Advantra® Rx
Prescription Drug Toolkit

AdvantraRx®

Medicare Prescription Drug Plans Made Easy

ARTK019

Four easy steps

to prescription drug savings

Now that you've carefully read through the step-by-step guide to *Making Medicare's Prescription Drug Coverage Work for You*, there are just a few simple things you need to do to enroll in an **Advantra®Rx** plan.

1. Study and compare each of the **AdvantraRx** plans and their benefits.
2. Look at each plan's formulary closely.
3. Complete the worksheet provided in this toolkit to find out which **AdvantraRx** plan is right for you.
4. Fill out the enclosed enrollment form and mail it in the provided pre-paid envelope or provide it to your sales consultant.

If you have any questions along the way, or would like an **AdvantraRx** representative to walk you through the enrollment process, please refer to the contact information on the back of the folder.

Plan Choice Worksheet

7 Easy Steps to Savings

Follow these simple steps to figure how much you can save with **Advantra®Rx**. All of your responses should be written in the chart below. For your convenience, each step and the portion of the chart where you write your response are numbered the same. (A calculator may be helpful.)

Step 1. Write down all your regular prescriptions.

Step 2.
- **A.** Write down each prescription's monthly cost.
- **B.** Add up the amounts to figure your current total monthly costs.
- **C.** Write the total in the box provided.
- **D.** Also write the total in the top box in Step 6.

Step 3.
- **A.** Look for your prescriptions on the **AdvantraRx** formulary on page 17 of this toolkit.
- **B.** As you find your prescriptions on the **AdvantraRx Value** formulary, circle the tier number it is listed under. This will help you decide which plan covers the most of your prescriptions.
- **C.** Repeat the first two parts of this step for both **AdvantraRx Premier** and **Premier Plus**.

1. Prescription Name	2. Monthly Cost	3. Value	Premier	Premier Plus
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
		1 2 3	1 2 3	1 2 3
TOTAL	$			

Step 4.

A. Now that you've circled the tier numbers for all the plans in Step 3, look at each column from Step 3 below and determine which plan contains the most ones (1's) and twos (2's).
B. The plan with the most 1's and 2's circled will most likely save you the most money.
C. Write this plan's name in the space provided below.
D. Then write its monthly premium, found in the Summary of Benefits on page 9, in the top box provided in Step 7.

Step 5.

A. Look for the Summary of Benefits on page 9 of this toolkit. Find your plan name at the top.
B. Then look down to see how much a tier one copay will cost under your selected plan. Under Step 5 of your Plan Choice Worksheet, write that amount in for every tier one prescription you will have under your selected plan.
C. Then look in the copay chart to see how much a tier two copay will cost under that plan. Write that amount under Step 5 for every tier two prescription you will have with that plan.
D. Do the same for your tier three prescriptions.
E. Add up the **AdvantraRx** copays and write the total in the space provided below. Also write this total in the middle box provided in Step 6 and Step 7.

Step 6.

Subtract the **AdvantraRx** monthly copay from your current monthly costs and write down the amount. This number is the amount you will save every month you are in the initial coverage period when you go to the pharmacy when you sign up for **AdvantraRx**.

Step 7.

Add your chosen plan's monthly premium, found in the Summary of Benefits on page 9, to the **AdvantraRx** monthly copay and write the total in the space provided. Compare this total with your current monthly pharmacy bill. With the completion of this worksheet, you are ready to enroll!

4.

AdvantraRx Plan Name
____

5.

AdvantraRx Copay
$
TOTAL

6.

Monthly Prescription Savings

$ ______
Current Monthly Costs

− $ ______
AdvantraRx Monthly Copay

$ ______
TOTAL SAVINGS

7.

AdvantraRx Monthly Spending

$ ______
AdvantraRx Premium

+ $ ______
AdvantraRx Monthly Copay

$ ______
TOTAL SPENDING

AdvantraRx is offered through the following Coventry Health Plans that contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare: Coventry Health and Life Insurance Company, Cambridge Life Insurance Company, and First Health Life & Health Insurance Company.

Introduction to the Summary of Benefits for Advantra®Rx

January 1, 2006–December 31, 2006

S5670

Thank you for your interest in Advantra®Rx. Our plan is offered by Coventry Health and Life Insurance Company, a Medicare Prescription Drug Plan that contracts with Medicare. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation or exclusion. To get a complete list of our benefits, please call AdvantraRx and ask for the Evidence of Coverage.

