

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 funded by the Kansas State Employees Health Care Commission 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:

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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.

Discount Medications – are medications Not Covered by the Plan but the Plan has a negotiated discount with Network Pharmacies when purchased. These items include but are not limited to: 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 & nasal steroids; 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 and other prescription medications designated by the Plan.

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 a 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. **(5)** For Non Covered Prescription Drug Products to be considered for coverage, You must have had an unsuccessful trial with one or more prescription drug listed on the Preferred Drug List for treatment of the condition. Non Covered Prescription Drug Products require Prior Authorization by the Plan and must meet all of the above Medical Necessity criteria to be considered for coverage. Your physician must contact the Plan to

obtain Prior Authorization before a Non Covered Prescription Drug Product is eligible for coverage. 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 Covered - Prescription Drug Products for which reimbursement by the Plan is not available. The decision as to what Prescription Drug Products are not covered is determined by the Plan and subject to periodic review and modification.

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 – Covered FDA approved prescription drug products that are not listed on the Preferred Drug List and are not considered to be Non Covered drugs by the Plan.

Out of Pocket Maximum – The combined total amount You will pay in Coinsurance and Copayments for covered medications each Plan Year.

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.

Patient Assistance Programs - Pharmaceutical manufacturers may sponsor patient assistance programs that provide financial assistance to individuals to augment any existing prescription drug coverage. Amounts paid through these patient assistance programs will not count toward meeting Plan Deductibles or Out Of Pocket Maximums. Patient Assistance Programs may include copay cards, coupons and other such manufacturer sponsored assistance programs.

Performance Drug List - encourages members to use lower cost generics PPIs - proton pump inhibitors before using non preferred brand products. Before a prescription for a non preferred drug can be processed, the member must have tried one of the generic PPIs - proton pump inhibitors alternatives available.

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://www.caremark.com>.

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 administration or injection must be obtained from the CVS/caremark Specialty Pharmacy;
5. the Prescription Drug Product is a covered service under the Plan and it is dispensed according to Plan guidelines.

Standard Prescription Drug Benefits

Coverage Level	Prescription Drug Product	Member Responsibility
Tier One	Generic Drugs	20% Coinsurance
Tier Two	Preferred Drugs	40% Coinsurance
Tier Three	Special Case Medications	40% Coinsurance Maximum of \$100 per standard unit of therapy
Tier Four	Non Preferred & Compound Medications	65% Coinsurance
Out of Pocket (OOP) Maximum	Applies to Tiers One through Four	Combined Medical & Pharmacy Individual \$5,750 Family \$11,500

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 injected must be purchased from the CVS/caremark Specialty Pharmacy. You cannot assign benefits under this program to any other person or entity. Non Covered Prescription Drug Products are not eligible for payment under the Plan unless Prior

Authorization has been obtained and the prescription is considered to be Medically Necessary by the Plan.

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

Generic Prescription Drug Products:

Your Coinsurance is 20% of the Allowed Charge for eligible prescription drugs.

Preferred Brand Name Prescription Drug Products:

For eligible Preferred Brand Name Drugs, Your Coinsurance is 40% of the Allowed Charge. The Preferred Drug List is subject to periodic review and modification.

Special Case Medications:

Your responsibility is 40% Coinsurance of the Allowed Charge not to exceed a maximum of \$100 per standard unit of therapy. For quantities less than a thirty (30) day supply, Your responsibility is 40% Coinsurance of the Allowed Charge not to exceed \$100.

Non Preferred Brand Name Drug Products:

For covered Non Preferred Brand Name Drug Products Your Coinsurance is 65% of the Allowed Charge.

Compound Medications:

Compound claims are only eligible for payment under this Plan when dispensed by a Network pharmacy. CVS/caremark Mail Order Pharmacy is a Network compounding pharmacy.

The Coinsurance will be 65% of the Allowed Charge of the Compounded Medication. All medications with a total cost of \$300 must be Prior Authorized by the Plan.

Claims for Compound Medications submitted for reimbursement must contain more than one (1) Legend Drug ingredient. If the Network pharmacy does not submit your claim for some reason 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.

ALL Compound drugs must be purchased at a Network pharmacy and if the TOTAL drug cost of the compound is over \$300 the purchase must be Prior

Authorized by the Plan. Claims for Compound Medications over \$300 that have not been prior authorized will be denied by the Plan.

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.

The Plan reserves the right to review all compounded claims and exclude any excessive charges including but not limited to charges for bases and bulk compounding powders.

Exclusion of Select Topical Analgesics: Select topical analgesics will be excluded from coverage by the Plan. Compounded claims for pain patches or creams containing ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness are Non Covered services. Pain patches with ingredients including but not limited to: lidocaine, menthol, capsaicin and methyl salicylate are Non Covered services.

Specialty Drug:

Specialty drugs are medication that have been designated by the Plan. 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://www.caremark.com> or 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. If You are participating in a Patient Assistance Program that provides payment in full or in part for Your Specialty Drug purchase, the amounts paid by the Patient Assistance Program will not count toward meeting the Plans Out Of Pocket requirements. Only Coinsurance and Copays that are actually paid by You will count toward meeting your Out Of Pocket Maximum.

For members requiring 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.

Comprehensive Site of Care Specialty Program

The Plan has identified certain Specialty Drugs for exclusive coverage under the Comprehensive Site of Care Specialty Program. CVS Specialty will work with You and Your provider on delivering these Specialty drug to You for self-administration or to Your provider for clinician administration or infusion. A complete list of prescription drugs included in the Comprehensive Site of Care Specialty Program is available on the Caremark website.

