CO-PAYMENTS
If the member elects to fill a brand name drug that is available in a generic version, the applicable co-payment will be brand co-payment plus the difference between generic and brand name ingredient cost.

1-34-Day Supply
Generic: $20.00
Brand Name: $60.00
Biotech Medications: $150.00

35-102-Day Supply
Generic: $40.00
Brand Name: $150.00

OUT OF POCKET MAXIMUM –
PER CALENDAR YEAR FOR PHARMACY CLAIMS ONLY (EMBEDDED).
Individual $1,000
Family $2,000

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)
PREVENTIVE CARE COVERAGE (Prescription is required)
Aspirin $0.00
Bowel Preps (For colorectal cancer screening, ages 50 to 74) $0.00
Breast Cancer Prevention medications (Tamoxifen and Raloxifen) $0.00
Folic Acid Supplements $0.00
Fluoride Chemoprevention supplements for children $0.00
Iron supplements for children age 6 to 12 months $0.00
Tobacco Cessation $0.00
Vitamin D for covered individuals over age 65 $0.00

Contraceptives (to include FDA approved OTCs) $0.00
**Brand Contraceptives with Generics available – Members will be charged the cost difference between the brand drug and its generic alternative

Vaccines and Immunizations $0.00
i. Hepatitis A
ii. Hepatitis B
iii. Herpes Zoster
iv. Human Papillomavirus
v. Influenza (Flu Shot)
vi. Measles, Mumps, Rubella
vii. Meningococcal
viii. Pneumococcal
ix. Tetanus, Diphtheria, Pertussis
x. Varicella

COVERED DRUGS
- Acthar Gel is only covered for pediatric patients under the age of 2 who have the clinical diagnosis for infantile spasms and meet established approval criteria.
COVERED DRUGS CONTINUED

- Anaphylaxis Agents (Epipen, Ana-Kit, epinephrine, etc.).
- Biotech Medications are available through a limited network of providers. The current biotech medication list is available at www.maxcarerx.com. Please contact MaxCare customer service for assistance in locating a participating biotech pharmacy provider.
- Compounded medications in which at least one ingredient is a prescription legend drug, up to a maximum $300.00 per compounded script.
- Contraceptives (to include FDA approved OTCs) such as spermicide, sponges, female condoms and ER contraceptives and diaphragms.
- ERD drugs such as Viagra, Cialis and Levitra.
- Glucagon Injection.
- Immunizations and Vaccines.
- Injectable drugs
- Insulin.
- Legend drugs, which under applicable federal and state laws require a prescription by a physician or certain other, licensed practitioners.
- Retin-A/Tretinoin and like products (topical only) are covered for persons through the age of 25 for the treatment of acne.

SUBJECT TO PRIOR AUTHORIZATION

- Prescriptions greater than $1,500 for a 30-day supply or $3,000 for a 90-day supply.
- Cialis 5mg strength is covered for diagnosis of BPH (30 units for up to a 30 day supply), subject to approved Clinical PA.
- Breast Cancer Prevention medication,Raloxifen (Evista)
- Prescriptions exceeding the established quantity limit will require prior authorization.
- Specialty Drugs
- Suboxone – approved for substance abuse only by certified prescriber.
- GLP-1 receptor agonists such as Bydureon, Byetta, Symlin and Victoza
- Short Acting Opioids (Actiq, Onsolis, Subsys, Fentora, Abstral, Lazanda) Approved for breakthrough cancer pain only.

SUBJECT TO QUANTITY LIMITS

- Diaphragms limited to one per year
- Glucose Meters – Covered one per year. (Except for Medicare Beneficiaries - Medicare is primary).
- Glucose Strips - Limited to two (2) packages per month.
- Impotence Medications. (Cialis, Levitra or Viagra is covered up to five (5) tablets per month.)
- Insulin syringes by prescription only - Limited to one (1) box of 100 per month.
- Migraine medications, subject to Maxcares standard quantity limits.
- Non-sedating Antihistamines (based on FDA maximum recommended dose)
- Oxycontin (and other opioids)
- Tobacco Cessation Products- limited to 2 quit attempts per year for 90 days per attempt
- Zostavax (shingles vaccination for members age 50 & over) – Lifetime limitation of one (1) injection.

SUBJECT TO STEP THERAPY

- Sodium glucose transporters
- Solodyn (trial of minocycline as first line therapy)
- Doryx (trial of doxycycline as first line therapy)
EXCLUSIONS AND LIMITATIONS

Items in the exclusions section are not covered and not eligible for prior authorization unless specifically listed in the covered drug or prior authorization section of the plan specification document.

- *Any quantity of drugs or medicine dispensed which exceed a 34-day supply, when taken in accordance with the directions of the prescriber. **Exceptions** - drugs included on the Maintenance Drug List, which may be dispensed in quantities sufficient for a 102-day supply.
- **Initial Dose therapy** – the initial dose of a maintenance medication, or the first dose in a 120 day period is allowed only up to a 34 day supply before quantities are allowed beyond 34-day supply and up to 102-day supply.
- Absorica
- Acthar Gel except for infantile spasms for children under age 2.
- Addyi
- All topical androgens and Aveed & Striant.
- Amrix
- Anabolic Steroids.
- Anti-Obesity drugs.
- Any medication consumed or administered (in whole or in part) where it is dispensed.
- Any prescription refills in excess of the number of refills specified by the physician or more than one year after the date of the physician’s prescription.
- Arestin
- Brand PPIs (Dexilant, etc.), except generic and OTC.
- Ciclodan Kit
- Compound medications that contain the “Bulk” products Gabapentin, Ketamine, Fentanyl, Baclofen, & Compound Kits.
- Compound medications limited to $300 maximum per script.
- Conzip
- Cosmetic drugs (Rogaine, bleaching agents, Melanin stimulating agents, etc.).
- Drugs or medications lawfully obtainable without a written prescription from a physician or other practitioner except those OTC Drugs listed under “Covered Drugs”.
- Duexis
- Edluar
- Fexmid
- Flonase Rx (brand only)
- Glumetza
- Impotence medications except as covered above.
- Infertility medications
- Intermezzo
- Investigational drugs
- Jublia/Kerydin
- Juxtapid and Kynamro
- Lorzone
- Nasacort AQ (triamcinolone)- all Rx
- Pain Patches, except those that are FDA approved fentanyl, butrans, or lidoderm patches.
- Plan Overrides consisting of early refills or quantity limit exceptions shall be limited to one (1) time only, per patient, without prior written consent from health plan administrator or designated agent. Clinical Prior Authorizations shall not exceed one year and any prior authorization requests without clinical merit resulting in a preliminary denial shall be discussed with health plan administrator or designated agent for final disposition and/or with written approval may be referred to third party medical review.
EXCLUSIONS AND LIMITATIONS CONTINUED

- Prescriptions for Non-FDA medications or Indications.
- Quartette
- Rayos
- Restasis
- Retin-A/Tretinoin and like products (topical only) are excluded for persons age of 26 and over.
- Rexaphenac
- Staxyn
- Tobacco Cessation products – Nasal sprays and E-Cigarettes
- Therapeutic devices or appliances, including support garments and other non-medical substances regardless of their intended uses.
- Unit-Dose Packaged Medications. **Exceptions:** Medications that would otherwise be covered by the Plan that are only available in unit-dose packaging.
- Vimovo
- Zipsor
- Zohydro & Zohydro ER
- Zuplenz
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