



## Medicare GenerationRx Prescription Drug ID Card

All Medicare-eligible retirees and Medicare-eligible dependents were reissued their Medicare GenerationRx ID card for prescription claims. You should have received the card by December 28 for an effective date of January 1, 2013.

The reason the prescription drug card was reissued was because the

original prescription drug card was sent in the Welcome Packet but should have been sent separately. To ensure that everyone has their ID card prior to January 1, 2013, a separate mailing containing only the ID card affixed to the Welcome Letter was sent. PEEHIP apologizes for any inconvenience this may cause.

As a reminder, you still need to keep your PEEHIP ID card and your Medicare card for hospital and medical claims. If you have any questions or concerns, do not hesitate to contact Medicare GenerationRx’s Customer Service at 877.633.7943. TTY users should dial 711. Customer Service is open 24 hours a day, 365 days a year.

## February 2013 Prescription Drug Changes

These changes are only applicable to the commercial plan and not the Medicare GenerationRx plan.

### Formulary Drug List Changes

The PEEHIP Board approved changes to the PEEHIP Drug Formulary as shown below effective February 1, 2013. These changes will result in either an increase or decrease in the amount you pay for these prescription drugs. All members affected by these changes will be mailed a letter prior to February 1, 2013. PEEHIP’s Formulary is a drug list that helps determine your copayment for each prescription. You will pay a lower copayment of \$40 for the Tier 2 preferred brand drugs and \$6 for the generic drugs on the PEEHIP Formulary List for a 30-day supply. Tier 3 non-formulary brand drugs have the highest copayment of \$60 for a 30-day supply. The PEEHIP Formulary Drug List is available on the PEEHIP Pharmacy Benefits web page at [www.rsa-al.gov/PEEHIP/pharm-benefits.html](http://www.rsa-al.gov/PEEHIP/pharm-benefits.html).

The following drugs have been moved from Tier 3 to Tier 2 and will have a lower copay of \$40 effective February 1, 2013:

|           |            |             |
|-----------|------------|-------------|
| Avodart   | Jalyn      | Qnasl       |
| Bydureon  | Jentadueto | Seroquel XR |
| Daliresp  | Korlym     | Tobi        |
| Hyper-Sal | Omnitrope  | Victoza     |

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The drugs in the chart below have been moved from Tier 2 to Tier 3 and will have a copay of \$60 effective February 1, 2013.

| Drug Name   | Alternative Drugs (Tier 2 brand or generic)                    |
|---|--|
| Banzel  | felbamate, lamotrigine, topiramate                             |
| Gabitril  | gabapentin, lamotrigine, topiramate                            |
| Gilenya   | Rebif, Copaxone  |
| Genotropin, Humatrope, Tev-Tropin<br>(effective 1/1/2013) | Omnitrope, Saizen  |
| Nutropin, Nutropin AQ/Nuspin                              | Omnitrope, Saizen  |
| Proventil, Ventolin                                       | ProAir   |
| Sabril  | divalproex, phenytoin, Valproic acid                           |
| Saphris   | Abilify, Seroquel XR   |
| Serevent  | Foradil  |
| Sucraid   | N/A  |
| Tekturna, Tekturna HCT, Valturna                          | Generic ACE Inhibitors, ACE combination ARB or ARB combination |
| Timoptic, Ocudose   | timolol  |
| Vytorin   | atorvastatin, lovastatin, pravastatin                          |
| Zavesca   | Enzyme replacement therapy                                     |

### Step Therapy Program Changes

The PEEHIP Board approved deleting three, adding eleven new, and revising five existing Step Therapy Programs as shown in the chart below effective February 1, 2013. Current members utilizing these drugs will be grandfathered from these step therapy requirements.