CVS Specialty may work with You and Your provider to provide Your treatment in an outpatient or home setting when appropriate. When CVS/caremark arranges the site of care for the administration of the prescription drug, claims must be submitted to Caremark for payment. The prescription drug itself will be subject to the standard pharmacy Coinsurance tiers. A twenty (20) percent Coinsurance will apply to the Allowed Amount for the administration or infusion of the medication.

Chronic Care Benefit

Prescription Drugs for:	Prescription Drug Product	Member Responsibility Per 30 Day Supply
Asthma	Generic Drug	10% to a maximum of \$20
	Preferred Brand Drug	20% to a maximum of \$40
Diabetes	Generic Drug	10% to a maximum of \$20
	Preferred Brands Drug	20% to a maximum of \$40

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

Discount medications are Non Covered prescription medications under this Plan. If You purchase a medication designated by the Plan as a Discount Medication, You will be responsible for 100% of the Allowed Charge. The Allowed Charge is the CVS/caremark contracted reimbursement rate, and provides You with a discount off the retail price of these Non Covered medication. **Discount Medications do not count toward meeting Your Health Plan Deductible or Out of Pocket Maximum.**

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://www.caremark.com> or 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.

Out of Pocket (OOP) Maximum

The Out of Pocket (OOP) Maximum for covered services in combination with the medical OOP under Plan A is \$5,750 per individual and \$11,500 per family. Once Your combined network medical and pharmacy OOP cost reaches the OOP Maximum, any additional covered medications under this Plan will be reimbursed at 100% of the Allowable Charge for the remainder of the calendar year.

Note: Discount medications and Non Covered Prescriptions Drug Products are not covered expenses under this Plan and therefore do not count toward the OOP Maximum and are not covered at 100% once the OOP maximum has been satisfied.

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 reduce stomach acid. 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, Generic and Preferred Brand Name drugs are available and considered a first line therapy. Non Preferred Brand Name Drugs for long-lasting reduction of gastric [stomach] acid production (PPIs - proton pump inhibitors) You have a history of having tried at least one (1) Generic option. 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.

Preventive Care

The following prescription and OTC items will be covered at 100% of the allowed charge by the Plan when purchased with a prescription from Your physician. For OTC items, You will need to present a physician's prescription to a Network pharmacy and have the claim run through the Caremark claim system or submit a paper claim with all proper documentation. This list is not all inclusive and subject to periodic review and modification as federal guidelines for preventive care are updated.

- Adults age 65 and over: Vitamin D
- Adults age 45 and over: Aspirin
- Pregnant Women at high risk for pre-eclampsia: Aspirin
- Immunizations: Children and Adult
- Iron Supplements: Children under age 1
- Screening for Colorectal Cancer age 50 and over: Bowel Preparation Medications
- Woman Breast Cancer Prevention age 35 and over
- Woman 55 and over : Folic Acid
- Woman Preventive Services: See Women's Contraception Section of this document
- Children 6 and under: Oral fluoride
- Tobacco Cessation Products: See Tobacco Control Section of this document

Tobacco Control Program

The Plan will pay 100% of the allowed amount for tobacco control products listed on the Preferred Drug List. The Plan retains the final discretionary authority on what constitutes a tobacco control drug products. This list is subject to periodic review and modification. For covered OTC products, You will need to present Your physician's prescription order for the OTC item to the Network pharmacy and request that the claim be run through the CVS/ caremark claim system or submit a paper claim with proper documentation of purchase and a copy of the prescription.

Enrollment in an approved tobacco control program is recommended with use of these tobacco control prescription medications. The HealthQuest tobacco control program available to You at no cost is available on the State of Kansas Web site at: **www.KansasHealthQuest.com**.

Women's Contraceptive 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 prescription contraceptive medications covered on the Preferred Drug List is subject to periodic review and modification. Female contraceptive products which are classified by the FDA as Over-The-Counter (OTC) are eligible for coverage under this Plan if purchased with a prescription from Your Physician. This includes contraceptive products that are FDA approved emergency contraceptives. To access coverage, You will need to present the prescription for the OTC item to the Network pharmacy and request that the claim be run through the CVS/caremark claim system or submit a paper claim with proper documentation of purchase and a copy of the prescription.

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.

Refill Guidelines

Refills for up to ninety (**90**) **day supply** may be obtained at one time for most medications. Refills may be obtained on the following schedule:

For Non-Controlled Substance prescriptions, the refill threshold is set at 75 percent. This means that 75 percent of a member's days supply must have lapsed before the prescription can be refilled.

For Controlled Substance prescriptions, the refill threshold is set at 80 percent. This means that 80 percent of a member's days supply must have lapsed before the prescription can be refilled.

Advance Purchases

Advance Purchase of maintenance 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, You 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. The Plan will reimburse You based upon the Allowed Amount for the service. You will be responsible for the difference between the pharmacy's billed charge and Allowed Charge in addition to applicable Coinsurance or Copayment.
- 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 Products 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 ninety (90) 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® 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://www.caremark.com>** or **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://www.caremark.com>.

