

## washington – large + small group **prescription drug rx \$10 / 50% / \$1,000**

### benefits

- Generic drugs: \$10 copayment for up to a 30-day supply purchased at a participating retail pharmacy  
**Toprol XL will be covered with a \$10 copayment until a generic equivalent becomes available**
- Brand name drugs: 50% coinsurance for up to a 30-day supply purchased at a participating retail pharmacy
- Compounded prescription drugs: 50% coinsurance for up to a 30-day supply purchased at a participating retail pharmacy

The prescription drug annual out-of-pocket maximum is \$1,000 per person/\$3,000 per family, per calendar year. Copayments or coinsurance for covered prescription drugs do not apply to your annual medical out-of-pocket maximums and any applicable medical deductibles.

### using your prescription drug benefit

- Your prescription drug benefit requires you to have your prescriptions filled at pharmacies that participate with Providence Health Plan. We have approximately 20,000 participating pharmacies available for your use nationwide. A list of our participating pharmacies, including preferred retail pharmacies, is available on our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans). You also may contact your Customer Service team if you need help locating a participating pharmacy near you or when you are away from your home.
- Prescriptions must be written by a participating physician or provider, except when provided for urgent/immediate care or emergency services. **(Applies to Personal Option Plan members only.)**
- You must present your current Providence Health Plan member identification card and pay your copayment or coinsurance at the time of purchase. Participating pharmacies may not charge you more than your copayment or coinsurance for covered prescriptions. Please contact your Customer Service team if you or your pharmacy have questions or need assistance with the processing of your prescription.
- You may purchase up to a 90-day supply (three copayments or one coinsurance will apply) of each maintenance drug at one time using a participating mail service pharmacy, as described under “ordering prescriptions by mail,” or at a participating retail pharmacy. Maintenance drugs are those that you have been on for at least 30 days and that you anticipate continuing on in the future. (Some quantity limitations and copayments for unit of use packaging may apply. Not all prescription drugs are available as a 90-day supply.)
- Insulin is covered by Providence Health Plan. Once you’ve received insulin for the first time with a prescription, you will not need another prescription to obtain insulin thereafter.
- Diabetes supplies and inhalation extender devices may be obtained at your participating pharmacy. However, these are considered medical supplies and devices and are subject to your group’s medical supplies and devices benefits, limitations and coinsurance.

### ordering prescriptions by mail

To purchase prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan member identification number to one of our participating mail order pharmacies. Participating mail order pharmacy information is available on our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans). (Not all prescription drugs are available by mail order.)

### use of non-participating pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use a nonparticipating pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase. You may be reimbursed by us upon submission of a Prescription Drug Reimbursement form, which can be obtained from our Web site or by contacting your Customer Service team and requesting one be sent to you. You must include any itemized pharmacy receipts along with this form. You will also need to provide explanation as to why you used a non-participating pharmacy. Once received, your claim will be reviewed (submission of a claim does not guarantee payment). If your claim is approved, we will reimburse you the cost of your prescription up to our participating pharmacy contracted rates, subject to Providence Health Plan benefits and limitations, less your applicable copayment or coinsurance. You are responsible for any amounts above our contracted rates.

## limitations

- All drugs must be Food and Drug Administration (FDA) approved, medically necessary, and require, by law, a prescription to dispense the medication. Newly approved FDA drugs will be reviewed by Providence Health Plan for safety and medical necessity and may be excluded from our formulary for up to 12 months after approval by the FDA pending review by our Pharmacy & Therapeutics Committee. Not all FDA-approved drugs are covered by us. In the case of an urgent situation, we will authorize the use of a drug during our review period so a member does not go without medically necessary treatment.
- Providence Health Plan uses a prescription drug formulary for therapeutic drugs. Some drugs may require prior authorization by us. If you need more detailed information about our drug formulary or drug coverage, including information on drugs requiring prior authorization, please visit our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans), or call your Customer Service team.
- Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Please have your provider contact us for prior authorization.
- Prescription dispensing limits: 1) topicals, up to 60 grams; 2) liquids, up to eight ounces; 3) tablets or capsules, up to 100 dosage units; and 4) multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30 consecutive day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior authorization is required for amounts exceeding any applicable medication dispensing limits.
- DDAVP is limited to a two-month supply per lifetime for the treatment of enuresis.
- Drugs or hormones to stimulate growth are covered only if there is a laboratory-confirmed diagnosis of growth hormone deficiency. These drugs are covered only for children under age 18, and for adults only if there is documented pituitary destruction and the drug use meets our medical policy criteria.
- Most injectable medications must be purchased through Providence Home Infusion and are only covered when they are: intended for self-administration; labeled by the FDA for self administration; and on our list of "Self Administered Injectable Drugs." For a copy of this list, visit our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans), or contact your Customer Service team.
- Imitrex injections (for migraines) are limited to two boxes (four injections) per month. In addition, oral and nasal migraine medications are limited to two unit-of-use packages per month. Prior authorization is required for additional amounts.
- Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount and must meet our medical necessity criteria.
- Methadone for treatment of pain management is covered. Methadone for treatment of chemical dependency may be covered under your chemical dependency benefits.

## exclusions

- Drugs that are not provided in accordance with our formulary management program.
- Drugs used for weight loss or cosmetic purposes.
- Drugs or medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Drugs that do not have at least one FDA-approved medication in a therapeutic amount.
- Over-the-Counter (OTC) drugs, medications, or vitamins that may be purchased without a provider's written prescription and prescription drugs for which there are OTC therapeutic equivalents.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. Some of these items may be covered under your medical benefits.
- Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of the common cold.
- Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment.
- Intrauterine devices (IUDs), diaphragms and other implantable contraceptives. These items are covered under your medical benefits.
- Drugs or medications delivered, injected or administered to you by a physician or other provider.
- Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults.
- Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra or drugs required for, or as a result of, sexual transformation.
- Smoking cessation drug therapy, including nicotine replacement therapy. Approved smoking cessation programs, including drug therapy, may be available under your medical benefit.
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions.
- Drugs or prescribed medications that are not medically necessary or are not provided according to our medical policy.
- Drugs used for the treatment of fertility/infertility.
- Fluoride, for members over the age of 10 years old.
- Replacement of lost or stolen medication.
- Drugs to stimulate hair growth, including, but not limited to, Rogaine (i.e., topical minoxidil) or other similar drug preparations.
- Drugs used in the treatment of shift work sleep disorder, drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Drugs that are placed on prescription-only status by federal or state mandate outside of required FDA-status assignment.

### customer service:

• Portland Metro Area:  
503-574-7500

• All Other Areas:  
1-800-878-4445

• TTY (For the Hearing Impaired):  
503-574-8702 or 888-244-6642