloc, Botox) <i>Recommend CPA. Limited to 30-day supply only through the retail pharmacy. Excluded at mail.</i>	A	A	
Contraceptives – Oral/Topical/Intravaginal <i>Recommend CPA. (For clients that have 90-day retail and/or mail benefit design, Seasonale will be allowed for 91 days.)</i>	C	C	
Contraceptives – Injectable (e.g. Depo-Provera, Lunelle) <i>Recommend CPA.</i>	C	C	
Impotency (e.g. Viagra) <i>Choose one of the following:</i> <i>All options have age edit (not covered for 18 and younger) Assumption is to triple quantity limits at mail, if covered.</i>	C	C	<input checked="" type="checkbox"/> Quantity limit 10 per 30 DS. No CPA applies.
			<input type="checkbox"/> CPA (max quantity 8)
			<input type="checkbox"/> Quantity limit 8 per 25 DS, then CPA (max quantity 12)
Obesity (e.g. Meridia, Phentermine, Xenical) <i>Age edit with CPA (not covered for 17 and younger)</i>	C	C	<input type="checkbox"/> Age edit with CPA
Migraine			

Migraine – Injectable/Nasal/Oral <i>Assumption is to triple quantity limits at mail, if covered.</i>	C	C	<input checked="" type="checkbox"/> Injectable Quantity limit 8 per 25 DS <input checked="" type="checkbox"/> Nasal Quantity limit 8 per 25 DS <input checked="" type="checkbox"/> Oral Quantity limit 18 per 25 DS			
Neuropathic Pain						
Lyrica**	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
Ophthalmic Agents						
Ophthalmic Immunomodulators* (e.g. Restasis) <i>Recommend CPA followed by quantity limit. One package of 60 single use vials per 25 days</i>	C	C	<input type="checkbox"/> CPA – Followed by Quantity Limit (60 per 25 DS)			
Osteoporosis Agents						
Oral Bisphosphonates*	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
Pain Management						
Actiq <i>Choose one of the following:</i>	C	C	<input type="checkbox"/> CPA - Followed by a DACON limitation <input type="checkbox"/> Quantity limit then CPA Quantity Limit 42 units per 365 days.			
Butorphanol – Quantity limit with CPA. <i>Recommend limit 2 bottles (5ml/25 days, 6 bottles/75 days, then CPA.</i>	C	C	2 bottles	Per 25 Days	6 bottles	Per 75 Days
Cox-2 Inhibitors † (e.g. Celebrex) <i>Age edit with Step Care (Automatically covered for ages 60 years and older; step care review for 59 years of age and younger)</i>	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			
Duragesic – Quantity limit with CPA. <i>Recommend 15 per 25 days supply/45 per 75 days supply, then CPA.</i>	C	C				
Fentora <i>Choose one of the following:</i>	C	C	<input type="checkbox"/> CPA - Followed by a DACON limitation <input type="checkbox"/> Quantity limit then CPA Quantity Limit 42 units per 365 days			
OxyContin*	C	C	<input type="checkbox"/> Quantity limit with CPA Daily average limit of 4, then CPA			
Topical Analgesic Agents* <i>Assumption is to triple quantity limits at mail, if covered.</i>	C	C	<input type="checkbox"/> CPA – Followed by Quantity Limit Lidoderm Quantity limit 90 per 25 DS Flector Patch Quantity limit 60 per 25 DS Pennsaid Soln Quantity limit 3 Bottles per 25 DS Voltaren Gel Quantity limit 10 tubes per 25 DS			
Smoking Cessation						
Smoking Cessation	C	C	Select coverage type: <input type="checkbox"/> CPA <input type="checkbox"/> CPA with \$500.00 limit Select type of medication coverage: <input type="checkbox"/> Rx <input checked="" type="checkbox"/> Rx and OTC			
Urology						
Benign Prostatic Hyperplasia† (e.g. Proscar, Avodart)	C	C	<input type="checkbox"/> Step Care Therapy (Start Date _____)			

ALL OTHER DRUGS NOT MENTIONED ABOVE WILL BE COVERED.

Note: Age edits, gender edits, and quantity limits are WHI's clinical recommendations.