You have choices in your Medicare Prescription Drug Coverage.

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like AdvantraRx. Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

How can I compare my options?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by AdvantraRx to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

Where is AdvantraRx available?

The service area for this plan includes Arkansas. You must live in one of these states to join this plan. There is more than one plan listed in this Summary of Benefits. If you are enrolled in one and wish to switch to another, you may do so only during certain times of the year. Please call Customer Service for more information.

Who is eligible to join?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area. Eligible individuals may only enroll in one Medicare Prescription Drug Plan at a time and may not be enrolled in a Medicare Advantage Plan (HMO, PPO), unless they are a member of Medicare Private-Fee-For-Services plan that does not offer Medicare prescription drug coverage or are enrolled in an 1876 Cost Plan. You may join a Medicare Prescription Drug Plan during certain times of the year.

Where can I get my prescriptions?

AdvantraRx has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. AdvantraRx may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or call Customer Service for an up-to-date list.

Do you cover Medicare Part B or Part D drugs?

We do not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biologicals and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

Does my plan have a prescription drug formulary?

AdvantraRx uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs. The plan may periodically make changes to the formulary. If the formulary changes, affected enrollees will be notified, in writing, before the change is made.

What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a service that your plan may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. If you have questions concerning our MTM Program please contact our Customer Service number listed at the end of this section.

What should I do if I have other insurance in addition to Medicare?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium.

Under certain circumstances, you can also buy a different Medigap policy without prescription drug coverage sold by your Medigap Issuer. Your Medigap Issuer cannot charge you more, based on any past or present health problems. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join AdvantraRx. Get this information before you decide to enroll in this plan.

How can I get help with drug plan costs?

Medicare beneficiaries with low or limited income and resources may qualify for additional assistance. If you qualify, your Medicare prescription drug plan costs, the amount of your premium and your drug costs at the pharmacy will be less. Once you have enrolled in AdvantraRx, Medicare will tell us how much assistance you are receiving, and we will send you information on the amount you will pay. If you are not receiving this additional assistance, you should contact 1-800-MEDICARE to see if you might qualify.

What are my protections in this plan?

All Medicare Prescription Drug Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Prescription Drug Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare prescription drug coverage in your area.

If AdvantraRx ever denies coverage for your prescription drugs, we will explain our decision to you. You always have the right to appeal and ask us to review the claim that was denied. In addition, if your physician prescribes a drug that is not on our formulary, is not a preferred drug or is subject to additional utilization rules, you may ask us to make a coverage exception.

Please call AdvantraRx for more information about this plan.

Customer Service Hours: 24 hours a day, 7 days a week

Current members should call toll-free 1-866-823-4646
TDD toll-free 1-866-236-1069

Prospective Members should call toll-free 1-800-882-3822
TDD 1-800-508-9548

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227).
TTY/TDD users should call 1-877-486-2048.
You can call 24 hours a day, 7 days a week.
Or visit www.medicare.gov.

If you have special needs, this document may be available in other formats.

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If you have any questions about these plans' benefits or costs, please contact AdvantraRx for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	AdvantraRx Value	AdvantraRx Premier	AdvantraRx Premier Plus
Outpatient Prescription Drugs	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.	You pay $20.58 each month for your Medicare Part D prescription benefits.	You pay $33.30 each month for your Medicare Part D prescription benefits.	You pay $44.00 each month for your Medicare Part D prescription benefits.
		This plan does not cover Medicare Part B prescription drugs.	This plan does not cover Medicare Part B prescription drugs.	This plan does not cover Medicare Part B prescription drugs.
		This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing, before the change. To view the plan's formulary, go to **www.AdvantraRx.com** on the web.	This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing, before the change. To view the plan's formulary, go to **www.AdvantraRx.com** on the web.	This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing, before the change. To view the plan's formulary, go to **www.AdvantraRx.com** on the web.

If you have any questions about these plans' benefits or costs, please contact AdvantraRx for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	AdvantraRx Value	AdvantraRx Premier	AdvantraRx Premier Plus
		People who have low incomes, who live in long-term care facilities, or who have access to Indian/Tribal/ Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details.	People who have low incomes, who live in long-term care facilities, or who have access to Indian/Tribal/ Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details.	People who have low incomes, who live in long-term care facilities, or who have access to Indian/Tribal/ Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details.
		There is no deductible.	There is no deductible.	There is no deductible.
		Before the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay the following for prescription drugs:	Before the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay the following for prescription drugs:	Before the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay the following for prescription drugs:
		$12 for a one-month (30-day) supply of Formulary Generic drugs you get at an in-network preferred pharmacy.	$5 for a one-month (30-day) supply of Formulary Generic drugs you get at an in-network preferred pharmacy.	$0 for a one-month (30-day) supply of Formulary Generic drugs you get at an in-network preferred pharmacy.

