BluegrassFamily Health

COMMONWEALTH OF KENTUCKY
2004 FORMULARY

GENERAL DEFINITION OF TERMS

1st Tier Medications – Typically generic medications. A generic medication is called by its chemical name, a manufacturer assigns a brand name. Also, the price of the generic medication is usually lower than that of a brand name medication. Both generic and brand name products have the same *active* ingredients. Overall, the generic medication is just as safe and effective as the brand name medication.

2nd Tier Medications – Typically preferred brand medications. Preferred brand medications may have generic equivalents. Once a branded medication is available as a generic product, the branded medication will move to non-preferred status and the generic medication will become the preferred medication.

3rd Tier Medications– Typically branded medications, not listed on 1st or 2nd Tier. Non-preferred medications are usually available at the highest copay tier for members with tiered pharmacy benefits. For members with a closed formulary benefit, prior plan approval is required for all non-preferred medications.

Prior Plan Approval *(PPA)* or Prior Authorization (PA) – Due to the nature of some medications, prior plan approval may be required for the medication to be covered at any copay tier. Medications that require PPA do so because of their potential for misuse and/or abuse and will require that plan criteria be met. If a medication requires PPA, the ordering physician should contact the plan's pharmacy benefit administrator. Prescriptions exceeding plan limitations ***(QL)*** and ***(SE)*** will also require PPA. See Restricted Medication List – Medications Requiring Prior Plan Approval ***(PPA)***.

Specialty Edit *(SE)* – In order to be considered for coverage, Bluegrass Family Health (BFH) may require that some medications be written by a specialty physician. Medications not meeting specialty edit will require ***(PPA)***. See Restricted Medication List – Medications Requiring Specialty Edit ***(SE)***.

Quantity Limits (QL) – Quantity limits have been placed on medications to be consistent with the maximum dosages that the Food and Medication Administration (FDA) has approved to be both safe and effective. Medications where the quantity exceeds the FDA's maximum daily dose will require PPA. Prescriptions exceeding plan limitations will require PPA. See Restricted Medication List – Medications with Quantity Limits ***(QL)***.

1ST AND 2ND TIER MEDICATIONS – (Preferred Drug List)

