

**CVS**  
**CAREMARK**

# Your Prescription Benefit



# **Prescription Drug Benefit Description**

*Herein called "Description"*

## **Prescription Drug Program For State of Kansas Employees Health Plan**

This booklet describes the Prescription Drug benefits available through the State of Kansas program. The prescription drug program is underwritten by the State of Kansas and administered by CVS Caremark. The State of Kansas reserves the right to change or terminate the program at any time or to change the company that administers the program.

The CVS Caremark Pharmacy and Therapeutics Committee administers the Preferred Drug List and assists the State in determining the appropriate tiers of coverage. CVS Caremark is not the insurer of this Program and does not assume any financial risk or obligation with respect to claims.

### **Contact Information**

For answers to any questions regarding

Your prescription claims payment contact:

**CVS Caremark**

P.O. Box 52136

Phoenix, Az 85072-2136

1-800-294-6324

<http://www2.caremark.com/kse/>

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## Section 1 Definitions

**Allowed Charge** – the maximum amount the Plan determines is payable for a covered expense. For this Plan the Allowed Charge will be the contracted reimbursement rate including any applicable sales tax. When this Plan is secondary to other insurance coverage, the Allowed Charge will be the amount allowed but not covered by the other plan subject to the coverage provisions of this Plan.

**Brand Name** – Typically, this means a drug manufactured and marketed under a trademark, or name by a specific drug manufacturer. For purposes of pricing, drug classification (e.g., brand vs. generic) will be established by a nationally recognized drug pricing and classification source.

**Compound Medication** – a medication mixed for a specific patient and not available commercially. To be eligible for reimbursement claims for compounds must list the 11 digit National Drug Code (NDC) for each ingredient used in the compound. National drug code (NDC) number, requiring a Physician's Order to dispense, and eligible for coverage under this Plan.

**Coinsurance** – is a sharing mechanism of the cost of health care and is expressed as a percentage of the Allowed Charge that will be paid by You and the balance paid by the Plan.

**Copayment** – a specified amount that You are required to pay for each quantity or supply of prescription medication that is purchased.

**Copayment/Coinsurance Maximum** – the maximum combined total for a Member on the Coinsurance and Copayments for Generic, Preferred and Special Case Medications. Coinsurance for Non Preferred Drug does not accumulate toward the Copayment/Coinsurance Maximum.

**Discount Medications** – are medications not covered by the plan but for which the Plan has a negotiated discount with network pharmacies. These items include medications with primary indications for use of: infertility; erectile dysfunction; medications used primarily for cosmetic purposes; dental preparations (toothpaste, mouthwash, etc.); prescription medications where an equivalent non prescription product is available Over-The-Counter - example: non sedating antihistamines; Drug Efficacy Study Implementation (DESI-5) medications – older medications which still require a prescription, but which the FDA has approved only on the basis of safety, not safety and effectiveness; Ostomy supplies.

**Drug Override** – a feature that allows Members who meet specific criteria outlined in the Plan to receive Non Preferred Drugs at the Preferred Drug Coinsurance level.

**Experimental, Investigational, Educational or Unproven Services** – medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan (at the time it makes a determination regarding

coverage) to be: **(1)** not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use; or **(2)** subject to review and approval by any Institutional Review Board for the proposed use; or **(3)** the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or **(4)** not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or **(5)** for the primary purpose of providing training in the activities of daily living, instruction in scholastic skills such as reading or writing, or preparation for an occupation or treatment for learning disabilities.

**Generic** – Typically, this means a medication chemically equivalent to a Brand Name drug on which the patent has expired. For purposes of pricing, drug classification (e.g., Brand vs. Generic) will be established by a nationally recognized drug pricing and classification source.

**Injectable Drug List** –Injectable medications covered under this plan include drugs that are intended to be self-administered by the Member and/or a family member as well as some injectable drugs that may need to be administered by medical professional. The cost to inject these drugs is not covered under this plan. Coverage is limited to those medications that have been designated by the Plan. This list is subject to periodic review and modification.

**Legend Drug** – medications or vitamins that by law require a physician’s prescription in order to purchase them.

**Maximum Allowable Cost List (MAC List)** – a list of specific multi-source Brand Name and Generic drug products that the maximum allowable costs have been established on the amount reimbursed to pharmacies.

**Maximum Allowable Quantity List** – some medications are limited in the amount allowed per fill. Limiting factors are FDA approval indications for (MAQ) as well as manufacture package size and standard units of therapy. The list is subject to periodic review and modification.

**Medically Necessary** – Prescription Drug Products which are determined by the Plan to be medically appropriate and: **(1)** dispensed pursuant to a Prescription Order or Refill; **(2)** necessary to meet the basic health needs of the Member; **(3)** consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies; and **(4)** commonly and customarily recognized as appropriate for treatment of the illness, injury, sickness or mental illness. The fact that a provider prescribed a Prescription Drug Product or the fact that it may be the only treatment for a particular illness, injury, sickness or mental illness does not mean that it is Medically Necessary. The fact that a medication may be medically necessary or appropriate does not mean that is a covered service.

**Member** – an individual eligible for benefits under the Plan as determined by the Plan Sponsor.

**Network Pharmacy** – a pharmacy that has entered into an agreement with CVS Caremark to provide Prescription Drug Product to Members and has agreed to accept specified reimbursement rates.

**Non Network Pharmacy** - a pharmacy that has not entered into an agreement with CVS Caremark to provide Prescription Drug Products to Members or agreed to accept the CVS Caremark reimbursement rates

**Non Preferred Drug** – Any drug not listed on the Preferred Drug List or the Special Case Medication List of the Plan are considered Non Preferred.

**Over The Counter (OTC)** – are drugs you can buy without a prescription from a health care provider. The U.S. Food and Drug Administration (“FDA”) determines whether medications are prescription or nonprescription. Nonprescription or OTC drugs are medications the FDA decides are safe and effective for use without a prescription.

**Performance Drug List** - encourages members to use lower cost generics before using non preferred brand products. Before a prescription for a non preferred drug in one (1) of three (3) specific classes of prescription drugs can be processed, the member must have tried one of the generic alternatives available. The three classes of prescription drugs include: cholesterol lowering statin medications (HMG’s – 3hydroxy-3-methyl-glutaryl), long-lasting reduction of gastric [stomach] acid production (PPIs – proton pump inhibitors), and high blood pressure medications (ARB’s – Angiotensin II Receptor Blockers).

**Pharmacy** – a licensed provider authorized to prepare and dispense drugs and medications. A Pharmacy must have a National Association of Boards of Pharmacy identification number (NABP number).

**Plan** – The benefits defined herein and administered on behalf of the State of Kansas by CVS Caremark.

**Plan Sponsor** – State of Kansas

**Preferred Drug List** – a list that identifies those Prescription Drug Products that are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modification. The Preferred Drug List is available at: <http://www2.caremark.com/kse/>.

**Preferred Drug** – a drug listed on the Preferred Drug List.

**Prescription Drug Product** – a medication, product or device registered with and approved by the U.S. Food and Drug Administration (“FDA”) as safe and effective when used under a health care provider’s care and dispensed under federal or state law only pursuant to a Prescription Order or Refill. For the purpose of coverage under the plan, this definition includes insulin and diabetic supplies: insulin syringes with needles, alcohol swabs, blood testing strips-glucose, urine testing strips-glucose, ketone testing strips and tablets, lancets and lancet devices.

**Prescription Order or Refill** – the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Prior Authorization** – the process of obtaining pre-approval of coverage for certain Prescription Drug Products, prior to their dispensing, and using guidelines approved by the Plan Sponsor. The Plan retains the final discretionary authority regarding coverage. The list of medications requiring prior authorizations is subject to periodic review and modification.

**Special Case Medication** – a group of high cost medications used for the treatment of catastrophic conditions. The list of Special Case Medications is designated by the plan and is subject to periodic review and modification.

**Specialty Drugs** - Utilized by a small percentage of the population with rather complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Specialty drugs may require specialized delivery and are administered as injectable, inhaled, oral or infusion therapies. Coverage under the drug plan is limited to medications that have been designated by the plan as Specialty Drugs and are either self-administered or self-injectable. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the CVS Caremark Specialty Mail Order Pharmacy. This list of Specialty Drugs is subject to periodic review and modification.

**Standard Unit of Therapy** – Up to a thirty (30) consecutive day supply of Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or "standard units of therapy guidelines." Some products may be subject to additional supply limits adopted by the Plan.

**Tobacco Control** – a program that encourages members to discontinue using tobacco products and reduce the risk of disease, disability, and death related to tobacco use.

**You or Your** – refers to the Member.

## **Section 2 Benefit Provisions**

### **Coverage For Outpatient Prescription Drug Products**

The plan provides coverage for Prescription Drug Products, if all of these conditions are met:

1. You are an eligible Member in the Plan; and
2. it is Medically Necessary;
3. it is obtained through a Network Retail, Network Home Delivery or a Non Network Retail Pharmacy;
4. Specialty Drugs for self administration or self injection must be obtained from the CVS Caremark Specialty Pharmacy;
5. the Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines.

## **Standard Prescription Drug Benefits**

<b>Coverage Level</b>	<b>Prescription Drug Product</b>	<b>Member Responsibility</b>
<b>Tier One</b>	<b>Generic Drugs</b>	<b>20% Coinsurance</b>
<b>Tier Two</b>	<b>Preferred Drugs</b>	<b>35% Coinsurance</b>
<b>Tier Three</b>	<b>Special Case Medications</b>	<b>Maximum of \$75 per standard unit of therapy</b>
<b>Coinsurance/ Copayment Maximum</b>	<b>Tier One, Tier Two and Tier Three Only</b>	<b>\$2580 per person per year</b>
<b>Tier Four</b>	<b>Non Preferred and Compound Medications</b>	<b>60% Coinsurance</b>
<b>Tier Five</b>	<b>Discount Medications</b>	<b>100% Coinsurance</b>

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Coinsurance or Copayment. The Provider and the patient, not the Plan or the employer determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be. If You use a Network Pharmacy, the Member's payment shall not exceed the Allowed Charge when You present Your identification card to the pharmacy as required. When a Non Network Pharmacy is used, You will be responsible for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Coinsurance or Copayment. Benefits for services received from a Retail Non Network Pharmacy will be paid to the primary insured. To be eligible for coverage under the Plan, Specialty Pharmacy products that are self-administered or self injected must be purchased from the CVS Caremark Specialty Pharmacy. You can not assign benefits under this program to any other person or entity.

Information on the Performance Drug List, Preferred Drug List, Special Case List, Self Injectable List or Specialty Drug List is available at: <http://www2.caremark.com/kse/> or [www.kdheks.gov/hcf/sehp](http://www.kdheks.gov/hcf/sehp).

### **Generic Prescription Drug Products:**

Your Coinsurance is 20% of the Allowed Charge.

### **Preferred Brand Name Prescription Drug Products:**

For eligible Preferred Brand Name Drugs, Your Coinsurance is 35% of the Allowed Charge. The Preferred Drug List is subject to periodic review and modification.

### **Special Case Medications:**

Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed a maximum of \$75 per standard unit of therapy. For quantities less than a thirty (30) day supply, Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed \$75.

**Non Preferred Brand Name Drug Products:**

Eligible Non Preferred Brand Name Drug Products (those not included on the Preferred Drug List) Your Coinsurance is 60% of the Allowed Charge.

**Compound Medications:**

The Coinsurance will be 60% of the Allowed Charge of the Compounded Medication. CVS Caremark Mail Order Pharmacy is a contracting compounding pharmacy.

Claims for Compound Medications submitted for reimbursement must contain more than one (1) Legend Drug ingredient. If you use a Non Network pharmacy, you will need to submit a paper claim for reimbursement. You will need to obtain the following information from the pharmacy to complete the claim form:

- List the VALID 11 digit National Drug Code (NDC) number for EACH ingredient used in the compound prescription.
- List the ingredient name for each NDC number.
- Indicate the “metric quantity” expressed in number of tablets, grams or milliliters for each ingredient NDC Number.
- Indicate the cost for EACH ingredient (dollar amount).
- Indicate the TOTAL compounded quantity.
- Indicate the TOTAL dollar amount paid by the patient.

