Retiree Health Plan
Prescription Drug Benefit Handbook

MY PAY + BENEFITS

MY MONEY
- Market-Competitive Compensation
- Retirement Programs
- Life + Accident Insurance
- Flexible Spending Accounts
- Caregiver Discounts

MY HEALTH
- Health Insurance
- Prescription Drug Program
- Dental Insurance
- Vision Insurance
- Short + Long-term Disability

MY WELL-BEING
- Paid Time Off (PTO)
- Healthy Choice
- Wellness Programs
- Employee Assistance Program
- Emergency Fund Programs

MY CAREER
- Merit Rewards
- Caregiver Celebrations
- Tuition Reimbursement
- Career Development

July 2020
Welcome to the Cleveland Clinic Retiree Health Plan, hereafter referred to as the “Health Benefit Program” (HBP) Prescription Drug Benefit Program. As a Cleveland Clinic or Regional hospital retiree, you have access to a comprehensive prescription drug benefit. To help you understand the benefits available to you under this program, the HBP has developed this Prescription Drug Benefit and Formulary Handbook (hereafter referred to as the Handbook). This Handbook is updated as needed.

This Handbook defines your prescription drug coverage. We encourage you to take the time to read this information carefully. You may wish to consider taking this Handbook with you when you visit your healthcare provider(s) to aid in the selection of effective, safe, and value-based prescription drug therapy. This information is also available on the Cleveland Clinic website at https://employeehealthplan.clevelandclinic.org.

You will find helpful information about:
- Where you can get your prescriptions filled;
- The HBP Prescription Drug Formulary;
- Prior Authorization and Formulary Exception Program;
- Quantity Limit and Step Therapy Programs; and
- The Specialty Drug Program

**Note to SilverScript Members:** This Handbook is for both Medicare eligible and approved and non-Medicare retirees. The section for SilverScript members (retirees who are Medicare eligible) includes abbreviated administrative information specifically for SilverScript. More detailed information can be found in your “Evidence of Coverage” sent to you by SilverScript.

Adherence to your prescribed drug therapy plan is critical to improving your quality of life and decreasing your out-of-pocket expenses in the long run. The HBP looks forward to assisting you with your prescription drug benefit needs.
# Table of Contents

## CLEVELAND CLINIC HBP PRESCRIPTION DRUG BENEFIT
- Prescription Drug Benefit Administration ................................................................. 1
- Prescription Drug Benefit Program Overview ............................................................. 1
- Non-Medicare HBP Prescription Drug Benefit Chart .................................................... 2
- Medicare Eligible and Approved HBP Prescription Drug Benefit Chart ......................... 3
- Prescription Drug Benefit Program Overview (continued)
  - Understanding the Formulary ..................................................................................... 4
  - Filling Your Prescriptions ....................................................................................... 4
  - Cleveland Clinic/Akron General Pharmacies and Specialty/Home Delivery Pharmacy .... 4
    - Cleveland Clinic/Akron General Pharmacies – Locations and Hours of Operation ... 5
    - Cleveland Clinic Home Delivery Pharmacy Ordering Instructions ......................... 7
- Advantages of Utilizing the Cleveland Clinic/Akron General Pharmacies and Home Delivery Pharmacy ................................................................. 7
- CVS/caremark or SilverScript Retail Pharmacy Network ........................................... 8
- CVS/caremark or SilverScript Mail Service Program ................................................ 8
  - New Prescriptions .................................................................................................. 8
  - Mail Service Refills ................................................................................................ 8
- Prescription Drug Benefit Guidelines ........................................................................... 8
  - Prescription Drug Benefit – Deductible ................................................................ 8
  - Deductible ............................................................................................................ 9

## HEALTH BENEFIT PROGRAM PRESCRIPTION DRUG BENEFIT FOR NON-MEDICARE ELIGIBLE RETIREES *(Administered by CVS/caremark)*
- Generic Medication Policy ....................................................................................... 9
- Prior Authorization .................................................................................................. 9
  - Pharmaceuticals Requiring Prior Authorization ...................................................... 10
- Formulary Failure Review Process ........................................................................... 10
- Instructions for a Physician on How to Complete the Prior Authorization, Formulary Exception and Appeal Form ................................................................. 14
  - Prior Authorization, Formulary Exception and Appeal Form .................................. 14
- Benefits and Coverage Clarification .......................................................................... 14
  - Breast Cancer Prevention Coverage .................................................................... 14
  - Contraceptive Coverage ...................................................................................... 15
  - Oral Medications for Onychomycosis (Nail Fungus) ............................................. 15
  - Over-The-Counter (OTC) Medications ................................................................. 15
  - Statin Medications for Primary Prevention of Cardiovascular Disease .................. 16
  - Non-Preferred Generic Medications .................................................................... 17
  - Lifestyle Medications .......................................................................................... 17
Table of Contents (continued)

Non-Covered Medications ............................................................................................................................ 17
Brand Name .................................................................................................................................................. 17
Brand and Generic Versions ........................................................................................................................ 18
Pharmacy Management Programs ............................................................................................................... 21
Mandatory Maintenance Drug Program ...................................................................................................... 21
Medications Limited by Provider Specialty ................................................................................................. 21
Quantity Level Limits ..................................................................................................................................... 22
Split Fill Program ........................................................................................................................................ 26
Mandatory Statin Cost Reduction Program
  Tablet Splitting .............................................................................................................................................. 26
  Generic Statins .............................................................................................................................................. 27
Step Therapy Program ................................................................................................................................... 27
Specialty Drug Benefit .................................................................................................................................... 28
Specialty Drug Copay Card Assistance Program ......................................................................................... 31
Prescription Drug Benefit Exclusions ......................................................................................................... 32

HEALTH BENEFIT PROGRAM PRESCRIPTION DRUG BENEFIT FOR MEDICARE ELIGIBLE RETIREES AND APPROVED RETIREES (Administered by SilverScript Insurance Company)
Generic Medication Policy .......................................................................................................................... 33
Prior Authorizations/Coverage Decisions/Appeals Process ........................................................................ 33
  Appointing a Representative .......................................................................................................................... 34
  Coverage Stages ........................................................................................................................................... 34
  Deductible ..................................................................................................................................................... 34
  Initial Coverage Stage ................................................................................................................................. 34
  Coverage Gap Stage .................................................................................................................................... 35
  Catastrophic Coverage Stage ....................................................................................................................... 35
Request for Redetermination of Medicare Prescription Drug Denial (Appeal) ........................................... 35
  Redetermination of Medicare Prescription Drug Denial Form Sample ........................................................... 36
  SilverScript Medicare Part D Coverage Determination Request Form ........................................................... 36
Benefits and Coverage Clarification ............................................................................................................... 36
  Contraceptive Coverage ............................................................................................................................... 36
  Quantity Level Limits .................................................................................................................................. 37
Prescription Drug Benefit Exclusions ........................................................................................................... 38

FORMS
Prior Authorization, Formulary Exception and Appeal Form (Non-Medicare) .................................................. 39
USPSTF Copay Free Statin Coverage Request Form ....................................................................................... 40
Medicare Part D Coverage Determination Request Form (Medicare Eligible and Approved) ....................... 41
Prescription Drug Benefit Administration

The HBP Prescription Drug Benefit is administered through CVS/caremark™ under the guidance of the Pharmacy Coordination Department and is divided into two groups: Non-Medicare eligible and Medicare eligible and approved retirees.

Both CVS/caremark and SilverScript have dedicated toll-free Customer Service phone numbers, e-mail, or website addresses available 24 hours a day, seven days a week:

CVS/caremark
866.804.5876
Email: customerservice@caremark.com

SilverScript® Insurance Company
866.693.4617
Website: https://clevelandclinic.silverscript.com

If your CVS/caremark/SilverScript Prescription card is lost or stolen, contact CVS/caremark/SilverScript at the phone number or e-mail address listed above for a replacement card.

Members can also go to both the applicable websites for the following:

- Prescription Refills for CVS/caremark Mail Service
- Order Status
- Pharmacy Locations
- Benefit Coverage
- Request Forms
- Frequently Asked Questions
- 13 Month Drug History
- Additional Health Information

When you call CVS/caremark or visit their website, please have the following information available:

- Member’s ID Number
- Member’s Date of Birth
- Payment Method

Prescription Drug Benefit Program Overview

The HBP Prescription Drug Benefit charts on pages 2 and 3 of this Handbook summarize drug categories such as generic, preferred, non-preferred, and specialty drugs, as well as deductible and out-of-pocket maximum information. Use this Handbook as a resource for information regarding:

- Options for filling your prescription medications;
- The HBP Prescription Drug Benefit guidelines;
- Benefits coverage and clarification;
- Pharmacy Coordination programs; and
- The HBP Prescription Formulary (non-Medicare members). SilverScript members have a different formulary which is mailed under separate cover by SilverScript. Both formularies are also available on our website at https://employeehealthplan.clevelandclinic.org.

Note: In addition to this Handbook, SilverScript members receive an “Evidence of Coverage” handbook which includes more detailed information relative to SilverScript’s coverage.

CVS/caremark is a trademark of CVSHealth Inc.
SilverScript is a registered trademark of SilverScript Insurance Company.
Non-Medicare HBP Prescription Drug Benefit  
*Administered Through CVS/caremark*

The Following Is a Summary Overview of the Prescription Drug Benefit for 2020

<table>
<thead>
<tr>
<th>Categories</th>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>TIER 4</th>
<th>Drugs &amp; Items at Discounted Rate</th>
<th>Non-Covered Drugs &amp; Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$200 Individual $400 Family</td>
<td>(Waived for generic prescriptions if obtained from a Cleveland Clinic/Akron General Pharmacy)</td>
<td></td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Member % Co-insurance</td>
<td></td>
<td>15%</td>
<td>45%</td>
<td>20%</td>
<td>Member Pays 100% of the Discounted Price</td>
<td>Not Available through Rx Plan</td>
</tr>
<tr>
<td>Cleveland Clinic/Akron Gen. Pharmacies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>up to 90-Day Supply</td>
<td></td>
<td>25%</td>
<td>50%</td>
<td>20%</td>
<td>Member Pays 100% of the Discounted Price</td>
<td>Not Available through Rx Plan</td>
</tr>
<tr>
<td>Member % Co-insurance</td>
<td></td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVS Store Pharmacies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-Day Supply</td>
<td></td>
<td>20%</td>
<td>50%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Service Program:</td>
<td></td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90-Day Supply</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleveland Clinic/Akron Gen. Pharmacies including Specialty &amp; Home Delivery:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-insurance?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Brand Name Drugs Not Listed in the Drug Formulary starting on page 35 and Certain Generic Drugs listed on page 16.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs1,2</td>
<td>See complete list of Specialty Drugs on pages 28–30.</td>
<td>See complete list of Lifestyle Drugs on page 17.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over-the-Counter Drugs</td>
<td>For a full list of non-covered drugs and certain OTC Medications that are covered, see pages 15, 17–20.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an Annual Out-of-pocket Maximum?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Components of Each Category</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Pharmacies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-insurance?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>CVS/caremark Mail Service Program:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-insurance?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Diabetic Supplies3</td>
<td>Asthma Delivery Devices3</td>
<td>and Prescription Vitamins4</td>
<td>Co-insurance 20%</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pharmacies5 in the Retail Network</td>
<td>Cleveland Clinic/Akron General Pharmacies (including Weston, Akron General Medical Center, Union Hospital Outpatient Pharmacy) Cleveland Clinic Specialty Pharmacy, Cleveland Clinic Home Delivery Pharmacy, CVS store pharmacies (CVS pharmacies located in Target stores), CVS/caremark Mail Service, CVS/specialty Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Benefit Program Includes: generic oral contraceptives — covered for Marymount HBP participants for clinical appropriateness only under the HBP.

1. Certain specialty medications are included in the Copay Card Assistance Program. Please refer to the Prescription Drug Benefit Handbook.

2. There are 3 options for obtaining medications in the category listed above. The options are: 1. Cleveland Clinic/Akron General Pharmacies in Akron, Cleveland, Dover, and Weston, 2. Cleveland Clinic Specialty Pharmacy, and 3. CVS/specialty Pharmacy. Specialty Drug prescription orders (first fill and refills) are limited to a one month supply.

3. Diabetic Supplies — All diabetic supplies covered, except for most insulin pumps and insulin pump supplies (with the exception of Omnipod Dash), continuous glucose monitors, and continuous glucose monitor supplies (which are covered under the medical benefit). Diabetic supplies covered under the prescription drug benefit include: needles purchased separately, test strips, lancets, glucose meters, syringes, lancing devices, injection pens, and Omnipod Dash. Members with type 1 diabetes who are under 18 years of age will have no out-of-pocket expense for their insulins and diabetic supplies covered under the prescription drug benefit.

Asthma Delivery Devices — Includes spacers used with asthma inhalers.

4. Refers to vitamins that require a prescription from your healthcare provider.

5. Members can use any Cleveland Clinic/Akron General pharmacy or any CVS store pharmacy for obtaining acute care medications (e.g., single course of antibiotic therapy) and for the first fill of maintenance medications but must use a Cleveland Clinic/Akron General Pharmacy or CVS/caremark Mail Service Program for all maintenance medications.

---

**Components of Each Category:**

- **Cleveland Clinic/Akron Gen. Pharmacies:**
  - Is there a Minimum or Maximum to the Rx % Co-insurance?
  - Yes
  - Yes
  - Yes
  - Yes

- **CVS Store Pharmacies:**
  - Is there a Minimum or Maximum to the Rx % Co-insurance?
  - Yes
  - Yes
  - Yes
  - Yes

- **Mail Service Program:**
  - Is there a Minimum or Maximum to the Rx % Co-insurance?
  - Yes
  - Yes
  - Yes
  - Yes

- **Diabetic Supplies:**
  - All diabetic supplies covered, except for most insulin pumps and insulin pump supplies (with the exception of Omnipod Dash), continuous glucose monitors, and continuous glucose monitor supplies.

- **Asthma Delivery Devices:**
  - Includes spacers used with asthma inhalers.

- **Prescription Vitamins:**
  - Refers to vitamins that require a prescription from your healthcare provider.

---

**Pharmacies in the Retail Network:**

- Cleveland Clinic/Akron General Pharmacies (including Weston, Akron General Medical Center, Union Hospital Outpatient Pharmacy)
- Cleveland Clinic Specialty Pharmacy
- Cleveland Clinic Home Delivery Pharmacy
- CVS store pharmacies (CVS pharmacies located in Target stores)
- CVS/caremark Mail Service
- CVS/specialty Pharmacy

---

**Prior Authorization Required:**

- See pages 10–13 for List of Pharmaceuticals Requiring Prior Authorization

**Diabetic Supplies**

- Co-insurance 20%

**Asthma Delivery Devices**

- No

**Prescription Vitamins**

- No
### Medicare Eligible and Approved HBP Prescription Drug Benefit

*Administered Through SilverScript®*

#### The Following Is a Summary Overview of the Prescription Drug Benefit for 2020

<table>
<thead>
<tr>
<th>Categories</th>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>TIER 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic Rx</td>
<td>Preferred Brands (Formulary)</td>
<td>Non-Preferred Brands (Non-Formulary)</td>
<td>Specialty Drugs (Hi-Tech)</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$100 Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Member % Co-insurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleveland Clinic Akron Gen. Pharmacies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient: up to 90-Day Supply</td>
<td>15%</td>
<td>25%</td>
<td>45%</td>
<td>20%</td>
</tr>
<tr>
<td>Specialty &amp; Home Delivery: up to 90-Day Supply</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Member % Co-insurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVS/caremark Retail: up to 90-Day Supply</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
</tr>
<tr>
<td>Mail Service Program: up to 90-Day Supply</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cleveland Clinic Akron Gen. Pharmacies including Specialty &amp; Home Delivery:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-insurance?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>$3 Minimum/$50 Maximum per 30-Day Supply</td>
<td>$3 Minimum/$50 Maximum per 30-Day Supply</td>
<td></td>
<td></td>
<td>$3 Minimum/$50 Maximum per Month Supply</td>
</tr>
<tr>
<td>CVS/caremark Retail up to 90-Day Supply</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-insurance?</td>
<td>$5 Minimum/$75 Maximum per 30-Day Supply</td>
<td>$5 Minimum/$75 Maximum per 30-Day Supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVS/caremark Mail Service Program</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there a Minimum or Maximum to the Rx % Co-insurance?</td>
<td>$15 Minimum/$225 Maximum 90-Day Supply</td>
<td>$15 Minimum/$225 Maximum 90-Day Supply</td>
<td></td>
<td>No Minimum/$100 Maximum per Month Supply</td>
</tr>
<tr>
<td><strong>Is there an Annual Out-of-pocket Maximum?</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Components of Each Category

<table>
<thead>
<tr>
<th>Generic Drugs</th>
<th>Brand Drugs</th>
<th>Specialty Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will be sent a copy of the SilverScript’s <em>Preferred Drug List</em>. You may also contact SilverScript to request a copy of the <em>Preferred Drug List</em> by calling the toll-free number on your SilverScript card.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Part B vs. Medicare Part D**

*Please note:* Most medications are covered under Medicare Part D, but there are some medications that can be covered under both Medicare Part B (i.e., the Medicare outpatient benefit) or Medicare Part D (i.e., the Medicare prescription drug benefit) depending on what the drug is used for and how it is administered. Please consult the SilverScript Prescription Drug Formulary or contact SilverScript using the toll-free phone number on the back of your SilverScript card for more information regarding Medicare Part B vs. Medicare Part D medications.

#### Major Chains in the Retail Network

- ACME, Cleveland Clinic/Akron General Pharmacies (including Weston, Akron General Medical Center, Union Hospital Outpatient Pharmacy), Costco, CVS, Discount Drug Mart, Giant Eagle, K-Mart, Marc’s, Medicine Shoppe, Rite Aid, Target, Walgreens, Wal-Mart, plus other chains and independent pharmacies.

---

SilverScript is a registered trademark of SilverScript Insurance Company.

**Note:** Effective January 1, 2018, diabetic testing supplies will no longer be covered under the Medicare Part D program. They will now be covered under Medicare Part B.

