

## PRESCRIPTION DRUG SUMMARY OF BENEFITS

PLAN CODE: DA040610



### POLICY MAXIMUMS

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	<u>Single</u>	<u>Family</u>
• RX Deductible:	N/A	N/A
• RX Coinsurance:	N/A	N/A
• RX Maximum Out of Pocket:	N/A	N/A
• Biopharmaceutical RX Maximum Out of Pocket:	N/A	N/A

All benefits are calculated on a per member per calendar year basis. Please present your member ID card at the pharmacy so discounts, deductible amounts, and maximum out of pocket amounts are calculated correctly. The deductible, coinsurance, and copays will apply to the maximum out of pocket amounts.

### COPAYS/COINSURANCE

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	<u>Tier 1 Generic</u>	<u>Tier 2 Brand</u>
<b>Formulary Legend Drugs:</b>	\$6	\$10
<b>Formulary Contraceptives:</b>	\$6+	\$10+
<b>Prior Authorized* (PA) Formulary:</b>	\$6	\$10
<b>Formulary Insulin Products:</b>	\$6	\$10
<b>Disposable Diabetic Supplies</b> (Swabs, syringes, strips, needles, lancets)	\$6	\$10
<b>*Biopharmaceutical Drugs<sup>++</sup>:</b>	\$6	\$10

### OVER THE COUNTER (OTC) DRUGS & OTHER \$0 COPAY MEDICATIONS

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• Chlorpheniramine	\$0	• Naphcon-A eye drops	\$0
• Fluoride Supplements	\$0 (Age 6 mo.– 6 yrs)	• Nasalcrom Nasal Spray	\$0
• Folic Acid	\$0 (Women under 42)	• Niacin (not 120mg SR)	\$0
• Prenatal Vitamins	\$0 (Women under 42)	• Opcon A eye drops	\$0
• Guaifenesin/Codeine Syrup	\$0	• Pseudoephedrine (not 120mg SR)	\$0
• Iron Supplements	\$0 (Age 6-12 months)	• Zaditor (ketotifen)	\$0

### BENEFIT MAXIMUMS & LIMITATIONS

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Infertility Drugs 50% up to \$1000 is the lifetime limit paid by Physicians Plus. Coinsurance on this benefit does not apply to the RX policy maximum out of pocket.

\* Biopharmaceuticals<sup>++</sup> All biopharmaceuticals require prior authorization. Page 2 of this document includes the current Biopharmaceutical drug list; this list is subject to change without notice, please find the most up to date list on our website at [www.pplusic.com](http://www.pplusic.com)

\* **BIOPHARMACEUTICAL DRUG LIST** – All biopharmaceuticals require prior authorization.

**Brand Name (Generic Name)**

**Actimmune**® (interferon gamma-1b)  
**Apokyn**® (apomorphine)  
**Aranesp**® (darbepoetin alfa)  
**Arixtra**® (fondaparinux)  
**Avonex**® (interferon beta-1a)  
**Betaseron**® (interferon beta-1b)  
**Cimzia**® (certolizumab Pegol)  
**Copaxone**® (glatiramer)  
**Enbrel**® (etanercept)  
**Epogen**® (epoetin alfa)  
**Extavia**® (interferon beta-1b)  
**Forteo**® (teriparatide)  
**Fragmin**® (dalteparin)  
**Genotropin**® (somatropin-rDNA)  
**Humatrope**® (somatropin-rDNA)  
**Humira**® (adalimumab)  
**Infergen**® (interferon alphacon-1)

**Brand Name (Generic Name)**

**Increlex**® (mecasermin-rDNA)  
**Intron-A**® (interferon alfa-2b)  
**Kineret**® (anakinra)  
**Kuvan**® (sapropterin)  
**Leukine**® (sargramostim)  
**Lovenox**® (enoxaparin)  
**Neulasta**® (pegfilgrastim)  
**Neumega**® (oprelvekin(interleukin-11; IL-11))  
**Neupogen**® (filgrastim)  
**Norditropin**® (somatropin-rDNA)  
**Nplate**® (romiplostim)  
**Nutropin**® (somatropin-rDNA)  
**Nutropin AQ**® (somatropin-rDNA)  
**Nutropin Depot**® (somatropin-rDNA)  
**Omnitrope**® (somatropin)  
**Pegasys**® (interferon alfa-2a)

**Brand Name (Generic Name)**

**Peg-Intron**® (interferon alfa-2b)  
**Procrit**® (epoetin alfa)  
**Promacta**® (eltrombopag)  
**Pulmozyme**® (dornase alfa)  
**Rebif**® (interferon beta-1a)  
**Regranex**® (becaplermin)  
**Saizen**® (somatropin-rDNA)  
**Sandostatin**® (octreotide)  
**Sandostatin LAR**® (octreotide)  
**Serostim**® (somatropin-rDNA)  
**Simponi**™ (golimumab)  
**Somatuline**® (lanreotide)  
**Somavert**® (pegvisomant)  
**Tev-Tropin**® (somatropin-rDNA)  
**Tyvaso**® (treprostinil)  
**Ventavis**® (iloprost)

**Maintenance Drug List:** Several medications used for chronic illnesses are available from your pharmacy in a 102-day supply for 3 copayments (1 (one) copay per 34 day supply). A list of these drugs can be obtained from our website at [www.pplusic.com](http://www.pplusic.com) or by contacting the Physicians Plus Pharmacy Services department at (608) 260-7803 or (800) 545-5015.

**Quantity Limitations:** The following medications have specific quantity limitations.

Sumatriptan Tablets (Imitrex)	[9] tablets per copay, 2 copays per month
Sumatriptan Injection (Imitrex)	[6] syringes per copay per month
Sumatriptan Spray (Imitrex)	[6] spray devices per copay, 2 copays per month
Samsca (PA)	[10] day supply per copay
Relpax (NF)*	[12] tablets per copay, 2 copays per month
Naratriptan (NF)*	[9] tablets per copay, 2 copays per month
Axert (NF)*	[6] tablets per copay, 2 copays per month
Zomig Nasal Spray (NF)*	[6] spray devices per copay, 2 copays per month
Zomig (NF)*	[6] tablets per copay, 2 copays per month
DDAVP	[2] spray bottles per copay
Ear & Eye Drops	[30] day supply or 2 containers per copay, whichever is less
Glucagon Kit	[1] (one) kit per copay
Pulmicort Inhaler	[1] (one) inhaler per copay
Other Inhalers	[2] inhalers or one month supply, whichever is less
Enoxaparin, Fragmin, Arixtra*	[14] day supply per copay
Regranex (PA)	[1] (one) copay per 15 gram tube
Vitamin A Derivatives (Retin-A)	Not covered for members over age [35] years

+ **Oral Contraceptives:** Oral contraceptives not to exceed a three month supply for one copayment. A list of these formulary medications can be obtained from our website at [www.healthychoicesbigrewards.com](http://www.healthychoicesbigrewards.com) or by contacting the Physicians Plus Pharmacy Services department at (608) 260-7803 or (800) 545-5015.

\***Prior Authorization (PA)** is required for some medications and ALL Biopharmaceuticals. Formulary status is subject to change, see our website at [www.pplusic.com](http://www.pplusic.com), GO-TO Rx Manager or contact Physicians Plus Pharmacy Services department at (608) 260-7803 or (800) 545-5015 for a current formulary and/or list of drugs requiring prior authorization. If a PA is approved, a tier 2 copay/coinsurance applies. If the PA is denied or not obtained, the member will be responsible for payment at the tier 3 level of benefits or payment in full.

(NF) Indicates Non-Formulary (NF) as of 9/1/2010.