Accu-Chek Active Glucometer
Accu-Chek Advantage Glucometer
Accu-Chek Compact Glucometer
Acebutolol
Acetamin/Codeine *(QL)*
Acetamin/Butalbital *(QL)*
Acetamin/Hydrocodone *(QL)*
Acetazolamide
Acetic Acid/ Hydrocort
ACLOVATE
Acyclovir – Oral
ADVAIR
AEROBID
AEROBID M
AEROCHAMBER
Albuterol
ALDARA
Allopurinol
Alora
ALPHAGAN
Alprazolam
ALTACE
ALUPENT 650mcg
Amantadine
AMARYL
Amidrine
Amiloride/HCTZ
Amiodarone
Amitriptyline
Amnesteem *(QL)*
Amoxicillin
Amoxicillin, clavulanate potassium 200, 400, 500, 875 only
Amphetamine Salt Combo 5, 10, 20, 30mg *(PPA over age 18)*
Ampicillin
Amylase/Lipase/Protease
Amylase/Lipase/Protease /Pancreatin
APAP/Dichlor/Isometh
Apri
ASACOL
Ascensia DEX2 Glucometer
Ascensia Elite Glucometer
ASTELIN
Atenolol
Atenolol/Chlorthalidone
Atropine
Atropine Sulfate
ATROVENT INHALER
AUGMENTIN 125, 250 only
AUGMENTIN ES/XR
Auroto
AVALIDE ***(PPA)***
AVANDAMET
AVANDIA
AVAPRO ***(PPA)***
Aviane
Azathioprine
Aviane
AZOPT
Bacitracin
Baclofen
BACTROBAN
BECONASE AQ
Belladonna/Phenobarb
BENZAMYCIN
Benzocaine/Antipyrine Otic
Benzonatate
Benztropine Mesylate
Betamethasone Dipropionate
Betamethasone Valerate
Betaxolol
Bethanechol
BETOPTIC S
Bisoprolol
Bisoprolol/HCTZ
Bromocriptine
Bumetanide
Bupropion
Buspirone HCL
Butalbital/APAP/Caffeine
Butalbital/Aspirin/Caff - Tabs Only
Butoconazole
Butorphanol Tartrate *(PPA)*, *(QL)*
CAFERGOT
Camila
CANASA
Captopril
Captopril/HCTZ
CARAC
Carbachol
Carbamazepine
Carbidopa/Levodopa
Carisoprodol
Cefaclor
Cefadroxil
Cefuroxime
CEFZIL
CELEXA
Cephalexin
Cephradine
Chloral Hydrate
Chlordiazepoxide
Chloroquine Phosphate
Chlorpromazine
Chlorpropamide
Chlorthalidone
Cholestyramine
Choline Mag. Trisal
Cimetidine
Clemastine
CLEOCIN VAGINAL CREAM
CLEOCIN T LOTION
Clindamycin
Clindamycin Solution
Clobetasol
Clofibrate
Clonazepam
Clonidine
Clorazepate
Codeine/Aspirin *(QL)*
Codeine/CPM/ PSE *(QL)*
Colchicine
COLESTID
COLOCORT
COREG
CORTEF 5, 10mg - NOT 20
CORTISPORIN OPHTH.
CORZIDE
Cromolyn Ophthalmic Solution
Cryselle
CUPRIMINE
CUTIVATE
CYCLESSA
Cyclobenzaprine
CYCLOGYL 0.5%
Cyclopentolate
Cyclophosphamide
Cyproheptadine
Cyclosporin
Cycrin
CYTOMEL
Danazol
DANTRIUM
DAPSONE
DECLOMYCIN
Deltasone
DEPAKOTE
DEPAKOTE SPRINKLES
Desipramine
Desmopressin Nasal Spray
Dexamethasone
Dexamethasone/Neomyc
Dexameth/Poly/Neomycin
Dexchlorpheniramine
Dextroamphetamine *(PPA over age 18)*
Diabetic Lancets - All
DIABETIC TEST STRIPS – ALL
DIATX
Diazepam
DIBENZYLINE
Diclofenac Sodium
Dicloxacillin
Dicyclomine

BOLD TYPEFACE indicates product is available at the 1st tier copayment .
CAPS indicates product is available at the 2nd tier copayment.

THE BLUEGRASS FAMILY HEALTH PREFERRED DRUG LIST HAS BEEN COMPILED TO RESPOND TO THE CONSTANTLY CHANGING NATURE OF MEDICATION THERAPY. THE LIST IS DYNAMIC AND IT IS SUBJECT TO CHANGE. YOU WILL BE NOTIFIED AT LEAST 30 DAYS IN ADVANCE OF ALL CHANGES. EVERY EFFORT HAS BEEN MADE TO INSURE THE ACCURACY OF THIS DOCUMENT. WE APOLOGIZE FOR ANY INCONVENIENCE ERRORS MAY CAUSE.