See pages 63 to 65 for SilverScript’s *Request for Medicare Prescription Drug Coverage Determination for Prior Authorization*.
Understanding the Formulary

The medications included in this Handbook are chosen by a group of healthcare professionals known as the Pharmacy and Therapeutics (P&T) Committee. This Committee reviews and selects FDA-approved prescription medications for inclusion in the Formulary based on the drug’s safety, effectiveness, quality and cost to the benefit program. All medications that have been reviewed but not added to the Formulary or that have not yet been reviewed by the P&T Committee are considered Non-Formulary.

The Formulary Handbook does not pertain to SilverScript members. SilverScript sends a formulary separately to their subscribers. The SilverScript Formulary is also available on the EHP website at https://employeehealthplan.clevelandclinic.org. Click on the “Retirees” tab.

Take your respective formulary with you to all doctor appointments. You are encouraged to share this with your physician when he or she is prescribing your medication to help ensure the most appropriate prescription drug therapy for your needs. Appropriate and cost-effective use of pharmaceutical therapies can be key to a successful strategy for improving individual patient outcomes and containing healthcare costs. The Handbook will assist with both of these goals – maintaining the quality of patient care while helping to keep the cost of prescription medications affordable.

The P&T Committee reviews and updates the Formulary throughout the year. Medications may be added to or removed from the Formulary during the year. Cleveland Clinic Health Benefit Program may add medications to the Formulary four times a year. Medications may be removed from the Formulary twice a year, once at the start of the benefit year in January and again at mid-year in July.

Two resources are available to assist you with determining if the drug prescribed for you is covered under your program (another reason why you should take the Handbook with you each time you visit your doctor). The two resources are: this Cleveland Clinic Health Benefit Program Prescription Drug Benefit and Formulary Handbook and our website. The website version of the Formulary is updated on a regular basis and contains the most current information regarding the Formulary. You can access this website by logging into https://employeehealthplan.clevelandclinic.org. The listing of a drug in the Formulary does not guarantee coverage if your contract does not cover that category of drugs (e.g., oral contraceptives, infertility agents).

Filling Your Prescriptions

Through your Prescription Drug Benefit you have six options for filling your prescription medications. The six options described on the following pages include the Cleveland Clinic/Akron General Pharmacies; Cleveland Clinic Specialty Pharmacy; Cleveland Clinic Home Delivery Pharmacy; the CVS store pharmacies; the CVS/caremark Mail Service Program; and the CVS/specialty Pharmacy.

Cleveland Clinic/Akron General Pharmacies and Home Delivery Pharmacy

HBP members receive a lower percentage co-insurance for their prescriptions by using Cleveland Clinic/Akron General Pharmacies in Akron, Cleveland, Dover, and Weston (Option 1), or the Specialty/Home Delivery Pharmacy (Option 2). In addition, a deductible will not be charged for prescriptions filled at these pharmacies with a generic medication. Call the pharmacy hotline at 216.445.MEDS (6337) for answers to your questions and to obtain pharmacist consultation services. You may receive up to a 90-day supply of medication at any of the Cleveland Clinic/Akron General Pharmacies.

You may pick up your prescriptions at any of the locations listed below or you can have your prescription(s) mailed to your home by using the Cleveland Clinic Specialty or Home Delivery Pharmacy. There is a turnaround time of up to ten business days for all home delivery pharmacy orders. Please Note: You cannot drop off or pick up prescription orders at the Cleveland Clinic Specialty or Home Delivery Pharmacy. See page 6 for details.

6. The Cleveland Clinic Home Delivery Pharmacy is only available to members within the states of Florida, Indiana, Nevada, Ohio, Pennsylvania, and West Virginia. All other members can utilize the CVS/caremark or SilverScript Mail Service Program — see page 8 for details.
Cleveland Clinic/Akron General Pharmacies – Locations and Hours of Operation

• Cleveland Clinic Pharmacies On Main Campus:
  Euclid Avenue Pharmacy (Parking Garage) .......................... 216.445.MEDS (6337), Fax: 216.445.6015
  Toll-free: 866.650.MEDS (6337), Direct Dial: 216.636.0760
  Monday–Friday, 8 a.m.–8 p.m.
  Saturday, Sunday and all Cleveland Clinic
  Holidays, 9 a.m.–5 p.m.

  Crile Pharmacy (A Building) .................................................. 216.445.MEDS (6337), Fax: 216.445.7403
  Toll-free: 866.650.MEDS (6337), Direct Dial: 216.636.0761
  Monday–Friday, 8 a.m.–6 p.m.

  Childrens Hospital and Surgical Pharmacy (P Building) .... 216.445.MEDS (6337), Fax: 216.444.9514
  Toll-free: 866.650.MEDS (6337), Direct Dial: 216.636.0762
  Monday–Friday, 9 a.m.–5 p.m.

  Taussig Cancer Center (R Building) ................................. 216.445.MEDS (6337), Fax: 216.445.2172
  Toll-free: 866.650.MEDS (6337), Direct Dial: 216.636.0763
  Monday–Friday, 8 a.m.–6 p.m.

• Cleveland Clinic Family Health Centers:
  Beachwood Family Health Center Pharmacy .................... 216.445.MEDS (6337), Fax: 216.839.3271
  26900 Cedar Road, Beachwood, OH 44122
  Toll-free: 866.650.MEDS (6337)
  Direct Dial: 216.839.3270
  Monday–Friday, 8 a.m.–6 p.m.

  Independence Ambulatory Pharmacy ............................... Toll-free: 866.650.MEDS (6337)
  5001 Rockside Road, Independence, OH 44131
  Direct Dial: 216.986.4610
  Monday–Friday, 9 a.m.–5 p.m.

  North Coast Cancer Care Ambulatory Pharmacy .............. Toll-free: 866.650.MEDS (6337), Fax: 419.609.2869
  417 Quarry Lakes Drive, Sandusky, OH 44870
  Direct Dial: 419.609.2845
  Monday–Friday, 9 a.m.–5 p.m.

  Richard E. Jacobs Family Health Center Pharmacy ............ 216.445.MEDS (6337), Fax: 440.965.4109
  33100 Cleveland Clinic Boulevard, Avon, OH 44011
  Toll-free: 866.650.MEDS (6337)
  Direct Dial: 440.695.4100
  Monday–Friday, 8 a.m.–6 p.m.

  Stephanie Tubbs Jones Health Center Pharmacy ............... 216.445.MEDS (6337), Fax: 216.767.4128
  13944 Euclid Avenue, East Cleveland, OH 44112
  Toll-free: 866.650.MEDS (6337)
  Direct Dial: 216.767.4200
  Monday–Friday, 9 a.m.–5 p.m.

  Strongsville Family Health Center Pharmacy .................. 216.445.MEDS (6337), Fax: 440.878.3148
  16761 Southpark Center, Strongsville, OH 44136
  Toll-free: 866.650.MEDS (6337)
  Direct Dial: 440.878.3125
  Monday–Friday, 8 a.m.–6 p.m.

  Twinsburg Family Health Center Pharmacy ...................... 216.445.MEDS (6337), Fax: 330.888.4105
  8701 Darrow Road, Twinsburg, OH 44087
  Toll-free: 866.650.MEDS (6337)
  Direct Dial: 330.888.4200
  Monday–Friday, 8 a.m.–6 p.m.

  Willoughby Hills Family Health Center Pharmacy ............. 216.445.MEDS (6337), Fax: 440.516.8629
  2570 SOM Center Road, Willoughby, OH 44094
  Toll-free: 866.650.MEDS (6337)
  Direct Dial: 440.516.862
  Monday–Friday, 8 a.m.–6 p.m.
• Akron General Medical Center Location:

Akron General Medical Center ........................................ 330.344.7732, Fax: 330.996.2927
Ambulatory Care Pharmacy  Monday–Friday, 7 a.m.–5:30 p.m.
400 Wabash Avenue, Akron, OH 44307

• Cleveland Clinic Regional Hospital Locations:

Fairview Hospital Health Center Pharmacy ....................... 216.445.MEDS (6337), Fax: 216.476.9905
18099 Lorain Road, Cleveland, OH 44111 Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.476.7119
Monday–Friday, 7 a.m.–7 p.m., Saturday, 9 a.m.–1 p.m.

Hillcrest Ambulatory Pharmacy ..................................... 440.312.5854, Fax: 440.312.5856
6770 Mayfield Road, Mayfield Heights, OH 44124 Monday–Friday, 7 a.m.–7 p.m., Saturday, 9 a.m.–1 p.m.

Lutheran Hospital Ambulatory Pharmacy ......................... 216.445.MEDS (6337), Fax: 419.774.3140
1730 West 25th Street, Cleveland, OH 44113 Toll-free: 866.650.MEDS (6337)
Direct Dial: 216.696.7055
Monday–Friday, 9 a.m.–5 p.m.

Mansfield Cancer Center Ambulatory Pharmacy ............... 216.445.MEDS (6337), Fax: 419.774.3140
1125 Aspira Court, Mansfield, OH 44906 Toll-free: 866.650.MEDS (6337)
Direct Dial: 419.774.3121
Monday–Friday, 8 a.m.–4 p.m.

Martin Memorial Medical Center Outpatient Pharmacy ...... 772.288.5813, Fax: 772.221.2064
200 SE Hospital Ave., Stuart, FL 34995 Monday–Friday, 7:30 a.m.–6 p.m.

Martin Health Physician Group Tradition Pharmacy .......... 772.345.8166, Fax: 772.345.8167
10080 SW Innovation Way, Suite 102 Monday–Friday, 7:30 a.m.–6 p.m.
Port St. Lucie, FL 34987

Marymount Family Pharmacy ......................................... 216.445.MEDS (6337), Fax: 216.587.8844
12000 McCracken Road, Suite 151 Toll-free: 866.650.MEDS (6337)
Garfield Heights, OH 44125 Direct Dial: 216.587.8822
Monday–Friday, 8 a.m.–6 p.m.

Medina Hospital Ambulatory Pharmacy .......................... 216.445.MEDS (6337), Fax: 330.721.5495
1000 East Washington Street, Medina, OH 44256 Toll-free: 866.650.MEDS (6337)
Direct Dial: 330.721.5490
Monday–Friday, 9 a.m.–5 p.m.

Cleveland Clinic Florida Ambulatory Pharmacy ............... 954.659.MEDS (6337), Fax: 954.659.6338
2950 Cleveland Clinic Blvd., Weston, FL 33331 Toll-free: 866.2WESTON (293.7866)
Direct Dial: 954.659.6337
Monday–Friday, 8 a.m.–7 p.m.

Union Hospital Outpatient Pharmacy ............................. 330.365.3845, Fax: 330-365-3817
659 Blvd. St., Dover, OH 44622 Monday–Friday: 7 a.m.–6 p.m., Saturday: 7 a.m.–3 p.m., Sunday: Closed

• Cleveland Clinic Specialty Pharmacy:

Cleveland Clinic Specialty Pharmacy .................................. Direct Dial: 216.448.7732, Fax: 216.448.5601
Toll-free: 844.216.7732, Fax: 844.337.3209
Monday–Friday, 7 a.m.–6 p.m.

• Free Shipping Mail Order by Cleveland Clinic:

Cleveland Clinic Home Delivery Pharmacy .......................... Direct Dial: 216.448.4200, Fax: 216.448.5603
Toll-free: 855.276.0885
Monday–Friday, 7 a.m.–6 p.m.
Cleveland Clinic Home Delivery Pharmacy Ordering Instructions

The Home Delivery Pharmacy is designed to ship medication directly to your home with no shipping charge. By using the Home Delivery Pharmacy, members receive a lower percentage co-insurance for their medications compared to the CVS/caremark Retail Pharmacy Network and can enjoy the convenience of having 90-day supplies of their maintenance medications delivered directly to their home. Here’s how you can get started:

1. Go to the MyRefills website at https://myrefills.clevelandclinic.net to set up your account, change your billing information and shipping address, or to check on the status of your order.

   Note: You will have to set up your Home Delivery account before the Home Delivery Pharmacy can process and ship your order. In addition, each member that wishes to use the Home Delivery Pharmacy needs a separate account.

2. The Home Delivery Pharmacy receives prescription orders in the following ways:
   - Called in by your physician to 855.276.0885
   - Faxed in by your physician to 216.448.5603
   - e-Scripted by your physician via EPIC (CCF Home Delivery Pharmacy)
   - Requested online through https://myrefills.clevelandclinic.net.

   If you have a hard copy of a new prescription, by law, you cannot fax the prescription to the Home Delivery Pharmacy. Please mail the prescription to:
   Cleveland Clinic Home Delivery Pharmacy
   9500 Euclid Ave AC5b-137
   Cleveland, OH 44195
   Phone: 216.448.4200
   Fax: 216.448.5603

   If you are transferring a prescription from a pharmacy other than a Cleveland Clinic/Akron General Pharmacy, please contact the Home Delivery Pharmacy at 216.448.4200 for assistance. Please note: Members cannot drop off or pick up their orders at the Home Delivery Pharmacy. Orders will be shipped free of charge to the address you designate.

The Cleveland Clinic Home Delivery Pharmacy is available Monday–Friday from 7 a.m. to 6 p.m. Please allow ten business days from the time they receive your prescription order(s) for delivery.

Please note: Eligibility is based upon the date the Home Delivery Pharmacy processes your prescription order and not on the day your order was received.

Please call 216.448.4200 for questions or additional information on the Cleveland Clinic Home Delivery Service.

Advantages of Utilizing the Cleveland Clinic/Akron General Pharmacies and Home Delivery Pharmacy

- **Lower cost**: You will pay less for prescription co-insurance. In addition, your deductible will be waived for prescriptions filled with a generic medication at these pharmacies.

- **Convenience**: You may request a 90-day supply of non-specialty medications at any Cleveland Clinic/Akron General Pharmacy. **Note**: The prescription must be written for a 90-day supply.

- **Peace of mind**: You will have access to a toll-free hotline number for questions and pharmacist consultation services during regular business hours.
**CVS/caremark Retail Pharmacy Network**

Members have the option of picking up acute care prescriptions (such as antibiotic therapy or pain medication) or the first fill of any maintenance medication (limited to a 30-day supply) at any Cleveland Clinic/Akron General Pharmacy or CVS store pharmacy. Refills of maintenance medications must be obtained through one of the three options identified in the Mandatory Maintenance Drug Program section on page 20. A complete list of these pharmacies can be found on the CVS/caremark website at [https://www.caremark.com](https://www.caremark.com). Please note that when using a CVS store pharmacy or the CVS/caremark Mail Service Program, member co-insurance is higher when compared to obtaining your prescriptions from a Cleveland Clinic/Akron General Pharmacy.

**Note:** Effective March 1, 2017, members may utilize any Cleveland Clinic/Akron General Pharmacy or any CVS store pharmacy for obtaining acute care prescriptions.

**CVS/caremark Mail Service Program**

**New Prescriptions**

CVS/caremark's Mail Service Program provides a way for you to order up to a 90-day supply of maintenance or long-term medication for direct delivery to your home. Follow this easy step-by-step ordering procedure:

1. For new maintenance medications, ask your doctor to write two prescriptions:
   - One, for up to a 90-day supply plus refills, to be ordered through the Mail Service Program; and
   - A second, to be filled immediately at any Cleveland Clinic/Akron General Pharmacy or CVS store pharmacy for use until you receive your prescription from the Mail Service Program.

2. Complete a Mail Service Order Form and send it to CVS/caremark, along with your original prescription(s) and the appropriate payment for each prescription. Be sure to include your original prescription, not a photocopy. Forms are available on CVS/caremark's website at [https://www.caremark.com](https://www.caremark.com).
   - You can expect to receive your prescription approximately 14 calendar days after CVS/caremark receives your order.
   - You will receive a new Mail Service Order Form and pre-addressed envelope with each shipment.

**Mail Service Refills**

Once you have processed a prescription through CVS/caremark, you can obtain refills using the Internet, phone or mail. Please order your prescription three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive from CVS/caremark. You will receive specific instructions related to refills from CVS/caremark.

**Prescription Drug Benefit Guidelines**

**Prescription Drug Benefit – Deductible**

The Prescription Drug Benefit has an annual deductible of **$200 individual/$400 family**.

**Note:** The annual deductible is waived if:

i. The member uses a Cleveland Clinic/Akron General Pharmacy to obtain their prescription and

ii. The prescription is filled using a generic medication.

This waiver is considered a value-added benefit. All prescriptions filled at a non-Cleveland Clinic/Akron General Pharmacy and all prescriptions filled with a brand name medication at any Cleveland Clinic/Akron General Pharmacy are subject to the annual deductible.

**Note:** Members who live in an area of the country not serviced by a Cleveland Clinic/Akron General pharmacy are not eligible for a waiver of the annual pharmacy deductible. The amount you have contributed to your annual deductible resets to $0 at midnight on December 31 each year. It is not based on a rolling 365 days.
Deductible and Out-of-Pocket Maximum

Your annual deductible must be satisfied before your out-of-pocket pharmacy expenses begin accumulating toward your annual out-of-pocket maximum expense. Not all pharmacy charges apply toward the deductible and out-of-pocket (OOP) maximum expenses. The total charges for medications not covered by the benefit program (e.g., Viagra, Levitra, weight control products, cosmetic agents, etc.) do not apply to either the deductible or out-of-pocket maximum.

In addition, if a generic version of the prescribed brand medication exists, the Prescription Drug Benefit will cover only up to the price of the generic version. If you receive the brand name medication, you are required to pay the price difference between the generic and the brand medication. That difference does not apply to the deductible or the OOP maximum (see Generic Medication Policy below).

Generic Medication Policy

Cleveland Clinic HBP supports and encourages the use of FDA-approved generic medications that are both chemically and therapeutically equivalent to manufacturers’ brand name products. Generically equivalent products are safe and effective treatments that offer savings as alternatives to brand name products.

Drugs that are available as generics are designated in this Handbook with an asterisk (*). However certain generic medications are considered non-preferred medications. Please see page 16 of this Handbook. All other drugs listed are the Preferred Brands (Tier 2) or Specialty (SP) drugs (Tier 4).

