

# Updates to your prescription benefits

## Clinical Programs

Effective January 1, 2016

The following clinical program updates will take place on January 1, 2016. This information will help you make informed decisions about your choice of prescription medications.

### SL Supply Limits

Supply Limits will be applied to new medications when other medications in their therapeutic class already have these clinical programs in place. Supply Limits establish the maximum quantity of a drug that is covered per copay or in a specified timeframe.

Therapeutic Use	Medication Name	New/Revised Supply Limit
<b>Acne</b>	adapalene 0.1% cream, gel (generic Differin)	45 g per copay
	tretinoin 0.05%, 0.025% cream (generic Retin-A)	20 g per copay
	tretinoin 0.01%, 0.025% gel (generic Retin-A)	15 g per copay
<b>Asthma</b>	QVAR 80 mcg	2 inhalers per month
<b>Cancer</b>	Targretin 1% Gel	120 g per copay
<b>Depression</b>	Pristiq 25 mg	30 tablets per month
<b>Growth Hormones</b>	Genotropin 12 mg Cartridge	8 cartridges per month
	Genotropin 5 mg Cartridge	18 cartridges per month
	Genotropin Miniquick 1.2 mg, 1.4 mg, 1.6 mg Cartridges	28 cartridges per month
	Humatrope 12 mg Cartridge	8 cartridges per month
	Humatrope 24 mg Cartridge	4 cartridges per month
	Humatrope 6 mg Cartridge	15 cartridges per month
	Humatrope 5 mg Vial	18 vials per month
	Norditropin FlexPro 10 mg/1.5 mL Pen	9 pens per month
	Norditropin FlexPro 15 mg/1.5 mL Pen	6 pens per month
	Norditropin FlexPro 5 mg/1.5 mL Pen	18 pens per month
	Norditropin FlexPro 30 mg/3 mL Pen	3 pens per month
	Norditropin NordiFlex 30 mg/3 mL	3 pens per month
Nutropin AQ 20 mg/2 mL Cartridge	5 cartridges per month	

	Nutropin AQ 10 mg/2 mL Cartridge	9 cartridges per month
	Nutropin AQ NuSpin 10 mg/2 mL Pen	9 pens per month
	Nutropin AQ NuSpin 20 mg/2 mL Pen	5 pens per month
	Nutropin AQ NuSpin 5 mg/2 mL Pen	18 pens per month
	Omnitrope 10 mg/1.5 mL Cartridge	9 cartridges per month
	Omnitrope 5 mg/1.5 mL Cartridge	18 cartridges per month
	Omnitrope 5.8 mg Vial	16 vials per month
	Saizen 5 mg Vial	18 vials per month
	Saizen 8.8 mg Vial	11 vials per month
	Saizen 8.8 mg Click Easy Cartridge	11 cartridges per month
<b>Opioid Dependence</b>	Suboxone 2/0.5 mg	30 sublingual films per month
	Suboxone 4/1 mg	30 sublingual films per month
	Zubsolv 8.6/2.1 mg	60 tablets per month
<b>Pain</b>	Dolophine 5 mg	360 tablets per month
	Dolophine 10 mg	180 tablets per month
	methadone 10 mg/5 mL solution	900 mL per month
	methadone 5 mg/5 mL solution	1,800 mL per month
	Methadose 40 mg Tablet	45 tablets per month
	methadone Intensol 10 mg/mL Concentrate	180 mL per month
	Oxycontin 80 mg	60 tablets per month
	Trelix 320.5/30/16 mg	40 capsules per copay
<b>Pulmonary Arterial Hypertension</b>	Orenitram 0.125 mg, 0.25 mg, 1 mg, 2.5 mg	180 tablets per month
<b>Skin Conditions</b>	Clobex 0.05% Lotion	59 mL per copay
	econazole nitrate 1% cream	15 g per copay
	Temovate 0.05% Cream, Gel, Ointment	15 g per copay
	Temovate 0.05% Scalp Solution	25 mL per copay
	Temovate-E 0.05% Emollient Cream	15 g per copay

The following medications are moving from quantity per duration (QD) to quantity per copay (QLL). For plans that have both types of limits there will be minimal member impact. If a plan takes only QLL, these will appear to be new supply limits.