| Step Therapy Program Name | Indication  | Drug Name   | Changes & Coverage Criteria Effective 2/1/2013   |
|---------------------------|---|---|--|
| Antipsychotics            | Schizophrenia, Recurrent Suicidal Behavior, Bipolar                               | Fazaclo, Fanapt, Invega, Latuda, Saphris              | NEW: Requires use of two 1st step generic antipsychotics (olanzapine, quetiapine IR, risperidone, risperidone ODT, ziprasidone) in last 365 days |
| Antipsychotics            | Bipolar, Schizophrenia, Major Depressive Disorder, Irritability/Autistic Disorder | Abilify   | NEW: Requires use of two 1st step generic antipsychotics, SSRI or SNRI in last 365 days  |
| Antipsychotics            | Bipolar, Schizophrenia, Major Depressive Disorder                                 | Seroquel XR   | NEW: Requires use of two 1st step generic antipsychotics, SSRI or SNRI in last 365 days  |
| Antiviral Agents          | Chronic Hepatitis C   | Ribavirin 400mg, 600mg, Riba-pak 400-400mg, 400-600mg | NEW: Requires use of 1st step generic ribavirin 200mg  |
| BPH Agents                | Benign Prostatic Hyperplasia  | Jalyn   | NEW: Requires use of a 1st step generic (finasteride, dutasteride, alfuzosin, doxazosin, prazosin, silodosin, tamsulosin, terazosin)             |
| BPH Agents                | Benign Prostatic Hyperplasia  | Rapaflo   | NEW: Requires use of a 1st step generic (finasteride, alfuzosin, doxazosin, prazosin, tamsulosin, terazosin)                                     |
| Bronchodilators           | COPD  | Arcapta, Serevent                                     | NEW: Requires use of 1st step Foradil  |

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| Step Therapy Program Name                          | Indication  | Drug Name  | Changes & Coverage Criteria Effective 2/1/2013   |
|--|---|--|--|
| Diabetes/<br>Biguanides                            | Type 2 Diabetes                                     | Fortamet, Glumetza                                   | REVISED: Requires use of 1st step generic metformin ER   |
| Cholesterol Absorption Inhibitor                   | Hypercholesterolemia, sitosterolemia                | Zetia  | DELETE from step therapy   |
| Glaucoma Agents                                    | Elevated Intraocular Pressure                       | Zioptan  | NEW: Requires use of 1st step latanoprost AND Lumigan or Travatan Z in last 365 days                                 |
| Glaucoma Agents                                    | Elevated Intraocular Pressure                       | Cosopt P/F   | NEW: Requires use of 1st step generic dorzolamide/timolol  |
| Glaucoma Agents                                    | Elevated Intraocular Pressure                       | Timoptic, Ocudose                                    | NEW: Requires use of 1st step generic timolol  |
| DPP4   | Type 2 Diabetes                                     | Tradjenta, Jentadueto, Januvia, Janumet/XR, Juvisync | DELETE from step therapy   |
| High Cholesterol/<br>Antihyperlipidemic Combo      | Primary Hypercholesterolemia and mixed dyslipidemia | Advicor  | NEW: Requires use of two 1st step generics (atorvastatin, lovastatin, pravastatin, simvastatin) in last 365 days     |
| High Cholesterol/<br>HMG CoA Reductase Inhibitors  | Primary hyperlipidemia and mixed dydlipidemia       | Livalo   | REVISED: Requires use of two 1st step generics (atorvastatin, lovastatin, pravastatin, simvastatin) in last 365 days |
| Nasal Steroids                                     | Rhinitis  | Qnasl  | REVISED: Requires use of a 1st step generic (fluticasone or flunisolide) in last 365 days                            |
| NSAIDS   | Osteoarthritis, rheumatoid arthritis                | Duexis   | REVISED: Requires use of a 1st step generic NSAID (ibuprofen, ketoprofen, ketorolac, naproxen)                       |
| Renin Inhibitors &<br>Antihypertensive Combination | Hypertension  | Tekturna, Tekturna HCT, Valturna, Amturnide          | DELETE from step therapy   |
| Tetracycline                                       | Infections caused by misc organisms                 | Adoxa Pak  | REVISED: Requires use of 1st step generic doxycycline  |

Additionally, the following existing Step Therapy programs are being amended/modified: Altoprev, Avodart, Bydureon, Daliresp, Horizant, Kombiglyze XR, Lescol/XL, Onglyza, Victoza, and Vytorin.