DIFLUCAN ***(150mg QL)***
Diflunisal
Digoxin
Diltiazem
Diltiazem SA Caps
Diltiazem SR
DIOVAN ***(PPA)***
DIOVAN HCT ***(PPA)***
Diphenoxylate/Atropine
Dipivefrin
DIPROLENE GEL, LOTION
DIPROLENE AF
Dipyridamole
Disopyramide
Disopyramide CR
Doxazosin Mesylate
Doxepin
Doxycycline - Tabs, Caps Only
EFFEXOR
EFUDEX
ELIDEL ***(PPA over age 16)***
ELMIRON
ELOCON
Enalapril
Epinephrine
Enpresse
EPIPEN
EPIPEN JR
Ergotamine Tartrate
Ergotamine/Caff/Bella/ Pb
Erlotamine/Caffeine
Errin
Erythromycin
ESCLIM
Esterified Estrogens
ESTRADERM
Estradiol
Estradiol Patches
ESTRATEST and HS
Estropipate
ESTROSTEP
Ethosuximide
Etodolac
EURAX LOTION
EZ-SPACER
Famotidine
Fenoprofen
FINACEA
FLONASE
Florinef Acetate
FLOVENT
Fludrocortisone Acetate
Flunisolide
Fluocinolone
Fluocinolone Acetonide
Fluocinonide
Fluoride/Polyvit; /FE
Fluoride/Vit A, D, C; /FE
Fluorometholone
FLUOROPLEX
Fluoxetine HCL
Fluphenazine
Flurazepam
Flurbiprofen Sodium
FML FORTE
Folic Acid
FORADIL
FLONASE
Furosemide
Gemfibrozil
Gentamicin
Gentamicin Sulfate
Glipizide
GLUCAGON EMERGENCY KIT
Glyburide
GOLYTELY
GRIFULVIN V
GRISACTIN
Griseofulvin Ultramicrosize
Guaifenesin
Guaifenesin/Codeine
Guaifenesin/Codeine/PSE
Guaifenesin/PSE
Guanabenz
Guenfacine
Haloperidol
Homatropine
HUMULIN
HUMALOG
Hydralazine
Hydrochlorothiazide (HCTZ)
Hydrocod/Acet *(QL)*
Hydrocod/Homatropine *(QL)*
Hydrocortisone
Hydrocortisone Rectal
Hydrocortisone/Pramox
Hydromorphone
Hydroxychloroquine
Hydroxyurea
Hydroxyzine
Hyoscyamine Sulfate
Ibuprofen
Imipramine
IMITREX-all forms
Indapamide
INDERAL LA
INDERIDE LA
Indomethacin
Indomethacin SR
INSULINS-ALL
INTAL INHALER
Isoniazid
Isosorbide Dinitrate
Isosorbide Mononitrate
Kariva
Ketoconazole
Ketoprofen
Ketorolac Tromethamine
KLARON
Labetalol
Lactulose
Lessina
Leucovorin
LEVATOL
Levlen
LEVLITE
Levobunolol
Levora
Levothyroxine
Levoxyl
LEXAPRO
Lidocaine Viscous
Lindane
Lisinopril
Lisinopril-HCTZ
Lithium Carbonate - All Forms
LIVOSTIN
LOESTRIN (not FE)
LOPRESSOR HCT
Lorazepam
LOTRISONE LOTION
Lovastatin
Low-Ogestrel
Loxapine
MACROBID
Maprotiline
MARINOL
MAXAIR
Mebendazole
Meclizine HCL
Meclofenamate
Medrol
Medroxyprogesterone
Megestrol
MENEST
Meperidine
Mephobarbital
MESTINON
Metaproterenol Oral
Metformin
Methadone *(QL)*
Methadose *(QL)*
Methazolamide
Methimazole
Methocarbamol
Methotrexate
Methyldopa
Methylphenidate *(PPA over age 18)*
Methylprednisolone
Methyltestosterone
Metoclopramide
Metoprolol Tartrate
METROCREAM
METROGEL
Metronidazole
Microgestin FE
Minocycline - Susp. Not Covered at Generic Tier
Minoxidil
MINTEZOL
Mirtazapine
Moexipril
Morphine *(PPA) (QL)*
MYCELEX TROCHE
Nabumetone
Nadolol
Naphazoline
Naproxen
Naproxen Sodium
NARDIL
NASACORT AQ
Necon
Nelova
Neomycin Sulfate
Neomycin/Gram/Polymyx
Neomycin/Polymyxin/HC
NIASPAN
Nicardipine
Nifedipine
Nifedipine SR
Nitrofurantoin
Nitrofurantoin
Macrocrystals
Nitroglycerin Ointment
Nitroglycerin Patches
Nitroglycerin Sublingual
Nora-Be
NOR QD
Nortrel 7/7/7
Nortriptyline
NOVOLIN
NOVOLOG
NULYTELY
NUVARING
Nystatin - Oral Powder Not Covered
OCUFLOX
Ogestrel
OPTIHALER
Oramorph SR *(PPA) (QL)*
Orphenadrine Citrate
Orphenadrine/ASA/Caff
ORTHO EVRA
ORTHO TRI-CYCLEN
OVCON
OVRETTE
Oxazepam
Oxaprozin
OXISTAT
Oxybutynin
Oxycodone/Acetamin *(QL)*
Oxycodone/Aspirin *(QL)*
Papavarine CR
PARNATE
PAXIL
PAXIL CR
PBZ
Pemoline (*PPA over age 18)*
Penicillin VK
PENTASA
Pentoxifylline
Perphenazine
Phenazopyridine
PHENERGAN 12.5MG, 25MG SUPP
Phenobarbital
Phenyleph/Pyril
Phenylephrine
Phenyl/Hydrocod/CPM
Phenylephrine/Prometh
Phenytoin
PHOSLO
Pilocarpine
Pindolol
Piroxicam
PLENDIL
Polymixin B Sulgate/TMP
Polymyxin B/Bacitracin
Portia
Potassium Chloride 10mEq
Potassium Iodide
Pramoxine /Hydrocort
Prazosin
Prednisolone
Prednisolone Acetate
Prednisolone Sodium Phosphate
PREDNISONE
PREMARIN
PREMPHASE
PREMPRO
Primidone
Probenecid
Procainamide
Procainamide SR
Prochlorperazine Maleate
Promethazine
Promethazine/Codeine
Promethazine DM
Prometh/Codeine/PE
Propafenone
Propoxyphene
Propoxyphene-N/APAP *(QL)*
Propoxy/ASA/Caffeine
Propranolol
Propranolol LA
Propranolol/HCTZ
Propylthiouracil
PROTONIX ***(PPA)***
PSE/Carbinox.
PSORIATEC
P-tlox/Phenir/Pyril
PULMICORT RESPULES
Pyrazinamide
Quinidine Gluconate
Quinidine Sulfate
Quinidine Sulfate SR
QVAR
Ranitidine
RELION
RHINOCORT
RHINOCORT AQUA
Rifampin
Rimantadine HCL
RISPERDAL ***(SE)***
ROWASA
RYNATAN
SALAGEN
Salsalate
SANSERT
Selegiline
Selenium Sulfide 2.5%
SEREVENT
SEREVENT DISKUS
Silver Sulfadiazine
SLO-BID
Sodium Chloride
Sodium Polystyrene
Sulfonate
SORIATANE
Sotalol
Spironolactone
Spironolactone/HCTZ