Therapeutic Use	Medication Name
<b>Acne</b>	Atralin 0.05% Gel (45 g per copay)
	Avita 0.025% Cream, Gel (20 g per copay)
	Azalex 20% Cream (30 g per copay)
	Benzaclin 1%/5% Gel (50 g per copay)
	Clindagel 1% Gel (40 mL per copay)
	Differin 0.1% Cream, Gel - brand only (45 g per copay)
	Differin 0.1% Lotion (59 mL per copay)
	Differin 0.3% Gel (45 g per copay)
	Retin-A 0.05%, 0.025% Cream - brand only (20 g per copay)
	Retin-A 0.01%, 0.025% Gel - brand only (15 g per copay)
	Retin-A Micro 0.04%, 0.1% Gel (20 g per copay)
	Tazorac 0.05%, 0.1% Cream, Gel (30 g per copay)
	Tretin-X 0.025%, 0.05%, 0.1% Cream (1 kit per copay)
	Tretin-X 0.0375% Cream (35 g per copay)
	Veltin 1.2%/0.025% Gel (30 g per copay)
Ziana 1.2%/0.025% Gel (30 g per copay)	
<b>Asthma</b>	Proair HFA (1 inhaler per copay)
	Proventil HFA (1 inhaler per copay)
	Ventolin HFA (1 inhaler per copay)
	Xopenex HFA (1 inhaler per copay)
<b>Diabetes</b>	GlucaGen 1 mg/mL (1 vial/kit per copay)
	Glucagon 1 mg/mL (1 vial/kit per copay)

## **N** Notification

Prior Authorization requires physicians to provide additional clinical information to verify member benefit coverage.

Therapeutic Use	Medication Name
<b>Cancer</b>	Targretin
<b>Skin Conditions</b>	Solaraze

## MN Medical Necessity

Medical Necessity evaluates the clinical appropriateness of a medication in terms of condition being treated, type of medication, frequency of use, and duration of therapy. The following medications will require Medical Necessity for coverage.

Therapeutic Use	Medication Name
Seizures	Qudexy XR

## STEP Step Therapy<sup>+</sup>

For customers with Step Therapy, these medications will be added to the program. A Step 1 medication must be tried before benefit coverage is available.

Therapeutic Use	Medication Name	Step 1 Medication
Fungal Infections	Jublia	<b>Must try two:</b> itraconazole (generic Sporanox), oral terbinafine (generic Lamisil), ciclopirox (generic Penlac)
	Kerydin	<b>Must try two:</b> itraconazole (generic Sporanox), oral terbinafine (generic Lamisil), ciclopirox (generic Penlac)
Gout	Uloric	allopurinol (generic Zyloprim)
High Cholesterol	Lescol XL	<b>Must try three:</b> atorvastatin (generic Lipitor), fluvastatin (generic Lescol), lovastatin (generic Mevacor), pravastatin (generic Pravachol), or simvastatin (generic Zocor)
	Livalo	<b>Must try three:</b> atorvastatin (generic Lipitor), fluvastatin (generic Lescol), lovastatin (generic Mevacor), pravastatin (generic Pravachol), or simvastatin (generic Zocor)
Skin Conditions	fluticasone propionate 0.05% gel, lotion	<b>Must try one:</b> hydrocortisone butyrate 0.1% ointment (generic Locoid), hydrocortisone valerate 0.2% cream (generic Westcort), prednicarbate 0.1% cream or ointment (generic Dermatop), triamcinolone acetonide 0.1% lotion or ointment (generic Kenalog)
	Soolantra	<b>Must try both:</b> an oral antibiotic (i.e., doxycycline, minocycline, tetracycline) and metronidazole 0.75% gel (generic Metrogel)

<sup>+</sup> For New Jersey fully-insured members this program is referred to as First Start.

## Need more information?



Contact your UnitedHealthcare representative with any questions about the January 1, 2016 pharmacy benefit updates.