

# **Mercy MedicareADVANTAGE (HMO/PPO)**

## **2010 Formulary (List of Covered Drugs)**

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN**

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Mercy MedicareADVANTAGE (HMO/PPO)  
hereinafter known as the “Plan”

This booklet provides a list of the Plan’s formulary. Medications may have been added or removed from the list after this was printed. To get current information about the Plan formulary in your area, please contact us at:

St. Louis HMO	314-214-8040 or 1-800-280-1602
St. Louis & Arkansas PPO	314-810-8300 or 1-800-919-6459
TTY/TDD	314-214-8094 or 1-800-468-4418
Southwest Missouri PPO	417-836-0429 or 1-866-875-0189
TTY/TDD	417-837-0249 or 1-800-446-1468

Representatives are available:

November 15 - March 2: 7 days a week, 8:00 a.m. - 8:00 p.m. (Central Time)

March 3 - November 14: Monday - Friday 8:00 a.m. - 5:00 p.m. (Central Time). Part D prescription drug calls are accepted until 8:00 p.m.

After hours, you will reach our voice mail system. Please leave a message so that we may return your call the next business day. You may also view the formulary on our website at: [www.mercyhealthplans.com](http://www.mercyhealthplans.com)

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Last Updated 10/20/2009

## **What is the Plan Formulary?**

A formulary is a list of covered drugs selected by the Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage (EOC).

## **Can the Formulary change?**

Generally, if you are taking a drug on our 2010 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2010 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of 10/20/2009. To get updated information about the drugs covered by the Plan, please visit our Web site at [www.mercyhealthplans.com](http://www.mercyhealthplans.com) or call our Customer Contact Center at the number listed in the front of this booklet.

## **How do I use the Formulary?**

There are two ways to find your drug within the formulary:

### **Medical Condition**

The formulary begins on page [7]. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category,

“Cardiovascular”. If you know what your drug is used for, look for the category name in the list that begins on page [7]. Then look under the category name for your drug.

### **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page [xx]. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

### **What are generic drugs?**

The Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active-ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

### **Are there any restrictions on my coverage?**

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from the Plan before you fill your prescriptions. If you don't get approval, the Plan may not cover the drug.
- **Quantity Limits:** For certain drugs, the Plan limits the amount of the drug that the Plan will cover. For example, the Plan provides 14 capsules per 25 days per prescription for Lunesta. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover drug B unless you try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page [7]. You can also get more information about the restrictions applied to specific covered drugs by visiting our Website at [www.mercyhealthplans.com](http://www.mercyhealthplans.com).

You can ask the Plan to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Plan’s formulary?” on page [3] for information about how to request an exception.

### **What if my drug is not on the Formulary?**

If your drug is not included in this formulary, you should first contact our Customer Contact Center and ask if your drug is covered. If you learn that the Plan does not cover your drug, you have two options:

- You can ask our Customer Contact Center for a list of similar drugs that are covered by the Plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by the Plan.
- You can ask the Plan to make an exception and cover your drug. See below for information about how to request an exception.

### **How do I request an exception to the Plan’s Formulary?**

You can ask the Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, the Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in tier 4.

Generally, the Plan will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician**

**supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

## **What do I do before I can talk to my doctor about changing my drugs or requesting an exception?**

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

If you are a current member of the Plan in 2009 and there are changes to your 2010 formulary, these changes will be communicated to you in the Annual Notice of Change letter mailed to you in October, 2009. You may also contact our Customer Contact Center or [www.mercyhealthplans.com](http://www.mercyhealthplans.com). Please see the section titled, "What if my drug is not on the Formulary?"

## **For more information**

For more detailed information about your Plan prescription drug coverage, please review your EOC and other plan materials.

If you have questions about the Plan, please call our Customer Contact Center at the number listed in the front of this booklet. Or visit [www.mercyhealthplans.com](http://www.mercyhealthplans.com).

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit [www.medicare.gov](http://www.medicare.gov).

### **Formulary Key**

- The information in the Requirements/Limits column tells you if the Plan has any special requirements for coverage of your drug.
- Therapeutic Categories are listed in bold.
- Therapeutic Classes are listed in bold italics below each therapeutic category.
- Brand name drugs are capitalized.
- Generic drugs are in lower case.
- PA indicates that Prior Authorization is required for this drug.
- QL indicates that the drug has Quantity Limits.
- ST indicates that the drug is part of a Step Therapy program.
- B/D indicates that the drug may be billed as a Medicare Part B or a Medicare Part D benefit, depending on the circumstances.
- INJ indicates that the drug is an injection
- LA indicates that the drug has limited availability. This medication may be available only at certain pharmacies
- OINT indicates that the drug is an ointment
- SOLN indicates that the drug is an oral solution
- SUSP indicates that the drug is an oral suspension
- SYR indicates that the drug is an oral syrup

### **Tier Key for Employer Groups**

If you are part of an employer group and your employer group chose a 3-Tier pharmacy benefit, you will pay your Generic copay for drugs that are listed in the formulary as Tier 1. You will pay your Preferred Brand copay for drugs that are listed in the formulary as Tier 2. You will pay your Non-Preferred Brand copay for drugs that are listed in the formulary as Tier 3 and Tier 4.

## **Mercy MedicareADVANTAGE HMO/PPO Formulary**

The formulary that begins on the next page provides coverage information about some of the drugs covered by the Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page [xx].

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., CELEBREX) and generic drugs are listed in lower-case italics (e.g., *ibuprofen*).

The information in the Notes column tells you if the Plan has any special requirements for coverage of your drug.

If you chose a plan that covers “Generic drugs through the Coverage Gap”, those drugs are designated as Tier 1. Please refer to our Evidence of Coverage for more information about this coverage.”