If a member or physician requests the brand name drug be dispensed when a generic is available, the participant will be required to pay their generic co-insurance AND the cost difference between the brand name drug price and the generic drug price.

Prior Authorization

Prior authorization is required for coverage of certain medications. These medications are listed in the subsequent pages and in the complete drug listing found in the HBP Prescription Drug Formulary Handbook. This list may change during the year due to new drugs being approved by the FDA or as new indications are established for previously approved drugs. A Prior Authorization, Formulary Exception and Appeal Form must be completed or sufficient documentation must be submitted by the member’s provider before a case will be reviewed. Please refer to the Formulary Failure Review Process on page 13 for information about obtaining a form. Completed forms can be faxed to 216.442.5790.

All prior authorization requests must meet the clinical criteria approved by the Pharmacy and Therapeutics (P&T) Committee before approval is granted. In some cases, approvals will be given a limited authorization date. If a limited authorization is given, both the member and the physician will receive documentation on when this authorization will expire. Prior authorization approvals are subject to future plan benefit changes or utilization management programs that may impact coverage of the authorized medication. Most requests will be processed within one to two business days from the time of receipt. A response will be faxed to the requesting physician, and the member will be informed of the request and the decision via mail.

Note: Prior authorization approvals are effective from the initial date of the authorization. No refunds or adjustments will be made for previously purchased medications.
Pharmaceuticals Requiring Prior Authorization

- Abilify
- Abilify Maintena
- Absorica LD (effective 4/1/20)
- Abstral
- Acne Treatments
- Actemra
- Actemra ACTPen
- Acthar gel
- Actiq
- Adakveo (medical benefit; effective 4/1/20)
- Adcel (under 7 years of age)
- Adcirca
- Adempas
- Adlyxin
- Admelog (effective 4/1/18)
- Aemcolo (effective 7/1/19)
- Afrezza (effective 4/1/20)
- Aimovig (effective 6/1/18)
- Ajovy (effective 10/1/18)
- Akynezo
- Albenza (effective 10/1/18)
- Alecensa (effective 4/1/19)
- Aliqopa (effective 4/1/19)
- Alunbrig
- Alyq
- Amjevita
- Ampyra
- Angelilq (effective date 1/1/20)
- Apidra (effective 3/1/18)
- Aptiom
- Aralast NP (medical benefit)
- Aristada
- Aristada Initio
- Aspirin
- Astagraf
- Aubagio
- Austedo
- Avanex
- Avsola (medical benefit; effective date 7/1/20)
- Ayvakit (effective date 7/1/20)
- Azedra (medical benefit; effective 7/1/19)
- Balversa (effective date 1/1/20)
- Banzel
- Basaglar (effective 3/1/18)
- Bavencio (medical benefit)
- Belbuca
- Beleodaq (medical benefit)
- Belrapzo (medical benefit; effective 4/1/20)
- Bendeka (medical benefit)
- Benlysta
- Beovu (medical benefit; effective 1/1/20)
- Beninert
- Besponsa (medical benefit)
- Betaseron
- Bethkis
- Bijuva (effective date 1/1/20)
- Blincyto (medical benefit)
- Boniva IV7 (medical benefit)
- Bosulif
- Botox (medical benefit)
- Braftovi (effective 4/1/20)
- Bristelle
- Briviact
- Brineura (medical benefit)
- Brukinsa (effective 4/1/20)
- Butrans
- Bydureon
- Byetta
- Bystolic (effective 7/1/19)
- Cablivi (effective 4/1/20)
- Cabometyx
- Calquence (effective 4/1/18)
- Caplyta (effective date 7/1/20)
- Caprelsa
-Celebrex
- Cerezyme
- Cinqair8
- Cinryze
- Cinvanti (effective 4/1/19)
- Climara Pro (effective date 1/1/20)
- CombiPatch (effective date 1/1/20)
- Comtrig
- Copaxone
- Copiktra (effective 4/1/19)
- Corlanor
- Cosentyx
- Cotelic
- Cressemba (effective 10/1/18)
- Crysivita (medical benefit)
- Cuvitru (effective 6/1/18)
- Cuvposa
- Cyramza (medical benefit)
- Daklinza
- Daliresp
- Daraprim
- Darzalex (medical benefit; effective 2/4/16)
- Daurismo (effective 4/1/19)
- Descoy
- Diclofenac gel
- Diclofenac solution
- Differin 0.1% cream
- Differin 0.3% gel
- Dihydroergotamine mesylate injection (effective date 1/1/20)
- Dihydroergotamine mesylate nasal spray (effective date 1/1/2020)
- Dipentum
- Doptelet (effective 4/1/19)
- Duavee (effective date 1/1/20)
- Duopa (medical benefit; effective 7/1/19)
- Dupixent8
- Dysport (medical benefit)
- Edular (effective date 1/1/20)
- Egrifta
- Elaprase (medical benefit)
- Elelyso (medical benefit)
- Elidel Cream
- Elmiron (effective 4/1/19)
- Elzonris (medical benefit; effective 7/1/19)
- Emend capsules, oral suspension
- Emgality (effective 10/1/19)
- Empliciti
- Emsam patches
- Emverm (effective 10/1/18)
- Enbrel
- Enstilar Foam (effective date 1/1/20)
- Entocort
- Entresto
- Entvyio
- Envarsus XR
- Epclusa
- Epidiolex (effective 4/1/19)
- Erelzi
- Erivedge
- Erleada (effective 6/1/2018)
- Erwinaze (medical benefit; effective 1/1/19)
- Erygel 2%
- Esbriet
- Eucrisa ointment
- Evenity (effective 7/1/19)
- Exjade
- Extavia

7. Member is responsible for 20% co-insurance.
8. In addition to meeting all other prior authorization criteria, members must also enroll in the corresponding EHP Healthy Choice Coordinated Care program to receive coverage for this medication.
Pharmaceuticals Requiring Prior Authorization (continued)

- Eylea (medical benefit)
- Fabrazyme (medical benefit; effective 10/1/18)
- Fanapt (effective 4/1/20)
- Farxiga
- Farydak
- Fasenra prefilled syringes
- Fasenra pens
- Fentora
- Ferrix
- Fetzima
- Fiasp (effective 4/1/18)
- Firazyr
- Flector
- Forteo
- Fycopma (effective 4/1/20)
- Gamifant (medical benefit; effective 4/1/19)
- Gattex
- Gazyva (medical benefit)
- Genotropin
- Giazo
- Gilenya
- Gilotrif
- Givlaari (medical benefit; effective date 7/1/20)
- Glassia (medical benefit)
- Glatiramer acetate
- Gleevec
- Grastek
- Growth Hormone
- Haegarda
- Harvoni
- Hectorol
- Hetlizo
- Hizentra
- Humalog U-200 (effective 1/1/19)
- Humatrope
- Humulin U-500 (effective 3/1/2018)
- Hycamtin
- Hyqvia
- Ibrance
- Idhifa (effective 4/1/2018)
- Ilaris
- Ilumya (effective 4/1/19)
- Ilixven (medical benefit)
- Imbruvica
- Imfinzi (medical benefit)
- Imlygic (medical benefit)
- Impavido
- Increlex
- Inflectra (medical benefit)
- Ingrezza
- Imbratra (medical benefit)
- Intermezzo (effective date 1/1/20)
- Invokamet/Invokamet XR (effective 1/1/19)
- Inlyta
- Invokana
- Inrebic (effective 4/1/20)
- Iressa
- Jadenu
- Jakafi
- Jardiance
- Jynarque (effective 4/1/20)
- Kadryna (medical benefit; effective 1/1/19)
- Kalbitor
- Kalydeco
- Kanuma (medical benefit)
- Kevzara
- Keytruda (medical benefit)
- Kineret
- Kisqali
- Kitabis Pak
- Korlym
- Krystexxa (medical benefit)
- Kuvan
- Kynriah (medical benefit)
- Kryprolis
- Latuda (effective 4/1/20)
- Lazanda
- Lenvitada (medical benefit)
- Lenvima
- Letairis
- Levaris (effective 3/1/18)
- Libtayo (medical benefit; effective 4/1/19)
- Lidoderm
- Linzess
- Lokelma (effective 4/1/19)
- Lonhala Magnair (effective 4/1/19)
- Lonsurf
- Lorbrena (effective 4/1/19)
- Lotronex
- Lucemyra (effective 4/1/19)
- Lucentis (medical benefit)
- Lumizyme (medical benefit)
- Lumoxiti (medical benefit; effective 4/1/19)
- Lupron
- Lutathera (effective 4/1/19)
- Luxturna (medical benefit; effective 1/10/18)
- Luzu
- Lynparza
- Macugen (medical benefit)
- Marinol
- Mavenclad (effective date 1/1/20)
- Mavryet
- Mayzent (effective 7/1/19)
- Melkinist
- Mektovi (effective 4/1/20)
- Mepris (medical benefit)
- MetroGel 1%
- MetroGel 1% with pump
- Metrolotion
- Mirvaso (effective 1/1/19)
- Motegory (effective 7/1/19)
- Movantik
- Mulpleta (effective 4/1/19)
- Mupirocin cream (effective date 1/1/20)
- Mylotarg (medical benefit)
- Myobloc (medical benefit)
- Myrbetrix
- Namenda XR
- Natpara
- Nayzilam (effective 4/1/20)
- Nerlynx (effective 6/1/18)
- Neupro
- Nexletol (effective date 7/1/20)
- Nexlizet (effective date 7/1/20)
- Nolaro
- Norditropin
- Northera (effective 4/1/19)
- Novolog (effective 3/1/18)
- Novolog Mix (effective 3/1/18)
- NovoXaf (effective 10/1/18)
- Nucala
- Nuexta
- Nulojix (medical benefit)
- Nuplazid
- Nurtec ODT (effective date 7/1/20)
- Nutropin AQ
- Nuveigil
- Ocaliva
- Ocrevus (medical benefit)
- Odacra (effective date 7/1/20)
- Odomzo
- Ofev
- Olumiant (effective 10/1/18)
- Olysio

7. Member is responsible for 20% co-insurance.

8. In addition to meeting all other prior authorization criteria, members must also enroll in the corresponding EHP Healthy Choice Coordinated Care program to receive coverage for this medication.
Pharmaceuticals Requiring Prior Authorization (continued)

- Omnipod Dash (effective 4/1/20)
- Omnitrope
- Opsumit (effective 4/1/20)
- Oncaspar (medical benefit; effective 4/1/19)
- Onpattro (medical benefit; effective 4/1/19)
- Onf
- Onivyde (medical benefit)
- Opirivo (medical benefit)
- Orenica
- Orenitram (effective date 7/1/20)
- Oralair
- Orilissa (effective 7/1/19)
- Orkambi
- Orteza
- Otrexup
- Oxbyta (effective 4/1/20)
- Oxervate (effective 4/1/20)
- Oxtellar XR (effective 4/1/20)
- Ozempic (effective 4/1/18)
- Ozurdex (medical benefit; effective date 7/1/20)
- Padcev (medical benefit; effective date 7/1/20)
- Palforzia (effective 4/1/20)
- Pegasys
- Peginteron
- Perjeta (medical benefit)
- Picato
- Pnakay (effective 4/1/20)
- Plegidy
- Pneumovax-23 (under 2 years of age)
- Polivy (medical benefit; effective 1/1/20)
- Pomalyst
- Portrazza (medical benefit)
- Poteligio (medical benefit; effective 4/1/19)
- Praluent
- Prefest (effective date 1/1/20)
- Premphase (effective date 1/1/20)
- PremPro (effective date 1/1/20)
- Preymis (effective 6/1/18)
- Pritiq
- Probuphine
- Prolastin-C (medical benefit)
- Prolia
- Promacta
- Proneve (medical benefit)
- Prudoxin cream
- Psoriasis Therapies
- Qbrexza (effective date 1/1/20)
- Qtern (effective 1/1/19)
- Qudexy XR
- Qwentza
- Radicava (medical benefit)
- Ragwitek
- Rasuvo
- Ryaldee
- Reblozyl (medical benefit; effective 4/1/20)
- Rebif
- Reclast (medical benefit)
- Relistor
- Remicade (medical benefit)
- Remodulin
- Renflexis (medical benefit)
- Repatha
- Restasis
- Restorida 7.5 mg (effective date 1/1/20)
- Restorida 22.5 mg (effective date 1/1/20)
- Retisert (medical benefit)
- Revatio
- Revlimid
- Rexuphenac
- Rexulti
- Reyov (effective date 7/1/20)
- Rheumatoid Arthritis Therapies
- Rhofade (effective 1/1/19)
- Rhopressa (effective 10/1/18)
- Rinvoq (effective 4/1/20)
- Rituxan (medical benefit)
- Rituxan Hycela (medical benefit, effective 4/1/19)
- Rozerem
- Rubraca
- Rukonset
- Ruxience (medical benefit; effective date 7/1/20)
- Ruzurgi (effective date 7/1/20)
- Rybelsus (effective 4/1/20)
- Rydar
- Sabril
- Saizen
- Samsca (effective 4/1/20)
- Saphris (effective 4/1/20)
- Secuado (effective 4/1/20)
- Segluromet (effective 6/1/18)
- Sensipar
- Sermorelin
- Seroquel XR
- Serostim
- Shingrix (under 50 years of age)
- Signifor
- Signifor LAR
- Siliq (effective 4/1/18)
- Simponi
- Sitavig
- Skyrizi (effective date 1/1/20)
- Solaraze
- Soliqua
- Soliris (medical benefit)
- Soolantra
- Sorilux Foam (effective date 1/1/20)
- Spinraza (medical benefit)
- Spravato (effective 4/1/19)
- Spritam (effective 4/1/20)
- Steglatro (effective 6/1/18)
- Steglujan (effective 6/1/18)
- Stivarga
- Strensiq
- Suboxone
- Subsys
- Sunosi (effective date 1/1/20)
- Supprelin LA (medical benefit)
- Sylvant (medical benefit)
- Symdeko (effective 6/1/18)
- Symproic (effective 4/1/18)
- Synagis (medical benefit; up to five injections per season)
- Syncare
- Syndros (effective 4/1/18)
- Synjardy/Synjardy XR (effective 1/1/19)
- Synribo
- Syprine
- Taclonex Ointment (effective date 1/1/20)
- Taclonex Topical Suspension (effective date 1/1/20)
- Tafinlar
- Tagrisso
- Takhzyro (effective 10/1/18)
- Taltz
- Talvez (effective 4/1/19)
- Tarceva (effective 4/1/19)
- Targretin (effective date 7/1/20)
- Tafidis (effective 4/1/18)
- Tecentriq (medical benefit)
- Tecfidera
- Techniflue
- Tegsedi (effective 4/1/19)
- Temazepam 7.5 mg (effective date 1/1/2020)

7. Member is responsible for 20% co-insurance.
8. In addition to meeting all other prior authorization criteria, members must also enroll in the corresponding EHP Healthy Choice Coordinated Care program to receive coverage for this medication.
Pharmaceuticals Requiring Prior Authorization (continued)

• Temazepam 22.5 mg (effective date 1/1/2020)
• Tepezza (medical benefit; effective date 7/1/20)
• Testopel (medical benefit)
• Teverdin (effective 4/1/19)
• Tigruntik (effective date 1/1/20)
• TOBI
• TOBI Podhaler
• Topamax immediate-release sprinkle capsules
• Toujeo
• Tracleer
• Treanda (medical benefit)
• Trelegy Ellipta (effective 4/1/19)
• Trelstar Mixject (medical benefit)
• Tremenfya (effective 4/1/18)
• Tresiba (effective 4/1/18)
• Triazolam (effective date 1/1/20)
• Trijardy XR (effective date 7/1/20)
• Trikafta (effective 4/1/20)
• Trintellix
• Triptodur (medical benefit)
• Trogarzo (medical benefit; effective 10/1/18)
• Trokendi XR
• Trulicity
• Truvada (for quantities > 30 tablets per 365 days)
• Turalio (effective 4/1/20)
• Tymlos
• Tysabri (medical benefit)
• Tyvaso
• Uloric
• Ultomiris (medical benefit; effective 7/1/19)
• Uptravi
• Valtoco (effective date 7/1/20)
• Varubi
• Vectibix (medical benefit; effective 7/1/18)
• Veltaka
• Vencliexa
• Venlafaxine ER Tablets
• Verzenio (effective 4/1/18)
• Viberzi
• Victoza
• Viekira
• Viibryd
• Vitarki (effective 4/1/19)
• Vosevi
• VPRIV
• Vrylar
• Vumerity (effective 4/1/20)
• Vyepi (medical benefit; effective date 7/1/20)
• Vydacal (effective 4/1/20)
• Vytomin
• Wakiix (effective 4/1/20)
• Xadago
• Xalkori
• Xeljanz
• Xeljanz XR
• Xeloda
• Xeomin (medical benefit)
• Xepi (effective 10/1/18)
• Xgeva
• Xiaflex (medical benefit)
• Xigmapi
• Xigduo XR (effective 1/1/19)
• Xodira
• Xofogo (medical benefit)
• Xolair®
• Xtanid
• Xultophy
• Xuriden
• Xyrem
• Yervoy (medical benefit)
• Yescarta (medical benefit)
• Yondelis (medical benefit)
• Yupelri (effective 4/1/19)
• Yutiq (medical benefit)
• Zavesca (effective 4/1/19)
• Zejula
• Zeboraf
e
• Zemaira (medical benefit)
• Zemplar
• Zepatier
• Zeposia (effective date 7/1/20)
• Zinplava (medical benefit)
• Zohydro ER
• Zolgensma (medical benefit)
• Zolpimist (effective date 1/1/20)
• Zomacton
• Zometa
• Zonalon cream
• Zorbtive
• Zostavax
• Zubolv
• Zulresso (medical benefit; effective 7/1/19)
• Zuplenz

7. Member is responsible for 20% co-insurance.
8. In addition to meeting all other prior authorization criteria, members must also enroll in the corresponding EHP Healthy Choice Coordinated Care program to receive coverage for this medication.

