



**City of Plano  
Employee Benefit Design Summary**

**PHARMACY BENEFIT**

**CAREMARK**

**TOLLFREE: 800-552-8159**

**ID CARD & NETWORK PHARMACIES:**

Identification Card must be shown to a participating network pharmacy at the time you obtain your prescription drug product. If you do not show your ID card to the pharmacy, you will be required to pay for the prescription drug product at full cost; there is no coverage for out of network pharmacy claims. Prescription benefits apply only to those who are covered under the medical plan.

**DIRECT MEMBER REIMBURSEMENT FOR MANUAL/PAPER CLAIM SUBMISSION:**

Members may submit pharmacy claims for manual reimbursement for the contracted discount less copayment for up to 90 days from service date. Please note that you may pay more with paper claim submission; the amount reimbursed will be based on the contracted discount, less required co-payments or deductibles that may apply. The member will be responsible for the copay/deductible plus the difference in cost between the billed & contracted amounts.

**SUPPLY & QUANTITY LIMITATIONS:**

As written by the prescribing physician, up to a consecutive 30-day supply of a prescription drug product is allowed at retail. Also, as written by the prescribing physician, up to a consecutive 90-day supply of a prescription drug product is allowed at retail (for the payment of up to three retail copayments).

As written by the prescribing physician, up to a consecutive 90-day supply of a prescription drug product is allowed at mail.

***In addition, the following medications have Standard Quantity Limitations:***

**THERAPEUTIC CLASS**

**Retail Quantity Limits**

**Mail Order Quantity Limits**

**Analgesics:**

Stadol Nasal Spray	3ml/30 days	available only at retail
Toradol	20 / 5 days	available only at retail
fentanyl patches	10 patches / 30 days	available only at retail

**Anti-Emetics:**

Aloxi 0.25mg/5ml	5ml/30 days	available only at retail
Anzemet 50mg & 100mg Tab	3/30 days	available only at retail
Anzemet 100mg/5ml & 12.5mg/.625ml Inj	5ml/30 days	available only at retail
Cesamet 1mg	20/30 days	available only at retail
Kytril 1mg Tab	6/30 days	available only at retail
Kytril 1mg/ml Inj	1 ml/30 days	available only at retail
Kytril 2mg/10ml Oral Sol	30ml/30 days	available only at retail
Zofran 24mg Tabs	1/30 days	available only at retail
Zofran 4mg & 8mg Tabs/ODT	9/ 30 day	available only at retail
Zofran Oral Sol	100/ 30 day	available only at retail
Zofran 2mg/ml Inj	10ml/ 30 day	available only at retail
Marinol 2.5mg, 5mg, & 10mg	60/30 days	available only at retail

**Erectile Dysfunction:**

Caverject	6 / 30 days	18 / 90 days
Edex	6 / 30 days	18 / 90 days
Muse	6 / 30 days	18 / 90 days
Viagra	6 / 30 days	18 / 90 days
Cialis	6 / 30 days	18 / 90 days
Levitra	6 / 30 days	18 / 90 days

**Migraine Agents:****Retail Quantity Limits****Mail Order Quantity Limits**

Amerge	9 / 30 days	27 / 90 days
Axert	6/ 30 days	18 / 90 days
Frova	9/ 30 days	27 / 90 days
Imitrex tabs	9 / 30 days	27 / 90 days
	2 pkg - 12 nasal	
Imitrex Nasal Spray 5 mg	units/30 days	6 pkg - 36 nasal units/90 days
	1 pkg- 6 nasal units/30	
	days	
Imitrex Nasal Spray 20 mg		3 pkg - 18 nasal units/90 days
Imitrex Injectable Vial	4 vials/30 days	15 vials/90 days
Imitrex Injectable Kits	2 kits - 4 inj/30 days	6 kits - 12 inj/90 days
Maxalt	9 / 30 days	27 / 90 days
Zomig tabs/Zomig ZMT 2.5 mg	6 / 30 days	18 / 90 days
Zomig tabs/Zomig ZMT 5 mg	3 / days	9 / 90 days
	1 pkg - 6 nasal units/30	
	days	
Zomig Nasal Spray		2 pkg - 12 nasal units/90 days
Relpax	6 / 30 days	18 / 90 days
	1 kit - 8 nasal units/30	
	days	
Migranal		3 kits - 24 nasal units/90 days