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 pharmacist, 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 that require prior authorization review. Please have Your physician call 1-866-814-5506.*

***ACROMEGALY**

octreotide
(SANDOSTATIN)
Mircera
Sandostatin LAR Depot
Signifor LAR
Somatuline Depot
Somavert

ADHD/NARCOLEPSY

Adderall
Adderall XR
Adzenys XR-ODT
Desoxyn
Dextroamphetamine
Products
Dexedrine
Dyanavel XR
Evekeo
ProCentra
Vyvanse

***ALCOHOL AND OPIOID DEPENDENCY**

Vivitrol

***ALLERGIC ASTHMA**

Nucala
Xolair

***ALPHA1-ANTITRYPSIN (AAT) DEFICIENCY**

Aralast NP
Glassia
Prolastin-C
Zemaira

***ANEMIA**

Aranesp
Epogen
Mircera

***BONE DISORDERS**

Strensiq

***BOTULINUM TOXINS**

Botox
Dysport

Myobloc
Xeomin

***CARDIAC DISORDERS**

Tikosyn

***CENTRAL PRECOCIOUS PUBERTY (CPP)**

leuprolide
Lupron Depot-PED
Supprelin LA

***COAGULATION DISORDERS**

Ceprotin

***CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS)**

Arcalyst
Ilaris

***CUSHING'S SYNDROME**

Korlym
Signifor

***CYSTIC FIBROSIS (CF)**

Bethkis
Cayston
Kalydeco
Kitabis Pak
Orkambi
Pulmozyme
tobramycin inhalation solution

DIABETIC

Symlin
Trulicity
Victoza

***ELECTROLYTE DISORDERS**

Samsca

***GASTROINTESTINAL DISORDERS – OTHER**

Cholbam
Gattex
Zorbtive

***GOUT**

Krystexxa

***GROWTH HORMONE (GH) AND RELATED DISORDERS**

Humatrope
Increlex

HEART FAILURE

Entresto

***HEMATOPOIETICS**

Mozobil
Neumega

***HEMOPHILIA AND RELATED**

***BLEEDING DISORDERS**

Advate
Adynovate
Alphanate
AlphaNine SD
Alprolix
Bebulin VH
BeneFIX
Coagadex
Corifact
Eloctate
Feiba NF
Feiba VH
Helixate FS
Hemofil M
Humate-P
Ixinity
Koate-DVI
Kogenate FS
Monoclote-P
Mononine
Novoeight
NovoSeven
Nuwiq
Obizur

Profilnine SD
Recombinate
RiaSTAP
Rixubis
Stimate Nasal Spray
Tretten
Wilate
Xyntha

***HEPATITIS C**

Daklinza
Harvoni
Incivek
Olysio
Peg-Intron
ribavirin capsules/tablets
Sovaldi
Technivie
Victrelis

***HEREDITARY
ANGIOEDEMA (HAE)**

Berinert
Cinryze
Firazyr
Kalbitor
Ruconest

***HORMONAL
THERAPIES**

Aveed
Eligard
Firmagon
leuprolide
Lupaneta Pack
Lupron Depot
Natpara
Trelstar
Vantas
Zoladex

***HUMAN
IMMUNODEFICIENCY
VIRUS (HIV)**

Egrifta
Fuzeon
Serostim

***IMMUNE THERAPIES**

Bivigam
Carimune NF
Cytogam
Flebogamma
GamaSTAN S/D
Gammagard
Gammaked
Gammaplex
Gamunex
Hizentra
HyQvia
Octagam
Privigen

***IMMUNE
(IDIOPATHIC)
THROMBOCYTOPENIA
(ITP)**

Nplate
Promacta

***INFECTIOUS DISEASE**

Actimmune
Alferon-N

***INFLAMMATORY
BOWEL DISEASE (IBD)**

Entyvio
Humira
Tysabri

***IRON OVERLOAD**

deferoxamine
(DESFERAL)
Exjade
Ferriprox
Jadenu

***LIPID DISORDERS**

Juxtapid
Kynamro
Repatha

***LIPODYSTROPHY**

Myalept

***LYSOSOMAL
STORAGE
DISORDERS (LSD)
AND RELATED
DISORDERS**

Adagen
Aldurazyme
Cerdelga
Cerezyme
Cystagon
Cystaran
Elaprase
Elelyso
Fabrazyme
Kanuma
Lumizyme
Myozyme
Naglazyme
Orfadin
Procysbi
Vimizim
VPRIV
Zavesca

MIGRAINE

Alsuma
Amerge
Axert
Frova
Imitrex Nasal Spray
Imitrex Tablet
Imitrex Injection
Maxalt/MLT
Onzetra Xsail
Relpax
Sumavel
Treximet
**Zecuity*
Zembrace SymTouch
Zomig/ZMT
Zomig Nasal Spray

***MOVEMENT
DISORDERS**

Apokyn
Northera
tetrabenazine

***MULTIPLE
SCLEROSIS (MS)**

Ampyra
Aubagio
Betaseron
Copaxone
Gilenya
Glatopa
Lemtrada
mitoxantrone
Rebif
Tecfidera
Tysabri

***NEUTROPENIA**

Granix
Leukine
Neulasta
Neupogen
Zarxio

***ONCOLOGY**

Adcetris
Afinitor
Alecensa
Arzerra
Avastin
azacitidine (Vidaza)
Beleodaq
Bendeka
Blincyto
Bosulif
capecitabine (Xeloda)
Caprelsa
Cometriq
Cotellic
Cyramza
Darzalex
decitabine (Dacogen)
Empliciti
Erbitux
Erivedge
Erwinaze
Farydak
Folotyng
Fusilev
Gazyva
Gilotrif
Gleevec
Halaven

Herceptin
Hycamtin Capsules
Ibrance
Iclusig
Imatinib mesylate
Imbruvica
Imlygic
Inlyta
Intron-A
Iressa
Istodax
Ixemptra
Jakafi
Jevtana
Kadcyla
Keytruda
Kyprolis
Lenvima
Lonsurf
Lynparza
Mekinist
mitoxantrone
Nexavar
Ninlaro
Odanzo
Oncaspar
Opdivo
Perjeta
Pomalyst
Portrazza
Proleukin
Revlimid
Rituxan
Sprycel
Stivarga
Sutent
Sylatron
Sylvant
Synribo
Tafinlar
Tagrisso
Tarceva
Targretin
temozolomide
(Temodar)
Thalomid
Torisel
Treanda
Tykerb
Unituxin