BOLD TYPEFACE indicates product is available at the 1st tier copayment .
CAPS indicates product is available at the 2nd tier copayment.

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Sprintec
STARLIX
Sucralfate tablets
SULAR
Sulfacetmide/Pred
SMZ/TMP
Sulfasalazine
Sulfisoxazole
Sulfonylureas
Sulindac
SYNTHROID
Tamoxifen Citrate
Temazepam
Terazosin
Terbutaline Sulfate
Tetracycline
Theophylline
Theophylline SR
Thiethylperazine
Thioridazine
Thiothixene
Thyroid, Desiccated
Ticlopidine
TILADE INHALER
Timolol
Tizanadine
TOBRADEX
Tobramycin Drops
Tolazamide
Tolbutamide
Tolmetin
TOPROL XL
Toresemide
Trazodone
Tramadol
Tretinoin– *(PPA over age 25)*
Triamcinolone
Triamcinolone/Nystatin
Triamterene/HCTZ
Triazolam
Trifluoperazine
Trifluridine
Trihexyphenidyl
Tri-Levlen
Trimethobenzamide
Trimethoprim
Trimox
TRINALIN REPETABS
TRI-NORINYL
Triple Sulfa Vaginal
Trivora
Tropicamide
UNIPHYL
UNIRETIC
UROCIT-K
Ursodiol
Valproic Acid
VANCERIL
VALTREX
Veetids
VELOSULIN
Verapamil
Verapamil LA Tablets
VIDEX
VIVELLE
VIVELLE DOT
Warfarin Sodium
WELLBUTRIN SR/XL
XALATAN
YASMIN
ZONALON
Zovia
ZYRTEC SYRUP

3rd TIER MEDICATIONS*

All other medications, for which a prescription is written, and medications that under Federal law may only be dispensed by prescription and are FDA approved for the treatment of a covered diagnosis, are available at the 3rd tier copayment. Plan limitations and restrictions will still apply.