Please Note-If an ingredient cost is \$0, a valid NDC number and quantity for the ingredient is still required. The total cost of all the ingredients in the compound must be less than the total dollar amount paid by the member for the compound.

**Specialty Drug:**

Specialty drugs are medication that have been designated by the Plan and are self-administered or self-injectable. To be eligible for coverage under the Plan, specialty drugs must be purchased from the CVS Caremark Specialty Pharmacy. The list of specialty drugs medications is available at: <http://www2.caremark.com/kse/> or [www.kdheks.gov/hcf/sehp](http://www.kdheks.gov/hcf/sehp) and is subject to periodic review and modification. Coinsurance will be determined based on the Preferred Drug or Non Preferred Drug status of the medication; however most specialty drugs will also be on the Special Case List due to their high cost.

For members with Specialty Drugs, CVS Caremark will enroll You in the Specialty Pharmacy program. The Specialty Pharmacy Program focuses on patients who have complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Should you be prescribed a drug on the Specialty Drug List simply call CaremarkConnect® at 1-800-237-2767. CVS Caremark will coordinate getting the prescription from the doctor, if necessary and work with You to set up delivery. As these products often require special handling, You can schedule drug delivery to Your home, office, doctor's office, local pharmacy or other location you designate. The medication along with any necessary supplies (at no additional cost) will typically be shipped overnight to You. You will not be charged any shipping

charges. You will need to provide CVS Caremark with payment information for your share of the drug cost.

You will be assigned a case manager who will be in contact with You on a regular basis to answer any question You may have regarding treatment, side effects and therapy compliance. These clinicians specialize in the management of chronic conditions. Individualized care plans are developed for patient-specific conditions and involve You, Your physician, nurse, case manager, and clinical pharmacist in a coordinated and monitored course of treatment. In addition, You will have access to pharmacists or nurses 24 hours a day, seven days a week should you have any question or concerns about therapy. This program offers You a convenient source for these Specialty Drugs, lower potential drug-to-drug interactions and improved therapy compliance.

**Copayment/Coinsurance Maximum**

The total Copayment/Coinsurance Maximum per year for Generic, Preferred or Special Case Medication is \$2,580 per person. Only Non Preferred Drugs being purchased with a Drug Override, accumulate toward the Copayment/Coinsurance Maximum. Purchases of Generic, Preferred, Special Medications and drugs purchased with a Drug Override in excess of the Member's Copayment/Coinsurance Maximum will be reimbursed at 100% of the Allowable Charge for the remainder of the calendar year.

**Chronic Care Benefit**

<b>Prescription Drugs for:</b>	<b>Prescription Drug Product</b>	<b>Member Responsibility Per 30 Day Supply</b>
<b>Asthma</b>	<b>Generic Drug</b>	<b>10% to a maximum of \$10</b>
	<b>Preferred Brand Drug</b>	<b>20% to a maximum of \$20</b>
<b>Diabetes</b>	<b>Generic Drug</b>	<b>10% to a maximum of \$10</b>
	<b>Preferred Brands Drug</b>	<b>20% to a maximum of \$20</b>

The chronic care benefit is designed to support self management of asthma and diabetes. Regularly taking Your medication along with monitoring peak flows and blood sugar levels are critical to the self management of asthma and diabetes. To promote adherence to medication therapy, the Coinsurance has been reduced on prescription drug products primarily used for the treatment of asthma and diabetes as indicated above for medications on the Preferred Drug List. Non Preferred drugs are not eligible for lower coinsurance and copayments. The Plan retains the final discretionary authority on what constitutes an asthma or diabetic prescription drug product. This list is subject to periodic review and modification.

**Discount Medications**

You will be responsible for 100% of the Allowed Charge. The Allowed Charge is the CVS Caremark contracted reimbursement rate, and provides members with a discount off the retail price of the medication.

Prescription drug products that are only eligible for a discount include the following: infertility; erectile dysfunction; medications used primarily for cosmetic purposes; dental preparations (toothpaste, mouthwash, etc.); prescription medications where an equivalent non prescription product is available Over-The-Counter - example: non sedating antihistamines; Drug Efficacy Study Implementation (DESI-5) medications - older medications which still require a prescription, but which the FDA has approved only on the basis of safety, not safety and effectiveness; Ostomy supplies.

### ***Injectable Medications***

Coverage for Injectable drugs under this Plan is limited to those medications that have been designated by the Plan Sponsor. A list of designated medications is available on the web at <http://www2.caremark.com/kse/> or [www.kdheks.gov/hcf/sehp](http://www.kdheks.gov/hcf/sehp). This list is subject to periodic review and modification. The Injectable treatment must be medically necessary and appropriate for the condition being treated. Some Injectable Medications are available through the Specialty Pharmacy program for home delivery. For those Injectable items that require a medical professional to administer the drug, the cost for that injection is not covered under this Plan. These charges should be billed to your medical insurance.

### ***Oral Anti Cancer Medication***

Refer to the separate rider attached to this benefit description.

### ***Performance Drug List***

The Preferred Drug List (PDL) provides You a number of Generic and Preferred Brand Name Drug options to lower cholesterol, reduce stomach acid and treat high blood pressure. We encourage You to take the PDL with You to Your medical appointments so that you can discuss your prescription therapy options with Your physician. Using Generic drugs will save You and the Plan money.

Under the Performance Drug List, members are encouraged to use Generic and Preferred Brand Name drugs when appropriate. Non Preferred Brand Name Drugs in the following three classes are covered by the Plan, if You have a history of having tried at least one (1) Generic option in the same class. The three (3) class of drugs are: drugs used for cholesterol lowering - statin medications (HMG's - 3-hydroxy-3-methyl-glutaryl), long-lasting reduction of gastric [stomach] acid production (PPIs - proton pump inhibitors), and high blood pressure medications (ARB's - Angiotensin II Receptor Blockers). The CVS Caremark claim system will review Your claims history to determine whether or not You have a prior history of using a generic product in the same therapeutic class before a claim for a Non Preferred Brand Name Drug will be paid by the Plan. The Coinsurance for all claims will be determined based on the coverage tier (Generic, Preferred Brand Name or Non Preferred Brand Name drugs) for the medication purchased.

### ***Tobacco Control Wellness Program***

<b>Prescription Drugs for:</b>	<b>Prescription Drug Product</b>	<b>Member Responsibility Per 30 Day Supply</b>
<b>Tobacco Control</b>	<b>Generic Drug</b>	<b>10% to a maximum of \$10</b>
	<b>Brand Name Drug</b>	<b>20% to a maximum of \$20</b>

Enrollment in an approved tobacco control program is recommended with use of these prescription medications. Information on the HealthQuest tobacco control program available to You at no cost, is available on the State of Kansas Web site at: [www.kansashealthquest.com](http://www.kansashealthquest.com). The Plan retains the final discretionary authority on what constitutes tobacco control prescription drug products. This list is subject to periodic review and modification.

### ***Weight Management Wellness Program***

<b>Prescription Drugs for:</b>	<b>Prescription Drug Product</b>	<b>Member Responsibility</b>
<b>Weight Control</b>	<b>Generic Drug</b>	<b>20% Coinsurance</b>
	<b>Preferred Brand Name Drug</b>	<b>35% Coinsurance</b>
	<b>Non Preferred Brand Name Drug</b>	<b>60% Coinsurance</b>

Enrollment in an approved weight management program is recommended with use of weight control prescription medications. The Plan will pay as indicated above toward the cost of weight control prescription drug products. Information on HealthQuest weight control programs is available on the State of Kansas Web site at: [www.kansashealthquest.com](http://www.kansashealthquest.com). The Plan retains the final discretionary authority on what constitutes weight management or weight control prescription drug products. This list is subject to periodic review and modification.

### ***Women's Preventive Care Services***

The Plan will pay 100% of the Allowed Charge for prescription contraceptive medications listed on the Preferred Drug List. If you and your health care provider select a prescription contraceptive medication not listed on the Preferred Drug List, you will be responsible for paying the Non Preferred Drug Coinsurance. The list of covered prescription contraceptive medications is subject to periodic review and modification. Items which are classified by the FDA as Over-The-Counter (OTC) are not eligible for coverage under this Plan.

### ***Initial Prescription Drug Product Purchase***

Covered Prescription Drug Products are subject to the initial fill limit of thirty (30) consecutive day supply or one standard unit of therapy which ever is less.

### **Refill Guidelines**

Refills for up to a sixty (60) **day supply** may be obtained at one time for most medications. Refills may be obtained on the following schedule:

<b>Supply of Prescription Product</b>	<b>Percentage Consumed</b>	<b>Refill Available <u>After</u></b>
<b>5 Day Supply</b>	<b>40%</b>	<b>2 Days</b>
<b>10 Day Supply</b>	<b>60%</b>	<b>6 Days</b>
<b>21 Day Supply</b>	<b>70%</b>	<b>15 Days</b>
<b>30 Day Supply</b>	<b>75%</b>	<b>22 Days</b>
<b>60 Day Supply</b>	<b>75%</b>	<b>45 Days</b>

### **Advance Purchases**

Advance Purchase of Prescription Drug Products are available for active employees only who will be departing the U.S. for an extended period of time. Copayment and Coinsurance will be the applicable Network Pharmacy payments as required for each thirty (30) day supply or standard unit of therapy received. Active employees may contact their Human Resource office to obtain the Advance Purchase Certificate. The completed form must be signed by both You and an agency employee with the authority to expend agency funds, and submitted to the State Employee Health Plan office **15 days in advance** of the anticipated departure date. Up to a one (1) year supply of medications may be obtained if the request is approved.

- When adequate time is not available to submit an Advance Purchase Request or purchases are made outside of the country the cardholder may submit the pharmacy receipts for reimbursement upon return from the extended absence. In order to be considered for reimbursement, the patient must have continuous coverage for the entire period of absence.
- Prescription drugs purchased by the Member in excess of the supply limits of the plan may be covered once the time period covered by the excess supply has elapsed so long as the excess supply purchased does not overlap any other purchases for the same product. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to State Employee Health Plan, 900 SW Jackson, Rm. 900-N, Topeka, Ks 66612.
- Prescription Drug Products purchased and used while outside the United States must include documentation of the purchase to include the original receipt that contains the patient's name, the name of the product, day supply and quantity purchased and price paid. An English translation and currency exchange rate for the date of service is required from You in order to process the claim. Only prescription drugs that are eligible for payment under this Plan may be claimed for

reimbursement. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to State Employee Health Plan, 900 SW Jackson, Rm. 900-N, Topeka, Ks 66612.

### ***Home Delivery***

CVS Caremark offers home delivery through the mail that may save You money on Your prescription drug services. The Home Delivery option is a convenient and cost effective way to obtain Your medication through the mail to any location in the United States. **The maximum supply available is a sixty (60) day supply.** All supply limits and plan requirements apply to mail order pharmacy purchases.

If You have an ongoing prescription and wish to start home delivery, CVS Caremark will work with you and your physician to get you enrolled in home delivery. Simply call FastStart<sup>®</sup> toll free at **1-866-772-9503**. You must have Your prescription information as well as Your physician's telephone and FAX numbers available for the representative. CVS Caremark will call Your physician directly for Your prescription information and enroll You for mail service as soon as Your physician provides the necessary information. You will need to provide CVS Caremark with payment information for your share of the drug cost.

If you have paper prescription, to begin home delivery, send the original prescription along with the Mail Order Service Profile form (available at <http://www2.caremark.com/kse/> or [www.kdheks.gov/hcf/sehp](http://www.kdheks.gov/hcf/sehp) or by calling **1-800-294-6324**) to CVS Caremark. You will need to include your payment information for your share of the drug cost.