Valchlor
Valstar
Vectibix
Velcade
Votrient
Xalkori
Xgeva
Yervoy
Zaltrap
Zelboraf
zoledronic acid (Zometa)
Zolinza
Zydelig
Zykadia
Zytiga

***OSTEOARTHRITIS
(OA)**

Gel-One
Hyalgan
Supartz

***OSTEOPOROSIS**

Forteo
zoledronic acid (Reclast)

***PAIN MANAGEMENT**

Prialt

***PAROXYSMAL
NOCTURNAL
HEMOGLOBINURIA
(PNH)**

Soliris

***PHENYLKETONURIA
(PKU)**

Kuvan

***PRE-TERM BIRTH**

Makena

***PSORIASIS**

Cosentyx
Enbrel
Humira
Otrexup
Rasuvo

***PULMONARY
ARTERIAL
HYPERTENSION (PAH)**

Adempas
epoprostenol
(Flolan)
Letairis
Orenitram
Remodulin
sildenafil
Tracleer
Tyvaso
Veletri
Ventavis

***PULMONARY
DISORDERS – OTHER**

Esbriet
Ofev

***RENAL DISORDERS**

Sensipar

***RESPIRATORY
SYNCYTIAL VIRUS**

Synagis

***RETINAL DISORDERS**

Avastin
Eylea
Lucentis
Macugen
Visudyne

***RHEUMATOID
ARTHRITIS (RA)**

Enbrel
Humira
Otrexup
Rasuvo
Rituxan

***SEIZURE DISORDERS**

Acthar
Sabril

***SLEEP DISORDERS**

Hettioz

***SYSTEMIC LUPUS
ERYTHEMATOSUS**

Benlysta

**TRETINOIN
PRODUCTS**

Atralin
Avita
Retin-A
Retin-A Micro
Tretin-X
Tretinoin
Veltin
Ziana

***UREA CYCLE
DISORDERS**

Buphenyl
Carbaglu
Ravicti

Section 5 Drug Tier 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 fax a letter documenting the medical necessity for the Prescription Drug Product to the CVS/caremark Exception Review Department at 1-888-487-9257 (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 if available in the therapeutic class
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.

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 Your 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.

Discount Tier Services – Claims for Prescription Drug Products not covered by the Plan benefits as Discount tier items may not be appealed.

Post-Service Claim – A Claim for a Plan benefit that is not a Pre-Service or Urgent Care 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. ox 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.

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 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 An External Review

You have the right to request an 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. 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. Compound claims for pain patches or creams containing ingredients (alone or in combination) for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness are Non Covered services. Pain patches with ingredients including but not limited to: lidocaine, menthol, capsaicin and methyl salicylate are Non Covered services.
8. Compound drugs purchased from a Non Network Pharmacy.
9. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law unless otherwise stated as eligible for coverage in this benefit description.
10. Injectable drugs administered by a Health Professional in an inpatient or outpatient setting.
11. Durable or disposable medical equipment or supplies, other than the specified diabetic and ostomy supplies.
12. Replacement Prescription Drug Products including damaged, lost, stolen or spilled Prescriptions.
13. Legend general vitamins except Legend prenatal vitamins, Legend vitamins with fluoride, and Legend single entity vitamins.
14. Prescription Drug Products that are not medically necessary.
15. Charges to administer or inject any drug.
16. 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.
17. Prescription Drug Products for which there is normally no charge in professional practice.
18. Therapeutic devices, artificial appliances, or similar devices, regardless of

intended use.

19. Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
20. Experimental, investigational, or unproven prescription drug products, treatments or therapies.
21. Prescription Drug Products that have not been approved by the Federal Food and Drug Administration.
22. 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.
23. Charges for the delivery of any drugs.
24. Prescription Drug Products approved for experimental use only.
25. 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
26. Coverage for allergy antigens under any circumstances.
27. 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 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://www.caremark.com> or 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	20% Coinsurance to a Maximum of \$100 dollars per Standard Unit of Therapy

Oral Anti-Cancer Prescription Drug Products:

Your responsibility is 20% Coinsurance of the Allowed Charge not to exceed \$100 per standard unit of therapy for covered Oral Anti-Cancer Prescription Drug Products. You will pay Coinsurance until You reach the Plan combined medical and pharmacy Out of Pocket Maximum. Once the Out of Pocket 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. 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 ninety (90) day supply may be obtained at one time for most medications.

For Non-Controlled Substance prescriptions, the refill threshold is set at 75 percent. This means that 75 percent of a member's days supply must have lapsed before the prescriptions can be refilled.

For Controlled Substance prescriptions, the refill threshold is set at 80 percent. This means that 80 percent of a member's days supply must have lapsed before the prescription can be refilled.

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 Employee Health Plan Preferred Drug List

2016

Effective 01/01/2016

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.