Drugs used to treat diagnoses that are excluded from the benefit will not be covered at any copayment tier.**

*** All restrictions apply. See Restricted Medication List for specific details.**
**** Examples include, but are not limited to, medications used for smoking cessation, weight loss, sexual dysfunction and cosmetic purposes.**

COMPOUNDED MEDICATIONS THAT ARE PREPARED BY A PHARMACIST AND ARE NOT FDA APPROVED IN THEIR FINAL FORM WILL NOT BE COVERED AT ANY COPAYMENT TIER.

RESTRICTED MEDICATION LIST

MEDICATIONS REQUIRING PRIOR PLAN APPROVAL *(PPA)*

Prior Plan Approval *(PPA)* or Prior Authorization (PA) – Due to the nature of some medications, prior plan approval may be required for the medication to be covered at any copay tier. Medications that require PPA do so because of their potential for misuse and/or abuse and will require that plan criteria be met. If a medication requires PPA, the ordering physician should contact the plan's pharmacy benefit administrator. Prescriptions exceeding plan limitations (QL) and (SE) will also require PPA.

Aciphex
Actiq
Adderall (over age 18)
Adderall XR (over age 18)
Amphetamine Salt Combo (over age 18)
Androderm
Androgel
Atacand
AVALIDE
AVAPRO
Avinza
Avita
Azelex
Benicar
Bextra
Butorphanol tartrate
Celebrex
Concerta (over age 18)
Copegus
Cozaar
Cylert (over age 18)
Dexedrine Brand (over age 18)
Dextroamphetamine (over age 18)
Dextrostat (over age 18)
Differin (over age 25)
DIOVAN
DIOVAN HCT
Duragesic
ELIDEL (over age 16)
Emend
Gleevec
Hyzaar
Kadian
Lamisil
Mesnex
Metadate CD (over age 18)
Methylphenidate (over age 18)
Micardis
Morphine
MS Contin
MSIR
Nexium
Omeprazole
Oramorph SR
Orfadin
Oxycodone – all products (not including acetaminophen or aspirin combinations)
OxyContin
OxyDose
OxyFast
Pemoline (over age 18)
Prevacid
Prilosec
PROTONIX
Provigil
Rebetol
Regranex

BOLD TYPEFACE indicates product is available at the 1st tier copayment .
CAPS indicates product is available at the 2nd tier copayment.

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Renova	Stadol Nasal Spray	Tevetan	Zelnorm
Retin-A (over age 25)	Strattera	Tevetan HCT	Zetia
Ritalin Brand (over age 18)	Symbyax	**Tretinoin (over age 25)**	Zithromax 600mg
Sporanox	Testoderm	Xyrem	Zyvox

ALL INJECTABLE MEDICATIONS DISPENSED AT A RETAIL PHARMACY (NOT INCLUDING INSULIN PRODUCTS, IMITREX, RHOGAM, DEPO PROVERA, LUNELLE AND EPIPENS) REQUIRE PRIOR PLAN APPROVAL.

ALL MEDICATIONS USED IN THE TREATMENT OF INFERTILITY REQUIRE PRIOR PLAN APPROVAL. **

** Not all plans provide coverage for the treatment of infertility. Plans provided for the Commonwealth of Kentucky, as well as some other Bluegrass Family Health plans, do not cover infertility. Please refer to your Schedule of Benefits or contact Bluegrass Family Health Pharmacy Services Department at (877) 205-6308 or (859) 335-3755.