Formulary Failure Review Process
The Formulary is designed to meet the needs of the majority of HBP members. However, if it is determined that you require treatment with a medication not included in the Formulary, your physician may request a review for preferred coverage of a Non-Formulary medication. To start the review process, your physician should call the EHP Pharmacy Management Department at 216.986.1050, option 4 or tollfree at 888.246.6648, option 4 and request a Prior Authorization, Formulary Exception and Appeal Form. See sample on page 39. You can also obtain a form online at https://employeehealthplan.clevelandclinic.org.

Physicians should complete the form using specific laboratory data, physical exam findings, and other supporting documentation whenever possible in order to document the medical necessity of using a Non-Formulary Medication. Approvals will be granted only if the physician can document ineffectiveness of Formulary alternatives or the reasonable expectation of harm from the use of Formulary medications. A separate form should be submitted for each member for each Non-Formulary drug.
All requests must be in writing and signed by the prescribing physician. If a Non-Formulary drug is approved, the member will be responsible for a 30% co-insurance, with no monthly maximum out-of-pocket. The co-insurance amount will be applied to the yearly maximum out-of-pocket. Most requests will be processed within one to two business days from the time of receipt. A response will be faxed to the requesting physician, and we will also inform the member of the request and the decision via mail.

**Note:** Lower co-insurance will be assessed from the date of authorization. No refunds or adjustments will be made for previously purchased prescriptions. Depending upon the strength and/or formulation of the drug prescribed by your provider, different quantity limits apply. Please consult the Quantity Level Limits section beginning on page 21 of this *Handbook* for the specific quantity limit that applies to the particular strength/formulation of your medication.

**Instructions for a Physician on How to Complete the Prior Authorization, Formulary Exception and Appeal Form:**

1. Complete all information requested.
2. Submit a separate form for each member and for each drug you wish to have reviewed.
3. Keep a copy for your records.
4. Fax the form to: Cleveland Clinic Employee Health Plan
   EHP Pharmacy Management Department
   216.442.5790
   OR
   Mail the form to: Cleveland Clinic Employee Health Plan
   EHP Pharmacy Management Department
   6000 West Creek Road, Suite 20
   Independence, Ohio 44131

**Exception Process** – Once received, requests will be processed within 72 hours. Expedited requests may be made by calling EHP Pharmacy Management at 216.986.1050, option 4, or toll-free at 888.246.6648, option 4. In most cases, these requests will be reviewed and processed the same business day; however, calls received after 4 p.m. or during the weekend will be handled the next business day. One of the following criteria must be met to file an expedited request:

- The drug is necessary to complete a specific course of therapy after discharge from an acute care facility (e.g., hospital, skilled nursing facility).
- The timeframe required for a standard review would compromise the member’s life, health or functional status.
- The drug requires administration in a timeframe that will not be met using the standard process.

**Prior Authorization, Formulary Exception and Appeal Form**

See page 39 in the back of this *Handbook* for a full size version of the Prior Authorization, Formulary Exception and Appeal Form.

**Benefits and Coverage Clarification**

Detailed benefit coverage clarification information about the HBP Prescription Drug Benefit is included in the following pages. This information complements and further explains the Prescription Drug Benefit chart on page 2 in this *Handbook* and in the *SPD*, Section One: “Getting Started.”

**Breast Cancer Prevention Coverage**

Under the provisions of the Affordable Care Act mandate regarding breast cancer preventive health services, generic raloxifene and tamoxifen will be covered under the HBP Prescription Drug Benefit at no out-of-pocket expense only for female members 35 years of age or older when accompanied by a valid prescription from the member’s healthcare provider.

**Note:** These provisions of the Affordable Care Act are for retirees still covered by the CVS/caremark Pharmacy Benefit Program and do not apply to those retirees participating in the SilverScript Medicare Part D program.
Contraceptive Coverage

Under the provisions of the Affordable Care Act mandate regarding women’s preventive health services, contraceptives will be covered under the HBP Prescription Drug Benefit within the following guidelines:

- Diaphragms, emergency contraceptives, generic oral contraceptives, generic injectables (medroxyprogesterone) will be covered with no out-of-pocket expense for the member. However, a prescription from your health care provider is required.
- Brand name oral contraceptives that are not available generically require prior authorization. If the prior authorization request is approved, the member will not have any out-of-pocket expense. If the prior authorization request is denied, the brand name contraceptive will not be covered.
- Members who receive a brand name formulation of a contraceptive that is available generically will not pay any co-insurance but will be charged the difference in cost between the brand name contraceptive product and the generic alternative.
- Contraceptive products that do not require a prescription to be purchased are not covered under the HBP Prescription Drug Benefit.
- Members who are employed at Marymount Hospital are excluded from this coverage.
- Mirena and other intrauterine devices (IUDs) are not covered under the HBP Prescription Drug Benefit. Rather, they are covered under the medical benefit and no co-payment will be charged.

Oral Medications for Onychomycosis (Nail Fungus)

All oral prescriptions for the treatment of nail fungus are covered at the Non-Preferred rate (see the Prescription Drug Benefit chart on page 2), which is 45% at Cleveland Clinic/Akron General Pharmacies and Home Delivery Service or 50% at all other locations. This Non-Preferred rate is in effect for brand name and generic medications appropriate for treating this condition. Formulary overrides to reimburse 25% at Cleveland Clinic/Akron General Pharmacies or 30% at all other locations are given to members who have this condition and diabetes or some form of peripheral vascular disease (poor blood flow). Overrides are also given to any member who has the fingernail form of this condition; however, only one course of treatment will be covered at the Formulary rate in a lifetime. To obtain an override, please have your healthcare provider complete and submit a Prior Authorization, Formulary Exception and Appeal Form.

Over-The-Counter (OTC) Medications

Certain over-the-counter (OTC) medications that are available without a prescription are covered under the Prescription Drug Benefit.

The member must have a prescription from his or her provider and fill the prescription at a Cleveland Clinic or CVS/caremark Retail Network Pharmacy. The list includes:

- **Aspirin**: Prior authorization required
- **Iron Supplements**: Covered at 100% for members age 0–12 months
- **Oral Fluoride Products**: Covered at 100% for members age 0–5 years
- **Folic Acid**: Covered at 100% for **female** members age 40 and under
- **Tobacco Cessation Medications**:
  - Must be prescribed by an EHP approved Tobacco Cessation provider (in person) or EHP Tobacco Cessation eCoaching program provider (online only)
  - Coverage includes generic bupropion, brand Chantix, generic nicotine gum, generic nicotine lozenges, and generic nicotine patches
  - **Prescriptions must be filled at any Cleveland Clinic/Akron General Pharmacy**

All other OTC medications are not covered. When an OTC drug is available in the identical strength and dosage form as the prescription medication, and is approved for the same indications, the prescription drug is usually not covered by the HBP. Providers should recommend the equivalent OTC product to the member.

**Note:** These provisions of the Affordable Care Act are for retirees still covered by the CVS/caremark Pharmacy Benefit Program and do not apply to those retirees participating in the SilverScript Medicare Part D program.
Statin Medications for Primary Prevention of Cardiovascular Disease

Under the provisions of the Affordable Care Act mandate regarding cardiovascular disease preventive health services, generic formulary low to moderate dose statins will be covered under the HBP Prescription Drug Benefit at no member out-of-pocket expense within the following guidelines:

1. Members are between 40 and 75 years of age.

2. Members on generic formulary low to moderate dose statins require prior authorization in order to receive their medication at no member out-of-pocket expense. To begin this process, please have the prescribing provider submit a USPSTF Copay Free Statin Coverage Request Form to the Employee Health Plan Pharmacy Management Department (see page 40). If the prior authorization request is approved, the member will not have any out-of-pocket expense. If the prior authorization request is denied, the standard plan benefits will apply regarding statin coverage (see page 26).

3. Members who receive a brand name formulation of a formulary statin that is available generically will not pay any co-insurance but will be charged the difference in cost between the brand name statin product and the generic alternative.

4. For members who do not go through the prior authorization process, the standard plan benefits will apply regarding statin coverage (see page 26).

5. Statin products that do not require a prescription to be purchased are not covered under the HBP Prescription Drug Benefit (i.e., red yeast rice).

Note: These provisions of the Affordable Care Act are for retirees still covered by the CVS/caremark Pharmacy Benefit Program and do not apply to those retirees participating in the SilverScript Medicare Part D program

Non-Preferred Generic Medications

Generic formulations of the medications listed below are considered non-preferred medications and are subject to a 50% member co-insurance with no monthly maximum out-of-pocket expense:

- Abilify
- Actigall
- Adderall XR9
- Astelin
- Astepro
- Atacand
- Atacand HCT
- Avalide
- Avita cream
- Azor
- Benicar
- Benicar HCT
- Boniva 150 mg tabs
- Celebrex
- Concerta9
- Coreg CR
- Congard
- Cymbalta
- Daypro
- Detrol LA 4 mg
- Diovan 320 mg
- Ecoza cream
- Edular
- Enstilar Foam
- Exforge HCT
- Fentora
- Focalin XR9
- Frova
- Hectorol
- Hydrocortisone valerate 0.2% cream
- Inderal LA
- Intermezzo
- Lamisil
- Lialda
- Micardis HCT
- Pristiq
- Qudexy XR
- Retin-A cream
- Rozerem
- Sorilux Foam
- Sporanox capsules
- Strattera9
- Taclonex ointment
- Taclonex Topical Suspension
- Tekturna
- Tekturna HCT
- Teveten
- Tribenzor
- Twynsta
- Uloric
- Vectical Ointment
- Vytoryn
- Zemplar
- Zolpimist

9. EHP members under the age of 20 who are utilizing generic formulations of Adderall XR, Concerta, Focalin XR, and Strattera will continue to pay a Tier 1 co-insurance.
**Lifestyle Medications**

The medications listed below are able to be purchased such that members pay 100% co-insurance on the discounted price of the medication. The member’s out of pocket expense does not apply toward their annual pharmacy deductible nor their annual out-of-pocket maximum.

- Acticlate
- Addyi
- Caverject
- Cialis
- Clomid (males only)
- Cosmetic Agents
- Denavir Cream
- Doryx
- Doryx MPC
- Edex
- Evzio
- Fertility Agents
- Flumadine
- Hysingla
- Intrarosa
- Jublia
- Kerydin
- Latisse
- Levitra
- Muse
- Naloxone
- Narcan
- Nateto
- Non-controlled Cough and Cold Agents
- Oral Allergy Medication
- Oral Androgen Products
- Osphen
- Penlac
- Pregnenolone
- Propecia
- Relenza
- Saxenda
- Stendra
- Targadox
- Testosterone Cypionate
- Testosterone Enanthate
- Topical Androgen Products
- Vaniqa
- Viagra
- VIBRA-TABS
- Vivodex
- Weight Control Products
- Xartemus XR
- Xerese
- Xofluza
- Zipsor
- Zorvolex
- Zovirax Cream
- Zovirax Ointment

**Non-Covered Medications**

Due to the availability of generically available or over-the-counter alternatives, medications in the following drug classes are not covered by the HBP Prescription Drug Benefit:

**Brand Name**

- Abilify
- Absorica
- Actigall
- Adcirca
- Adderall XR
- Afinitor
- Aggrenox
- AirDuo
- Ambien
- Ambien CR
- Ampyra
- Asacol HD
- Astepro
- Boniva 150 mg tablets
- Celebrex
- Cleocin T 1% solution
- Cleocin T 1% gel
- Cleocin T 1% lotion
- Cleocin T 1% swab
- Concerta
- Coreg CR
- Corgard
- Crestor
- Cymbalta
- Daypro
- Detrol LA 4 mg
- Ecoza Cream
- Epclusa
- Epipen
- Epipen Jr.
- Flector
- Focalin XR
- Gleevec
- Harvoni 90/400 mg tablets
- Hectorol
- Inderal LA
- Kaletra
- Lialda
- Lyrica
- Nuvaring
- Onfi
- Oral Contraceptives (See Contraceptive Coverage information on page 14)
- Prometrium
- Protopic
- Retin-A Cream
- Revatio
- Sensipar
- Strattera
- Suboxone films
- Sustiva
- Tenormin
- Tracleer 62.5 mg tablets
- Tracleer 125 mg tablets
- Uloric
- Vagifem
- Valcyte
- Vibramycin
- Xopenex
- Zemplar
- Zytila
- Zyvox
Brand and Generic Versions

- 510(k) medical devices
- Unapproved drugs
- Abilify MyCite
- Aciphex
- Acyclovir oral solution
- Azithromycin 2% ointment
- Aklief
- Alcortin A 1-2-1% gel
- Altoprev
- Altreno
- Amcinonide 0.1% Cream
- Amcinonide 0.1% lotion
- Amcinonide 0.1% ointment
- Amrix
- Ana-Lex cream
- Anaprox DS
- Anovera
- Anucort-HC
- Anusol-HC suppositories
- Apadaz
- Aplenzin
- Aralast NP (Rx benefit)
- Arestin
- Atenolol+SyrSpended PH4 oral suspension
- Atridox
- Atropine Sulfate Ophthalmic Ointment
- Auvi-Q
- Avage
- AVAR Cleanser (sulfacetamide/sulfur 10-2%)
- AVAR Foam (sulfacetamide/sulfur 9.5-5%)
- AVAR LS Cleanser (sulfacetamide/sulfur 10-2%)
- AVAR LS Foam (sulfacetamide/sulfur 10-2%)
- AVAR Pad (sulfacetamide/sulfur 10-2%)
- AVAR-E emollient Cream (sulfacetamide/sulfur 10-5%)
- AVAR-E Green Cream (sulfacetamide/sulfur 10-5%)
- AVAR-E LS Cream (sulfacetamide/sulfur 10-2%)
- Avanex (medical benefit)
- Avonex (medical benefit)
- Awee
- Avenova Sol Neutrox
- Avsola (Rx benefit)
- Azelex Cream
- Azesco
- Bavencio (Rx benefit)
- Beconase AQ
- Beleodaq (Rx benefit)
- Belsomra
- Bendeka (Rx benefit)
- BenzaClin
- Benzoinate 150mg capsules
- Benzoyl Peroxide Agents
- Beovu (Rx benefit)
- Besponsa (Rx benefit)
- Betamethasone valerate 0.12% (Luxiq)
- Betaseron
- Binosto
- Bionect
- Blincyto (Rx benefit)
- Boniva IV (Rx benefit)
- Bontesta
- Botox (Rx benefit)
- Brineura (Rx benefit)
- Briviact
- Bryhali
- Butalbital/acetaminophen
- Butalbital/acetaminophencaffeine
- Butalbital/acetaminophencaffeine/codeine
- Butalbital/naproxen/caffeine/codeine 100mg
- Butalbital/naproxen/caffeine/codeine 200mg
- Butalbital/naproxen/caffeine/codeine 300mg
- Caduet
- Caphex 0.01% shampoo
- Carac 0.5% cream
- Caropin
- Cenovis
- Centany
- Centany AT
- Cepora
- Ceradex
- Ceramax Cream
- Chlorhexidine 250mg tablets
- Cimzia (for the diagnosis of Psoriasis)
- Cipro HC
- CiproDex
- Clarifioo (sulfacetamide/sulfur 10-5%)
- Clarus
- Clindacin ETZ 1%
- Clindacin P 1%
- Clindacin PAC 1%
- Clindamycin 1% foam
- Clindamycin-benzoyl peroxide 1.2%-5% gel
- Clindamycin-benzoyl peroxide 1%-5% gel
- Clindamycin-benzoyl peroxide 1%-5% gel with pump
- Clindamycin-tretinoin 1.2-0.25% gel
- Clinpro
- Clofastos propionate 0.05% Foam (hydroalcoholic)
- Clofastos propionate 0.05% Foam (non-aqueous)
- Clofastos propionate 0.05% Lotion
- Clofastos propionate 0.05% Shampoo
- Clofastos propionate 0.05% Spray
- Clotololone 0.1% Cream
- Consensi
- Conzip
- Copaxone (medical benefit)
- Cordran 0.05% Cream
- Cordran 0.05% Lotion
- Cordran 0.05% Ointment
- Cordran tape 4 mcg/sqcm
- Cortifom aerosol 90mg
- Cosentyx (only for the diagnosis of Psoriasis)
- Cotempla
- Covaryl
- Covaryl HS
- Crysvita (Rx benefit)
- Cyclobenzaprine 7.5mg tablets
- Cycloset
- Dacogen
- Darzalex (Rx benefit)
- Dayvigo
- Denata 5000 cream
- Dentagel
- Dermasorb AF 3%-0.5% cream
- Dermazene
- Desonate 0.05% gel
- Desonide 0.05% Lotion
- Desoximetasone 0.05% cream
- Desoximetasone 0.05% ointment
- Dexilant
- Dextenza
- Dextycum
- Diclegis
- Diclopr
- Differin 0.1% gel
- Differin 0.1% lotion
- Differin 0.3% gel with pump
- Diflorasone 0.05% emollient cream
- Diflorasone diacetate 0.05% Cream
- Diflorasone diacetate 0.05% Ointment
- Disalcid
- Donnatal
- Doryx
- Doxycycline monohydrate 75mg capsules/tablets
- Doxycycline monohydrate 150mg tablets
- Dritro-Creme HP
- Duvia (Rx and medical benefits)
- Ducac
- Dukalkr Pressair
- Duxes
- DULERA
- Duopa (Rx benefit)
- Durazol
- Durolane
- Dutompro
Brand and Generic Versions (continued)