This document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

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

Your Kansas State Employees Preferred Drug List As Of January 2016

ANALGESICS

NSAIDs

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

NSAIDs, COMBINATIONS

diclofenac sodium delayed-rel/misoprostol

NSAIDs, TOPICAL

diclofenac sodium soln
diclofenac sodium gel (VOLTAREN GEL)

COX-2 INHIBITORS

celecoxib

GOUT

allopurinol
colchicine (COLCRYS)
probenecid
febuxostat (ULORIC)

OPIOID ANALGESICS

codeine/acetaminophen
fentanyl transdermal
fentanyl transmucosal lozenge
hydrocodone/acetaminophen
hydromorphone
hydromorphone ext-rel
methadone
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
tramadol
tramadol ext-rel
buprenorphine transdermal (BUTRANS)
fentanyl citrate buccal (FENTORA)
fentanyl sublingual spray (SUBSYS)
fentanyl sublingual tabs (ABSTRAL)
oxycodone ext-rel (OXYCONTIN)
oxymorphone ext-rel (OPANA ER)
tapentadol (NUCYNTA)
tapentadol ext-rel (NUCYNTA ER)

NON-OPIOID ANALGESICS

butalbital/acetaminophen/caffeine tabs
butalbital/aspirin/caffeine

ANTI-INFECTIVES

ANTIBACTERIALS

Cephalosporins

First Generation
cefadroxil
cephalexin

Second Generation

cefprozil
cefuroxime axetil

Third Generation

cefdinir
cefixime (SUPRAX)

Erythromycins/Macrolides

azithromycin
clarithromycin
clarithromycin ext-rel
erythromycin delayed-rel
erythromycin ethylsuccinate
erythromycin stearate
erythromycin/sulfisoxazole
fidaxomicin (DIFICID)

Fluoroquinolones

ciprofloxacin
ciprofloxacin ext-rel
levofloxacin
moxifloxacin

Penicillins

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

Tetracyclines

doxycycline hyclate
minocycline
tetracycline

ANTIFUNGALS

clotrimazole troches
fluconazole
griseofulvin ultramicronsize
itraconazole
nystatin
terbinafine tabs
voriconazole

ANTIMALARIALS

atovaquone/proguanil
chloroquine
mefloquine
artemether/lumefantrine (COARTEM)

ANTITUBERCULAR AGENTS

ethambutol
isoniazid

Your Kansas State Employees Preferred Drug List As Of January 2016

pyrazinamide
rifampin

ANTIVIRALS

Cytomegalovirus Agents
valganciclovir

Herpes Agents

acyclovir caps, tabs
famciclovir
valacyclovir

Influenza Agents

oseltamivir (TAMIFLU)
zanamivir (RELENZA)

MISCELLANEOUS

clindamycin
dapstone
ivermectin
metronidazole
nitrofurantoin ext-rel
nitrofurantoin macrocrystals
nitrofurantoin susp
sulfamethoxazole/trimethoprim
sulfamethoxazole/trimethoprim DS
tinidazole
trimethoprim
vancomycin
albendazole (ALBENZA)
rifaximin (XIFAXAN 550 mg)
tedizolid (SIVEXTRO)

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

lomustine (CEENU)
altretamine (HEXALEN)
busulfan (MYLERAN)
chlorambucil (LEUKERAN)
cyclophosphamide caps
(CYCLOPHOSPHAMIDE caps)
melphalan (ALKERAN)

ANTIMETABOLITES

mercaptopurine
methotrexate (Trexall)
thioguanine (TABLOID)

HORMONAL ANTINEOPLASTIC AGENTS

Antiandrogens

bicalutamide
flutamide

Antiestrogens

tamoxifen

Aromatase Inhibitors

anastrozole
exemestane
letrozole

Progestins

megestrol acetate

MISCELLANEOUS

etoposide
hydroxyurea
tretinoin caps
mitotane (LYSODREN)
procarbazine (MATULANE)

CARDIOVASCULAR

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

epplerenone
spironolactone

ALPHA BLOCKERS

doxazosin
terazosin

ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC COMBINATIONS

candesartan
candesartan/hydrochlorothiazide
eprosartan
irbesartan
irbesartan/hydrochlorothiazide
losartan
losartan/hydrochlorothiazide
telmisartan
telmisartan/hydrochlorothiazide
valsartan
valsartan/hydrochlorothiazide

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2016

olmesartan (BENICAR)
olmesartan/hydrochlorothiazide (BENICAR HCT)

ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER COMBINATIONS

amlodipine/telmisartan
amlodipine/valsartan
amlodipine/olmesartan (AZOR)

ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATIONS

amlodipine/valsartan/hydrochlorothiazide
olmesartan/amlodipine/hydrochlorothiazide
(TRIBENZOR)

ANTIARRHYTHMICS

amiodarone
disopyramide
flecainide
propafenone
propafenone ext-rel
sotalol

ANTILIPEMICS

Bile Acid Resins
cholestyramine
colestipol
colesevelam (WELCHOL)

Cholesterol Absorption Inhibitors

ezetimibe (ZETIA)

Fibrates

fenofibrate
fenofibric acid delayed-rel
gemfibrozil

HMG-CoA Reductase Inhibitors/Combinations

atorvastatin
fluvastatin
lovastatin
pravastatin
simvastatin ezetimibe/simvastatin
(VYTORIN) rosuvastatin (CRESTOR)

Niacins/Combinations

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

Omega-3 Fatty Acids omega-3 acid ethyl esters

BETA-BLOCKERS

atenolol
bisoprolol
carvedilol
labetalol
metoprolol succinate ext-rel
metoprolol tartrate

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

* Listing does not include generic Cardizem LA

CALCIUM CHANNEL BLOCKER/ANTILIPEMIC 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

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2016

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
isosorbide mononitrate ext-rel

Sublingual/Translingual

nitroglycerin lingual spray (NITROLINGUAL)
nitroglycerin sublingual (NITROSTAT)

Transdermal

nitroglycerin transdermal

NITRATE/VASODILATOR COMBINATIONS

isosorbide dinitrate/hydralazine (BIDIL)

MISCELLANEOUS

hydralazine
methyldopa
midodrine
ranolazine ext-rel (RANEXA)