MEDICATIONS REQUIRING SPECIALTY EDIT ***(SE)***

Specialty Edit *(SE)* – In order to be considered for coverage, Bluegrass Family Health (BFH) may require that some medications be written by a specialty physician. Medications not meeting specialty edit will require ***(PPA).***

Abilify (Psychiatry)
Arava (Rheumatology)
Enbrel (Rheumatology)
Geodon (Psychiatry)
Symbyax (Psychiatry)
Humira (Rheumatology)
Kineret (Rheumatology)
RISPERDAL (Psychiatry)
Seroquel (Psychiatry)
Strattera (Psychiatry)
Tracleer (Cardiology/Pulmonary)
Zyprexa (Psychiatry)
Zyprexa Zydis (Psychiatry)

MEDICATIONS WITH QUANTITY LIMITS ***(QL)***

Quantity Limits (QL) – Quantity limits have been placed on medications to be consistent with the maximum dosages that the Food and Medication Administration (FDA) has approved to be both safe and effective. Medications where the quantity exceeds the FDA's maximum daily dose will require PPA. Prescriptions exceeding plan limitations will require PPA.

Accutane
Acetaminophen w/codeine, butalbital, or hydrocodone
All hydrocodone products
All meperidine products
All methadone products
All morphine products
All oxycodone products
Ambien
Amerge – 9 per rx/ month
Amnesteem
Anzemet
Arixtra
Butorphanol Tartrate - 4 per rx/month *(PPA required)*
Darvocet N-100
DIFLUCAN 150mg – 1 per rx
Flonase - One Unit (16)
Fragmin
Helidac -1 rx per year
Imitrex 50mg Tablets – 9 per rx/month
Imitrex Nasal Spray – 6 Units per rx/month
Imitrex Injection - 2 kits (4 Injections) per rx/month
Kytril
Lariam - 12 per 3 months
Lovenox
Maxalt - 6 per rx/month
Migranal - 4 units per rx/month
MS Contin ***(PPA required)***
Oramorph SR *(PPA required)*
Oxycontin ***(PPA required)***
Oxyfast ***(PPA required)***
Oxyir ***(PPA required)***
Prevpac- 1 rx per year
Propoxyphene Napsylate w/Apap
Prozac Weekly
Relenza - 1 unit per year
Relpax
Stadol Nasal Spray – 4 per rx/month***(PPA required)***
Sonata
Tamiflu - 10 caps per year
Tritec - 1 rx per year
Zithromax 600mg ***(PPA required)***
Zofran
Zomig – 6 per rx/month

✓ **PHARMACY BENEFITS** – For **HMO/EPO members, and POS/PPO members using the in-network pharmacy benefits,** you must use a participating pharmacy (except in an urgent or emergent situation) to access your Bluegrass Family Health pharmacy benefits. Presenting a valid ID card to the pharmacist is vital! To be eligible, medications must be processed online by your pharmacist; claims not filed online by a participating pharmacy may not be eligible for reimbursement. For **POS/PPO members using the out-of-network pharmacy benefits,** you must submit a detailed pharmacy receipt to Bluegrass Family Health for reimbursement. ALL requests for reimbursement must include the member's Bluegrass Family Health ID #, be accompanied by a written statement of why the claim was not filed by the pharmacy, and a pharmacy receipt that includes the name of the medication, the name of the pharmacy where the medication was purchased, the quantity dispensed, the days supply, and the

amount the pharmacy charged. You will be reimbursed based on your benefits and the applicable copayment will be deducted from your reimbursement.

If you are at the pharmacy and you do not have your Bluegrass Family Health identification card, or if the pharmacist is having trouble filing the claim online, please instruct the pharmacist to contact the Bluegrass Family Health Pharmacy Services Department at (877) 205-6308 or (859) 335-3755.