***New prescriptions and refills will typically arrive directly at Your home within 10-14 business days from the day You mail Your order.*** The mail order pharmacy is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than plan maximums per fill, the mail order pharmacy will fill the exact quantity prescribed.

### ***For refills:***

The prescription label lists the date when You can request a refill and shows how many refills You have left. Refill prescriptions on the Internet by visiting <http://www.caremark.com>. Have Your prescription number, date of birth and credit card information ready. You can also order refills by phone or through the mail. To use the automated phone service, call the toll-free number on the prescription label and have the prescription number, ZIP code and credit card information ready. Or, mail the refill slip and payment to **CVS Caremark** in the envelope that was included with Your previous shipment.

### ***Paper Claims***

Members will need to file a paper claim for the following situations:

- **Anytime Prescription Drug Products are purchased from a Non Network Pharmacy.**

- If You do not present Your Identification Card at a Network Pharmacy and are charged the retail cost of the Prescription, You will be responsible for filing a paper claim for reimbursement. (The CVS Caremark Help Desk **1-800-364-6331** can assist in transmitting a claim on-line if the Member does not have their Identification Card available.)
- If a Prescription Drug Product requires prior authorization and it has not been obtained, the Member may pay the full purchase price for the Product and submit a claim along with documentation for consideration of coverage under the Plan. Payment is not guaranteed by the Plan.

In any of these situations, You must pay full retail price at the pharmacy. A claim form should then be completed and sent (along with the original receipt and any additional information) to: **CVS Caremark / P.O. Box 52136 / Phoenix, AZ 85072-2136**. Reimbursement to the Member for the cost of the prescription is limited to the Allowed Charge a Network Pharmacy would have been paid, less applicable Coinsurance or Copayments. Claim forms can be found on the internet at <https://www2.caremark.com/kse/>.

### **Time Limit for Filing Claims**

You are responsible for making sure the Network Pharmacy knows You have prescription drug coverage and submits a claim for You. Most claims under this program are submitted electronically at the time of purchase. For those claims that are not, electronic claims may be submitted or adjusted within thirty (30) days of purchase. If You use a Non Network Provider, You must submit the notice yourself. Notice of Your claim must be given to the Plan within ninety (90) days after You receive services. If it is not reasonably possible for You to submit a claim within ninety (90) days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and ninety (90) days after You receive services.

## **Section 3 Coordination of Benefits**

### ***Coordination of Benefits with Medicare as Primary***

When Medicare is primary, the Plan will pay the balance of the Medicare Allowed Charge in full.

### ***Coordination of Benefits with Commercial Insurance***

Only prescription drug products covered under this Plan are eligible for payment. The Allowed Charge will be the amount allowed but not covered by the other plan. Payments are subject to this Plan's applicable Coinsurance, Copayments and Plan provisions and limitations.

**Order of Benefit Determination**

If You are covered under more than one group plan providing drug coverage, the plan that covers You as an active employee is primary to the plan that covers You as a dependent (spouse or child) or retired employee, unless otherwise required by Medicare.

Determination of primary/secondary coverage for dependent children will be based upon the "birthday rule" unless otherwise required by court order or by law. The primary plan is the plan of the parent whose birthday is earlier (month and day) in the year.

If the parents are not married or separated (whether or not they were married) or are divorced, and the court decree does not allocate responsibility for health care or expenses, the order of benefit determination will be as follows:

- a) The plan of the custodial parent;
- b) The plan of the spouse of the custodial parent;
- c) The plan of the noncustodial parent, and then
- d) The plan of the spouse of the noncustodial parent.

## Section 4 Prior Authorization

Certain Prescription Drug Products require Prior Authorization to be covered by the Plan. Prior Authorization is usually initiated by Your physician or other authorized representative on Your behalf, however it remains Your responsibility. If these Prescription Drug Products are not authorized before being dispensed, You will be responsible for paying the full retail charge. In this case, You will need to submit a paper claim with supporting documentation to allow for consideration under the Plan. The Plan retains the final discretionary authority regarding coverage by the Plan. The following list of medications require Prior Authorization to be covered. This list is subject to periodic review and modifications:

***\* Drugs highlighted in bold italic type are Specialty Drugs are available through the CVS Caremark Specialty Pharmacy only. For Specialty Drugs call CaremarkConnect®: 1.800.237.2767.***

### ADHD/Narcolepsy

Adderall  
Adderall XR  
Amphetamine-  
Dextroamphetamine  
Amphetamine-  
Dextroamphetamine SR  
Desoxyn  
Dexedrine  
Vyvanse

### \*Anemia

***Aranesp***  
***Epogen***  
***Procrit***

### \*Arthritis Agents

***Enbrel***  
***Humira***

### \*Asthma

***Xolair***

### \*CAPS

***Arcalyst***  
***Ilaris***  
***Kineret***

### \*Cardiac Disorders

***Tikosyn***  
***Samsca***

### \*Cystic Fibrosis

***Cayston***  
***Pulmozyme***  
***Tobi***

### Diabetic

Byetta  
Symlin  
Victoza

### \*Growth Hormones

***Norditropin***

### \*Hematopoietics

***Mozobil***  
***Neumega***

### \*Hepatitis C

***Copegus***  
***Infergen***  
***Intron A***  
***Pegasys***  
***Peg-Intron***  
***Rebetol***  
***Ribavirin***  
***Ribasphere***

### \*Hereditary Angioedema

***Kalbitor***

### \*HIV

***Egrifta***  
***Fuzeon***

### \*Hormonal Therapies

***Eligard***

### \*Inflammatory Bowel Disease

***Humira***  
***Enbrel***

**\*Lysosomal Storage Disorders**

*Zavesca*  
*Orfadin*

**Migraine**

*Amerge*  
*Axert*  
*Frova*  
*Imitrex Nasal Spray*  
*Imitrex Tablet*  
*Imitrex Injection*  
*Maxalt*  
*Maxalt MLT*  
*Relpax*  
*Treximet*  
*Zomig*  
*Zomig Nasal Spray*  
*Zomig ZMT*

**\*MS Drugs**

*Ampyra*  
*Avonex*  
*Betaseron*  
*Copaxone*  
*Extavia*  
*Gilenya*  
*Rebif*

**\*Neutropenia**

*Leukine*  
*Neulasta*  
*Neupogen*

**\*Oncology**

*Afinitor*  
*Gleevec*  
*Hycamtin capsules*  
*Intron A*  
*Iressa*  
*Ixempra*  
*Nexavar*  
*Oforta*  
*Revlimid*  
*Sprycel*  
*Sutent*  
*Tarceva*  
*Tasigna*  
*Temodar*

**\*Oncology cont.**

*Thalomid*  
*Tykerb*  
*Valstar*  
*Vidaza*  
*Votrient*  
*Xeloda*  
*Zolinza*  
*Zometa*

**\*Osteoporosis**

*Forteo*  
*Prolia*

**Pain**

*Stadol Nasal Spray*

**\*Phenylketonuria**

*Kuvan*

**\*Psoriasis**

*Enbrel*  
*Humira*

**\*Pulmonary Arterial Hypertension**

*Adcirca*  
*Letairis*  
*Revatio*  
*Tracleer*  
*Tyvaso*  
*Ventavis*

**\*Renal**

*Senispar*

**\*Rheumatoid Arthritis**

*Humira*

**\*Seizure Disorders**

*Acthar*  
*Sabril*

**Tretinoin Products**

*Altinac*  
*Atralin*  
*Avita*  
*Retin-A*  
*Tretinoin*  
*Veltin*  
*Ziana*

**\*Urea Cycle Disorders**

*Carbaglu*

**\*Other Drugs**

*Actimmune*  
*Botox*  
*Crinone*  
*Dysport*  
*Exjade*  
*Myobloc*  
*Nplate*  
*Ocetrotide acetate*  
*Promacta*  
*Sandostatin*  
*Somatuline*  
*Somavert*  
*Vivitrol*  
*Xenazine*  
*Xeomin*

## **Section 5 Drug Override**

If You are taking a Non Preferred Drug and can show that You tried at least **two (2)** different Preferred Drugs in the same therapeutic class, Your physician may call the CVS Caremark Prior Authorization Department at 1-800-294-5979 (for physician use only) to request a drug override. Approvals will be granted in the following situations:

- 1) The patient has used at least two (2) Preferred Drugs, one of which was a generic drug  
**and**
  - a) The Preferred Drugs were ineffective for the patient, or
  - b) The patient could not tolerate the Preferred Drugs
- or**
- 2) The patient meets other pre-established clinical criteria approved by the Plan Sponsor.

If the request is approved, an override will be entered to allow the Non Preferred Drug to be paid for at the Preferred Drug Coinsurance. Non Preferred Drugs which have been approved for an override based on the above criteria will count toward the Coinsurance/Copayment maximum.

## **Section 6 Other Plan Provisions**

### ***Fraudulent, Inappropriate Use or Misrepresentation***

You and Your dependent(s) coverage may be terminated and other appropriate action taken as determined by the Plan Sponsor, if You or Your dependents participate in any act that constitutes fraud, gross misbehavior, misrepresentation or omission of pertinent facts in applying for or seeking benefits under the Plan. This shall also include other improper action as determined by the Plan Sponsor. This includes but is not limited to:

- a. Misrepresent or omission of material facts to obtain coverage or allowing unauthorized persons use of Your State of Kansas Drug Plan identification card to obtain services, supplies or medication that are not prescribed or ordered for You or a covered family member or for which You are not otherwise entitled to receive. In this instance, Coverage for You and/or any covered dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.
- b. Permitting the unauthorized use of Your State of Kansas Drug Plan identification card to obtain medication, services or supplies for someone not covered under Your State of Kansas Prescription Drug membership. In this instance, Coverage of the member and/or dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

- c. Using another State of Kansas member's Prescription Drug Plan identification card to obtain medication, services or supplies for You or some other third party not specifically covered under that membership may result in the termination of your coverage and that of your dependents by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

## ***Appeal and External Review***

### **Definitions**

The following terms are used herein to describe the claims and appeals review services provided by CVS Caremark:

***Adverse Benefit Determination*** – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a covered Plan benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a covered Plan benefit based on the application of a utilization review or on a determination of a plan Member's eligibility to participate in the Plan. An adverse benefit determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate. The Plan's determination of a drug's particular coverage tier is not an Adverse Benefit Determination eligible for appeal or external review. For example, the Plan's designation of a drug a "Discount Medication" (Tier 5) is not considered an Adverse Benefit Determination and therefore is not eligible for appeal or external review.

***Claim*** – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.

***Medically Necessary (Medical Necessity)*** – Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
- Use of the medication, service, or product represents the most appropriate level of care for the Member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
- Use of medication, service or product is not solely for the convenience of the Member, Member's family, or provider.

***Post-Service Claim*** – A Claim for a Plan benefit that is not a Pre-Service Claim.

**Pre-authorization** – CVS Caremark pre-service review of a Member’s initial request for a particular medication. CVS Caremark will apply a set of pre-defined criteria (provided by the Plan Sponsor) to determine whether there is need for the requested medication.

**Pre-Service Claim** – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include Member requests for pre-authorization.

**Urgent Care Claim** – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the Member, and/or could result in the Member’s failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the Member’s condition, would subject the Member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS Caremark will defer to the Member’s attending health care provider as to whether or not the Member’s Claim constitutes an Urgent Care Claim

## **Claims and Appeals Process**

### **Pre-authorization Review:**

CVS Caremark will implement the prescription drug cost containment programs requested by the Plan Sponsor by comparing Member requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS Caremark determines that the Member’s request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

### **Appeals of Adverse Benefit Determinations:**

If an Adverse Benefit Determination is rendered on the Member’s Claim, the Member may file an appeal of that determination. The Member’s appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after the Member receives notice of the Adverse Benefit Determination. If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the Member and/or the Member’s attending physician may submit an appeal by calling CVS Caremark. The Member’s appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

The Member's appeal and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark  
Appeals Department  
MC109  
P.O. Box 52084  
Phoenix, AZ 85072-2084  
Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll-free number: 1-866-443-1183

**CVS Caremark Review:**

The review of a Member's Claim or appeal of an Adverse Benefit Determination will be conducted in accordance with the requirements of any State and Federal laws. Members will be accorded all rights granted to them under relevant laws. CVS Caremark will provide the first-level review of appeals of Pre-Service Claims. If the Member disagrees with CVS Caremark's decision, the Member can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization ("IRO").