If you have any questions about these plans' benefits or costs, please contact AdvantraRx for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	AdvantraRx Value	AdvantraRx Premier	AdvantraRx Premier Plus
		$42 for a one-month (30-day) supply of Formulary Preferred Brand drugs you get at an in-network preferred pharmacy.	$20 for a one-month (30-day) supply of Formulary Preferred Brand drugs you get at an in-network preferred pharmacy.	$25 for a one-month (30-day) supply of Formulary Brand drugs you get at an in-network preferred pharmacy.
		N/A	$58 for a one-month (30-day) supply of Brand drugs you get at an in-network preferred pharmacy.	$66 for a one-month (30-day) supply of Brand drugs you get at an in-network preferred pharmacy.
		$36 for a three-month (90-day) supply of Formulary Generic drugs you get at an in-network preferred pharmacy.	$15 for a three-month (90-day) supply of Formulary Generic drugs you get at an in-network preferred pharmacy.	$0 for a three-month (90-day) supply of Formulary Generic drugs you get at an in-network preferred pharmacy.

If you have any questions about these plans' benefits or costs, please contact AdvantraRx for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	AdvantraRx Value	AdvantraRx Premier	AdvantraRx Premier Plus
		$126 for a three-month (90-day) supply of Formulary Preferred Brand drugs you get at an in-network preferred pharmacy.	$60 for a three-month (90-day) supply of Formulary Preferred Brand drugs you get at an in-network preferred pharmacy.	$75 for a three-month (90-day) supply of Formulary Brand drugs you get at an in-network preferred pharmacy.
		N/A	$174 for a three-month (90-day) supply of Brand drugs you get at an in-network preferred pharmacy.	$198 for a three-month (90-day) supply of Brand drugs you get at an in-network preferred pharmacy.
		$24 for a three-month (90-day) supply of mail-order Formulary Generic drugs.	$10 for a three-month (90-day) supply of mail-order Formulary Generic drugs.	$0 for a three-month (90-day) supply of mail-order Formulary Generic drugs.
		$84 for a three-month (90-day) supply of mail-order Formulary Preferred Brand drugs.	$40 for a three-month (90-day) supply of mail-order Formulary Preferred Brand drugs.	$50 for a three-month (90-day) supply of mail-order Formulary Brand drugs.
		N/A	$116 for a three-month (90-day) supply of mail-order Brand drugs.	$132 for a three-month (90-day) supply of mail-order Brand drugs.

If you have any questions about these plans' benefits or costs, please contact AdvantraRx for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	AdvantraRx Value	AdvantraRx Premier	AdvantraRx Premier Plus
		After the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay 100% of your prescription drug costs.	After the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay 100% of your prescription drug costs.	After the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay 100% of your prescription drug costs.
		After your yearly out-of-pocket drug costs reach $3,600, you pay the greater of: •$2 for generic or preferred brand drug that is a multi-source drug and $5 for all other drugs, or •5% coinsurance.	After your yearly out-of-pocket drug costs reach $3,600, you pay the greater of: •$2 for generic or preferred brand drug that is a multi-source drug and $5 for all other drugs, or •5% coinsurance.	After your yearly out-of-pocket drug costs reach $3,600, you pay the greater of: •$2 for generic or preferred brand drug that is a multi-source drug and $5 for all other drugs, or •5% coinsurance.
		Certain prescription drugs will have maximum quantity limits. Contact plan for details.	Certain prescription drugs will have maximum quantity limits. Contact plan for details.	Certain prescription drugs will have maximum quantity limits. Contact plan for details.
		Your provider must get prior authorization from AdvantraRx Value for certain prescription drugs. Contact plan for details.	Your provider must get prior authorization from AdvantraRx Premier for certain prescription drugs. Contact plan for details.	Your provider must get prior authorization from AdvantraRx Premier Plus for certain prescription drugs. Contact plan for details.