### Prior Authorization Program Changes

The PEEHIP Board approved the medications below to be added to or deleted from the Prior Authorization Drug List effective February 1, 2013. An FDA approved indication is required for coverage, to prevent unapproved off-label use of these medications. Your doctor's office may call the Prior Authorization toll-free phone and fax numbers 800.347.5841 and 877.606.0728, respectively, to request a Prior Authorization review. **All members currently utilizing these drugs will be mailed a letter prior to February 1, 2013.**

**Drugs to be added to the Prior Authorization List:** Acthar HP, Alliskiren Products (Amturnide, Tekamlo, Tekturna, Tekturna HCT, and Valturna), Banzel, Cayston, Egrifta, Felbatol, Gabitril, Immune Globulin (Gammagard liquid, Gammaked, Gamunex-C, Hizentra, and Lamictal ODT), Lamictal XR, Lazanda, Omontys, Picato, Pulmozyme, Sucraid, Stavzor, Tobi, and Zavesca. **Drugs to be deleted from the Prior Authorization List:** Bydureon, Topamax, and Zonegran.

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### Quantity Level Limit Program Changes

Effective **February 1, 2013**, the PEEHIP Board approved the inclusion of the medications shown in the list below in the QLL Program. A quantity of each medication will be covered by PEEHIP without a Prior Authorization (PA). If your prescription calls for more than the limit specified below, a PA is required. If the PA is not approved, a member may purchase the additional quantity at their own expense. The limits are recommended by the U.S. Food & Drug Administration (FDA) and medical studies based on manufacturers' guidelines. The purpose of the PA is to prevent stockpiling or misuse and also helps PEEHIP control the cost by limiting the "extra" supply of these medications. **All members affected by these changes will be mailed a letter prior to February 1, 2013.**

Additionally, the following existing quantity limits will have a revised dosage: Advicor, Beconase AQ, Byetta, Cayston, Crestor, Fanapt, Fentora, Flunisolide, Foradil, Lescol/XL, Livalo, Nasacort AQ, Nasonex, Omnaris, Onsolis, Rhinocort Aqua, Seroquel XR, Simcor, Tobi, Veramyst, Victoza, and Zetia.

### Quantity Level Limit Program Changes effective February 1, 2013:

|   |   |
|---|---|
| Abstral (120 tablets)   | Korlym (120 tablets)  |
| Adoxa Pak (60 tablets)  | Lamictal ODT (5mg = 240 tablets; 25mg or 50mg = 180tablets; 100mg or 150mg=90tablets; 200mg = 60 tablets) |
| Afinitor (30 tablets)   | Lamictal XR (25mg or 50mg=180tablets; 100mg or 150mg=90tablets; 200mgXR, 250mgXR, 300mgXR = 60 tablets)   |
| Arcapta (30 capsules)   | Latuda (30 tablets)   |
| Banzel (200mg=480tablets; 400mg=240tablets; Suspension=2400ml)        | Lazanda (15 bottles)  |
| Bydureon (4 vials per 28 days)  | Picato (0.015%=3 tubes/56 days; .05%=2 tubes/56 days)   |
| Cosopt P/F (60 dropperettes)  | Pulmozyme (60 ampules)  |
| Demerol (50mg and 100mg = 180 tablets; solution = 900ml)              | Qnasl (1 unit)  |
| Diastat (2 (one twin pack))   | Sabril (180 tablets)  |
| Duexis (90 tablets)   | Sprycel (30 tablets - 50mg, 70mg, 80mg, 100mg, 140mg; 60 tablets - 20mg)                                  |
| Egrifta (60 vials)  | Subsys (120 unit doses)   |
| Fazaclo (90 tablets)  | Sucraid (240ml)   |
| Felbatol (400mg = 270 tablets; 600mg = 180 tablets; Solution = 900ml) | Tasigna (120 capsules)  |
| Gabril (120 tablets)  | Timoptic (60 units)   |
| Gilenya (30 capsules)   | Vimpat (60 tablets)   |
| Horizant (600mg=60tablets, 300mg=30tablets)                           |   |

### Gender Edits

Effective February 1, 2013, the Board approved adding gender edits on three drugs and deleting gender edits on two drugs based on FDA guidelines.

|                         |                                |
|-------------------------|--------------------------------|
| Jalyn, Avodart, Rapaflo | Add Gender Edit - Male Only    |
| Uroxatral, Flomax       | Delete Gender Edit - Male Only |