**Sedatives/Hypnotics:**

Ambien	14 / 30 days	available only at retail
Ambien CR	14 / 30 days	available only at retail
Lunesta	14 / 30 days	available only at retail
Rozerem	14 / 30 days	available only at retail
Sonata	14 / 30 days	available only at retail
Dalmane	14 / 30 days	available only at retail
Doral	14 / 30 days	available only at retail
Halcion	10 / days	available only at retail
Prosom	14 / 30 days	available only at retail
Restoril	14 / 30 days	available only at retail

**PRIOR AUTHORIZATION REQUIRED LIMITATIONS:**

The following medications require Prior Authorization:

Actiq (PA at retail, available only at retail)

Xolair

Forteo

Lotronex/Zelnorm/Amitiza

Wellbutrin SR/XL

Fuzeon Kit

Topical Acne - PA for participants age 26 and up - tretinoin such as Retin-A, Retin-A Micro, Tretin-X, tretinoin plus Differin

Tazorac - PA all ages

Psoriasis Agents - Amevive, Raptiva, Soriatane

Lupron Products

Provigil

**COPAY & DEDUCTIBLE INFORMATION:**

Members enrolled in Option 1 must first satisfy the \$100 drug deductible per Covered Family per calendar year;

there is no deductible for members enrolled in Option 2.

**Retail Copays (per 30-day supply):** \$8 per prescription order or refill for a Generic prescription product, \$35 per prescription order or refill for a Brand prescription product on the Preferred Drug List, and \$50 per prescription order or refill for a Brand prescription product which is not on the Preferred Drug List.

**Mail Order Copays:** \$16 per Prescription Order or Refill for a Generic prescription product, \$70 per prescription order or refill for a Brand prescription product on the Preferred Drug List, and \$100 per prescription order or refill for a Brand prescription product which is not on the Preferred Drug List.

**OVER-THE-COUNTER MEDICATION COVERAGE:**

Over-the-counter medications are not covered, with the exception of Claritin-OTC and Prilosec-OTC (both covered at Tier-1/Generic copayment). These medications are only covered when purchased at a network pharmacy with a valid written prescription.

**MANDATORY GENERICS**

Generic medications are mandatory and will be provided when available. Members and/or physicians can choose brand-name medications instead and pay the appropriate copayment (Tier 2 or 3) plus the difference between the brand and generic alternative.

**COVERED PRESCRIPTION DRUG ITEMS:**

Some of the general categories of covered prescription drugs are listed below:

Legend Drugs (drugs that require a prescription)

Compound prescriptions

Diabetic supplies

Insulin & Insulin Syringes

Oral Contraceptives, Depo-Provera, Nuvaring, patches

Erectile Dysfunction/organic impotence drugs (subject to Quantity Limitations)

Prenatal Vitamins

Anaphylaxis Kit e.g. Epi-pen

Hemophilic factors

Topical Dental Flouride (up to age 19)

Injectibles e.g. multiple sclerosis, hepatitis

**PRESCRIPTION DRUG ITEMS NOT COVERED:**

Over-the-counter medications, except for Claritin-OTC and Prilosec-OTC (covered at tier-1 copay)

Non-insulin syringes

Insulin related devices such as blood glucose monitors, insulin pump

Biological serums and proteins

Diet control drugs (anorexiant)

Medical devices/supplies even if a prescription is required e.g. stockings, blood glucose monitor, respiratory machine

Fertility Drugs

Diagnostic agents (test kits)

Contraceptive devices e.g. diaphragm, IUD

Smoking Cessation drugs

Hair growth stimulants

Growth hormones

Vitamins and cosmetic alteration drugs other than those listed as covered

Emergency contraceptives e.g. RU486(Mifepristone), Preven

Experimental drugs or drugs required to be labeled "Caution -- Limited by federal law to investigation use"

**SPECIALTY PHARMACY**

**Specialty pharmacy items must be obtained through Caremark Specialty Pharmacy.**