If you have any questions about these plans' benefits or costs, please contact AdvantraRx for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	AdvantraRx Value	AdvantraRx Premier	AdvantraRx Premier Plus
		Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. In addition to paying the copayments/ coinsurances listed below, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.	Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. In addition to paying the copayments/ coinsurances listed below, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.	Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. In addition to paying the copayments/ coinsurances listed below, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

If you have any questions about these plans' benefits or costs, please contact AdvantraRx for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	AdvantraRx Value	AdvantraRx Premier	AdvantraRx Premier Plus
		$12 for a one-month (30-day) supply of Formulary Generic drugs you get at an out-of-network pharmacy.	$5 for a one-month (30-day) supply of Formulary Generic drugs you get at an out-of-network pharmacy.	$0 for a one-month (30-day) supply of Formulary Generic drugs you get at an out-of-network pharmacy.
		$42 for a one-month (30-day) supply of Formulary Preferred Brand drugs you get at an out-of-network pharmacy.	$20 for a one-month (30-day) supply of Formulary Preferred Brand drugs you get at an out-of-network pharmacy.	$25 for a one-month (30-day) supply of Formulary Brand drugs you get at an out-of-network pharmacy.
		N/A	$58 for a one-month (30-day) supply of Brand drugs you get at an out-of-network pharmacy.	$66 for a one-month (30-day) supply of Brand drugs you get at an out-of-network pharmacy.

Advantra® Rx Value

Formulary
(List of Covered Drugs)

This document includes AdvantraRx Value's partial formulary as of September 21, 2005.
For a complete, updated formulary, please visit our website at www.AdvantraRx.com or call 1-800-882-3822,
8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

S5670_S5674_S0197-AbFormAdvRxval06c CMS Approval Date: 10/04/2005

What is the AdvantraRx Value formulary?

A formulary is a list of drugs selected by AdvantraRx Value 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. AdvantraRx Value will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at an AdvantraRx Value network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by AdvantraRx Value. For a complete listing of all prescription drugs covered by AdvantraRx Value, please visit our website at www.AdvantraRx.com or call 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

Can the formulary change?

Yes, AdvantraRx Value may add or remove drugs from the formulary during the year. The enclosed formulary is current as of September 21, 2005. To get updated information about the drugs covered by AdvantraRx Value, please visit our website at www.AdvantraRx.com or call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548. If we remove drugs from the formulary, or 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 members who take the drug that it will be removed at least 60 days before the date that 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 the formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from the formulary and provide notice to members who take the drug.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 22. The drugs in the 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 Agents." If you know what your drug is used for, look for the category name in the list that begins on page 22. 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 26. The Index provides an alphabetical list of all 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.

How much will I pay for AdvantraRx covered drugs?

If you qualified for extra help with your drug costs, your costs for your drugs may be different than those described below. Please refer to your Evidence of Coverage or call Customer Service to find out what your cost are.

The amount you pay depends on which drug tier your drug is in under our plan. (You can find out which drug tier your drug is in by looking in the formulary that begins on page 22.)

The amount you pay depends on whether you fill your prescription at a retail pharmacy or at a mail-order pharmacy. Generally, when you go to a retail pharmacy you will pay for a 30-day supply. In addition, if you fill your prescription through the mail-order pharmacy, you can get a 90-day supply.

You will pay a copayment for your drugs until your total drug costs (the amount you paid, plus the amount AdvantraRx Value has paid) reach $2,250. Once your total drug costs reach $2,250, there is a gap in your coverage. This means you have to pay the full amount for your drugs. You pay the full amount until you have paid $3,600 out of pocket. After you have paid $3,600 out of pocket, you will generally pay the greater of:

- $2 for generic or a preferred brand drug that is a multi-source drug and $5 for all other drugs, or
- 5% coinsurance

You can ask AdvantraRx Value to make an exception to your drug's tier placement. See the section "How do I request an exception to AdvantraRx Value's formulary?" for information about how to request an exception.

Are there any other restrictions on coverage?

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

- **Prior Authorization:** AdvantraRx Value requires you to get prior authorization for certain drugs. (You may need prior authorization for drugs that are on the formulary or drugs that are not on the formulary **and** were approved for coverage through the exceptions process.) This means that you will need to get approval from AdvantraRx Value before you fill your prescriptions. If you don't get approval, AdvantraRx Value may not cover the drug.
- **Quantity Limits:** For certain drugs, AdvantraRx Value limits the amount of the drug that AdvantraRx Value will cover. For example, AdvantraRx Value provides 4 units per prescription for FOSAMAX per 30 days. This <u>**may**</u> be in addition to a standard 30- or 90-day supply.
- **Step Therapy:** In some cases, AdvantraRx Value requires you to first try certain drugs to treat your medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, AdvantraRx Value may not cover Drug B unless you try Drug A first. If Drug A does not work for you, AdvantraRx Value 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 22.