**Timing of Review:**

**Pre-Authorization Review** – CVS Caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours.

**Pre-Service Claim Appeal** – CVS Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the Member's appeal. If CVS Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the Member may appeal that decision by providing the information described above. A decision on the Member's second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the Member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).

**Post-Service Claim Appeal** – CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives the appeal.

**Scope of Review:**

During its pre-authorization review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, CVS Caremark shall:

- Take into account all comments, documents, records and other information submitted by the Member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the Member in a manner consistent with how such provisions have been applied to other similarly-situated Members; and
- Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If a Member appeals CVS Caremark's denial of a Pre-Service Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professional who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

**Notice of Adverse Benefit Determination:**

Following the review of a Member's Claim, CVS Caremark will notify the Member of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the Member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

**Authority as Claims Fiduciary:**

CVS Caremark shall serve as the claims fiduciary with respect to pre-authorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Services Claims, and review of Post-Service Claims. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS Caremark is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO. Likewise, CVS Caremark is not responsible for the conduct of any State External Review conducted by an External Review Organization (discussed below).

**Procedure For Pursuing A State External Review**

You have the right to request a State External Review when the reason for the final second appeal and notice of an Adverse Benefit Decision was that the prescription drug was not medically necessary or was experimental or investigational. CVS Caremark will notify You in writing regarding a final Adverse Benefit Decision and of the opportunity to request an External Review.

Within 120 days of receipt of the notice of the second appeal and notice of the Adverse Benefit Decision, You, Your treating Physician or health care provider acting on Your behalf with Your written authorization, or Your legally authorized designee must make a written request for an External Review to the State Employee Health Plan, 900 SW Jackson, Rm. 900 N, Topeka, Kansas 66612. The State Employee Health Plan will work with the Kansas Insurance Department to obtain an external review.

Within 10 business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Department will notify You and other involved parties as to whether the request for External Review is granted.

For those requests that qualify for External Review, the External Review Organization will issue a written decision to You and the Kansas Insurance Department within 30 days. The External Review Organization will issue its written decision within 72 hours when the request for External Review involves an Emergency Medical Condition. If any party is not satisfied with the decision of the External Review organization, they may pursue normal remedies of law.

The right to External Review shall not be construed to change the terms of coverage under this Benefit Description. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts. You may not pursue, either concurrently or sequentially, an External Review under both state and federal law. You shall have the option of designating which External Review process will be utilized.

## **Exclusions**

The Plan does not cover the following:

1. Prescription Drug Products in amounts exceeding the supply limit referenced in Section 2.
2. Drugs which are prescribed, dispensed, or intended for use while You are an inpatient in a hospital or other facility.
3. Benefits are not available to the extent a Prescription Drug Product has been covered under another contract, certificate or rider issued by the Plan Sponsor.
4. Prescription Drug Products furnished to a Member by any local, state or federal government entity; except as otherwise provided by law, any Prescription Drug Product to the extent payment or benefits are provided or available from any local, state or federal government entity (for example, Medicare) regardless of whether payment or benefits are received.
5. Prescription Drug Products for any condition, illness, injury, sickness or mental illness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
6. Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to dispense. In addition, the Compounded Medication must have FDA approval and all required information must be provided on the claim.
7. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law.
8. Injectable drugs administered by a Health Professional in an inpatient or outpatient setting.
9. Durable or disposable medical equipment or supplies, other than the specified diabetic and ostomy supplies.
10. Replacement Prescription Drug Products including damaged, lost, stolen or spilled Prescriptions.
11. Legend general vitamins except Legend prenatal vitamins, Legend vitamins with fluoride, and Legend single entity vitamins.
12. Prescription Drug Products that are not medically necessary.
13. Charges to administer or inject any drug.
14. Prescription Drug Products that are administered or entirely used up at the time and place ordered, such as in a clinic or physician's office.
15. Prescription Drug Products for which there is normally no charge in professional practice.
16. Therapeutic devices, artificial appliances, or similar devices, regardless of intended use.
17. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.

18. Experimental, investigational, or unproven prescription drug products, treatments or therapies.
19. Prescription Drug Products that have not been approved by the Federal Food and Drug Administration.
20. Health care services and drugs customarily provided by the research sponsors of a clinical trial free of charge for any insured participating in a clinical trial.
21. Charges for the delivery of any drugs.
22. Prescription Drug Products obtained for use in connection with the treatment of drug addiction.
23. Prescription Drug Products approved for experimental use only.
24. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice
25. Coverage for allergy antigens under any circumstances.
26. Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.

## **Section 7 Oral Anti-Cancer Medication Rider**

This rider outlines the coverage provided for oral anti-cancer prescription drug products.

### *Definitions:*

**Allowed Charge** – the maximum amount the Plan determines is payable for a covered expense. For this Plan the Allowed Charge will be the contracted reimbursement rate including any applicable sales tax. When this Plan is secondary to other insurance, the Allowed Charge will be the amount allowed but not paid by the other plan subject to the coverage provisions of this Plan.

**Oral Anti-Cancer Prescription Drug Product** – orally administered Prescription Drug Products used to kill or slow the growth of cancerous cells.

**Specialty Drugs** - Utilized by a small percentage of the population with rather complex and/or chronic conditions requiring expensive and/or complicated drug regimens that require close supervision and monitoring on an ongoing basis. Specialty drugs may require specialized delivery and are administered as injectable, inhaled, oral or infusion therapies. The major conditions these drugs treat include some cancer medications. Coverage under the drug plan is limited to medications that have been designated by the plan as Specialty Drugs and are either self-administered or self-injectable. To be eligible for coverage under the Plan, Specialty Drugs must be purchased from the CVS Caremark Specialty Pharmacy. This list of Specialty Drugs is subject to periodic review and modification.

**Standard Unit of Therapy** – Up to a thirty (30) consecutive day supply of Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or "standard units of therapy guidelines." Some products may be subject to additional supply limits adopted by the Plan.

## Benefit Provisions:

### Coverage For Outpatient Prescription Drug Products:

The plan provides coverage for Prescription Drug Products, if all of these conditions are met:

1. You are an eligible Member in the Plan; and
2. it is Medically Necessary;
3. it is obtained through a Network Retail, Network Home Delivery, or a Non Network Retail Pharmacy;
4. Specialty Drugs for self administration or self injection must be obtained from the CVS Caremark Specialty Pharmacy;
5. The Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines.

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Coinsurance. The Provider and the patient, not the Plan or the employer determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be. If You use a Network Pharmacy, the Member's payment shall not exceed the Allowed Charge when You present Your identification card to the pharmacy as required. When a Non Network Pharmacy is used, You will be responsible for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Coinsurance. Benefits for services received from a Retail Non Network Pharmacy will be paid to the primary insured. You can not assign benefits under this program to any other person or entity. Prior authorization may be required for some prescription products.

To be eligible for coverage under the Plan, Specialty Pharmacy products that are self-administered or self injected must be purchased from the CVS Caremark Specialty Pharmacy. Should you be prescribed a drug on the Specialty Drug list, simply call CaremarkConnect® at 1-800-237-2767. CVS Caremark offers home delivery through the mail of most prescription products. The Home Delivery option is a convenient way to obtain Your medication through the mail at any location in the United States.

A complete list of Oral Anti-Cancer Prescription Drug Products is available at <http://www2.caremark.com/kse/> or [www.kdheks.gov/hcf/sehp/default.htm](http://www.kdheks.gov/hcf/sehp/default.htm). The Plan retains the final discretionary authority regarding coverage by the Plan. This list is subject to periodic review and modification.

Oral Anti-Cancer Prescription Drug Products	
Coverage	Member Responsibility
Coinsurance	25% Coinsurance to a Maximum of \$75 dollars per Standard Unit of Therapy
Coinsurance Maximum	\$750 per member per year

**Oral Anti-Cancer Prescription Drug Products:**

Your responsibility is 25% Coinsurance of the Allowed Charge not to exceed \$75 per standard unit of therapy for covered Oral Anti-Cancer Prescription Drug Products. You will pay Coinsurance until You reach the Coinsurance Maximum of \$750 per member per year. Once the Coinsurance Maximum has been met, the Plan pays 100% of the Allowed Charged for covered Oral Anti-Cancer Prescription Drug Products covered under this rider for the remainder of the calendar year. The Plan retains the final discretionary authority on what constitutes an oral cancer prescription drug product. This list is subject to periodic review and modification. The Plan retains the final discretionary authority on what constitutes an Oral Anti-Cancer Prescription Drug Product. This list is subject to periodic review and modification.

**Initial Prescription Drug Product Purchase**

Covered Prescription Drug Products are subject to the initial fill limit of thirty (30) consecutive day supply or one standard unit of therapy whichever is less. Some products may be subject to additional supply limits adopted by the Plan. Specialty Medications are limited to a 30 day supply.

**Refill Guidelines**

Refills for up to a sixty (60) day supply may be obtained at one time for most medications. Refills may be obtained on the following schedule:

Supply of Prescription Product	Percentage Consumed	Refill Available After
5 Day Supply	40%	2 Days
10 Day Supply	60%	6 Days
21 Day Supply	70%	15 Days
30 Day Supply	75%	22 Days
60 Day Supply	75%	45 Days

**Time Limit for Filing Claims**

You are responsible for making sure the Network Pharmacy knows You have prescription drug coverage and submits a claim for You. Most claims under this program are submitted electronically at the time of purchase. For those claims that are not, electronic claims may be submitted or adjusted within thirty (30) days of purchase. If You use a Non Network Provider, You must submit the notice yourself. Notice of Your claim must be given to the Plan within ninety (90) days after You receive services. If it is not reasonably possible for You to submit a claim within ninety (90) days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and ninety (90) days after You receive services.

**Exclusions:**

The Plan does not cover the following:

1. Prescription Drug Products in amounts exceeding the supply limit allowed under this rider.
2. Drugs which are prescribed, dispensed, or intended for use while You are an inpatient in a hospital or other facility.
3. Benefits are not available for any Prescription Drug Products for which a claim for benefits has already been processed under another contract, certificate or rider issued by the Plan Sponsor.
4. Prescription Drug Products furnished to a Member by any local, state or federal government entity; except as otherwise provided by law, any Prescription Drug Product to the extent payment or benefits are provided or available from any local, state or federal government entity (for example, Medicare) regardless of whether payment or benefits are received.
5. Prescription Drug Products for any condition, illness, injury, sickness or mental illness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
6. Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to dispense. In addition, the Compounded Medication must have FDA approval and all necessary information must be provided on the claim.
7. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law.
8. Injectable and Prescription Drug Products administered by a Health Professional in an inpatient or outpatient setting.
9. Prescription Drug Products that the Plan determines are not medically necessary.
10. Experimental or unproven prescription drug products, treatments or therapies.
11. Prescription Drug Products that have not been approved by the Federal Food and Drug Administration.
12. Health care services and drugs customarily provided by the research sponsors of a clinical trial free of charge for any insured participating in a clinical trial.
13. Charges to administer or inject any drug.
14. Prescription Drug Products that are administered or entirely used up at the time and place ordered, such as in a clinic or physician's office.
15. Prescription Drug Products for which there is normally no charge in professional practice.
16. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
17. Charges for the delivery of any drugs.
18. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.
19. Replacement Prescription Drug Products including damaged, lost, stolen or spilled Prescriptions.

## Section 8 Preferred Drug List



### *Kansas State Group Health Insurance Program Member Preferred Drug List 2013*

For questions or additional information, access the State of Kansas website at <http://www.kdheks.gov/hcf/sehp> or call the **Kansas State Employees Prescription Drug Program** toll-free at 1-800-294-6324.