- Dyanavel XR
- Dympista
- Dysport (Rx benefit)
- EC-Naprosyn
- EC-Naproxen
- ED BRON GP Liquid
- Edecrin
- EEMT
- EEMT HS
- Elaprase (Rx benefit)
- Elelyso (Rx benefit)
- Eletone
- Eletone Twinpack
- Elzonris (Rx benefit)
- Emflaza (both Rx and medical benefits)
- Emla 2.5% — 2.5% cream
- Emulsion SB
- Enbrel (only for the diagnosis of Psoriasis)
- Endari
- Etonogestrel/ethinyl estradiol vaginal ring
- Entty
- Epaned
- Epiceram
- Epiduo Gel with Pump
- Epiduo Forte Gel with Pump
- Erwinaze (Rx benefit)
- Erythromycin-benzoyl peroxide 3-5% gel
- Eskata
- Esterified Estrogens/Methyltestosterone
- Ethacrynic acid
- Ethacrynate Sodium
- Euflexxa
- Evekeo
- Evoclin 1% Foam
- Exondys 51 (both Rx and medical benefits)
- Extavia (medical benefit)
- Eylea (Rx benefit)
- Ezallor
- Fabrazyme (Rx benefit)
- Fenoprofen
- Flolipid
- Fionsa
- Fluocinonide gel
- Fluocinonide ointment
- Fluocinonide-E Cream
- Fluocinolone 0.01% (Derma-smoothe) Oil
- Fluocinonide 0.1% Cream
- Fluoridex
- Fluoroplex 1% cream
- Flurandrenolide 0.05% Cream
- Flurandrenolide 0.05% lotion
- Forfivo XL
- Fortamet
- Fosamax Oral Solution
- Fosamax Plus D
- Freestyle Libre diabetic test strips
- Galafold
- Gamifant (Rx benefit)
- Ganirelix
- Gazyva (Rx benefit)
- Gel-One
- Gel-Syn
- GenVisc 850
- Genadur
- Glyset
- GoNitro
- Gralise
- Guainfenesin-codeine liquid
- Guainfenesin DAC
- Guainfenesin DAC syrup
- Halog (halcinonide) 0.1% Cream
- Halog 0.1% ointment
- Hemangeol
- Hemmorex-HC suppositories
- Homatropine Hydrobromide
- Horizant
- HPR Plus
- Hyalog
- Hyaluronate Sodium Gel
- Hydrocortisone Acetate
- Hydrocortisone Acetate/Pramoxine
- Hydrocortisone butyrate (Locoid) 0.1% Lotion
- Hydrocortisone butyrate 0.1% cream (Locoid Lipo)
- Hydroquinone
- Hydroquinone Time Release
- Hydroxyprogesterone pens/vials
- Hygel
- Hylafem
- Hylatopic Plus
- Hymovis
- Hypophen
- Hypochlorous Acid Solution
- Iluvien (Rx benefit)
- Imbruvica 140 mg tablets
- Imbruvica 280 mg tablets
- Imfinzi (Rx benefit)
- Immunix (Rx benefit)
- Impozx
- Inbrija
- Inderal XL
- Injectafer (Rx benefit)
- InnoPran XL
- Iodoquinol-Hydrocortisone 1-1.9%
- Irenka
- Isomebethpene/Acetaminophen/Dichlorphenazone
- Isopomo Homatropine
- Ixifi
- Jatanzo
- Jeuveau
- Jornay PM
- Juxtapla (Rx benefit)
- Kanuma (Rx benefit)
- Karbinal ER
- Kappargo Sprinkles ER
- Katerzia
- Keveyis
- Keytruda (Rx benefit)
- Keytrza
- Lamotrigine (Rx benefit)
- Laronidase (Rx benefit)
- Lartruvo
- Lieutenant (Rx benefit)
- Linezolid oral suspension (members ≥ 12 years of age)
- Liptruzet
- Lodine extended-release
- Lodine immediate-release 300 mg capsules
- Lopressor HCT
- Lorzone
- Loyon
- Lucentis (Rx benefit)
- Lumizyme (Rx benefit)
- Lumoxiti (Rx benefit)
- Lurasil
- Lutathera (Rx benefit)
- Lyxvor extended-release
- Luxturna (Rx benefit)
- Lyrica CR
- Macugen (Rx benefit)
- Makana
- ME/Naphos/MBSiop/Hyo1
- Meclofenamate
- Mefenamic Acid
- Megestrol acetate 625 milligrams/5 milliliters suspension
- Mepsevii (Rx benefit)
- Methylphenidate ER 72 mg tablets
- Mifrad
- Miren (Rx benefit)
- Monodox
- Mydayis
- Miflumofen (Rx benefit)
- Mylotarg (Rx benefit)
- Myobloc (Rx benefit)
- Naproxen controlled-release
- Naproxen delayed-release
- Naproxen EQ
- Naproxen extended-release
- Naproxen suspension
- Nasacort
- Nasacort AQ
- Nasonex
- Neosalus
Brand and Generic Versions (continued)

- Neosalus CP
- Neuc
- Nexium
- Nexplanon
- Nitrolingual
- Noritrate
- Novacort External gel 2-1-1%
- Nucynta extended-release
- Nucynta immediate-release
- Nulojix (Rx benefit)
- Nuvail
- Ocrevus (Rx benefit)
- O deficits
- Omitriva
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
- Onzetra Xsail
- Ofirmev
- Omidria
- Omnaris
- Oncaspar (Rx benefit)
- Onivyde (Rx benefit)
- Onmel
- Onpatro (Rx benefit)
Brand and Generic Versions  (continued)

- UroAv-B
- Ustell
- Uticap
- Utira-C
- Utrona-C
- Utopic
- Vanatol LQ
- Vanatol S
- Vanoxide HC
- Vectibix (Rx benefit)
- Veltin
- Venelex Ointment
- Veramyst
- Verdeso 0.05% Foam
- Vilamit MB
- Vileve MB
- Vimovo
- Virtussin
- Virtussin DAC
- Visco-3
- Vivitol
- Voltaren 1% gel
- Vusion 0.25%-0.15% ointment
- Vyepi (Rx benefit)
- Vyleesi
- Vyondys 53
- Vytone 1.9%-1% cream
- Vyvanse
- Xalix
- Xeomin (Rx benefit)
- Xeotox Pads
- Xhance
- Xiaflex (Rx benefit)
- Ximino
- Xenofo (Rx benefit)
- Xyosted
- Yervoy (Rx benefit)
- Yescarta (Rx benefit)
- Yonsa
- Yoospira
- Yutiq (Rx benefit)
- Yuvalfem
- Zantac
- Zegerid
- Zelapar
- Zemaira (Rx benefit)
- Zembrace
- Zencia wash liquid (sulfacetamide/sulfur 9-4%)
- Zensedi (effective 1/1/19)
- Zetontana
- Ziana
- Zilretta
- Zinplava (Rx benefit)
- Zolgensma (Rx benefit)
- Zovirax oral suspension
- Ztiido
- Zulresso (Rx benefit)
- Zyflo continuous-release/extended-release
- Zyflo immediate-release

Pharmacy Management Programs

Mandatory Maintenance Drug Program

Members may use any of the Cleveland Clinic/Akron General Pharmacies, or a CVS store pharmacy for obtaining prescription medications for an immediate need, a one-time prescription medication (example: antibiotics), or the first fill of a maintenance medication. Maintenance medications include drugs taken regularly to treat chronic medical conditions such as asthma, diabetes, or high blood pressure, as well as drugs taken on a long-term basis, such as contraceptives.

Refills of all maintenance drugs must be obtained through one of the following three options:

- **Cleveland Clinic Pharmacy Home Delivery Service** – Home delivery enables you to order up to a 90-day supply of your maintenance medication refill prescriptions, which are delivered to your home, saving you a trip to the pharmacy. There is no extra charge for home delivery and you will save 5% on your co-insurance compared to using the CVS/caremark Mail Service Program (see page 7 for details).

- **Cleveland Clinic/Akron General Pharmacies** – Drop off your maintenance prescriptions for refill at any of the 19 Cleveland Clinic/Akron General Pharmacy locations in northeast Ohio or the Weston Pharmacy in Florida. You can obtain up to a 90-day supply of medication and you will save 5% on your co-insurance (see page 3 for details).

- **CVS/caremark Mail Service Program** – You can order up to a 90-day supply of your maintenance medication prescription to be delivered to your home, but will not get the same 5% discount available when you order your prescription from a Cleveland Clinic/Akron General Pharmacy or the Home Delivery Pharmacy.

In addition, some maintenance medications must be refilled for three month supplies at a Cleveland Clinic/Akron General Pharmacy, through the Cleveland Clinic Home Delivery Pharmacy, or through the CVS/caremark Mail Service in order to be covered. A complete list of these maintenance medications can be found at [https://employeehealthplan.clevelandclinic.org](https://employeehealthplan.clevelandclinic.org).

Medications Limited by Provider Specialty

The continual development of complex drug therapy options requires that certain medications be prescribed by an appropriate specialist (e.g., cardiologist, neurologist, oncologist) to ensure appropriate use. If these medications are not prescribed by an approved specialist, prior authorization (see page 9) must be obtained for coverage under the Prescription Drug Benefit. The first medication included in this category is **Multaq**, which must be prescribed by a cardiologist. Additional medications limited by provider specialty (prescription written by a specialist) may be added to the Formulary in the future. Prescriptions written by non-specialists will need prior authorization. Please consult the **HBP Prescription Drug Formulary Handbook** to determine if your medication is limited by provider specialty.
Quantity Level Limits

Quantity level limits are applied to medications for various reasons. For example, to prevent medication misuse or abuse, to promote adherence to an appropriate course of therapy for reasons of efficacy and safety, and to prevent the stockpiling of medication. The Cleveland Clinic Health Benefit Program will continue to monitor drug utilization to possibly expand quantity level limits for other medications.

- Abilify: 1 tablet per day
- Absorica LD: 2 capsules per day
- Abstral: 4 tablets per day; restricted to 30-day supply
- Actemra ACTPen: 4 auto-injector pens per 28 days
- Actemra prefilled syringes: 4 prefilled syringes per 28 days
- Acthar gel: two 5 milliliter vials per prescription
- Actiq: 4 lozenges per day; restricted to 30-day supply
- Actonel 35 mg: 4 tablets per 28 days
- Actos 15 mg: 1 tablet per day
- Adcirca: 2 tablets per day
- Adempas: 90 tablets per 30 days
- Adlyxin: 6 mL (2 pens) per 30 days
- Aemcolo: 12 tablets per 30 days
- Afinitor: limit based on instructions for use; included in split fill program
- Aimovig: 1 auto-injector/prefilled syringe per 30 days
- AirDuo: 1 inhaler per 30 days
- Ajovy: 3 prefilled syringes (225 mg ea) per 90 days
- Akynzeo: 1 capsule per day
- Albenza: 120 tablets per 30 days
- Alecensa: 240 capsules per 30 days
- Alunbrig: 180 tablets per 30 days
- Alyq: 2 tablets per day
- Ambien controlled-release: 1 tablet per day
- Ambien immediate-release: 1 tablet per day
- Amblyf: 1 tablet per day
- Amerge tablets: 9 tablets per 30 days
- Ampyra: 60 tablets per 30 days
- Angeliq: 1 tablet per day
- Anzemet: 6 tablets per 30 days
- Aptiom 200 mg, 400 mg: 1 tablet per day
- Atripla 600 mg, 800 mg: 2 tablets per day
- Aralen: 30 tablets per 30 days
- Arnuity Ellipta: 1 inhaler (30 blisters) per 30 days
- Austedo 6 mg: 720 tablets per 90 days
- Austedo 9 mg: 450 tablets per 90 days
- Austedo 12 mg: 360 tablets per 90 days
- Avalide: 1 tablet per day
- Avapro: 1 tablet per day
- Axert tablets: 12 tablets per 30 days
- Ayvakit: 1 tablet per day
- Azor: 1 tablet per day
- Balversa 3mg: 84 tablets per 28 days
- Balversa 4mg: 56 tablets per 28 days
- Balversa 5mg: 28 tablets per 28 days
- Baxdela: 28 tablets per 14 days; 28 vials per 14 days
- Braffovii: 6 capsules per day
- Belbuca: 2 films per day
- Benicar: 1 tablet per day
- Benicar HCT: 1 tablet per day
- Bevespi Aerosphere: 1 inhaler per 30 days
- Bijuva: 1 capsule per day
- Biktarvy: 1 tablet per day
- Boniva 150 mg: 1 tablet per 30 days
- Bosulif: limit based on instructions for use; included in split fill program
- Breo Ellipta: 1 inhaler per 30 days
- Briselle: 1 tablet per day
- Briviat oral solution: 20 mL per day
- Briviate tablets: 2 tablets per day
- Brukinsa: 4 capsules per day; included in split fill program
- Butrans: 4 patches per 28 days
- Bydureon pens: 4 pens per 30 days
- Bydureon vials: 4 vials per 30 days
- Byetta: 2.4 mL (1 pen) per 30 days
- Bystolic 2.5 mg: 1 tablet per day
- Bystolic 5 mg: 1 tablet per day
- Bystolic 10 mg: 1 tablet per day
- Bystolic 20 mg: 2 tablets per day
- Cablivi: 1 kit per day
- Cabometyx: 1 tablet per day
- Calquence: 60 capsules per 30 days
- Caplyla: 1 capsule per day
- Cimzia starter kit: 6 syringes per lifetime
- Cimzia maintenance kit: 2 syringes per 28 days
- ClimaraPro: 4 patches per 28 days
- CombiPatch: 8 patches per 28 days
- Cometriq: limited based on instructions for use
- Copaxone 20 mg/mL: 1 prefilled syringe per day
- Copaxone 40 mg/mL: 12 prefilled syringes per 28 days
- Copiktra: 2 capsules per day
- Corlanor: 60 tablets per 30 days
- Cosentyx: 30-day supply; limit based on instructions for use
- Cosentyx: 1 syringe/pen per 28 days
- Cotelllic: 21 tablets per 28 days
- Cremesma: 1 vial per day; 2 capsules per day
- Crestor: 1 tablet per day
- Cymbalta: 1 capsule per day
- Daklinza: 1 tablet per day
- Daurismo 100 mg: 30 tablets per 30 days
- Daurismo 25 mg: 60 tablets per 30 days
- Desco: 1 tablet per day
- Detrol LA 2 mg: 1 capsule per day
- Dihydroergotamine mesylate injections-60 vials/ampules (1 mL per vial) per 90 days
- Dihydroergotamine mesylate nasal spray-24 vials (3 kits) per 90 days
- Dipentum: 4 capsules per day
## Quantity Level Limits (continued)

- **Doptelet**: 15 tablets per 365 days
- **Dovato**: 1 tablet per day
- **Duavee**: 1 tablet per day
- **Dupixent**: 26 syringes per 365 days
- **Edarbi**: 1 tablet per day
- **Edarbyclor**: 1 tablet per day
- **Edular**: 1 tablet per day
- **Effexor XR 37.5 mg**: 1 capsule/tablet per day
- **Effexor XR 75 mg**: 1 capsule/tablet per day
- **Elidel cream**: 60 grams per 30 days
- **Eliquis Starter Pack**: 74 tabs every 30 days
- **Eliquis 2.5 mg**: 60 tabs every 30 days
- **Eliquis 5 mg**: 74 tabs every 30 days
- **Elmiron**: 3 capsules per day
- **Emcyt**: 30-day supply; limit based on instructions for use
- **Emend**: limit based on instructions for use
- **Emgality 100 mg syringes**: 3 syringes per 30 days
- **Emgality 120 mg pens/syringes**: 6 prefilled pens/syringes per 180 days
- **Enbrel 50 mg/mL pens**: 4 pens per 28 days
- **Enbrel 50 mg/mL syringes**: 4 syringes per 28 days
- **Enbrel 25 mg/mL syringes**: 8 syringes per 28 days
- **Enbrel 25 mg/mL vials**: 8 vials per 28 days
- **Enstilar Foam**: 120 grams per 30 days
- **Entocort**: 3 capsules per day
- **Entresto**: 2 tablets per day
- **Entyvio**: 8 vials per 3-5 days
- **Envarsus XR**: 1 tablet per day
- **Epleura**: 1 tablet per day
- **EpiPen (generic only)**: 4 pens per 30 days; 24 pens per 365 days
- **EpiPen Jr. (generic only)**: 4 pens per 30 days; 24 pens per 365 days
- **Erlivedge**: limit based on instructions for use; included in split fill program
- **Erleada**: 4 tablets per day
- **Esbriet**: 9 capsules per day
- **Estradiol vaginal tablets**: 18 tablets per 30 days
- **Eucrisa ointment**: 60 grams per 30 days
- **Eventy**: 2 prefilled syringes per 30 days
- **Exforge**: 1 tablet per day
- **Exforge HCT**: 1 tablet per day
- **Eylea**: One 0.05 mL injection every 4 weeks
- **Famvir**: 30 tablets per 365 days
- **Fanapt**: 2 tablets per day
- **Fanapt titration pak**: 8 tablets per 365 days
- **Farxiga**: 1 tablet per day
- **Farydak**: 6 capsules per 21 days
- **Fasenra pens**: 3 pens per 180 days
- **Fasenra prefilled syringes**: 3 syringes per 180 days
- **Fentora**: 4 tablets per day; restricted to 30-day supply
- **Fetzima**: 30 capsules per 30 days
- **Flector**: 2 patches per day; restricted to 30-day supply
- **Forteo**: One pen (2.4 milliliters) per 30 days
- **Fosamax 35 mg**: 4 tablets per 28 days
- **Fosamax 70 mg**: 4 tablets per 28 days
- **Frova tablets**: 9 tablets per 30 days
- **Fycompa**: 1 tablet per day
- **Gattex**: 30 vials per 30 days
- **Genvoya**: 1 tablet per day
- **Giotrif**: 1 tablet per day
- **Glatopa 20 mg/mL**: 1 prefilled syringe per day
- **Glaptopa 40 mg/mL**: 12 prefilled syringes per 28 days
- **Gleevec**: limit based on instructions for use; included in split fill program
- **Glyxambi**: 1 tablet per day
- **Harvoni**: 1 tablet per day
- **Hetlioz**: 1 capsule per day
- **Humira prefilled syringe kit 40 mg/0.8 mL**: 2 syringes per 28 days
- **Humira prefilled syringe kit 10 mg/0.2 mL**: 2 syringes per 28 days
- **Humira prefilled syringe kit 20 mg/0.4 mL**: 2 syringes per 28 days
- **Humira pediatric crohns disease starter pack**: 3 syringes per lifetime
- **Humira adult crohns disease starter pack**: 6 pens per lifetime
- **Humira pen-injector kit 40 mg/0.8 mL**: 2 pens per 28 days
- **Humira psoriasis starter pack**: 4 pens per lifetime
- **Hyacintin**: 30-day supply; limit based on instructions for use
- **Ibrance**: 21 tablets per 28 days
- **Idhifa**: 1 tablet per day
- **Ilumya**: 5 syringes per 12 months
- **Imbruvica 70 mg capsules**: one capsule per day
- **Imbruvica 140 mg capsules**: 3 capsules per day
- **Imbruvica 420 mg tablets**: one tablet per day
- **Imbruvica 560 mg tablets**: one tablet per day
- **Imitrex tablets**: 9 tablets per 30 days
- **Imitrex nasal spray**: 9 sprays per 30 days
- **Imitrex injection**: 4 kits per 30 days
- **Impavido**: 3 capsules per day
- **Inflectra**: limit based on instruction for use
- **Ingrezza**: 60 capsules per 30 days
- **Inlyta 1 mg tablets**: 180 tablets per 30 days; included in split fill program
- **Inlyta 5 mg tablets**: 120 tablets per 30 days; included in split fill program
- **Intermezzo**: 1 tablet per day
- **Invokamet/Invokamet XR**: 2 tablets per day
- **Invokana**: 1 tablet per day
Quantity Level Limits (continued)