You can ask AdvantraRx Value to make an exception to these restrictions or limits. See the section "How do I request an exception to AdvantraRx Value's formulary?" below 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 Customer Service and ask if your drug is covered. This document includes only a partial list of covered drugs, so AdvantraRx Value may cover your drug. You can contact Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

If you learn that AdvantraRx Value does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by AdvantraRx Value. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by AdvantraRx Value.
- You can ask AdvantraRx Value 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 AdvantraRx Value's formulary?

You can ask AdvantraRx Value to make an exception to its coverage rules. There are several types of exceptions that you can request.

- You can ask AdvantraRx Value to cover your drug even if it is not on the formulary.
- You can ask AdvantraRx Value to waive

coverage restrictions or limits on your drug. For example, for certain drugs, AdvantraRx Value limits the amount of the drug that it will cover. If your drug has a quantity limit, you can ask for the limit to be waived and cover more.

- You can ask AdvantraRx Value to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Tier 2 drug, you can ask AdvantraRx Value to cover it as a Tier 1 drug instead. This would lower the amount you must pay for your drug. Please note, if your request to cover a drug that is not on the formulary is granted, you may not ask AdvantraRx Value to provide a higher level of coverage for the drug.

Generally, AdvantraRx Value will only approve your request for an exception if the alternative drugs included on the plan's formulary, the low-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 Customer Service to ask 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, AdvantraRx Value must make a decision within 72 hours of your request.

What are generic drugs?

AdvantraRx Value covers both brand name drugs and generic drugs. A generic drug has the same active-ingredient formula as the brand name drug. Generic drugs usually cost less than brand name drugs and are approved by the Food and Drug Administration (FDA).

Generic drugs are listed in lower-case italics (e.g., *digoxin*) within the formulary on page 22. Brand name drugs are capitalized in the formulary (e.g., CLARINEX).

For more information

For more detailed information about your AdvantraRx Value prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about AdvantraRx Value, please call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548. Or visit www.AdvantraRx.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.

AdvantraRx Value's formulary

The formulary that begins on page 22 provides coverage information about some of the drugs covered by AdvantraRx Value. If you have trouble finding your drug in the list, turn to the Index that begins on page 26. Remember: This is only a partial list of drugs covered by AdvantraRx Value. If your prescription is not in this partial formulary, please visit our website at www.AdvantraRx.com or call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548 for additional help.

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

The information in the Requirements/Limits column tells you if AdvantraRx Value has any special requirements for coverage of your drug. The following abbreviations may be used in the Requirements/Limits column:

- **PA–Prior Authorization:** AdvantraRx Value requires you to get prior authorization for certain drugs. (You may need prior authorization for drugs that are on the formulary or drugs that are not on the formulary **and** were approved for coverage through the exceptions process.)

This means that you will need to get approval from AdvantraRx Value before you fill your prescriptions. If you don’t get approval, AdvantraRx Value may not cover the drug.

- **QL–Quantity Limits:** For certain drugs, AdvantraRx Value limits the amount of the drug that AdvantraRx Value will cover. For example, AdvantraRx Value provides 4 units per prescription for FOSAMAX per 30 days. This **may** be in addition to a standard 30- or 90-day supply.
- **ST–Step Therapy:** In some cases, AdvantraRx Value requires you to first try certain drugs to treat your medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, AdvantraRx Value may not cover Drug B unless you try Drug A first. If Drug A does not work for you, AdvantraRx Value will then cover Drug B.
- *–Drugs marked with an asterisk “*” do not count towards your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.