CENTRAL NERVOUS SYSTEM

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
lamotrigine ext-rel
lamotrigine orally disintegrating tabs
levetiracetam
levetiracetam ext-rel

oxcarbazepine
phenobarbital
phenytoin
phenytoin sodium extended
primidone
tiagabine
topiramate
valproic acid
zonisamide
lacosamide (VIMPAT)

ANTIDEMENTIA

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

ANTIDEPRESSANTS

Monoamine Oxidase Inhibitors (MAOIs)

phenelzine
tranylcypromine

Selective Serotonin Reuptake Inhibitors (SSRIs)

citalopram
escitalopram
fluoxetine
paroxetine HCl
paroxetine HCl ext-rel
sertraline
fluoxetine (FLUOXETINE 60 mg)
vilazodone (VIBRYD)
vortioxetine (BRINTELLIX)

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

duloxetine delayed-rel
venlafaxine
venlafaxine ext-rel
desvenlafaxine ext-rel (KHEDEZLA)
desvenlafaxine ext-rel (PRISTIQ)

Tricyclic Antidepressants (TCAs)

amitriptyline
desipramine
doxepin
imipramine HCl
nortriptyline

Miscellaneous Agents

bupropion
bupropion ext-rel
mirtazapine
trazodone

ANTIPARKINSONIAN AGENTS

amantadine
bentropine
bromocriptine
carbidopa/levodopa

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2016

carbidopa/levodopa ext-rel
carbidopa/levodopa orally disintegrating tabs
carbidopa/levodopa/entacapone
entacapone
pramipexole
pramipexole ext-rel (MIRAPEX ER)
ropinirole
ropinirole ext-rel
selegiline
trihexyphenidyl
rasagiline mesylate (AZILECT)
rotigotine transdermal (NEUPRO)

ANTIPSYCHOTICS

Atypicals

aripiprazole
clozapine
olanzapine
quetiapine
risperidone
ziprasidone
lurasidone (LATUDA)
quetiapine ext-rel (SEROQUEL XR)

Miscellaneous

chlorpromazine
fluphenazine
haloperidol
perphenazine
thiothixene
trifluoperazine

ATTENTION DEFICIT HYPERACTIVITY DISORDER

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

FIBROMYALGIA

milnacipran (SAVELLA)
pregabalin (LYRICA)

HYPNOTICS

Benzodiazepines
temazepam

Nonbenzodiazepines

eszopiclone
zolpidem
zolpidem ext-rel

Tricyclics

doxepin (SILENOR)

MIGRAINE

Ergotamine Derivatives
dihydroergotamine inj
dihydroergotamine spray

Selective Serotonin Agonists

naratriptan
rizatriptan
sumatriptan
sumatriptan inj
sumatriptan nasal spray
zolmitriptan
eletriptan (RELPAK)
zolmitriptan nasal spray (ZOMIG)

Selective Serotonin Agonist/Nonsteroidal Drug (NSAID) Combinations

sumatriptan/naproxen sodium (TREMIMET)

MOOD STABILIZERS

lithium carbonate
lithium carbonate ext-rel

MUSCULOSKELETAL THERAPY AGENTS

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

MYASTHENIA GRAVIS

pyridostigmine
pyridostigmine ext-rel

NARCOLEPSY

armodafinil (NUVIGIL)

POSTHERPETIC NEURALGIA (PHN)

gabapentin ext-rel (GRALISE)

PSYCHOTHERAPEUTIC-MISCELLANEOUS

Alcohol Deterrents
acamprosate calcium
disulfiram

Opioid Antagonists

naltrexone

Partial Opioid Agonist/Opioid Antagonist Combinations

buprenorphine/naloxone sublingual tabs
buprenorphine/naloxone sublingual film
(SUBOXONE FILM)

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2016

Vasomotor Symptom Agents

paroxetine mesylate (BRISDELLE)

ENDOCRINE AND METABOLIC

ANDROGENS

testosterone cypionate

testosterone enanthate

testosterone soln (AXIRON)

testosterone transdermal (ANDRODERM)

ANTI-DIABETICS

Alpha-glucosidase Inhibitors

acarbose

Amylin 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

dulaglutide (TRULICITY)

liraglutide (VICTOZA)

Insulins

insulin aspart (NOVOLOG)

insulin aspart protamine 70%/insulin aspart 30%

(NOVOLOG MIX 70/30)

insulin detemir (LEVEMIR)

insulin glargine (LANTUS)

insulin glargine (TOUJEO)

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

Insulin Sensitizer/Biguanide

Combinations

pioglitazone/metformin

Insulin Sensitizer/Sulfonylurea

Combinations

pioglitazone/glimepiride

Meglitinides

nateglinide

repaglinide

Sodium-Glucose Co-transporter 2

(SGLT2) Inhibitors

dapagliflozin (FARXIGA)

empagliflozin (JARDIANCE)

Sodium-Glucose Co-transporter 2

(SGLT2) Inhibitor/Biguanide

Combinations

dapagliflozin/metformin ext-rel (XIGDUO XR)

Sulfonylureas

glimepiride

glipizide

glipizide ext-rel

glyburide

Supplies

BD insulin syringes and needles

lancets

ONETOUCH ULTRA kits and test strips

ONETOUCH VERIO kits and test strips

ANTI-OBESITY

Anorexiatic Combinations

lorcaserin (BELVIQ)

naltrexone/bupropion ext-rel (CONTRAVE)

CALCIUM REGULATORS

Bisphosphonates

alendronate

ibandronate

risedronate (ACTONEL)

risedronate delayed-rel (ATELVIA)

Calcitonins

calcitonin-salmon

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

norethindrone acetate/EE 1/20 and iron -

Lomedia 24 Fe

drospirenone/EE/levomefolate 3/20 and

levomefolate (BEYAZ)

norethindrone acetate/EE 1/20 and iron

chewable (MINASTRIN 24 FE)