- ✓ **BENEFIT EXCLUSIONS** – Bluegrass Family Health will not cover, at any copayment tier, any medications prescribed for the treatment of diagnoses excluded from coverage. The list of 1st and 2nd tier medications does not provide information regarding the specific coverage and limitations an individual member may have. Many members have specific exclusions and copays which arenot reflected in this list. The list applies only to outpatient medications provided to members and does not apply to medications used in inpatient settings. If a member has any specific questions regarding their coverage, they should contact BFH. The following general exclusions pertain to all covered individuals:

A. Over the Counter (OTC) medications or their equivalents are not covered, unless otherwise specified in the list of 1st and 2nd tier medications.
B. Nicotine Smoking Cessation products (i.e., transdermal nicotine, nicotine gum) are not covered.
C. Medication Products specifically listed as not covered.
D. Any medication products used for cosmetic purposes, including hair loss, are not covered.
E. Experimental medication products or any medication product used in an experimental manner, or for conditions not approved by the FDA, are not covered.
F. Replacement of lost, stolen or spilled medication is not covered.
G. Medications on the Prior Plan Approval ***(PPA)*** List that do not meet the medical necessity criteria are not covered.
H. Weight loss medications are not covered.
I. Medications for the treatment of sexual dysfunction are not covered unless specified in plan documentation.
J. Compounded medications that are prepared by a pharmacist and are not FDA-approved in their final form are not covered.
K. Medications not approved by the FDA.

- ✓ **URGENT AND EMERGENT SITUATIONS** – If you are out of the area and need to have a prescription filled for an urgent or emergent condition, for your convenience you may take the prescription and your Bluegrass Family Health identification card to a participating chain pharmacy such as Wal-Mart, Rite-Aid, K-Mart, Kroger or CVS and pay just your copayment. If the pharmacist has difficulty processing the claim, he or she may contact the Pharmacy Help Desk at (877) 205-6308. If you do not have access to a participating pharmacy you may take the prescription to a non-participating pharmacy and file the pharmacy receipt for reimbursement.

- ✓ **REFUNDS** – If you pay out-of-pocket for a prescription at a participating pharmacy, you may return to the pharmacy within 30 days, have the claim processed online and be reimbursed the eligible out-of-pocket expenses. If you are reimbursed by Bluegrass Family Health for an eligible out-of-pocket prescription expense, you may be paid based on the Bluegrass Family Health's contracted pharmacy rates. These contracted rates are usually less than the pharmacy's retail charges, resulting in a net cost to you greater than your usual copayment. Requests for out-of-pocket prescription reimbursement received more than six months after the prescription was filled will not be eligible for reimbursement. ALL requests for reimbursement must include the member's Bluegrass Family Health ID #, be accompanied by a written statement of why the claim was not filed by the pharmacy, and a pharmacy receipt that includes the name of the medication, the name of the pharmacy where the medication was purchased, the quantity dispensed, the days supply, and the amount the pharmacy charged. You will be reimbursed based on your benefits and the applicable copayment will be deducted from your reimbursement.

- ✓ **DISPENSE AS WRITTEN (DAW) –** State law requires that when there is a generic medication available for a branded medication that the pharmacist dispense the generic product unless otherwise stated by the physician to dispense as written, or it is requested by the patient. If a member specifically requests a brand name medication, the member will be subject to their 3rd tier copayment and may be responsible for any difference in price between the generic medication and the brand name medication.

- ✓ **PHARMACY SERVICES DEPARTMENT** – Bluegrass Family Health has a team of employees that is dedicated to assisting you with any questions or concerns you have regarding your prescription drug benefits. You may contact Pharmacy Services at (877) 205-6308 or (859) 335-3755

For additional information please see the Bluegrass Family Health Preferred drug list at www.bluegrassfamilyhealth.com.

BOLD TYPEFACE indicates product is available at the 1st tier copayment .
CAPS indicates product is available at the 2nd tier copayment.

THE BLUEGRASS FAMILY HEALTH PREFERRED DRUG LIST HAS BEEN COMPILED TO RESPOND TO THE CONSTANTLY CHANGING NATURE OF MEDICATION THERAPY. THE LIST IS DYNAMIC AND IT IS SUBJECT TO CHANGE. YOU WILL BE NOTIFIED AT LEAST 30 DAYS IN ADVANCE OF ALL CHANGES. EVERY EFFORT HAS BEEN MADE TO INSURE THE ACCURACY OF THIS DOCUMENT. WE APOLOGIZE FOR ANY INCONVENIENCE ERRORS MAY CAUSE.