Drug Name	Drug Tier	Requirements/ Limits
ANALGESICS–PAIN		
acetaminophen w/ codeine	1	
fentanyl patches	1	
hydrocodone/apap	1	
morphine	1	
oxycodone	1	
oxycodone er	1	PA
oxycodone/apap	1	
propoxyphene/apap	1	
tramadol	1	
ANTIBACTERIALS–INFECTION		
amoxicillin	1	
amoxil/clavulanate	1	
AVELOX	2	QL
cefaclor	1	
cefuroxime	1	
CEFZIL	2	
ciprofloxacin	1	
clarithromycin	1	QL
doxycycline	1	
erythromycin base	1	
OMNICEF	2	
PCE	2	
penicillin	1	
smz-tmp ds	1	
ZITHROMAX	2	QL
ANTI-CONVULSANTS–SEIZURE		
carbamazepine	1	
DEPAKOTE	2	
DILANTIN	2	
gabapentin	1	
KEPPRA	2	QL
LAMICTAL	2	PA
phenytoin	1	
TEGRETOL XR	2	
TOPAMAX	2	PA
ANTIDEMENTIA AGENTS–ALZHEIMER’S DISEASE		
ARICEPT	2	QL

Drug Name	Drug Tier	Requirements/ Limits
NAMENDA	2	QL
RAZADYNE	2	QL
ANTIDEPRESSANTS–DEPRESSION		
amitriptyline	1	
bupropion sr	1	
citalopram	1	QL
EFFEXOR XR	2	QL, ST
fluoxetine	1	
LEXAPRO	2	QL
mirtazapine tablets	1	QL
paroxetine	1	QL
trazodone	1	
ZOLOFT	2	QL
ANTIEMETICS–NAUSEA/VOMITING		
ZOFRAN	2	PA, QL
ANTIFUNGALS–FUNGAL INFECTION		
fluconazole	1	PA, QL
itraconazole	1	PA
LAMISIL	2	PA, QL
nystatin	1	
terconazole	1	
ANTIGOUT AGENTS–GOUT		
allopurinol	1	
colchicine	1	
probenecid	1	
ANTIHISTAMINES–ALLERGY		
CLARINEX	2	QL
*loratadine**	1	QL
promethazine	1	
ANTI-INFLAMMATORIES–ARTHRITIS/PAIN		
CELEBREX	2	ST, PA, QL
diclofenac	1	
etodolac	1	
ibuprofen	1	
indomethacin	1	
ketoprofen	1	
naproxen	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
ANTIMALARIALS–MALARIA		
quinine	1	
ANTIMIGRAINE AGENTS–MIGRAINE		
DEPAKOTE ER	2	
MAXALT	2	QL
RELPAX	2	QL
ANTINEOPLASTICS–CANCER		
ARIMIDEX	2	QL
AROMASIN	2	QL
FASLODEX	2	PA
FEMARA	2	
flutamide	1	
LUPRON	2	PA
megestrol	1	
tamoxifen	1	
ANTIPARKINSON AGENTS–PARKINSON'S DISEASE		
amantadine	1	
benztropine	1	
bromocriptine	1	
carbidopa/levodopa	1	
COMTAN	2	
MIRAPEX	2	
pergolide	1	
selegiline	1	
trihexyphenidyl	1	
ANTIPSYCHOTICS–BEHAVIORAL HEALTH		
ESKALITH	2	
haloperidol	1	
lithium carbonate	1	
RISPERDAL	2	QL
SEROQUEL	2	QL
thiothixene	1	
ANTIRHEUMATIC AGENTS–ARTHRITIS		
ENBREL	2	PA
methotrexate	1	
ANTIVIRALS–VIRAL INFECTION		
acyclovir	1	
HEPSERA	2	ST, PA, QL

Drug Name	Drug Tier	Requirements/ Limits
PEGASYS	2	PA
ribavirin	1	PA
rimantadine	1	
ANXIOLYTICS–ANXIETY		
buspirone	1	
hydroxyzine hcl	1	
BLOOD GLUCOSE REGULATORS–DIABETES		
ACTOS	2	PA, QL
glipizide	1	
glyburide	1	
INSULIN SYRINGE	2	
LANTUS	2	
metformin	1	
NOVOLIN 70/30	2	
NOVOLIN VIAL	2	
NOVOLOG	2	
NOVOLOG MIX VIAL	2	
PRECOSE	2	
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS–BLOOD THINNERS		
cilostazol	1	
COUMADIN	2	
dipyridamole	1	
heparin sodium	1	
pentoxifylline	1	
PLAVIX	2	QL
warfarin	1	
CARDIOVASCULAR AGENTS–HEART/BLOOD PRESSURE		
ALTOPREV	1	QL
amiodarone	1	
atenolol	1	
AVALIDE	2	QL
AVAPRO	2	QL
benazepril	1	QL
bisoprolol	1	
bumetanide	1	
CARDIZEM LA	2	QL