The Preferred Drug List is subject to change. To locate covered prescriptions online, access the State of Kansas website at <http://www.kdheks.gov/hcf/sehp> for the most current drug list.

#### *What is a Preferred Drug List?*

A Preferred Drug List is a list of safe and cost-effective drugs, chosen by a committee of physicians and pharmacists. Drug lists have been used in hospitals for many years to help ensure quality drug use. The Kansas State Employees Preferred Drug List will be continually revised to reflect the changing drug market.

#### *Should I ask my physician to switch my current medications to a medication that is on the Preferred Drug List?*

Many of your medications will already be on the Preferred Drug List. However, if you have a medication that is not, ask your physician to choose a similar Preferred Drug List product for you to use.

#### *Should I use generics?*

There are many medications on the market that do not come in generic form. For those drugs that do, your pharmacist should suggest safe and effective generic alternatives.

**Boldface** type indicates generic availability; boldface may not apply to every strength or dosage form under the listed generic name.

*Effective 01/01/2013*

## Your Kansas State Employees Preferred Drug List As Of January 2013

### ANALGESICS

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#### **NSAIDs**

diclofenac sodium delayed-rel  
diflunisal  
etodolac  
ibuprofen  
meloxicam  
nabumetone  
naproxen  
naproxen sodium  
oxaprozin  
sulindac

#### **NSAIDs, COMBINATIONS**

naproxen/esomeprazole delayed-rel (VIMOVO)

#### **NSAIDs, TOPICAL**

diclofenac sodium gel (VOLTAREN GEL)  
diclofenac sodium soln (PENNSAID)

#### **COX-2 INHIBITORS**

celecoxib (CELEBREX)

#### **GOUT**

allopurinol  
probenecid  
colchicine (COLCRYS)  
febuxostat (ULORIC)

#### **OPIOID ANALGESICS**

codeine/acetaminophen  
hydrocodone/acetaminophen  
tramadol  
tramadol ext-rel

#### **OPIOID ANALGESICS, CII**

fentanyl transdermal  
hydromorphone  
morphine  
morphine ext-rel  
morphine supp  
oxycodone caps, tabs 5 mg  
oxycodone concentrate 20 mg/mL  
oxycodone tabs 15 mg, 30 mg,  
soln 5 mg/5 mL  
oxycodone/acetaminophen 5/325  
hydromorphone ext-rel (EXALGO)  
morphine ext-rel (AVINZA)  
oxycodone ext-rel (OXYCONTIN)  
oxymorphone ext-rel (OPANA ER)  
tapentadol (NUCYNTA)  
tapentadol ext-rel (NUCYNTA ER)

#### **NON-OPIOID ANALGESICS**

butalbital/acetaminophen/caffeine  
butalbital/aspirin/caffeine

### ANTI-INFECTIVES

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#### **ANTIBACTERIALS**

**Cephalosporins**  
*First Generation*  
cefadroxil  
cephalexin

#### *Second Generation*

cefaclor  
cefprozil  
cefuroxime axetil

#### *Third Generation*

cefdinir  
cefixime (SUPRAX)

#### **Erythromycins/Macrolides**

azithromycin  
clarithromycin  
clarithromycin ext-rel  
erythromycin delayed-rel  
erythromycin ethylsuccinate  
erythromycin stearate  
erythromycin/sulfisoxazole

#### **Fluoroquinolones**

ciprofloxacin ext-rel  
ciprofloxacin tabs  
levofloxacin  
ciprofloxacin susp (CIPRO susp)  
moxifloxacin (AVELOX)

#### **Penicillins**

amoxicillin  
amoxicillin/clavulanate  
amoxicillin/clavulanate ext-rel  
ampicillin  
dicloxacillin  
penicillin VK

#### **Tetracyclines**

doxycycline hyclate  
minocycline  
tetracycline

#### **ANTIFUNGALS**

clotrimazole troches  
fluconazole  
itraconazole  
ketoconazole  
nystatin  
terbinafine tabs  
voriconazole  
griseofulvin ultramicrosized (GRIS-PEG)

#### **ANTIMALARIALS**

atovaquone/proguanil  
chloroquine  
mefloquine  
artemether/lumefantrine (COARTEM)

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## Your Kansas State Employees Preferred Drug List As Of January 2013

### **ANTIRETROVIRAL AGENTS**

#### **Antiretroviral Combinations**

##### **lamivudine/zidovudine**

abacavir/lamivudine (EPZICOM)  
abacavir/lamivudine/zidovudine (TRIZIVIR)  
efavirenz/emtricitabine/tenofovir (ATRIPLA)  
emtricitabine/tenofovir (TRUVADA)

#### **Chemokine Receptor Antagonists**

maraviroc (SELZENTRY)

#### **Fusion Inhibitors**

enfuvirtide (FUZEON)

#### **Integrase Inhibitors**

raltegravir (ISENTRESS)

#### **Non-nucleoside Reverse Transcriptase**

##### **Inhibitors**

##### **nevirapine**

delavirdine (RESCRIPTOR)  
efavirenz (SUSTIVA)  
etravirine (INTELENCE)  
nevirapine ext-rel (VIRAMUNE XR)  
rilpivirine (EDURANT)

#### **Nucleoside Reverse Transcriptase**

##### **Inhibitors**

##### **abacavir**

##### **didanosine delayed-rel**

##### **lamivudine**

##### **stavudine**

##### **zidovudine**

didanosine soln (VIDEX soln)  
emtricitabine (EMTRIVA)

#### **Nucleotide Reverse Transcriptase**

##### **Inhibitors**

tenofovir (VIREAD)

#### **Protease Inhibitors**

atazanavir (REYATAZ)  
darunavir (PREZISTA)  
fosamprenavir (LEXIVA)  
indinavir (CRIXIVAN)  
lopinavir/ritonavir (KALETRA)  
nelfinavir (VIRACEPT)  
ritonavir (NORVIR)  
saquinavir mesylate (INVIRASE)  
tipranavir (APTIVUS)

### **ANTITUBERCULAR AGENTS**

##### **ethambutol**

##### **isoniazid**

##### **pyrazinamide**

##### **rifampin**

### **ANTIVIRALS**

#### **Cytomegalovirus Agents**

##### **ganciclovir**

valganciclovir (VALCYTE)

### **Hepatitis Agents**

#### *Hepatitis B*

adefovir dipivoxil (HEPSERA)  
entecavir (BARACLUDE)  
lamivudine (EPIVIR-HBV)  
telbivudine (TYZEKA)

#### *Hepatitis C*

##### **ribavirin**

boceprevir (VICTRELIS)  
ribavirin oral soln (REBETOL)  
telaprevir (INCIVEK)

### **Herpes Agents**

#### **acyclovir caps, tabs**

#### **famciclovir**

#### **valacyclovir**

### **Influenza Agents**

#### **amantadine**

#### **rimantadine**

oseltamivir (TAMIFLU)  
zanamivir (RELENZA)

### **MISCELLANEOUS**

#### **clindamycin**

#### **dapsone**

#### **metronidazole**

#### **nitrofurantoin ext-rel**

#### **nitrofurantoin macrocrystals**

#### **nitrofurantoin susp**

#### **sulfamethoxazole/trimethoprim**

#### **sulfamethoxazole/trimethoprim DS**

#### **tinidazole**

#### **trimethoprim**

#### **vancomycin**

rifaximin (XIFAXAN 550 mg)

## **ANTINEOPLASTIC AGENTS**

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### **ALKYLATING AGENTS**

#### **cyclophosphamide**

altretamine (HEXALEN)  
busulfan (MYLERAN)  
chlorambucil (LEUKERAN)  
lomustine (CEENU)  
melphalan (ALKERAN)  
temozolomide (TEMODAR)

### **ANTIMETABOLITES**

#### **mercaptopurine**

capecitabine (XELODA)  
methotrexate (TREXALL)  
thioguanine

### **HORMONAL ANTINEOPLASTIC AGENTS**

#### **Antiandrogens**

##### **bicalutamide**

##### **flutamide**

#### **Antiestrogens**

##### **tamoxifen**

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## Your Kansas State Employees Preferred Drug List As Of January 2013

fulvestrant (FASLODEX)  
toremifene (FARESTON)

### **Aromatase Inhibitors**

**anastrozole**  
**exemestane**  
**letrozole**

### **Luteinizing Hormone-releasing Hormone (LHRH) Agonists**

**leuprolide acetate**  
goserelin acetate (ZOLADEX)

### **Progestins**

**megestrol acetate**

### **IMMUNOMODULATORS**

lenalidomide (REVLIMID)  
thalidomide (THALOMID)

### **KINASE INHIBITORS**

dasatinib (SPRYCEL)  
erlotinib (TARCEVA)  
everolimus (AFINITOR)  
imatinib mesylate (GLEEVEC)  
lapatinib (TYKERB)  
nilotinib (TASIGNA)  
pazopanib (VOTRIENT)  
sorafenib (NEXAVAR)  
sunitinib (SUTENT)

### **TOPOISOMERASE INHIBITORS**

topotecan caps (HYCAMTIN caps)

### **MISCELLANEOUS**

**etoposide**  
**hydroxyurea**  
**tretinoin caps**  
bexarotene caps (TARGRETIN caps)  
mitotane (LYSODREN)  
procarbazine (MATULANE)  
vorinostat (ZOLINZA)

## **CARDIOVASCULAR**

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### **ACE INHIBITORS**

**benazepril**  
**captopril**  
**enalapril**  
**fosinopril**  
**lisinopril**  
**perindopril**  
**quinapril**  
**ramipril**  
**trandolapril**

### **ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS**

**amlodipine/benazepril**  
trandolapril/verapamil ext-rel (TARKA)

### **ACE INHIBITOR/DIURETIC COMBINATIONS**

**benazepril/hydrochlorothiazide**  
**captopril/hydrochlorothiazide**  
**enalapril/hydrochlorothiazide**  
**fosinopril/hydrochlorothiazide**  
**lisinopril/hydrochlorothiazide**  
**quinapril/hydrochlorothiazide**

### **ADRENOLYTICS, CENTRAL**

**clonidine**  
**clonidine transdermal**  
**guanfacine**

### **ALDOSTERONE RECEPTOR ANTAGONISTS**

**eplerenone**  
**spironolactone**

### **ALPHA BLOCKERS**

**doxazosin**  
**terazosin**

### **ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC COMBINATIONS**

**eprosartan**  
**irbesartan**  
**irbesartan/hydrochlorothiazide**  
**losartan**  
**losartan/hydrochlorothiazide**  
**valsartan/hydrochlorothiazide**  
(DIOVAN HCT)  
olmesartan (BENICAR)  
olmesartan/hydrochlorothiazide  
(BENICAR HCT)  
telmisartan (MICARDIS)  
telmisartan/hydrochlorothiazide  
(MICARDIS HCT)  
valsartan (DIOVAN)

### **ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER COMBINATIONS**

**amlodipine/olmesartan (AZOR)**  
**amlodipine/valsartan (EXFORGE)**

### **ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATIONS**

**amlodipine/valsartan/hydrochlorothiazide**  
(EXFORGE HCT)  
**olmesartan/amlodipine/hydrochlorothiazide**  
(TRIBENZOR)

### **ANTIARRHYTHMICS**

**amiodarone**  
**disopyramide**  
**flecainide**  
**propafenone**

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## Your Kansas State Employees Preferred Drug List As Of January 2013

**propafenone ext-rel**  
**sotalol**  
dofetilide (TIKOSYN)

### **ANTIPIPEMICS**

**Bile Acid Resins**  
**cholestyramine**  
**colestipol**  
colesevelam (WELCHOL)

**Cholesterol Absorption Inhibitors**  
ezetimibe (ZETIA)

### **Fibrates**

**fenofibrate**  
**gemfibrozil**  
fenofibrate (ANTARA)  
fenofibrate (LIPOFEN)  
fenofibrate, micronized (TRICOR)  
fenofibric acid delayed-rel (TRILIPIX)

