

# PacifiCare SignatureValue®

## Offered by PacifiCare of Arizona, Inc.

National Rx 15/35  
 HMO Pharmacy Schedule of Benefits

| Summary of Benefits  | Formulary Generic | Formulary Brand-Name |
|--|-------------------|----------------------|
| <b>Retail Pharmacy Copayment<br/>(per Prescription Unit or up to 30 days)</b>                | <b>\$15</b>       | <b>\$35</b>          |
| <b>Mail Service Pharmacy Copayment<br/>(up to three Prescription Units or up to 90 days)</b> | <b>\$30</b>       | <b>\$70</b>          |

This Schedule of Benefits provides specific details about your Prescription Drug Benefit, as well as the exclusions and limitations. Together, this document and the Supplement to the Combined Evidence of Coverage and Disclosure Document, as well as the medical Combined Evidence of Coverage and Disclosure Document, determine the exact terms and conditions of your prescription drug coverage.

### What do I pay when I fill a prescription?

There are selected brand-name medications where you will have a generic Copayment of just \$15. Contact PacifiCare's Customer Service department for Formulary information.

### Preauthorization for All Non-Formulary Drugs

All non-Formulary drugs must be Preauthorized by PacifiCare in order to be covered under this pharmacy benefit. If approved, you will pay the applicable generic or brand-name Copayment.

Non-Formulary drugs may be Preauthorized in the following instances:

- No Formulary alternative is appropriate and the drug is Medically Necessary for patient care, as determined by PacifiCare and consistent with professional practice.
- The Formulary alternative has failed after a therapeutic trial. Your Contracting Physician will be asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternative.
- The Formulary alternative is not appropriate as determined by a review of Physician chart notes.
- Your Contracting Physician provides evidence in the form of documents, records or clinical trials which establishes that use of the requested non-

Formulary drug over the Formulary drug is Medically Necessary, as determined by PacifiCare.

### Preauthorization for Selected Formulary Drugs

Selected Formulary drugs must also be Preauthorized by PacifiCare to determine that they are Medically Necessary and being prescribed according to treatment guidelines consistent with standard professional practice to be eligible for coverage. If approved, you will pay the applicable generic or brand-name Copayment. For a list of the Formulary medications that require PacifiCare's Preauthorization, please contact PacifiCare's Customer Service department.

**Please note:** If you are prescribed a non-Formulary or Selected Formulary medication for acute treatment that requires immediate use upon Hospital discharge, an urgent care or emergency room visit after normal business hours, you may receive a one-time authorization for coverage. You will need to obtain Preauthorization before refilling this prescription.

### Medication Covered by Your Benefit

When prescribed by your Contracting Physician as Medically Necessary and filled at a Contracting Pharmacy, subject to all the other terms and conditions of this outpatient Prescription Drug Benefit, the following medications are covered.

- **Disposable all-in-one prefilled insulin pens,** insulin cartridges and needles for nondisposable pen devices are covered when Medically Necessary in accordance with PacifiCare's Preauthorization process.
- **Federal Legend Drugs:** Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."

- **Formulary oral contraceptives**, diaphragms and transdermal hormone replacement therapy are covered under the pharmacy benefit. Non-Formulary oral contraceptive, diaphragms and transdermal hormone replacement therapy may require Preauthorization for coverage. Other contraceptive drugs and devices are covered under the medical benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Document.
- **Generic Drugs:** Comparable generic drugs may be substituted for brand-name drugs. For brand-name drugs that have FDA-approved equivalents, a prescription may be filled with a generic drug unless a brand-name drug is Medically Necessary and Preauthorized by PacifiCare, or is on PacifiCare's Selected Brands List. Preauthorization is necessary even if your Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. A copy of the Selected Brands List is available upon request from PacifiCare's Customer Service department and may be found on PacifiCare's Web site at [www.pacificare.com](http://www.pacificare.com). If you choose to use a medication not included on the Formulary and not Preauthorized by PacifiCare, you will be responsible for the full retail price of the medication.
- **Immunosuppressants** to prevent organ rejections.
- **Miscellaneous Prescription Drug Coverage:** For the purposes of determining coverage, the following items are considered prescription drug benefits: glucagon insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices and anaphylaxis prevention kits (including, but not limited to, EpiPen<sup>®</sup>, Ana-Kits<sup>®</sup>, and Ana-Guard<sup>®</sup>). See the medical benefit portion of the Combined Evidence of Coverage and Disclosure Document for coverage of other injectable medications.
- **Oral medications** (clomiphene citrate only) used for Infertility.
- **Special dietary formulas** for Members with phenylketonuria (or other heritable diseases).
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only according to state law.
- **Allergy serum** is not covered. Allergy serum may be available under your medical benefits. Refer to your medical Combined Evidence of Coverage and Disclosure Document.
- **Administered drugs:** Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during the course of a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Please refer to Section Five of your Combined Evidence of Coverage and Disclosure Document.
- **Cerezyme for Gauchers Disease** is limited to no greater than 30 units per kilogram (u/kg), per month, given divided doses.
- **Cosmetic drugs:** Drugs, medicines or cosmetic aids prescribed to primarily improve or otherwise modify your external appearance are not covered.
- **Compounded medication:** Any Medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount (compounded medications), unless prior authorized by PacifiCare.
- **Diagnostic drugs:** Drugs used for diagnostic purposes are not covered.
- **Dietary or nutritional** products and food supplements, whether prescription or nonprescription, including vitamins (except prenatal), minerals, health or beauty aids, herbal supplements and/or alternative medicine, are not covered.
- **Drug therapeutic class:** If an over-the-counter (OTC) drug is available in a prescription drug strength, all drugs in the drug therapeutic class are not covered.
- **Drugs prescribed by a dentist** or drugs used for dental treatment.
- **Elective or voluntary enhancement procedures**, services, supplies and medications, including, but not limited to, weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, discolored nails and mental performance. Examples of these drugs include, but are not limited to, Penlac<sup>®</sup>, Retin-A<sup>®</sup>, Renova<sup>®</sup>, Vaniqa<sup>®</sup>, Propecia<sup>®</sup>, Lustra<sup>®</sup>, Xenical<sup>®</sup>, or Meridia<sup>®</sup>. This provision does not exclude Medically Necessary medications directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.
- **Infertility:** All forms of prescription medication for the treatment of Infertility are not covered. If your employer has purchased coverage for Infertility treatment, prescription medications for the treatment of Infertility may be covered under that benefit.