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
cholestyramine	1	
clonidine	1	
digoxin	1	
diltiazem cd	1	QL
doxazosin	1	QL
enalapril	1	
felodipine	1	
fosinopril	1	QL
furosemide	1	
gemfibrozil	1	
hydralazine	1	
hydrochlorothiazide	1	
indapamide	1	
INNOPRAN XL	2	QL
isosorbide mononitrate	1	QL
labetalol	1	
LANOXIN	2	
lisinopril	1	
LOFIBRA	2	
methyldopa	1	
metolazone	1	
metoprolol	1	
MICARDIS	2	QL
nadolol	1	
NIASPAN ER	2	
nifedipine xl	1	QL
NITRO-DUR	1	QL
nitroglycerin caps	1	
prazosin	1	
procainamide	1	
propranolol	1	
quinapril	1	QL
quinidine sulfate	1	
spironolactone	1	
terazosin	1	QL
TOPROL XL	2	QL
torsemide	1	
triamterene/hctz	1	

Drug Name	Drug Tier	Requirements/ Limits
verapamil	1	
VYTORIN	2	QL
ZOCOR	2	QL
DERMATOLOGICAL AGENTS–SKIN PREPARATIONS		
betamethasone val	1	
clobetasol	1	
clotrimazole/betamethasone	1	
DENAVIR	2	QL
fluocinolone	1	
fluocinonide	1	
LAMISIL	2	PA, QL
METROGEL VAG	2	
METROLOTION	2	
mometasone	1	
tretinoin	1	
triamcinolone	1	
GASTROINTESTINAL AGENTS–STOMACH		
ASACOL	2	
cimetidine	1	
dicyclomine	1	
Diphenoxylate/atropine	1	
famotidine	1	
glycolax	1	
hyoscyamine	1	
lactulose	1	
metoclopramide	1	
PRILOSEC OTC*	1	QL
PROTONIX	2	PA, QL
ranitidiine tablets	1	
sucralfate	1	
sulfasalazine	1	
ursodiol	1	
GENITOURINARY AGENTS		
bethanechol	1	
ENABLEX	2	QL
LEVITRA	2	QL
nitrofurantn	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
oxybutynin	1	
PROSCAR	2	QL
SANCTURA	2	
HORMONAL AGENTS–HORMONES		
dexamethasone	1	
ESTRACE VAG	2	
estradiol	1	QL
estropipate	1	
EVISTA	2	
FORTEO	2	PA
FOSAMAX	2	QL
LEVOTHROID	2	
levothyroxine	1	
levoxyl	1	
MIACALCIN	2	
prednisolone	1	
prednisone	1	
PREMARIN	2	QL
PREMPHASE	2	QL
PREMPRO	2	QL
propylthiouracil	1	
SYNTHROID	2	
thyroid	1	
IMMUNOLOGICAL AGENTS		
azathioprine	1	PA
INFLAMMATORY BOWEL DISEASE AGENTS–RECTAL		
anucort-hc	1	
PROCTOCORT	2	
proctosol	1	
OPHTHALMIC AGENTS–EYE		
AZOPT	2	
betaxolol	1	
brimonidine	1	
erythromycin	1	
levobunolol	1	
LUMIGAN	2	
pilocarpine	1	

Drug Name	Drug Tier	Requirements/ Limits
timolol	1	
TRAVATAN	2	
VOLTAREN	2	
RESPIRATORY AGENTS–BREATHING		
albuterol	1	QL
ASMANEX	2	QL
ASTELIN NASAL	2	
COMBIVENT	2	QL
FORADIL	2	
ipratropium neb sol	1	
NASACORT AQ	2	QL
NASONEX	2	QL
PROVENTIL HFA	2	
QVAR	2	
SINGULAIR	2	ST, PA, QL
SPIRIVA	2	QL
theophylline	1	
TILADE	2	
SEDATIVES/HYPNOTICS–SLEEP		
AMBIEN	2	QL
SKELETAL MUSCLE RELAXANTS–MUSCLE RELAXER		
baclofen	1	
carisoprodol	1	
cyclobenzaprine	1	
tizanidine	1	
THERAPEUTIC NUTRIENTS / MINERALS / ELECTROLYTES–VITAMINS/MINERALS		
k+ potassium	1	
KLOR-CON	2	
K-LYTE/CL	2	
MICRO-K	2	
pot chloride	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

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Advantra®Rx Premier

Formulary
(List of Covered Drugs)

This document includes AdvantraRx Premier's partial formulary as of September 21, 2005.
For a complete, updated formulary, please visit our website at www.AdvantraRx.com or call 1-800-882-3822,
8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

What is the AdvantraRx Premier formulary?