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2016

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
norgestrel/EE 0.3/30 - Low-O gestrel
drospirenone/EE/levomefolate 3/30 and
levomefolate(SAFYRAL)

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

Transdermal

norelgestromin/EE

Vaginal

etonogestrel/EE ring (NUVARING)

ENDOMETRIOSIS

danazol

ESTROGENS

Oral

estradiol
estropipate
estrogens, conjugated (PREMARIN)

Transdermal

estradiol
estradiol (DIVIGEL)
estradiol (EVAMIST)
estradiol (MINIVELLE)

Vaginal

estradiol vaginal crm (ESTRACE)
estradiol vaginal tabs (VAGIFEM)
estrogens, conjugated crm (PREMARIN crm)

ESTROGEN/PROGESTINS

Oral

EE/norethindrone acetate - Jinteli
estradiol/norethindrone
estrogens, conjugated/medroxyprogesterone
(PREMPHASE)
estrogens, conjugated/medroxyprogesterone
(PREMPRO)

ESTROGEN/SELECTIVE ESTROGEN RECEPTOR MODULATOR COMBINATIONS

conjugated estrogens/bazedoxifene (DUAVEE)

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)

HYPERPARATHYROID TREATMENT, VITAMIN D ANALOGS

calcitriol (1,25-D3)
doxercalciferol
paricalcitol

PHOSPHATE BINDER AGENTS

calcium acetate
calcium acetate (PHOSLYRA)
sevelamer carbonate (RENVELA)
sucroferric oxyhydroxide (VELPHORO)

PROGESTINS

Oral

medroxyprogesterone acetate
megestrol acetate susp (MEGACE ES)
norethindrone acetate
progesterone, micronized

SELECTIVE ESTROGEN RECEPTOR MODULATORS

raloxifene
ospemifene (OSPHENA)

Your Kansas State Employees Preferred Drug List As Of January 2016

THYROID AGENTS

Antithyroid Agents

methimazole
propylthiouracil

Thyroid Supplements

levothyroxine
levothyroxine(SYNTHROID)
levothyroxine - Levoxyl
liothyronine

VASOPRESSINS

desmopressin spray, tabs

MISCELLANEOUS

cabergoline
levocarnitine

GASTROINTESTINAL

ANTIIDIARRHEALS

difenoxylate/atropine
loperamide

ANTIEMETICS

dronabinol
granisetron
meclizine
metoclopramide
ondansetron
prochlorperazine
promethazine
trimethobenzamide
doxylamine/pyridoxine delayed-rel (DICLEGIS)
granisetron transdermal (SANCUSO)

ANTISPASMODICS

dicyclomine

CHOLELITHOLYTICS

ursodiol

H₂ RECEPTOR ANTAGONISTS

cimetidine
famotidine
ranitidine

INFLAMMATORY BOWEL DISEASE

Oral Agents

balsalazide
budesonide delayed-rel caps
sulfasalazine
sulfasalazine delayed-rel
budesonide ext-rel (UCERIS)
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 supp (CANASA)

IRRITABLE BOWEL SYNDROME

Irritable Bowel Syndrome with Constipation

linaclotide (LINZESS)

Irritable Bowel Syndrome with Diarrhea

alosetron (LOTRONEX)

LAXATIVES

lactulose
peg 3350/electrolytes
polyethylene glycol 3350
peg 3350/electrolytes (MOVIPREP)
peg 3350/electrolytes (SUCLEAR)
sodium sulfate/potassium sulfate/
magnesium sulfate (SUPREP)

OPIOID-INDUCED CONSTIPATION

naloxegol (MOVANTIK)

PANCREATIC ENZYMES

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

PROSTAGLANDINS

misoprostol

PROTON PUMP INHIBITORS

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

SALIVA STIMULANTS

cevimeline
pilocarpine tabs

STEROIDS, RECTAL

hydrocortisone crm
hydrocortisone acetate/pramoxine foam
(PROCTOFOAM-HC)

ULCER THERAPY COMBINATIONS

lansoprazole + amoxicillin + clarithromycin
bismuth/metronidazole/tetracycline (PYLERA)

MISCELLANEOUS

sucralfate

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

alfuzosin ext-rel
finasteride
tamsulosin

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dutasteride (AVODART)
sildenafil (RAPAFLO)

URINARY ANTISPASMODICS

oxybutynin
oxybutynin ext-rel
tolterodine
tolterodine ext-rel
trospium
trospium ext-rel
mirabegron ext-rel (MYRBETRIQ)
oxybutynin gel (GELNIQUE)
solifenacin succinate (VESICARE)

VAGINAL ANTI-INFECTIVES

clindamycin crm
metronidazole
terconazole

MISCELLANEOUS

bethanechol
phenazopyridine
potassium citrate ext-rel

HEMATOLOGIC

ANTICOAGULANTS

Injectable
enoxaparin

Oral

warfarin
apixaban (ELIQUIS)
dabigatran etexilate (PRADAXA)
rivaroxaban (XARELTO)

Synthetic Heparinoid-like Agents

fondaparinux

PLATELET AGGREGATION INHIBITORS

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

PLATELET SYNTHESIS INHIBITORS

anagrelide

MISCELLANEOUS

cilostazol

IMMUNOLOGIC AGENTS

ALLERGENIC EXTRACTS

ragweed pollen allergen extract (RAGWITEK)
timothy grass pollen allergen extract (GRASTEK)

DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)

hydroxychloroquine
leflunomide

methotrexate
methotrexate (RHEUMATREX)

IMMUNOSUPPRESSANTS

Antimetabolites
azathioprine
azathioprine (AZASAN)

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES

Potassium
potassium chloride ext-rel
potassium chloride liquid

VITAMINS AND MINERALS

Folic Acid/Combinations
folic acid
folic acid/vitamin B6/vitamin B12

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

ANAPHYLAXIS TREATMENT AGENTS

epinephrine (AUVI-Q)
epinephrine (EPIPEN)
epinephrine (EPIPEN JR.)