**HMG-CoA Reductase  
Inhibitors/Combinations**

**atorvastatin**  
**fluvastatin**  
**lovastatin**  
**pravastatin**  
**simvastatin**  
ezetimibe/simvastatin (VYTORIN)  
fluvastatin ext-rel (LESCOL XL)  
rosuvastatin (CRESTOR)

### **Niacins/Combinations**

niacin ext-rel (NIASPAN)  
niacin ext-rel/simvastatin (SIMCOR)

### **Omega-3 Fatty Acids**

omega-3 acid ethyl esters (LOVAZA)

### **BETA-BLOCKERS**

**atenolol**  
**bisoprolol**  
**carvedilol**  
**labetalol**  
**metoprolol**  
**metoprolol ext-rel**  
**nadolol**  
**pindolol**  
**propranolol**  
**propranolol ext-rel**  
carvedilol phosphate ext-rel (COREG CR)  
nebivolol (BYSTOLIC)

### **BETA-BLOCKER/DIURETIC COMBINATIONS**

**atenolol/chlorthalidone**  
**bisoprolol/hydrochlorothiazide**  
**metoprolol/hydrochlorothiazide**

### **CALCIUM CHANNEL BLOCKERS**

**Dihydropyridines**  
**amlodipine**

**felodipine ext-rel**  
**nifedipine ext-rel**

### **Nondihydropyridines**

**diltiazem ext-rel**  
**verapamil ext-rel**

**CALCIUM CHANNEL BLOCKER/  
ANTIPIPEMIC COMBINATIONS**  
**amlodipine/atorvastatin**

### **DIGITALIS GLYCOSIDES**

**digoxin**  
**digoxin ped elixir**

### **DIRECT RENIN INHIBITORS/DIURETIC COMBINATIONS**

aliskiren (TEKTURNA)  
aliskiren/hydrochlorothiazide  
(TEKTURNA HCT)

### **DIRECT RENIN INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS**

aliskiren/amlodipine (TEKAMLO)

### **DIRECT RENIN INHIBITOR/ CALCIUM CHANNEL BLOCKER/ DIURETIC COMBINATIONS**

aliskiren/amlodipine/hydrochlorothiazide  
(AMTURNIDE)

### **DIURETICS**

#### **Carbonic Anhydrase Inhibitors**

**acetazolamide**  
**acetazolamide ext-rel**  
**methazolamide**

#### **Loop Diuretics**

**bumetanide**  
**furosemide**  
**torsemide**

#### **Potassium-sparing Diuretics**

**amiloride**

#### **Thiazides and Thiazide-like Diuretics**

**chlorthalidone**  
**hydrochlorothiazide**  
**indapamide**  
**metolazone**

#### **Diuretic Combinations**

**amiloride/hydrochlorothiazide**  
**spironolactone/hydrochlorothiazide**  
**triamterene/hydrochlorothiazide**

### **NITRATES**

#### **Oral**

**isosorbide dinitrate ext-rel tabs**  
**isosorbide dinitrate oral**  
**isosorbide mononitrate**

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## Your Kansas State Employees Preferred Drug List As Of January 2013

### isosorbide mononitrate ext-rel

#### Sublingual

nitroglycerin sublingual (NITROSTAT)  
nitroglycerin sublingual aerosol (NITROMIST)  
nitroglycerin sublingual spray  
(NITROLINGUAL)

#### Transdermal

**nitroglycerin transdermal**

### NITRATE/VASODILATOR

#### COMBINATIONS

isosorbide dinitrate/hydralazine (BIDIL)

### PULMONARY ARTERIAL

#### HYPERTENSION

#### Endothelin Receptor Antagonists

ambrisentan (LETAIRIS)  
bosentan (TRACLEER)

#### Phosphodiesterase Inhibitors

**sildenafil** (REVATIO)  
tadalafil (ADCIRCA)

#### Prostaglandin Vasodilators

iloprost (VENTAVIS)  
treprostinil (REMODULIN)  
treprostinil (TYVASO)

### MISCELLANEOUS

**hydralazine**  
**methyldopa**  
**midodrine**  
ranolazine ext-rel (RANEXA)

## CENTRAL NERVOUS SYSTEM

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### ANTI-ANXIETY

#### Benzodiazepines

**alprazolam**  
**clonazepam tabs**  
**diazepam**  
**lorazepam**  
**oxazepam**

#### Miscellaneous

**buspirone**  
**clomipramine**  
**fluvoxamine**

### ANTICONVULSANTS

**carbamazepine**  
**carbamazepine ext-rel**  
**diazepam rectal gel**  
**divalproex sodium delayed-rel**  
**divalproex sodium ext-rel**  
**ethosuximide**  
**gabapentin**  
**lamotrigine**  
**levetiracetam**  
**levetiracetam ext-rel**

### oxcarbazepine

**phenobarbital**  
**phenytoin sodium extended**  
**primidone**  
**topiramate**  
**valproic acid**  
**zonisamide**  
lacosamide (VIMPAT)  
lamotrigine ext-rel (LAMICTAL XR)  
lamotrigine orally disintegrating tabs  
(LAMICTAL ODT)  
phenytoin (DILANTIN INFATABS)  
pregabalin (LYRICA)  
rufinamide (BANZEL)  
vigabatrin (SABRIL)

### ANTIDEMENTIA

**donepezil**  
**galantamine**  
**galantamine ext-rel**  
**rivastigmine**  
memantine (NAMENDA)  
rivastigmine transdermal (EXELON PATCH)

### ANTIDEPRESSANTS

#### Monoamine Oxidase Inhibitors (MAOIs)

**phenelzine**  
**tranylcypromine**  
isocarboxazid (MARPLAN)

#### Selective Serotonin Reuptake Inhibitors

#### (SSRIs)

**citalopram**  
**escitalopram**  
**fluoxetine**  
**paroxetine HCl**  
**paroxetine HCl ext-rel**  
**sertraline**  
fluoxetine (FLUOXETINE 60 mg)  
vilazodone (VIIBRYD)

#### Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)\*

\* Indicates the proposed mechanism of action, based on the American Psychiatric Association Summary of Treatment Recommendations.

**venlafaxine**  
**venlafaxine ext-rel**  
desvenlafaxine ext-rel (PRISTIQ)  
duloxetine delayed-rel (CYMBALTA)

#### Tricyclic Antidepressants (TCAs)

**amitriptyline**  
**desipramine**  
**doxepin**  
**imipramine HCl**  
**nortriptyline**

#### Miscellaneous Agents

**bupropion**  
**bupropion ext-rel**  
**mirtazapine**

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## Your Kansas State Employees Preferred Drug List As Of January 2013

trazodone

### ANTIPARKINSONIAN AGENTS

amantadine  
bentztropine  
bromocriptine  
carbidopa/levodopa  
carbidopa/levodopa ext-rel  
carbidopa/levodopa/entacapone  
entacapone (COMTAN)  
pramipexole  
ropinirole  
ropinirole ext-rel  
selegiline tabs  
trihexyphenidyl  
apomorphine (APOKYN)  
rasagiline mesylate (AZILECT)  
rotigotine transdermal (NEUPRO)

### ANTIPSYCHOTICS

#### Atypicals

clozapine  
olanzapine  
quetiapine  
risperidone  
ziprasidone  
aripiprazole (ABILIFY)  
asenapine (SAPHRIS)  
iloperidone (FANAPT)  
paliperidone ext-rel (INVEGA)  
quetiapine ext-rel (SEROQUEL XR)

#### Miscellaneous

chlorpromazine  
fluphenazine  
haloperidol  
perphenazine  
thiothixene  
trifluoperazine

### ATTENTION DEFICIT HYPERACTIVITY DISORDER

amphetamine/dextroamphetamine mixed salts ext-rel  
dexmethylphenidate  
dextroamphetamine  
dextroamphetamine ext-rel  
methylphenidate  
methylphenidate ext-rel  
atomoxetine (STRATTERA)  
dexmethylphenidate ext-rel (FOCALIN XR)  
guanfacine ext-rel (INTUNIV)  
lisdexamfetamine (VYVANSE)  
methylphenidate transdermal (DAYTRANA)

### FIBROMYALGIA

milnacipran (SAVELLA)

### HUNTINGTON'S DISEASE AGENTS

tetrabenazine (XENAZINE)

### HYPNOTICS

Benzodiazepines  
temazepam

#### Nonbenzodiazepines

zolpidem  
zolpidem ext-rel

#### Tricyclics

doxepin (SILENOR)

### MIGRAINE

Ergotamine Derivatives  
dihydroergotamine inj

#### Selective Serotonin Agonists

naratriptan  
sumatriptan  
sumatriptan inj  
sumatriptan nasal spray  
rizatriptan (MAXALT)  
sumatriptan inj (SUMAVEL DOSEPRO)  
zolmitriptan (ZOMIG)  
zolmitriptan nasal spray (ZOMIG)

#### Selective Serotonin Agonist/ Nonsteroidal Drug (NSAID)

#### Combinations

sumatriptan/naproxen sodium (TREXIMET)

### MOOD STABILIZERS

lithium carbonate  
lithium carbonate ext-rel

### MULTIPLE SCLEROSIS AGENTS

glatiramer (COPAXONE)  
interferon beta-1a (REBIF)  
interferon beta-1b (BETASERON)  
interferon beta-1b (EXTAVIA)

### MUSCULOSKELETAL THERAPY AGENTS

baclofen  
carisoprodol  
chlorzoxazone  
cyclobenzaprine  
dantrolene  
methocarbamol  
orphenadrine/aspirin/caffeine  
tizanidine

### MYASTHENIA GRAVIS

pyridostigmine

### NARCOLEPSY/CATAPLEXY

armodafinil (NUVIGIL)  
sodium oxybate (XYREM)

### POSTHERPETIC NEURALGIA (PHN)

gabapentin ext-rel (GRALISE)

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## Your Kansas State Employees Preferred Drug List As Of January 2013

### PSYCHOTHERAPEUTIC- MISCELLANEOUS

Alcohol Deterrents  
**disulfiram**

Opioid Antagonists  
**naltrexone**

### ENDOCRINE AND METABOLIC

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#### ANDROGENS

testosterone cypionate  
testosterone enanthate  
testosterone gel (FORTESTA)  
testosterone soln (AXIRON)  
testosterone transdermal (ANDRODERM)

#### ANTI-DIABETICS

Alpha-glucosidase Inhibitors  
**acarbose**

Amlylin Analogs  
pramlintide (SYMLINPEN)

Biguanides  
**metformin**  
**metformin ext-rel**

Biguanide/Sulfonylurea Combinations  
**glipizide/metformin**

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors  
linagliptin (TRADJENTA)  
sitagliptin phosphate (JANUVIA)

Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/  
Biguanide Combinations  
linagliptin/metformin (JENTADUETO)  
sitagliptin/metformin (JANUMET)  
sitagliptin/metformin ext-rel (JANUMET XR)

Incretin Mimetic Agents  
exenatide ext-rel (BYDUREON)  
liraglutide (VICTOZA)

Insulins  
insulin aspart (NOVOLOG)  
insulin aspart protamine 70%/insulin aspart 30% (NOVOLOG MIX 70/30)  
insulin detemir (LEVEMIR)  
insulin glargine (LANTUS)  
insulin glulisine (APIDRA)  
insulin human (HUMULIN R U-500)  
insulin human (NOVOLIN R)  
insulin isophane human (NOVOLIN N)  
insulin isophane human 70%/regular 30% (NOVOLIN 70/30)

Insulin Sensitizers  
**pioglitazone** (ACTOS)

Insulin Sensitizer/Biguanide Combinations  
**pioglitazone/metformin** (ACTOPLUS MET)

Insulin Sensitizer/Sulfonylurea Combinations  
pioglitazone/glimepiride (DUETACT)