- Inrebic: 4 capsules per day
- Iressa: 1 tablet per day
- Iressa: 30-day supply; limit based on instructions for use
- Jakafi: limit based on instructions for use; included in split fill program
- Janumet/Janumet XR: 2 tablets per day
- Januvia: 1 tablet per day
- Jardiance: 1 tablet per day
- Jentadueto/Jentadueto XR: 2 tablets per day
- Jynarque: 2 tablets per day
- Kalydeco: 60 tablets per 30 days
- Kazano: 2 tablets per day
- Kevzara: 2.28 milliliters (2 syringes) per 30 days
- Kinerec: 240 vials per 30 days
- Kineret prefilled syringes: 18.76 mL (28 prefilled syringes) per 28 days
- Kisqali 200 dose: 21 tablets per 30 days
- Kisqali 400 dose: 42 tablets per 30 days
- Kisqali 600 dose: 63 tablets per 30 days
- Kisqali Femara 200 dose: 49 tablets per 30 days
- Kisqali Femara 400 dose: 70 tablets per 30 days
- Kisqali Femara 600 dose: 91 tablets per 30 days
- Kombiglyze XR: 2 tablets per day
- Kytril: 12 tablets per 30 days
- Latuda: 1 tablet per day
- Lazanda: 30 bottles per month; restricted to 30-day supply
- Lenvima: limit based on instructions for use; included in split fill program
- Lescol/Lescol XL: 1 tablet per day
- Letairis: 1 tablet per day
- Lialda: 4 tablets per day
- Librax: 8 capsules per day
- Lidocaine 2% gel: 30 grams per 25 days
- Lidocaine 4% gel: 30 grams per 25 days
- Lidocaine 5% ointment: 50 grams per 25 days
- Lidocaine 4% solution: 50 milliliters per 25 days
- Linzess: 1 tablet per day
- Lokelma: 30 packets per 30 days
- Lonhala Magnair: 2 vials per day
- Lonsurf: limit based on instructions for use
- Lorbrena 100 mg: 30 tablets per 30 days
- Lorbrena 25 mg: 90 tablets per 30 days
- Lovaza: 4 capsules per day
- Lucentis: 2 injections per 28 days
- Lucemyra: 224 tablets per 6 months
- Lunesta: 1 tablet per day
- Lynparza: 16 capsules per day
- Lyrica CR: 1 tablet per day
- Lysteda: 30 tablets per 30 days
- Mavenclad: 20 tablets per 365 days
- Mavyret: 84 tablets per 28 days
- Maxalt tablets: 9 tablets per 30 days
- Mayzent 2 mg tablets: 30 tablets per 30 days
- Mayzent 0.25 mg tablets: 120 tablets per 30 days
- Mekinist: 1 tablet per day
- Mektovi: 6 tablets per day
- Mesalamine tablets: 6 tablets per day
- Micardis: 1 tablet per day
- Micardis HCT: 1 tablet per day
- Movantik: 1 tablet per day
- Mulpleta: 7 tablets per 365 days
- Mupirocin cream: 60 grams per prescription fill
- Myrbetriq: 1 tablet per day
- Namenda XR: 1 capsule per day
- Natpara: 2 cartridges per 28 days
- Nayzilam: 8 spray bottles per 30 days
- Nerlynx: 6 tablets per day
- Nesina: 1 tablet per day
- Neupro: 1 patch per day
- Nexavar: limit based on instructions for use; included in split fill program
- Nexletol: 1 tablet per day
- Nexlizet: 1 tablet per day
- Nikita: 1 tablet per day
- Ninlaro: 3 capsules per 28 days
- Northera 100 mg: 3 capsules per day
- Northera 200 mg: 6 capsules per day
- Northera 300 mg: 6 capsules per day
- Nucala: 1 vial, auto-injector, or prefilled syringe per 28 days
- Nuplazid: 2 tablets per day
- Nurtec ODT: 8 tablets per 30 days
- Nuvaring: 1 ring per 28 days
- Ocaliva: 1 tablet per day
- Ocrevus: 4 vials (40 milliliters) per 365 days
- Odactra: 1 tablet per day
- Odefsey: 1 tablet per day
- Odomzo: 1 capsule per day
- Ofev: 2 capsules per day
- Olumiant: 1 tablet per day
- Olysin: 1 capsule per day
- Omeclamox: 80 capsules/tablets per 180 days
- Omnipod Dash: 10 pods per 30 days
- Onglyza: 1 tablet per day
- Opsumit: 1 tablet per day
- Orenitram: 3 tablets per day
- Orenitram: 125 mg/mL: 4 autoinjectors per 28 days
- Orenitram subcutaneous: 4 vials per 28 days
- Orilissa 150 mg tablets: 30 tablets per 30 days
- Orilissa 200 mg tablets: 60 tablets per 30 days
- Orkambi: 4 tablets per day
- Oseni: 1 tablet per day
- Otezla: 2 tablets per day
- Otrexup: 4 auto-injector pens per 30 days
- Oxbyra: 3 tablets per day
- Oxervate: 56 milliliters per lifetime
Quantity Level Limits (continued)

- Oxtellar XR 150 mg: one tablet per day
- Oxtellar XR 300 mg: one tablet per day
- Oxtellar XR 600 mg: 4 tablets per day
- Piqray 200 mg pack: 28 tablets per 28 days
- Piqray 250 mg pack: 56 tablets per 28 days
- Piqray 300 mg pack: 56 tablets per 28 days
- Palforzia 300 mg maintenance kit: 30 sachets per 30 days
- Palforzia initial dose escalation kit – two kits per year
- Palforzia up-dosing kits – one kit per year per dosing level
- Plaquenil: 90 tablets per 30 days
- Pliaglis 7%: 7% cream-30 grams per 25 days
- Pomalyst: 1 capsule per day
- Praluent: 2 syringes/pens per 28 days
- Prefect: 1 tablet per day
- Premphase: 1 tablet per day
- Prempro: 1 tablet per day
- Prevac: 112 capsules/tablets per 180 days
- Previmis solution: 24 milliliters per day
- Previmis tablets: 1 tablet per day
- Pristiq: 1 tablet per day
- Progesterone capsules: 2 capsules per day
- Prudoxin: 60 grams per 90 days
- Qbrexa: 30 cloths per 30 days
- Qtern: 1 tablet per day
- Ranexa: 2 tablets per day
- Rasuvo: 4 auto-injector pens per 30 days
- Relistor tablets: 90 tablets per 30 days
- Relistor syringes/vials: 30 prefilled syringes or 30 vials per 30 days
- Relipax tablets: 12 tablets per 30 days
- Remicade: limit based on instructions for use
- Renflexis: limit based on instructions for use
- Repatha 140 mg/mL: 2 syringes/pens per 28 days
- Repatha 420 mg/mL: 1 cartridge per 28 days
- Restasis: 60 single-use vials per 30 days
- Revatio injectable vials: 1,125 milliliters per 30 days
- Revatio oral suspension: 112 milliliters per 30 days
- Revatio tablets: 90 tablets per 30 days
- Revlimid: 30-day supply; limit based on instructions for use
- Rexulti: 1 tablet per day
- Reyvow 50 mg: 4 tablets per 30 days
- Reyvow 100 mg: 8 tablets per 30 days
- Rhopressa: 5 milliliters per 30 days
- Rinoq: 1 tablet per day
- Rozerem: 1 tablet per day
- Rubraca: 120 tablets per 30 days; included in split fill program
- Ruzurgi: 150 tablets per 30 days
- Rybelsus: 1 tablet per day
- Rydapt: 240 capsules per 30 days
- Samsca: 2 tablets per day
- Saphris: 2 sublingual tablets per day
- Secuado: 1 patch per day
- Seebri Neohaler: 60 capsules per 30 days
- Segluromet: 2 tablets per day
- Silili: 2 syringes (3 milliliters) per 28 days
- Simponi 50 mg syringes: 1 syringe per 28 days
- Simponi 50 mg auto-injector: 1 auto-injector per 28 days
- Simponi 100 mg syringes: 1 syringe per 28 days
- Simponi 100 mg auto-injectors: 1 auto-injector per 28 days
- Skyrizi: 2 prefilled syringes per 84 days
- Soliqua: 15 mL (5 pens) per 30 days
- Sonata: 1 capsule per day
- Sorilux Foam: 120 grams per 30 days
- Sovaldi: 30 tablets per 30 days
- Spravato: 4 kits per 28 days
- Spritam: 60 tablets per 30 days
- Spritam: 60 tablets per 30 days
- Sprycel: limit based on instructions for use; included in split fill program
- Steglatro: 1 tablet per day
- Steglujan: 1 tablet per day
- Stelara 45 mg/0.5 mL injection: 1 vial per 12 weeks
- Stelara 90 mg/mL prefilled syringe: 1 syringe per 12 weeks
- Suboxone sublingual tablets: 45 tablets per 365 days
- (without prior authorization)
- Subsys: 4 spray units per day; restricted to 30-day supply
- Sunosi: 1 tablet per day
- Sustiva capsules: 2 capsules per day
- Sustiva tablets: 1 tablet per day
- Sutent: limit based on instructions for use; included in split fill program
- Symdeko: 60 tablets per 30 days
- Symproic: 1 tablet per day
- Synflex: 2 patches per 25 days
- Synjardy/Synjardy XR: 2 tablets per day
- Tabloid: 30-day supply; limit based on instructions for use
- Taclonex Ointment: 60 grams per 30 days
- Taclonex Topical Suspension: 60 grams per 30 days
- Tafinlar: 4 capsules per day
- Tagrisso: 4 spray units per day
- Takhzyro: 2 syringes per day
- Taltz: 1 syringe/auto-injector per 28 days
- Talzenna 1 mg: 30 capsules per 30 days
- Talzenna 0.25 mg: 90 capsules per 30 days
- Tamiflu capsules: 10 capsules per 180 days
- Tamiflu suspension: 120 mL per 180 days
- Tarceva 25 mg tablets: 60 tablets per 30 days
- Tarceva 100 mg tablets: 30 tablets per 30 days
- Talzenna 25 mg tablets: 30 tablets per 30 days
- Targetit: limit based on instructions for use; included in split fill program
- Tasigna: limit based on instructions for use; included in split fill program
- Tavalisse: 2 tablets per day
- Tazverik: 8 tablets per day
## Quantity Level Limits (continued)

- Tecfidera 120 mg capsules: 14 capsules per 6 months
- Tecfidera 240 mg capsules: 60 capsules per 30 days
- Tecfidera starter pack: 60 capsules per 6 months
- Technivie: 2 tablets per day
- Tegsedi: 6 mL (4 prefilled syringes) per 28 days
- Tekturna: 1 tablet per day
- Tekturna HCT: 1 tablet per day
- Temazepam: 1 tablet per day
- Teslac: 30-day supply; limit based on instructions for use
- Teveten: 1 tablet per day
- Tibsovo: 60 tablets per 30 days
- Tiglutik: 600 mL per 30 days
- Toradol 10 mg: 20 tablets per 30 days
- Tracleer: 2 tablets per day
- Tracleer: 60 tablets per 30 days
- Tradjenta: 1 tablet per day
- Tremfya: 2 syringes per 84 days
- Triazolam: 1 tablet per day
- Tribenzor: 1 tablet per day
- Trijardy XR: 2 tablets per day
- Trikafta: 84 tablets per 28 days
- Trintellix: 30 tablets per 30 days
- Trulance: 1 tablet per day
- Trulicity: 4 pens (2 mL) per 30 days
- Valtoco: 10 doses per 30 days
- Valtrex 500 mg: 10 tablets per 30 days
- Valtrex 1000 mg: 30 tablets per 365 days
- Various acetaminophen containing products: 4 grams a day
- Varubi: 4 tablets per 28 days; restricted to 28-day supply
- Vascepa 1 gram: 4 capsules per day
- Vascepa 0.5 grams: 8 capsules per day
- Vectaril: 100 grams per 30 days
- Veeffect: limited based on instructions for use
- Venclexa: limited based on instructions for use
- Verzenio: 60 tablets per 30 days; included in split fill program
- Viberzi: 2 tablets per day
- Victoza: 3 pens (9 mL) per 30 days
- Viekira: 4 tablets per day
- Viibryd: 30 tablets per 30 days
- Vitrakvi 100 mg: 60 capsules per 30 days
- Vitrakvi 25 mg: 180 capsules per 30 days
- Vitrakvi 20 mg/mL oral solution: 300 mL per 30 days
- Vosevi: 1 tablet per day
- Votrient: 800 mg per day; included in split fill program
- Vumerity: 4 capsules per day
- Vyndamax: 1 capsule per day
- Vyndaqel: 4 capsules per day
- Vyorin: 1 tablet per day
- Wakix: 2 tablets per day
- Wellbutrin XL: 1 tablet per day
- Xadago: 1 tablet per day
- Xarelto Stater Pack: 51 tabs every 30 days
- Xarelto 2.5 mg: 60 tabs every 30 days
- Xarelto 10 mg: 30 tabs every 30 days
- Xarelto 15 mg: 30 tabs every 30 days
- Xarelto 20 mg: 30 tabs every 30 days
- Xeljanz 5 mg: 2 tablets per day
- Xeljanz 10 mg: 2 tablets per day
- Xeljanz XR 11 mg: 1 tablet per day
- Xeljanz XR 22 mg: 1 tablet per day
- Xepi: One tube per 30 days
- Xigduo XR: 2 tablets per day
- Xiidra: 60 single-use vials per 30 days
- Xolair 75 milligram syringes: 2 prefilled syringes per 28 days
- Xolair 150 milligram syringes: 4 prefilled syringes per 28 days
- Xtandi: 120 capsules per 30 days
- Xultophy: 5 pens (15 mL) per 30 days
- Xyrem: 540 mL per 30 days
- Xylose: 30 capsules per 30 days
- Xylenx: 1 tablet per day
- Zacks: 1 tablet per day
- Zejula: 100 capsules per 30 days
- Zelboraf: 8 tablets per day; included in split fill program
- Zepatier: 1 tablet per day
- Zepotier: 1 tablet per day
- Zoloft: 30 tablets per 30 days
- Zolofr: 30 tablets per 30 days
- Zoloft: 30 tablets per 30 days
- Zyvox oral suspension: 12 bottles (1800 mL) per 30 days
- Zyvox tablets: 2 tablets per day
- Zoloft: 30 tablets per 30 days
- Zyvox: 30 tablets per 30 days
- Zyvox: 30 tablets per 30 days
- Zypatrom: 1 tablet per day
- Zypitamag: 1 tablet per day
- Zytiga: 4 tablets per day; included in split fill program
- Zofran: 30 tablets per 30 days
15. Covered under the prescription benefit and delivered by specialty pharmacy to member’s health care provider.
16. Not covered as first line therapy. Use Humatrope or Norditropin.
**Split Fill Program**

HBP members *beginning* therapy with any of the medications listed below will be limited to a 15-day supply for the initial two months of therapy to ensure the member tolerates the medication:

- Afinitor
- Bosulif
- Erivedge
- Gleevec
- Imbruvica
- Inlyta
- Jakafi
- Nexavar
- Rubraca
- Sprycel
- Sutent
- Tarceva
- Targretin
- Tasigna
- Verzenio
- Votrient
- Xandi
- Zelboraf
- Zolinza
- Zytiga

**Mandatory Statin Cost Reduction Program**

Cholesterol medications in the statin class are among the most commonly prescribed medications to HBP members. These statins are considered maintenance medications. Refills for statin medications must be obtained from any Cleveland Clinic/Akron General Pharmacy to be included in the Statin Cost Reduction Program. Tablet splitting Lipitor, generic Lipitor, or using one of the generic statins such as fluvastatin immediate release, lovastatin, pravastatin, rosuvastatin, or simvastatin will help members save money. The annual deductible must be satisfied before members receive the reduced co-insurance associated with this program.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Is this Medication Available Generically?</th>
<th>Do I Have to Split Tablets?</th>
<th>Member Cost Amount per 90-Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crestor</td>
<td>rosuvastatin</td>
<td>Yes</td>
<td>Yes (but not if your dose is 40 mg/day)</td>
<td>Generic Crestor10 – $6.0011</td>
</tr>
<tr>
<td>Lescol</td>
<td>fluvastatin immediate release</td>
<td>Yes</td>
<td>No</td>
<td>Generic Lescol10 immediate release – $6.0011</td>
</tr>
<tr>
<td>Lipitor</td>
<td>atorvastatin</td>
<td>Yes</td>
<td>Yes (but not if your dose is 80 mg/day)</td>
<td>Generic Lipitor10 – $6.00</td>
</tr>
<tr>
<td>Mevacor</td>
<td>lovastatin</td>
<td>Yes</td>
<td>No</td>
<td>Generic Mevacor10 – $6.0011</td>
</tr>
<tr>
<td>Pravachol</td>
<td>pravastatin</td>
<td>Yes</td>
<td>No</td>
<td>Generic Pravachol10 – $6.0011</td>
</tr>
<tr>
<td>Zocor</td>
<td>simvastatin</td>
<td>Yes</td>
<td>No</td>
<td>Generic Zocor10 – $6.0011</td>
</tr>
</tbody>
</table>

10. Members pay the lesser of $6.00 or the Usual and Customary (U&C) price for the particular generic statin prescription being filled.