## Exclusions and Limitations

While the Prescription Drug Benefit covers most medications, there are some that are not covered or are limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Five of your Combined Evidence of Coverage and Disclosure Document.

- **Injectable medications** are not covered, except as listed in the Pharmacy Schedule of Benefits in the section entitled, "Medications Covered by Your Benefit." Injectable medications, including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products, may be covered under your medical benefit. Injectable medications may be subject to PacifiCare's Preauthorization requirements. Refer to your medical Combined Evidence of Coverage and Disclosure Document.
- **Inpatient medications:** Medications administered to a Member while an Inpatient receiving skilled care in a medical Facility, Hospital, rest home, nursing home, sanitarium, Skilled Nursing Facility, or extended care Facility are not covered. Inpatient pharmacy benefits are covered as a basic medical benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Document for additional information.
- **Investigational or Experimental drugs:** Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel. For non-Food-and-Drug-Administration-approved indications, see Off-Label Drug exclusion. Further information about Investigation and Experimental therapies can be found in the medical Combined Evidence of Coverage and Disclosure Document.
- **Medications dispensed by a Non-Participating Pharmacy** are not covered (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
- **Medications prescribed by Non-Participating Physicians** are not covered (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
- **Methadone:** Methadone for the treatment of narcotic addiction or detoxification is not covered under the pharmacy benefit. See medical Combined Evidence of Coverage and Disclosure Document.
- **New procedures, services, supplies and medications** until they are reviewed for safety, efficacy and cost-effectiveness and approved by PacifiCare are not covered.
- **Non-approved drugs:** Drugs determined by PacifiCare's Pharmacy and Therapeutics Committee to be ineffective, duplicative or to have preferred therapeutic alternatives available are not covered.
- **Non-covered medical condition:** Prescription medication for the treatment of a non-covered medical condition.
- **Non-covered services:** Any prescription drug prescribed in connection with a service excluded under your health plan is not covered.
- **Off-label drug use:** Off-label drug use means that the Provider has prescribed a drug approved by the U.S. Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. PacifiCare excludes coverage for off-label drug use, including off-label self-injectable drugs, except as described in the Combined Evidence of Coverage and Disclosure Document and any applicable Attachments. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition. (3) The drug is Medically Necessary to treat the condition. (4) The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: *The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Dispensing Information* or in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective. (5) The drug is administered as part of a core medical benefit as determined by PacifiCare (see Section Five of your Combined Evidence of Coverage and Disclosure Document.) Nothing in this section shall prohibit PacifiCare from use of a Formulary, Copayment, Preauthorization process, technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Investigational or Experimental will allow the Member to use the Independent Medical Review System as defined in the medical Combined Evidence of Coverage and Disclosure Document.
- **Over-the-counter drugs:** Medications (except insulin) available without a prescription (over-the-counter) or for which there is a nonprescription equivalent available, even if ordered by a Physician are not covered. All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices are not covered.
- **Progesterone and estrogen products:** Specially compounded progesterone and estrogen products including progesterone suppositories are not covered.
- **Prior to Effective Date:** Drugs or medicines purchased and received prior to the Member's

effective date or subsequent to the Member's termination are not covered.

- **Replacement** of lost, stolen or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered.
- **Sexual dysfunction medication:** All forms of medications prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence and anorgasmia or hyporgasmia, are not covered. An example of such medications would include Viagra®.
- **Smoking cessation products**, including, but not limited to, nicotine gum, nicotine patches, and nicotine nasal spray, are not covered.
- **Therapeutic devices or appliances**, including, but not limited to, support garments and other nonmedical substances, insulin pumps and related supplies (these services are provided as durable medical equipment), hypodermic needles and syringes not related to diabetic needs or cartridges. Birth control devices, supplies or preparations that do not require a Contracting Physician's prescription by law are also not

covered, even if prescribed by a Contracting Physician.

- **Unit/convenience dosage forms:** Unit dose, prepackaged medications, individual packets, etc are not covered.
- **Weight loss medication:** Services to treat obesity (excessive weight), including, but not limited to, prescription or nonprescription weight loss medications, weight control programs, supplies or supplements are not covered.
- **Workers' compensation:** Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient are not covered.

### Additional Questions

PacifiCare reserves the right to expand the prior authorization requirement for any drug product.

Questions? Call the HMO/POS Customer Service department at 1-800-347-8600, TDHI 1-800-360-1797.