Meglitinides  
**nateglinide**  
repaglinide (PRANDIN)

Sulfonylureas  
**glimepiride**  
**glipizide**  
**glipizide ext-rel**  
**glyburide**

Supplies  
ACCU-CHEK kits and test strips  
BD insulin syringes and needles  
lancets  
ONETOUCH kits and test strips

#### CALCIUM REGULATORS

Bisphosphonates  
**alendronate**  
**ibandronate**  
risedronate (ACTONEL)  
risedronate delayed-rel (ATELVIA)

Calcitonins  
**calcitonin-salmon**

Parathyroid Hormones  
teriparatide (FORTEO)

#### CONTRACEPTIVES

EE = ethinyl estradiol  
ME = mestranol

#### Monophasic

*10 mcg Estrogen*  
norethindrone acetate/EE 1/10 and EE 10 and iron (LO LOESTRIN FE)

*20 mcg Estrogen*  
**drospirenone/EE 3/20**  
**levonorgestrel/EE 0.1/20 - Lessina**  
**norethindrone acetate/EE 1/20**  
**norethindrone acetate/EE 1/20 and iron**  
drospirenone/EE/levomefolate 3/20 and levomefolate (BEYAZ)  
norethindrone acetate/EE 1/20 and iron (LOESTRIN 24 FE)

*30 mcg Estrogen*  
**desogestrel/EE 0.15/30**  
**drospirenone/EE 3/30**  
**levonorgestrel/EE 0.15/30 - Levora**  
**norethindrone acetate/EE 1.5/30**  
**norethindrone acetate/EE 1.5/30 and iron**

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## Your Kansas State Employees Preferred Drug List As Of January 2013

**norgestrel/EE 0.3/30 - Low-Ogestrel**

*35 mcg Estrogen*

**ethynodiol diacetate/EE 1/35 - Zovia 1/35**

**norethindrone/EE 0.5/35**

**norethindrone/EE 1/35**

**norgestimate/EE 0.25/35**

*50 mcg Estrogen*

**ethynodiol diacetate/EE 1/50 - Zovia 1/50**

**norethindrone/ME 1/50**

**Biphasic**

**desogestrel/EE**

**Triphasic**

**desogestrel/EE**

**levonorgestrel/EE - Trivora**

**norethindrone/EE**

**norgestimate/EE**

**norgestimate/EE (ORTHO TRI-CYCLEN LO)**

**Four Phase**

**estradiol valerate and dienogest/**

**estradiol valerate (NATAZIA)**

**Extended Cycle**

**levonorgestrel/EE 0.1/20 and EE 10**

**levonorgestrel/EE 0.15/30**

**levonorgestrel/EE 0.15/30 and EE 10**

**Progestin Only**

**norethindrone**

**Emergency Contraception**

**levonorgestrel - Next Choice \***

**levonorgestrel - Next Choice One Dose \***

**ulipristal (ELLA)**

\* Covered for members under 17 years of age.

**Transdermal**

**norelgestromin/EE (ORTHO EVRA)**

**Vaginal**

**etonogestrel/EE ring (NUVARING)**

**ENDOMETRIOSIS**

**danazol**

**ESTROGENS**

**Oral**

**estradiol**

**estropiate**

estrogens, conjugated (PREMARIN)

**Transdermal**

**estradiol**

estradiol (DIVIGEL)

estradiol (EVAMIST)

estradiol (VIVELLE-DOT)

**Vaginal**

estradiol vaginal tabs (VAGIFEM)

**Boldface** type indicates generic availability; boldface may not apply to every strength or dosage form under the listed generic name.

estrogens, conjugated crm (PREMARIN crm)

**ESTROGEN/PROGESTINS**

**Oral**

**EE/norethindrone acetate**

**estradiol/norethindrone**

estrogens, conjugated/medroxyprogesterone (PREMPHASE)

estrogens, conjugated/medroxyprogesterone (PREMPRO)

**GLUCOCORTICOIDS**

**dexamethasone**

**fludrocortisone**

**hydrocortisone**

**methylprednisolone**

**prednisolone sodium phosphate**

**prednisolone syrup**

**prednisone**

**GLUCOSE ELEVATING AGENTS**

glucagon, human recombinant

(GLUCAGEN HYPOKIT)

glucagon, human recombinant

(GLUCAGON EMERGENCY KIT)

**HUMAN GROWTH HORMONES**

somatropin (NORDITROPIN)

**HYPERPARATHYROID TREATMENT,**

**VITAMIN D ANALOGS**

**calcitriol (1,25-D3)**

doxercalciferol (HECTOROL)

paricalcitol (ZEMPLAR)

**PHENYLKETONURIA TREATMENT**

**AGENTS**

sapropterin (KUVAN)

**PHOSPHATE BINDER AGENTS**

**calcium acetate**

calcium acetate (PHOSLYRA)

lanthanum (FOSRENOL)

sevelamer carbonate (RENEVELA)

**PROGESTINS**

**Oral**

**medroxyprogesterone acetate**

**norethindrone acetate**

**progesterone, micronized**

**SELECTIVE ESTROGEN RECEPTOR**

**MODULATORS**

raloxifene (EVISTA)

**THYROID AGENTS**

**Antithyroid Agents**

**methimazole**

**propylthiouracil**

## Your Kansas State Employees Preferred Drug List As Of January 2013

### Thyroid Supplements

levothyroxine  
levothyroxine (SYNTHROID)  
levothyroxine - Levoxyl  
liothyronine

### VASOPRESSINS

desmopressin spray, tabs

### MISCELLANEOUS

cabergoline  
levocarnitine

### GASTROINTESTINAL

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#### ANTI-DIARRHEALS

diphenoxylate/atropine  
loperamide

#### ANTIEMETICS

dronabinol  
granisetron  
meclizine  
metoclopramide  
ondansetron  
prochlorperazine  
promethazine  
trimethobenzamide caps  
granisetron transdermal (SANCUSO)  
scopolamine (TRANSDERM SCOP)

#### ANTI-SPASMODICS

chlordiazepoxide/clidinium  
dicyclomine  
hyoscyamine sulfate  
hyoscyamine sulfate ext-rel  
hyoscyamine sulfate orally disintegrating tabs

#### CHOLELITHOLYTICS

ursodiol

#### H<sub>2</sub> RECEPTOR ANTAGONISTS

cimetidine  
famotidine  
ranitidine

#### INFLAMMATORY BOWEL DISEASE

##### Oral Agents

balsalazide  
budesonide delayed-rel caps  
sulfasalazine  
sulfasalazine delayed-rel  
mesalamine delayed-rel tabs (ASACOL)  
mesalamine delayed-rel tabs (ASACOL HD)  
mesalamine delayed-rel tabs (LIALDA)  
mesalamine ext-rel caps (APRISO)  
mesalamine ext-rel caps (PENTASA)

##### Rectal Agents

hydrocortisone enema

##### mesalamine rectal susp

hydrocortisone acetate foam (CORTIFOAM)  
mesalamine rectal susp (SFROWASA)  
mesalamine supp (CANASA)

#### IRRITABLE BOWEL SYNDROME

##### Irritable Bowel Syndrome with Constipation

lubiprostone (AMITIZA)

##### Irritable Bowel Syndrome with Diarrhea

alosetron (LOTROXEX)\*

\* For safety reasons, to prescribe Lotronex, the physician must be enrolled in the Prescribing Program for Lotronex. Physicians must understand the benefits and risks of treatment with Lotronex for severe diarrhea-predominant IBS, including the information in the Prescribing Information, Medication Guide and Patient-Physician Agreement for Lotronex. To enroll or for more information on the Prescribing Program for Lotronex, call 1-888-423-5227 or visit [www.lotronex.com](http://www.lotronex.com) to complete the Physician Enrollment Form.

#### LAXATIVES

lactulose  
peg 3350/electrolytes  
polyethylene glycol 3350  
lactulose (KRISTALOSE)  
peg 3350/electrolytes (MOVIPREP)  
peg 3350/electrolytes + bisacodyl (HALFLYTELY)  
sodium sulfate/potassium sulfate/magnesium sulfate (SUPREP)

#### PANCREATIC ENZYMES

pancrelipase delayed-rel (CREON)  
pancrelipase delayed-rel (ZENPEP)

#### PROSTAGLANDINS

misoprostol

#### PROTON PUMP INHIBITORS

lansoprazole delayed-rel  
omeprazole delayed-rel  
omeprazole/sodium bicarbonate caps  
pantoprazole delayed-rel  
dexlansoprazole delayed-rel (DEXILANT)  
esomeprazole delayed-rel (NEXIUM)

#### SALIVA STIMULANTS

cevimeline  
pilocarpine tabs

#### STEROIDS, RECTAL

hydrocortisone crm

#### MISCELLANEOUS

sucralfate

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## Your Kansas State Employees Preferred Drug List As Of January 2013

methylnaltrexone (RELISTOR)

### GENITOURINARY

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#### **BENIGN PROSTATIC HYPERPLASIA**

**alfuzosin ext-rel**  
**finasteride**  
**tamsulosin**  
dutasteride (AVODART)  
silodosin (RAPAFLO)

#### **URINARY ANTISPASMODICS**

**oxybutynin**  
**oxybutynin ext-rel**  
**tolterodine**  
**tropium**  
oxybutynin gel (GELNIQUE)  
solifenacin succinate (VESICARE)

#### **VAGINAL ANTI-INFECTIVES**

**clindamycin crm**  
**metronidazole**  
**terconazole**

#### **MISCELLANEOUS**

**bethanechol**  
**phenazopyridine**  
**potassium citrate**  
pentosan polysulfate sodium (ELMIRON)

### HEMATOLOGIC

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#### **ANTICOAGULANTS**

**Injectable**  
**enoxaparin**

#### **Oral**

**warfarin**  
dabigatran etexilate (PRADAXA)  
rivaroxaban (XARELTO)

#### **Synthetic Heparinoid-like Agents**

**fondaparinux**

#### **HEMATOPOIETIC GROWTH FACTORS**

darbepoetin alfa (ARANESP)  
epoetin alfa (PROCRIT)  
filgrastim (NEUPOGEN)  
pegfilgrastim (NEULASTA)

#### **IDIOPATHIC THROMBOCYTOPENIC PURPURA AGENTS**

eltrombopag (PROMACTA)

#### **PLATELET AGGREGATION INHIBITORS**

**clopidogrel**  
**dipyridamole**  
dipyridamole ext-rel/aspirin (AGGRENOX)  
prasugrel (EFFIENT)  
ticagrelor (BRILINTA)

#### **PLATELET SYNTHESIS INHIBITORS**

**anagrelide**

#### **STEM CELL MOBILIZERS**

plerixafor (MOZOBL)

#### **MISCELLANEOUS**

**cilostazol**

### IMMUNOLOGIC AGENTS

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#### **BIOLOGIC DISEASE-MODIFYING AGENTS**

adalimumab (HUMIRA)  
etanercept (ENBREL)

#### **DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)**

**hydroxychloroquine**  
**leflunomide**  
**methotrexate**  
methotrexate (RHEUMATREX)

#### **IMMUNOMODULATORS**

##### **Interferons**

interferon alfa-2b (INTRON A)  
interferon alfacon-1 (INFERGEN)  
peginterferon alfa-2a (PEGASYS)  
peginterferon alfa-2b (PEGINTRON)  
peginterferon alfa-2b (SYLATRON)

##### **Miscellaneous**

canakinumab (ILARIS)

#### **IMMUNOSUPPRESSANTS**

##### **Antimetabolites**

**azathioprine**  
**mycophenolate mofetil**  
azathioprine (AZASAN)  
mycophenolate sodium delayed-rel  
(MYFORTIC)

##### **Calcineurin Inhibitors**

**cyclosporine**  
**cyclosporine, modified**  
**tacrolimus**

##### **Rapamycin Derivatives**

sirolimus (RAPAMUNE)

### NUTRITIONAL/SUPPLEMENTS

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#### **ELECTROLYTES**

##### **Potassium**

**potassium chloride ext-rel**  
**potassium chloride liquid**

#### **VITAMINS AND MINERALS**

##### **Folic Acid/Combinations**

**folic acid**  
**folic acid/vitamin B6/vitamin B12**

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## Your Kansas State Employees Preferred Drug List As Of January 2013

### **Prenatal Vitamins**

#### **prenatal vitamins**

prenatal vitamins/DHA/docusate/folic acid  
(CITRANATAL 90 DHA)  
prenatal vitamins/DHA/docusate/folic acid  
(CITRANATAL DHA)  
prenatal vitamins/DHA/docusate/folic acid  
(CITRANATAL HARMONY)  
prenatal vitamins/docusate/folic acid  
(CITRANATAL RX)  
prenatal vitamins/docusate/folic acid + DHA  
(CITRANATAL ASSURE)  
prenatal vitamins/folic acid + pyridoxine  
(CITRANATAL B-CALM)

### **Miscellaneous**

**cyanocobalamin inj**  
**ergocalciferol (D2)**  
**fluoride drops**  
**fluoride tabs**  
**multivitamins/fluoride drops, tabs**  
**multivitamins/fluoride/iron drops, tabs**  
**vitamin ADC/fluoride drops**  
**vitamin ADC/fluoride/iron drops**

## **RESPIRATORY**

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### **ANAPHYLAXIS TREATMENT AGENTS**

epinephrine (EPIPEN)  
epinephrine (EPIPEN JR.)