11. Under this program, the standard generic medication policy applies, if the member receives the brand name versions of Crestor, Lescol, Lipitor, Mevacor, Pravachol, or Zocor.

**Tablet Splitting**

Members using Lipitor, or generic Lipitor are required to split their tablets for coverage under the HBP Prescription Drug Benefit. The Cleveland Clinic’s purchase prices for each of these medications are similar for different strength tablets. For example, an equal quantity of generic Lipitor 20 mg tablets and generic Lipitor 40 mg tablets cost the same. Therefore, members who split larger dose tablets in half to obtain their prescribed dose reduce the total amount of tablets purchased. This reduces medication costs and allows the HBP to pass on significant savings to members (For additional savings, see Generic Statins below).

If your provider prescribes a dose appropriate for tablet splitting, the prescription should be written that way. For example, if your daily dose is Generic Lipitor 20 mg, your prescription should be written as follows:

Generic Lipitor 40 mg #45 – Take one-half tablet daily
This will provide you with 90 20 mg doses.

Members on maximum doses (e.g., generic Lipitor 80 mg per day) of any statin products cannot split their tablets. However, they still receive the reduced co-insurance as long as their prescription is written for a 90-day supply and is filled by any Cleveland Clinic/Akron General Pharmacy.
Generic Statins
Using the generic alternatives listed above delivers significant cost savings to members. For example, a 90-day supply of the generic medications atorvastatin, fluvastatin immediate release, lovastatin, pravastatin, rosuvastatin, or simvastatin obtained through the Cleveland Clinic Home Delivery Pharmacy costs $6. Members who receive brand name statins Lescol, Lipitor, Mevacor, Pravachol, or Zocor will pay the price difference between brand name and generic costs (see Generic Medication Policy on page 8). In addition, members who use generic fluvastatin immediate release, lovastatin, pravastatin, or simvastatin do not need to split tablets to receive their reduced co-insurance.

Step Therapy Program
The Step Therapy Program promotes the first-line use of effective, value-based medications over higher cost alternatives. Prescriptions for equally effective – but less expensive – generic medications for covered conditions will be approved with preferred rates. The Step Therapy Program stops payment of prescription claims for higher cost alternative medications that have not received prior authorization. The following medications are included in the Step Therapy Program:

<table>
<thead>
<tr>
<th>Medication(s) Requiring Step Therapy</th>
<th>Formulary Alternatives(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td></td>
</tr>
<tr>
<td>Myorisan</td>
<td>Zenatane</td>
</tr>
<tr>
<td>Antidepressants</td>
<td></td>
</tr>
<tr>
<td>Pristiq</td>
<td>Venlafaxine capsules, venlafaxine ER capsules</td>
</tr>
<tr>
<td>Blood Pressure Medication</td>
<td></td>
</tr>
<tr>
<td>Atacand</td>
<td>Benicar HCT, Tekturna</td>
</tr>
<tr>
<td>Atacand HCT</td>
<td>Diovan, Tekturna HCT</td>
</tr>
<tr>
<td>Avalide</td>
<td>Divoan HCT, Teveten</td>
</tr>
<tr>
<td>Avapro</td>
<td>Micardis, Lisinopril</td>
</tr>
<tr>
<td>Benicar</td>
<td>Micardis HCT, Losartan</td>
</tr>
<tr>
<td>Cholesterol Lowering Medications</td>
<td></td>
</tr>
<tr>
<td>Lescol extended-release</td>
<td>Livalo, Zypitamag</td>
</tr>
<tr>
<td>Lescol immediate-release</td>
<td>Nikita, Atorvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Alogliptin</td>
<td>Januvia, Kombiglyze XR</td>
</tr>
<tr>
<td>Alogliptin/metformin</td>
<td>Glyxambi, Nesina</td>
</tr>
<tr>
<td>Alogliptin/pioglitazone</td>
<td>Jentadueto, Onglyza</td>
</tr>
<tr>
<td>Janumet</td>
<td>Jentadueto XR, Oseni</td>
</tr>
<tr>
<td>Janumet XR</td>
<td>Kazano, Tradjenta</td>
</tr>
<tr>
<td>Gastrointestinal Medications</td>
<td></td>
</tr>
<tr>
<td>Delzicol</td>
<td>Giazo, Pentasa</td>
</tr>
<tr>
<td>Dipentum</td>
<td>Lialda</td>
</tr>
<tr>
<td>Growth Hormone</td>
<td></td>
</tr>
<tr>
<td>Genotropin</td>
<td>Omnitrope, Zomacton</td>
</tr>
<tr>
<td>Nutropin</td>
<td>Saizen</td>
</tr>
<tr>
<td>Nutropin AQ</td>
<td>Tev-Tropin</td>
</tr>
<tr>
<td>Immune Modulators</td>
<td></td>
</tr>
<tr>
<td>Amjevita</td>
<td>Kineret, Stelara</td>
</tr>
<tr>
<td>Cimzia</td>
<td>Orencea, Xeljanz</td>
</tr>
<tr>
<td>Enbrel</td>
<td>Remicade, Xeljanz XR</td>
</tr>
<tr>
<td>Erelzi</td>
<td>Remiflexis</td>
</tr>
<tr>
<td>Inflectra</td>
<td>Simponi (subcutaneous)</td>
</tr>
<tr>
<td>Stimulants</td>
<td></td>
</tr>
<tr>
<td>Nuvigil</td>
<td>Modafinil</td>
</tr>
</tbody>
</table>

12. During the benefit year, new medications may be added to this list. Members will be notified before these changes take effect.

13. Alogliptin and alogliptin/metformin are the preferred DPP-IV inhibitor products under the EHP prescription drug benefit.
Specialty Drug Benefit

Specialty drugs can be obtained from any Cleveland Clinic/Akron General Pharmacy including the Specialty Pharmacy, or from the CVS/specialty Pharmacy. Members enjoy lower out-of-pocket expenses by using a Cleveland Clinic/Akron General Pharmacy to obtain their specialty drugs. Members with certain chronic conditions may wish to participate in the Accordant Rare Disease Management Program. Please refer to your SPD for more details.

Members will be responsible for their co-insurance for all drugs that are determined to be self-administrable by the member. Self-administrable medications are defined as medications that are typically administered orally or subcutaneously (SC) and have patient instruction for use in the package insert (PI). Some intramuscular injections are also considered self-administrable due to frequency of injection and PI instructions for the patient on how to self-administer the drug. A co-insurance applies at all locations where the drug can be obtained. If a self-administrable drug is administered in a doctor’s office, the member will be responsible for the office co-payment as well as the drug co-insurance. If administered in the physician’s office, the co-insurance is not applied to the pharmacy deductible or out-of-pocket maximum, unless stated otherwise below as being a medication that is white-bagged. White-bagging refers to a specialty pharmaceutical, that is not intended to be self-administered, being shipped or delivered by an in-network specialty pharmacy directly to the location where it will be administered by the member’s chosen health care provider. Most Medications that are not self-administered are covered under the medical benefit.

- Actemra
- Acthar gel
- Actimmune
- Adempas
- Adcebris
- Adcirca
- Advate
- Afinitor
- Aimovig
- Ajovy
- Alecensa
- Alkeran
- Alyq
- Alunbrig
- Ampyra
- Apokyn
- Aptivus
- Aralast NP
- Aranesp
- Arava
- Arcalyt
- Arimidex
- Aristada
- Aristada Initio
- Armosin
- Atripla
- Aubagio
- Austedo
- Avonex
- Ayyakit
- Balversa
- Banzel
- Baraclode
- Benlysta
- Berinert
- Betaseron
- Bethkis
- Biktarvy
- Bosulif
- Braftovi
- Brukinsa
- Buphenyl
- Cabiivi
- Cabometyx
- Caprelsa
- Caysen
- Cerezyme
- Cimzia
- Cinigrain
- Cinryze
- Combivir
- Cometriq
- Complera
- Copaxone
- Copegus
- Copiktra
- Costenox
- Cotelic
- Cresemba
- Crixivan
- Cuprimine
- Cytophosphamide
- Cytoxan
- Daklinza
- Daurismo
- Descovy
- Desferal
- Doptelet
- Dupixent
- Edurant
- Egrifta
- Eligard
- Emcyt
- Emgality
- Emtriva
- Enbrel
- Entyvio
- Eplucza
- Epidiolex
- Epivir
- Epivir HBV
- Epogen
- Epoprostenol
- Epticom
- Ergamisol
- Erivedge
- Erleada
- Ebriet
- Evoidity
- Exjade
- Extavia
- Faresto
- Farydak
- Fasenra pens
- Fasenra prefilled syringes
- Femara
- Ferrirrox
- Firazyr
- Firmagon
- Flolan
- Forteo
- Fuzeon
- Fycopma
- Gattex
- Genotropin
- Genvoya
- Gilenya
- Giotrif
- Glassia
- Gleevac
- Gleostine
- Granix
- Haegarda
- Harvoni
- Hecoria
- Hespere
- Hetioz
- Humatrope
- Humira
- Hycamtin
- Ibrance
- Ilaris
- Ilumya
- Illuvien
- Imbruvica
- Impavido
- Incivek
- Increlex
- Infergen
- Ingenzza
- Inlyta
- Inrebic
- Intelence
- Intron-A
- Invirase
- Iressa
- Isentress
- Jayden
- Jakafi
- Juxtapid
- Jynarque
- Kalbitor
- Kaletra
- Kalydecro
- Kevzaara
- Kinere
- Kitabuc Pak
- Kisqali
- Korlym
- Kuvan
- Kyprolis
- Lenvima
- Letairis
- Leukaver
- Leukine
- Leuproline
- Lexiva
- Lokefma

15. Covered under the prescription benefit and delivered by specialty pharmacy to member’s health care provider.
16. Not covered as first line therapy. Use Humatrope or Norditropin.
Specialty Drug Benefit (continued)

- Lonsurf
- Lorbrena
- Lupron
- Lynparza
- Lyso đèn
- Matulane
- Mavenclad
- Mayvret
- Mayzent
- Mekinist
- Mektovi
- Mozobil
- Multiplet
- Myleran
- Natpara
- Nayzilam
- Nelnor
- Neulasta
- Neumega
- Neupogen
- Nexavar
- Nexletol
- Nexlizet
- Nelnor
- Norditropin
- Northera
- Norvir
- Nocifil
- Nplate
- Nucala
- Nuedexta
- Nuplazid
- Nurtec ODT
- Nutropin
- Nutropin AQ
- Ocaliva
- Octreotide
- Odefsey
- Odomzo
- Ofev
- Olumiant
- Olysio
- Omnitrope
- Omontys
- Onfi
- Opsurmit
- Orenzia
- Orenitram
- Orfadin
- Orilissa
- Orkambi
- Otezla
- Oxbryta
- Oxervate
- Oxosoralen
- Oxettar XR
- Palforzia
- Panretin
- Peg Intron
- Pegasys
- Piqray
- Pleggridy
- Prolastin-C
- Prolix
- Promacta
- Pulmozyme
- Purinethol
- Purixan
- Rasuvo
- Ravicti
- Rebetol
- Rebif
- Regranex
- Remodulin
- Repatha
- Rescriptor
- Restasis
- Retinivir
- Revatio
- Revlimid
- Reyataz
- Reyvow
- Ribapak/Ribavirin Ribasphere
- Rilutek
- Rinoq
- Rituxan
- Rubraca
- Ruconest
- Ruzurgi
- Rybdelsus
- Rydapt
- Qbrexa
- Sabril
- Saizen
- Samsca
- Sandostatin
- Selecleryl
- Sensipar
- Sermorelin
- Serostim
- Simponi
- Sivextro
- Skyrizi
- Somavert
- Soriatane
- Sooladi
- Spravato
- Spritam
- Spryce
- Stelara
- Stimate
- Stivarga
- Stresniq
- Stuibild
- Suclid
- Sulfamylon
- Sunosi
- Sustiva
- Sutent
- Sylatron
- Symdeko
- Synarel
- Syprine
- Tabloid
- Tafinlar
- Tagrisso
- Takzyro
- Taliz
- Talzenna
- Tarceva
- Target
- Tasigna
- Tavalisse
- Tazverik
- Tecfidera
- Technivie
- Tega
- Tedstrin
- Temodar
- Tey-Tron
- Thalomid
- Thioguanine
- Tibsovo
- Tiguila
- Tivicay
- TOBI
- TOBI Podhaler
- Tracleer
- Treistar
- Triumeq
- Trizivir
- Truvada
- Turalio
- Tykerb
- Tymlos
- Tyvaso
- Tyzeka
- Ubrelvy
- Uptavir
- Valcyte
- Valtoco
- Veletri
- Voltassa
- Venclexta
- Ventavis
- VePesid
- Vesanoid
- Videx
- Videx EC
- Viekira
- Viracept
- Viramune
- Viread
- Vitekta
- Vitakvi
- Vosevi
- Votrient
- Vumerity
- Vyndamax
- Vyndagel
- Wakix
- Xalkori
- Xeljanz
- Xeljanz XR
- Xeloda
- Xenazine
- Xgeva
- Xolair
- Xtandi
- Xyrem
- Zanxio
- Zavesca
- Zejula
- Zelboraf
- Zemaira
- Zepatier
- Zeposia
- Zerit
- Zigen
- Xiidra
- Zoladex
- Zolinza
- Zomacton
- Zortieve
- Zortress
- Zyakin
- Zykladia
- Zyliga

Specialty drugs CANNOT be obtained through the CVS/caremark Retail Pharmacy Network. There are two options for obtaining these medications:

1. Cleveland Clinic Specialty Pharmacy or Cleveland Clinic/Akron General Pharmacies in Akron, Cleveland, Dover and Weston
2. CVS/specialty Pharmacy – toll-free at 800.237.2767

15. Covered under the prescription benefit and delivered by specialty pharmacy to member’s health care provider.
16. Not covered as first line therapy. Use Humatrope or Norditropin.
17. Not covered as first line therapy. Use Repatha.
Specialty Drug Copay Card Assistance Program

The Cleveland Clinic Employee Health Plan reserves the right to change/adjust specialty drug copays to meet the needs of a manufacturer-sponsored variable member copay assistance program. As such, certain specialty medications require the use of the manufacturer’s copay assistance card. For those specialty medications included in the Copay Card Assistance Program, the member’s copay will be adjusted upward to maximize the financial benefit offered by the pharmaceutical manufacturer, but this adjustment will be completely offset by the copay card, such that members will have no additional out of pocket expense above and beyond what they are currently paying for their specialty medication. The value of the manufacturer’s copay card will apply to your annual deductible but will not apply to your annual out of pocket maximum.

In the event the manufacturer discontinues a specialty medication’s copay assistance card, the member’s cost share will revert back to the benefit design outlined on page 2 of the Cleveland Clinic Employee Health Plan Prescription Drug Benefit Handbook.

Please refer to the EHP Pharmacy Benefits link on the Cleveland Clinic Employee Health Plan’s website for updates on medications included in the Copay Card Assistance Program. If you have any questions, please contact EHP Pharmacy Management at 216.986.1050, option 4.

The specialty medications included in the Copay Card Assistance Program include:

- Actemra
- Actemra ACTPen
- Acthar Gel
- Adcirca
- Advate
- Adynovate
- Afinitor
- Aimovig
- Ajovy
- Alecensa
- Alunbrig
- Ampyra
- Atripla
- Banzel
- Benlysta subcutaneous
- Berinert
- Betaseron
- Biktaryv
- Cabometyx
- Cayston
- Cimzia
- Cinqair
- Complera
- Copaxone
- Cosentyx
- Daurismo
- Descovy
- Doptelet
- Dupixent
- Emgality
- Enbrel
- Epcilusa
- Esbriet
- Evenly
- Eptiade
- Fasenra
- Forteo
- Genvoya
- Gilena
- Gilenya
- Glatiramer acetate
- Glatopa
- Gleevac
- Harvoni
- Humatrope
- Humira
- Ibrance
- Ilaris
- Imatinib
- Imbruvica
- Inlyta
- Intelege
- Iressa
- Isentress
- Isentress HD
- Jadenu
- Jakafi
- Juluca
- Kalydeco
- Kezvara
- Kineret
- Kisqali
- Lenivima
- Lorbroena
- Lupron Depot
- Lupron Depot-Ped
- Lynparza
- Mavret
- Mayzent
- Mekinist
- Neulasta
- Nivolum
- Norditropin
- Norvir
- Nucala
- Odefsey
- Odomzo
- Ofev
- Olumiant
- Orenzia
- Orilissa
- Orkambi
- Otezla
- Praluent
- Promacta
- Pomalyst
- Prezista
- Prolia
- Pulmozyme
- Repatha
- Restasis
- Restasis Multidose
- Revlimid
- Rubraca
- Rydapt
- Sandostatin
- Simponi subcutaneous
- Somavert
- Sovaldi
- Sprycel
- Stelara
- Stivarga
- Strild
- Sustiva
- Sutent
- Tafinlar
- Tagrisso
- Talzenna
- Tasigna
- Tavalisse
- Tivicay
- Tracleer
- Tremfya
- Trikafta
- Triumeq
- Truvada
- Tykerb
- Tymlos
- Tyxyso
- Upravix
- Venclexta
- Viekira Pak
- Vitakvi
- Vosevi
- Votrient
- Xalkori
- Xeljan
- Xeljanz XR
- Xgeva
- Xiidra
- Xolair
- Xtandi
- Xyrem
- Zarxio
- Zejula
- Zelboraf
- Zortress
- Zykdia
Prescription Drug Benefit Exclusions

1. The replacement of lost or damaged prescriptions. Stolen medications will be covered at the benefit program rate when accompanied by a police report.

2. Drugs prescribed for the treatment of sexual dysfunction.

3. Drugs to enhance libido function.

4. Enteral feedings, food supplements, lactose-free foods, specialized formulas, vitamins and/or minerals that do not require a prescription are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.