ANTICHOLINERGICS

ipratropium soln
tiotropium (SPIRIVA)

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

ipratropium/albuterol soln
ipratropium/albuterol, CFC-free aerosol (COMBIVENT RESPIMAT)
umeclidinium/vilanterol (ANORO ELLIPTA)

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ANTI-HISTAMINES, SEDATING

clemastine 2.68 mg
cyproheptadine
hydroxyzine HCl

ANTI-TUSSIVES

benzonatate

ANTI-TUSSIVE 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

BETA AGONISTS

Inhalants

Short Acting

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

Long Acting

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

Oral Agents

albuterol
albuterol ext-rel
terbutaline

CYSTIC FIBROSIS

tobramycin inhalation soln

LEUKOTRIENE RECEPTOR

ANTAGONISTS

montelukast
zafirlukast

MAST CELL STABILIZERS

cromolyn soln

NASAL ANTI-HISTAMINES

azelastine spray
olopatadine spray

PHOSPHODIESTERASE-4 INHIBITORS

roflumilast (DALIRESP)

STEROID/BETA AGONIST COMBINATIONS

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)
fluticasone (FLOVENT DISKUS)
fluticasone, CFC-free aerosol (FLOVENT HFA)
mometasone (ASMANEX)

XANTHINES

theophylline ext-rel tabs

MISCELLANEOUS

ipratropium spray

TOPICAL

DERMATOLOGY

Acne

Oral

isotretinoin

Topical

adapalene
benzoyl peroxide
clindamycin gel, lotion, soln
clindamycin/benzoyl peroxide
clindamycin/benzoyl peroxide (BENZACLIN)
erythromycin gel 2%
erythromycin soln
erythromycin/benzoyl peroxide
sulfacetamide lotion 10%
sulfacetamide/sulfur crm, gel, lotion, pads
tretinoin
tretinoin (ATRALIN)
tretinoin gel microsphere (RETIN-A MICRO)
adapalene/benzoyl peroxide (EPIDUO)
clindamycin/benzoyl peroxide (ACANYA)
tazarotene (TAZORAC)

Actinic Keratosis

fluorouracil crm, soln 5%, soln 2%
imiquimod (ZYCLARA)
ingenol mebutate (PICATO)

Antibiotics

gentamicin
mupirocin
silver sulfadiazine

Antifungals

ciclopirox
clotrimazole
econazole
ketoconazole
naftifine (NAFTIN)
nystatin
efinaconazole (JUBLIA)
luliconazole (LUZU)

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Antipsoriatics

Oral

acitretin

methoxsalen oral

Topical

calcipotriene

calcipotriene (SORILUX)

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%

clo cortolone crm 0.1% (CLODERM)

desoximetasone crm, oint 0.05%

fluocinolone acetonide crm, oint 0.025%

fluticasone propionate crm, lotion 0.05%,
ointment 0.005%

hydrocortisone butyrate crm, 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%

hydrocortisone butyrate lotion 0.1% (LOCOID)

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,
ointment 0.05%

clobetasol propionate crm, foam, gel, lotion, oint,
shampoo, soln

diflorasone diacetate oint 0.05%

halobetasol propionate crm, oint 0.05%

Emollients

ammonium lactate 12%

Immunomodulators

tacrolimus

pimecrolimus (ELIDEL)

Local Analgesics

lidocaine patch

Local Anesthetics

lidocaine/prilocaine

Rosacea

doxycycline monohydrate (ORACEA)

metronidazole crm, gel, lotion 0.75%

metronidazole gel 1%

sulfacetamide/sulfur

azelaic acid gel (FINACEA)

ivermectin (SOOLANTRA)

Scabicides and Pediculicides

malathion

permethrin 5%

Miscellaneous Skin and Mucous

Membrane

imiquimod

podofilox

penciclovir (DENA VIR)

MOUTH/THROAT/DENTAL AGENTS

Anesthetics - Topical Oral

lidocaine viscous

Steroids - Mouth/Throat

triamcinolone paste

OPHTHALMIC

Antiallergics

azelastine

cromolyn sodium

olopatadine (PATADAY)

olopatadine (PATANOL)

Anti-infectives

bacitracin

ciprofloxacin

erythromycin

gentamicin

levofloxacin

neomycin/polymyxin B/gramicidin

ofloxacin

polymyxin B/bacitracin

polymyxin B/trimethoprim

sulfacetamide oint, soln 10%

tobramycin

besifloxacin (BESIVANCE)

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 oint 0.3%/0.1%

(TOBRADEX OINTMENT)

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

Anti-inflammatories

Nonsteroidal

bromfenac sodium
diclofenac sodium
ketorolac
bromfenac sodium 0.07% (PROLENSA)

Steroidal

dexamethasone sodium phosphate
fluorometholone
prednisolone acetate 1%
difluprednate (DUREZOL)
loteprednol 0.2% (ALREX)
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
dorzolamide/timolol maleate/preservative-free
(COSOPT PF)

Carbonic Anhydrase Inhibitor/Sympathomimetic Combinations

brinzolamide/brimonidine (SIMBRINZA)

Immunomodulators

cyclosporine, emulsion (RESTASIS)

Prostaglandins

latanoprost
travoprost
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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