### **ANTICHOLINERGICS**

ipratropium soln  
tiotropium (SPIRIVA)

### **ANTICHOLINERGIC/BETA AGONIST COMBINATIONS**

ipratropium/albuterol soln  
ipratropium/albuterol, CFC-free aerosol  
(COMBIVENT RESPIMAT)

### **ANTIHISTAMINES, SEDATING**

clemastine 2.68 mg  
cyproheptadine  
hydroxyzine HCl

### **ANTITUSSIVES**

benzonatate

### **ANTITUSSIVE COMBINATIONS**

#### **Opioid**

codeine/chlorpheniramine/pseudoephedrine  
codeine/guaifenesin liquid  
codeine/guaifenesin/pseudoephedrine  
codeine/promethazine  
codeine/promethazine/phenylephrine  
hydrocodone/homatropine

#### **Non-opioid**

dextromethorphan/brompheniramine/  
pseudoephedrine  
dextromethorphan/promethazine

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### **BETA AGONISTS**

#### **Inhalants**

##### *Short Acting*

**albuterol soln**  
albuterol sulfate, CFC-free aerosol  
(PROAIR HFA)  
albuterol sulfate, CFC-free aerosol  
(PROVENTIL HFA)

##### *Long Acting*

formoterol inhalation caps (FORADIL)  
formoterol inhalation soln (PERFOROMIST)  
indacaterol (ARCAPTA NEOHALER)  
salmeterol xinafoate (SEREVENT)

#### **Oral Agents**

**albuterol**  
**albuterol ext-rel**  
**terbutaline**

### **LEUKOTRIENE RECEPTOR ANTAGONISTS**

montelukast  
zafirlukast

### **MAST CELL STABILIZERS**

cromolyn soln

### **NASAL ANTIHISTAMINES**

azelastine spray  
azelastine spray (ASTEPRO)

### **NASAL STEROIDS**

flunisolide spray  
fluticasone spray  
triamcinolone acetonide spray  
mometasone spray (NASONEX)

### **PHOSPHODIESTERASE-4 INHIBITORS**

roflumilast (DALIRESP)

### **STEROID/BETA AGONIST COMBINATIONS**

budesonide/formoterol (SYMBICORT)  
fluticasone/salmeterol (ADVAIR)  
fluticasone/salmeterol, CFC-free aerosol  
(ADVAIR HFA)  
mometasone/formoterol (DULERA)

### **STEROID INHALANTS**

budesonide inh susp  
beclomethasone, CFC-free aerosol (QVAR)  
budesonide (PULMICORT FLEXHALER)  
mometasone (ASMANEX)

### **XANTHINES**

theophylline ext-rel tabs

### **MISCELLANEOUS**

ipratropium spray

## Your Kansas State Employees Preferred Drug List As Of January 2013

### TOPICAL

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#### DERMATOLOGY

##### Acne

###### *Oral*

**isotretinoin**

###### *Topical*

**adapalene**

**benzoyl peroxide**

**clindamycin gel, lotion, soln**

**clindamycin/benzoyl peroxide**

**clindamycin/benzoyl peroxide (DUAC)**

**erythromycin gel 2%**

**erythromycin soln**

**erythromycin/benzoyl peroxide**

**sulfacetamide lotion 10%**

**sulfacetamide/sulfur crm, gel, lotion, pads**

**tretinoin**

adapalene/benzoyl peroxide (EPIDUO)

clindamycin/benzoyl peroxide (ACANYA)

clindamycin/tretinoin (VELTIN)

tretinoin (ATRALIN)

tretinoin gel microsphere (RETIN-A MICRO)

##### **Actinic Keratosis**

**fluorouracil crm 5%**

diclofenac sodium gel (SOLARAZE)

fluorouracil (CARAC)

imiquimod (ZYCLARA)

ingenol mebutate (PICATO)

##### **Antibiotics**

**gentamicin**

**mupirocin**

**silver sulfadiazine**

retapamulin (ALTABAX)

##### **Antifungals**

**ciclopirox**

**clotrimazole**

**econazole**

**ketoconazole**

**nystatin**

##### **Antipsoriatics**

###### *Oral*

acitretin (SORIATANE)

methoxsalen oral (OXSORALEN-ULTRA)

###### *Topical*

**calcipotriene**

calcipotriene (SORILUX)

tazarotene (TAZORAC)

##### **Antiseborrheics**

**ketoconazole shampoo 2%**

**selenium sulfide shampoo 2.5%**

##### **Corticosteroids**

###### *Low Potency*

**alclometasone crm, oint 0.05%**

**desonide crm, lotion, oint 0.05%**

**fluocinolone acetonide soln 0.01%**

**hydrocortisone crm 2.5%**

**hydrocortisone lotion 1%**

###### *Medium Potency*

**betamethasone valerate crm, lotion,  
ointment 0.1%**

**desoximetasone crm, oint 0.05%**

**fluocinolone acetonide crm, oint 0.025%**

**fluticasone propionate crm, lotion 0.05%,  
ointment 0.005%**

**hydrocortisone butyrate crm, lotion, oint,  
soln 0.1%**

**hydrocortisone valerate crm, oint 0.2%**

**mometasone crm, lotion, oint 0.1%**

**triamcinolone acetonide crm, lotion 0.025%**

**triamcinolone acetonide crm, lotion,  
ointment 0.1%**

###### *High Potency*

**betamethasone dipropionate augmented  
crm, lotion 0.05%**

**betamethasone dipropionate crm, lotion,  
ointment 0.05%**

**desoximetasone crm, oint 0.25%, gel 0.05%**

**diflorasone diacetate crm 0.05%**

**fluocinonide crm, gel, oint, soln 0.05%**

**triamcinolone acetonide crm 0.5%**

###### *Very High Potency*

**betamethasone dipropionate augmented  
gel, oint 0.05%**

**clobetasol propionate crm, foam, gel,  
lotion, oint, shampoo 0.05%**

**diflorasone diacetate oint 0.05%**

**halobetasol propionate crm, oint 0.05%**

##### **Emollients**

**ammonium lactate 12%**

##### **Immunomodulators**

pimecrolimus (ELIDEL)

tacrolimus (PROTOPIC)

##### **Local Analgesics**

lidocaine patch (LIDODERM)

##### **Local Anesthetics**

**lidocaine/prilocaine**

##### **Rosacea**

**metronidazole crm, gel, lotion 0.75%**

**sulfacetamide/sulfur**

azelaic acid gel (FINACEA)

doxycycline monohydrate (ORACEA)

metronidazole gel 1% (METROGEL)

##### **Scabicides and Pediculicides**

**malathion**

**permethrin 5%**

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## Your Kansas State Employees Preferred Drug List As Of January 2013

**Miscellaneous Skin and Mucous Membrane**  
imiquimod  
podofilox

### **MOUTH/THROAT/DENTAL AGENTS**

**Anesthetics - Topical Oral**  
lidocaine viscous

**Steroids - Mouth/Throat**  
triamcinolone paste

### **OPHTHALMIC**

**Antiallergics**  
azelastine  
cromolyn sodium  
alcaftadine (LASTACAPT)  
loteprednol 0.2% (ALREX)  
olopatadine (PATADAY)

**Antifungals**  
natamycin (NATACYN)

**Anti-infectives**  
bacitracin  
ciprofloxacin  
erythromycin  
gentamicin  
levofloxacin  
neomycin/polymyxin B/gramicidin  
ofloxacin  
polymyxin B/bacitracin  
polymyxin B/trimethoprim  
sulfacetamide soln 10%  
tobramycin  
moxifloxacin (MOXEZA)  
moxifloxacin (VIGAMOX)

**Anti-infective/Anti-inflammatory Combinations**  
neomycin/polymyxin B/  
bacitracin/hydrocortisone oint  
neomycin/polymyxin B/dexamethasone  
neomycin/polymyxin B/hydrocortisone  
susp  
sulfacetamide/prednisolone phosphate  
10%/0.25%

tobramycin/  
dexamethasone susp 0.3%/0.1%  
tobramycin/dexamethasone susp 0.3%/0.05%  
(TOBRADEX ST)  
tobramycin/loteprednol (ZYLET)

### **Anti-inflammatories**

*Nonsteroidal*  
diclofenac sodium  
ketorolac

bromfenac sodium (BROMDAY)

*Steroidal*  
dexamethasone sodium phosphate  
fluorometholone  
prednisolone acetate 1%  
difluprednate (DUREZOL)  
loteprednol 0.5% (LOTEMAX)

**Antivirals**  
trifluridine

**Beta-blockers**  
*Nonselective*  
levobunolol  
metipranolol  
timolol maleate  
timolol maleate gel  
timolol hemihydrate (BETIMOL)

*Selective*  
betaxolol (BETOPTIC S)

### **Carbonic Anhydrase Inhibitors**

*Topical*  
dorzolamide  
brinzolamide (AZOPT)

**Carbonic Anhydrase Inhibitor/  
Beta-blocker Combinations**  
dorzolamide/timolol maleate/preservative-free  
(COSOPT PF)

**Prostaglandins**  
latanoprost  
tafluprost (ZIOPTAN)  
travoprost (TRAVATAN Z)

**Sympathomimetics**  
brimonidine 0.15%, 0.2%  
brimonidine 0.1% (ALPHAGAN P)

**Sympathomimetic/Beta-blocker  
Combinations**  
brimonidine/timolol (COMBIGAN)

**OTIC**  
**Anti-infectives**  
acetic acid  
acetic acid/aluminum acetate  
ofloxacin otic

**Anti-infective/Anti-inflammatory  
Combinations**  
neomycin/polymyxin B/hydrocortisone  
ciprofloxacin/dexamethasone (CIPRODEX)

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**Kansas State Employees**  
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Topeka, KS 66612

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**Kansas State Employees**  
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**\* Important Message on Back**

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## Prescription Card

RxBIN 004336  
RxPCN ADV  
RxGRP RX1600  
Issuer (80840) 9151014609

**Kansas State  
Employees Group  
Health Plan**

 ID **123456789 01**  
NAME **JOHN Q SAMPLE**

02 DepFirstName1 DepLastName1 03 DepFirstName2 DepLastName2

04 DepFirstName3 DepLastName3 05 DepFirstName4 DepLastName4

06 DepFirstName5 DepLastName5 07 DepFirstName6 DepLastName6

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# Your Prescription Cards

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\*Source: Generic Pharmaceutical Association Web site: <http://www.gphaonline.org>  
\*\*Savings are based on plan participant copayments. The amount of your savings will be based on your benefit plan.

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