5. Drugs used for experimental or investigational purposes.

6. Drugs used for the treatment of infertility and/or the preservation of fertility.

7. Drugs not included in the Patient Protection and Affordable Care Act that can be purchased without a prescription.

8. Medicinal foods (regardless of whether they require a prescription or not).

9. Insulin pumps and insulin pump supplies.

10. Prescriptions ordered or provided by a member of your immediate family.

11. Histamine H2 Receptor Antagonist (H2RA) drugs for members one year of age or older.

12. Proton Pump Inhibitor (PPI) drugs for members one year of age or older.


14. Medical devices approved via the FDA 510(k) Premarket Notification review process.

15. Unapproved prescription drugs that do not have FDA approval, such as drugs classified as grandfathered, DESI, or GRAS/E.


Refer to page 17 to see the Lifestyle Medications (i.e., Drugs & Items at Discounted Rate) and Noncovered Drugs & Items for additional exclusions.

18. Members may contact Pharmacy Management at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4 between the hours of 8 a.m. and 4:30 p.m., Monday through Friday to request an override so that they are able to purchase a replacement supply at their expense. The member will be responsible for 100% of the discounted price.
Please Note: On pages 33–36 and 41–43 “we/us/our” refers to SilverScript Insurance Company.

The information listed below is brief excerpts from your Evidence of Coverage (EOC). If you want more detailed information, please refer to your EOC. If you want a printed copy, feel free to contact SilverScript Customer Care 24 hours a day, 7 days a week toll-free at 866.425.9732 (TTY users should call toll-free at 866.236.1069).

Generic Medication Policy
Generally, a “generic” drug works the same as a brand drug and usually costs less. In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you with the generic version. Usually, the brand name drug will not be covered when the generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

The Cleveland Clinic HBP supports and encourages the use of FDA-approved generic medications that are both chemically and therapeutically equivalent to manufacturers’ brand name products. Generically equivalent products are safe and effective treatments that offer savings as alternatives to brand name products.

Medications that are available as generics for Medicare eligible and approved retirees are listed in the SilverScript Gold Formulary in lower case italics.

Prior Authorizations/Coverage Decisions/Appeals Process
For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists develop these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan’s rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare’s rules and regulations for drug coverage and cost.

If your drug is not covered, you or your provider will need to get approval from the plan before we will agree to cover the drug for you. This is called “prior authorization”. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan. A copy of this form is located in the back of this Handbook. Or you may find the form on our website at: http://clevelandclinic.silverscript.com under the documents tab. Click the “Prior Authorization” link.
You and your provider may ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking for an exception, your provider can help you request an exception to the rule.

A **“coverage decision”** is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

An **“appeal”** is a formal way of asking us to review and change a decision we have made. When you make an appeal, we review the decision we have made to check to see if we were following the rules properly. Your appeal is handled by different reviewers than those who made the unfavorable decision. When we have completed the review we give you or your provider our decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal. Please see your *Evidence of Coverage* for further details.

**Appointing a Representative**

You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.

Examples:

- There may be someone who is already legally authorized to act as your representative under State law.
- If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call SilverScript Customer Care 24 hours a day, 7 days a week toll-free at 866.425.9732 (TTY users should call toll-free at 866.236.1069.) and ask for the “Appointment of Representative” form. (This form is also available on our website: [http://clevelandclinic.silverscript.com](http://clevelandclinic.silverscript.com) under the documents tab. Click the **“Appointment of Representative Form”**.

**Coverage Stages**

Section 5 of your *Evidence of Coverage* will explain the various coverage stages that a member may reach during the course of the year. These stages are called: Deductible, Initial Coverage, Coverage Gap, and Catastrophic Coverage.

**Please note:** Explanation of Benefits (EOB) provided by SilverScript each month will not factor in your added HBP program.

**Deductible**

The deductible will be $100 per individual. If you fill your generic medication at a Cleveland Clinic/Akron General Pharmacy, your deductible will be waived. Brand medications or medications filled outside of a Cleveland Clinic/Akron General Pharmacy will be subjected to the $100 deductible.

**Initial Coverage Stage**

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescriptions. You will stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the $4,020 limit for the Initial Coverage Stage.
**Coverage Gap Stage**
The Cleveland Clinic HBP is providing additional coverage that is keeping your co-insurances consistent through the Coverage Gap. Therefore, you will see no change in co-payments until you qualify for Catastrophic Coverage. When you reach an out-of-pocket limit of $6,350, you leave the Coverage Gap Stage.

**Catastrophic Coverage Stage**
You qualify for the Catastrophic Coverage Stage when your true-out-of-pocket (TrOOP) costs have reached the $6,350 limit for the plan year. Once you are in Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

During this stage, the plan will pay most of the cost for your drugs. During this stage, you will pay no more than: the greater of 5% co-insurance or $3.60 for generic drugs (or drugs treated as generic) and $8.95 for all other drugs. The HBP will pay the rest.

Please refer to your Evidence of Coverage and any amendments you may receive from SilverScript that describe the benefit program coverage. The Evidence of Coverage also list exclusions (benefits that are not covered). Please refer to Chapter 7 for additional information on what to do if you have a problem or a complaint (coverage decisions, appeals, or complaints). If you would like a printed copy, feel free to contact SilverScript Customer Care 24 hours a day, 7 days a week toll-free at 866.425.9732. TTY users should call toll-free at 866.236.1069.

**Request for Redetermination of Medicare Prescription Drug Denial (Appeal)**
If SilverScript Insurance Company denies your request for coverage of (or payment for) a prescription medication, you have the right to ask for a redetermination (appeal) of their decision. You have 60 days from the date of their Notice of Denial of Medicare Prescription Drug Coverage to ask for a redetermination. The Redetermination Form (sample on page 55) is available on SilverScript's website at www.silverscript.com or on the EHP website at https://employeehealthplan.clevelandclinic.org. Click on the Retiree button on the left. The completed form should be sent to:

**Appeals Department**
MC109
P.O. Box 52000
Phoenix, AZ 85072-2000
**Fax number:** 855.633.7373

You can also ask for an appeal via the SilverScript website at www.silverscript.com. Expedited appeal requests can be made by phone at 866.884.9479 (TTY866.236.1069). Call the toll-free numbers 24 hours a day, 7 days a week.

**Who May Make a Request:** Your prescriber may ask SilverScript for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact SilverScript to learn how to name a representative.
Redetermination of Medicare Prescription Drug Denial Form

SilverScript Medicare Part D Coverage Determination Request Form
See page 63 in the back of this Handbook for full size usable form.

Benefits and Coverage Clarification
Detailed benefit coverage clarification information about the HBP Prescription Drug Benefit is included in the following pages. This information complements and further explains the Prescription Drug Benefit chart on page 3 in this Handbook and in the SPD, Section One: “Getting Started.”

Contraceptive Coverage
Under the provisions of the Affordable Care Act mandate regarding women’s preventative health services, contraceptives will be covered under the HBP Prescription Drug Benefit within the following guidelines:

- Diaphragms, emergency contraceptives, generic oral contraceptives, generic injectables (medroxyprogesterone), Nuvaring, and Ortho Evra will be covered with no out-of-pocket expense for the member. However, a prescription from your health care provider is required.
- Brand name oral contraceptives that are not available generically require prior authorization. If the prior authorization request is approved, the member will not have any out-of-pocket expense. If the prior authorization request is denied, the brand name contraceptive will not be covered.
- Members who receive a brand name formulation of a contraceptive that is available generically will not pay any co-insurance but will be charged the difference in cost between the brand name contraceptive product and the generic alternative.
- Contraceptive products that do not require a prescription to be purchased are not covered under the HBP Prescription Drug Benefit.
- Members who are employed at Marymount Hospital are excluded from this coverage since 2014.
- Mirena and other intrauterine devices (IUDs) are not covered under the HBP Prescription Drug Benefit. Rather, they are covered under the medical benefit and no co-payment will be charged.
Quantity Level Limits

Quantity level limits are applied to medications for several reasons, including preventing medication misuse or abuse; ensuring appropriate, effective and safe courses of therapy; and preventing the stockpiling of medication. The table below lists the medications included in the SilverScript Quantity Limit Program.

- Actos: 30 tablets per 30 days
- Advair: 1 inhaler per 30 days
- Amaryl: 240 tablets per 30 days
- Ambien: 30 tablets per 30 days/90 tablets per 365 days
- Amerge: 12 tablets per 30 days
- Atrovent: 2 inhalers per 30 days
- Colcrys: 120 tablets per 30 days
- Combivent: 2 inhalers per 30 days
- Dexilant: 30 tablets per 30 days
- Duragesic: 10 patches per 30 days
- Flonase: 1 bottle per 30 days
- Flovent HFA: 2 inhalers per 30 days
- Flunisolide: 2 bottles per 30 days
- Glucophage 500 mg: 150 tablets per 30 days
- Glucophage 850 mg: 90 tablets per 30 days
- Glucophage 1000 mg: 75 tablets per 30 days
- Glucophage XR 500 mg: 120 tablets per 30 days
- Glucophage XR 750 mg: 60 tablets per 30 days
- Glucotrol 5 mg: 240 tablets per 30 days
- Glucotrol 10 mg: 120 tablets per 30 days
- Glucotrol XL 2.5 mg: 240 tablets per 30 days
- Glucotrol XL 5 mg: 120 tablets per 30 days
- Glucotrol XL 10 mg: 60 tablets per 30 days
- Imitrex Injection: 12 injections per 30 days
- Imitrex Tab: 12 tablets per 30 days
- Imitrex 4 mg/0.5 mL injection: 18 injections per 30 days
- Imitrex 5 mg/act nasal solution: 24 inhalers per 30 days
- Imitrex 20 mg/act nasal solution: 12 inhalers per 30 days
- Lamisil: 90 tablets per 365 days
- Lyrica 25 mg, 50 mg, 75 mg, 100 mg, 150 mg: 120 caps per 30 days
- Lyrica 200 mg: 90 caps per 30 days
- Lyrica 225 mg, 300 mg: 60 caps per 30 days
- Lyrica oral solution: 946 mL per 30 days
- Maxalt: 18 tablets per 30 days
- Maxalt-MLT: 18 tablets per 30 days
- MS Contin: 90 tablets per 30 days
- MS Contin 200 mg: 60 tablets per 30 days
- Neurontin 100 mg: 1080 capsules per 30 days
- Neurontin 300 mg: 360 caps per 30 days
- Neurontin 400 mg: 270 caps per 30 days
- Neurontin 600 mg: 180 caps per 30 days
- Neurontin 800 mg: 120 caps per 30 days
- Nexium: 30 tablets per 30 days
- Prilosec 10 mg or 40 mg: 30 tablets per 30 days
- Prilosec 20 mg: 60 tablets per 30 days
- Protonix: 30 tablets per 30 days
- Pulmicort Flexhaler: 2 inhalers per 30 days
- Relpax: 12 tablets per 30 days
- Serevent: 1 inhaler per 30 days
- Symbicort: 1 inhaler per 30 days
- Ventolin HFA: 2 inhalers per 30 days
- Victoza: 3 pens per 30 days
- Xopenex HFA: 2 inhalers per 30 days
- Zomig 2.5 mg or 5 mg: 12 tablets per 30 days
- Zomig-ZMT: 12 tablets per 30 days
Prescription Drug Benefit Exclusions

1. The replacement of lost or damaged prescriptions. Stolen medications will be covered at the benefit program rate when accompanied by a police report.

2. Drugs prescribed for the treatment of sexual dysfunction.

3. Drugs to enhance libido function.

4. Enteral feedings, food supplements, lactose-free foods, specialized formulas, vitamins and/or minerals that do not require a prescription are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.

5. Drugs used for experimental or investigational purposes.

6. Drugs that can be purchased without a prescription.

7. Drugs used for cosmetic purposes.

8. Drugs used for the treatment of infertility.

9. Drugs not included in the Patient Protection and Affordable Care Act that can be purchased without a prescription.

10. Medicinal foods (regardless of whether they require a prescription or not).

11. Prescriptions ordered or provided by a member of your immediate family.

20. Members may contact Pharmacy Coordination at 216.986.1050, option 4 or toll-free at 888.246.6648, option 4 between the hours of 8 a.m. and 4:30 p.m., Monday through Friday to request an override so that they are able to purchase a replacement supply at their expense. The member will be responsible for 100% of the discounted price.
Member Name: __________________________________________

Member EHP Insurance ID Number: ____________________________ Member DOB: ____________________________

Requesting Physician’s Name: __________________________________________

Office Phone Number: ____________________________ Office Fax Number: ____________________________

Requesting Physician’s Signature: ____________________________ Date: ____________________________

Requesting Medication: __________________________________________

Strength: ____________________________ Quantity: ____________________________ Dosage Regimen: ____________________________

Diagnosis: __________________________________________

Medical Rationale for Requested Medication: __________________________________________

Formulary Agents Tried and Failed by the Member:

<table>
<thead>
<tr>
<th>Drug &amp; Strength</th>
<th>Dosing Regimen</th>
<th>Dates Used (Approximate)</th>
<th>Documentation of Treatment Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Please include any and all documentation pertaining to the request. Completion of this form does not guarantee approval. Requests are reviewed on all available information. Decisions are generally made within two business days, but may take longer pending clinical review. Decision letters will be sent via fax to the requesting provider and to the member via U.S. mail.

Internal Use Only: DO NOT WRITE BELOW

<table>
<thead>
<tr>
<th>Medical</th>
<th>Pharmacy</th>
<th>MDR Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved Tier 1</td>
<td>Initial Determination</td>
<td>Provider 1st Level</td>
</tr>
<tr>
<td>Approved Tier 2</td>
<td>Member 1st Level</td>
<td>Provider 2nd Level</td>
</tr>
<tr>
<td>Denied</td>
<td>Member 2nd Level</td>
<td>External Review</td>
</tr>
</tbody>
</table>
Member Name: ____________________________________________
Member EHP Insurance ID Number: __________________ Member DOB: __________________
Requesting Physician’s Name: ____________________________________________
Office Phone Number: __________________ Office Fax Number: __________________
Requesting Physician’s Signature: __________________ Date: __________________
Requested Statin: ____________________________________________
Strength: __________________ Quantity: __________________ Dosage Regimen: ____________

Please answer the following questions in regards to the member (Patient):

1. Age _____ (Must be aged 40 to 75)
2. History of cardiovascular disease (CVD)? Yes ☐ No ☐ (Copay free statin is for primary prevention only)
3. ≥1 CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking)? Yes ☐ No ☐
4. Gender? Male ☐ Female ☐
5. Race? White ☐ African American ☐ Other ☐
6. Total cholesterol _________mg/dL; HDL cholesterol _________mg/dL; LDL cholesterol _________mg/dL
7. Systolic blood pressure _________mm Hg
8. History of diabetes? Yes ☐ No ☐
9. On treatment for hypertension? Yes ☐ No ☐
10. Smoker? Yes ☐ No ☐ Former ☐ (Quit date: ___/___/___)
11. On statin therapy? Yes ☐ No ☐ (Copay free statin is for low- or moderate-intensity statin only)
12. On aspirin therapy? Yes ☐ No ☐
13. Known history of familial hypercholesterolemia? Yes ☐ No ☐

Internal Use Only: DO NOT WRITE BELOW

<table>
<thead>
<tr>
<th>Medical</th>
<th>Pharmacy</th>
<th>MDR Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved Tier 1</td>
<td>Initial Determination</td>
<td>Provider 1st Level</td>
</tr>
<tr>
<td>Approved Tier 2</td>
<td>Member 1st Level</td>
<td>Provider 2nd Level</td>
</tr>
<tr>
<td>Denied</td>
<td>Member 2nd Level</td>
<td>External Review</td>
</tr>
</tbody>
</table>

Please complete this form and return via fax: 216.442.5790.
REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:  
SilverScript Insurance Company  
Prescription Drug Plan  
P.O. Box 52000, MC109  
Phoenix AZ 85072-2000

Fax Number:  
1-855-633-7673

You may also ask us for a coverage determination by phone at 1-866-235-5660 or through our website at www.silverscript.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee’s Information

Enrollee’s Name ____________________________ Date of Birth __________

Enrollee’s Address __________________________

City __________________ State ___________ Zip Code ___________

Phone __________________ Enrollee’s Member ID # __________

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor’s Name __________________________

Requestor’s Relationship to Enrollee __________________________

Address __________________________

City __________________ State ___________ Zip Code ___________

Phone __________________

Representation documentation for requests made by someone other than enrollee or the enrollee’s prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

☐ I need a drug that is not on the plan’s list of covered drugs (formulary exception).*

Y0080_APLS_CovDet_2012 File & Use 12/18/2011
☐ I have been using a drug that was previously included on the plan’s list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan’s limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

* NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.

Additional information we should consider (attach any supporting documents):

---

**Important Note: Expedited Decisions**

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber’s support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Signature of person requesting the coverage determination (the enrollee, or the enrollee’s prescriber or representative):

________________________ Date: __________________
REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION (Cont’d)

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber’s supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

<table>
<thead>
<tr>
<th>Prescriber’s Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name ____________________</td>
</tr>
<tr>
<td>Address __________________</td>
</tr>
<tr>
<td>City ____________________ State _______ Zip Code __________</td>
</tr>
<tr>
<td>Office Phone _____________ Fax __________</td>
</tr>
<tr>
<td>Prescriber’s Signature ___________ Date __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis and Medical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication: ____________________</td>
</tr>
<tr>
<td>New Prescription OR Date Therapy Initiated:</td>
</tr>
<tr>
<td>Height/Weight: ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale for Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]</td>
</tr>
<tr>
<td>☐ Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change [Specify below: Anticipated significant adverse clinical outcome]</td>
</tr>
<tr>
<td>☐ Medical need for different dosage form and/or higher dosage [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]</td>
</tr>
<tr>
<td>☐ Request for formulary tier exception [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]</td>
</tr>
<tr>
<td>☐ Other (explain below)</td>
</tr>
</tbody>
</table>

Required Explanation: ________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

43