A formulary is a list of drugs selected by AdvantraRx Premier 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. AdvantraRx Premier will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at an AdvantraRx Premier network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by AdvantraRx Premier. For a complete listing of all prescription drugs covered by AdvantraRx Premier, please visit our website at www.AdvantraRx.com or call 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

Can the formulary change?

Yes, AdvantraRx Premier may add or remove drugs from the formulary during the year. The enclosed formulary is current as of September 21, 2005. To get updated information about the drugs covered by AdvantraRx Premier, please visit our website at www.AdvantraRx.com or call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548. If we remove drugs from the formulary, or 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 members who take the drug that it will be removed at least 60 days before the date that 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 the formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from the formulary and provide notice to members who take the drug.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 34. The drugs in the 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 Agents." If you know what your drug is used for, look for the category name in the list that begins on page 34. 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 39. The Index provides an alphabetical list of all 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.

How much will I pay for AdvantraRx Premier covered drugs?

If you qualified for extra help with your drug costs, your costs for your drugs may be different than those described below. Please refer to your Evidence of Coverage or call Customer Service to find out what your cost are.

The amount you pay depends on which drug tier your drug is in under our plan. (You can find out which drug tier your drug is in by looking in the formulary that begins on page 34.)

The amount you pay depends on whether you fill your prescription at a retail pharmacy or at a mail-order pharmacy. Generally, when you go to a retail pharmacy you will pay for a 30-day supply. In addition, if you fill your prescription through the mail-order pharmacy, you can get a 90-day supply.

You will pay a copayment for your drugs until your total drug costs (the amount you paid, plus the amount AdvantraRx Premier has paid) reach $2,250. Once your total drug costs reach $2,250, there is a gap in your coverage. This means you have to pay the full amount for your drugs. You pay the full amount until you have paid $3,600 out of pocket. After you have paid $3,600 out of pocket, you will generally pay the greater of:

- $2 for generic or a preferred brand drug that is a multi-source drug and $5 for all other drugs, or
- 5% coinsurance

You can ask AdvantraRx Premier to make an exception to your drug's tier placement. See the section "How do I request an exception to AdvantraRx Premier's formulary?" for information about how to request an exception.

Are there any other restrictions on coverage?

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

- **Prior Authorization:** AdvantraRx Premier requires you to get prior authorization for certain drugs. (You may need prior authorization for drugs that are on the formulary or drugs that are not on the formulary **and** were approved for coverage through the exceptions process.) This means that you will need to get approval from AdvantraRx Premier before you fill your prescriptions. If you don't get approval, AdvantraRx Premier may not cover the drug.
- **Quantity Limits:** For certain drugs, AdvantraRx Premier limits the amount of the drug that AdvantraRx Premier will cover. For example, AdvantraRx Premier provides 4 units per prescription for FOSAMAX per 30 days. This **may** be in addition to a standard 30- or 90-day supply.
- **Step Therapy:** In some cases, AdvantraRx Premier 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, AdvantraRx Premier may not cover Drug B unless you try Drug A first. If Drug A does not work for you, AdvantraRx Premier 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 34.

You can ask AdvantraRx Premier to make an exception to these restrictions or limits. See the section "How do I request an exception to AdvantraRx Premier's formulary?" below 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 Customer Service and ask if your drug is covered. This document includes only a partial list of covered drugs, so AdvantraRx Premier may cover your drug. You can contact Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

If you learn that AdvantraRx Premier does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by AdvantraRx Premier. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by AdvantraRx Premier.
- You can ask AdvantraRx Premier 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 AdvantraRx Premier's formulary?

You can ask AdvantraRx Premier to make an exception to its coverage rules. There are several types of exceptions that you can request.

- You can ask AdvantraRx Premier to cover your drug even if it is not on the formulary.

- You can ask AdvantraRx Premier to waive coverage restrictions or limits on your drug. For example, for certain drugs, AdvantraRx Premier limits the amount of the drug that it will cover. If your drug has a quantity limit, you can ask for the limit to be waived and cover more.
- You can ask AdvantraRx Premier to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Tier 2 drug, you can ask AdvantraRx Premier to cover it as a Tier 1 drug instead. This would lower the amount you must pay for your drug. Please note, if your request to cover a drug that is not on the formulary is granted, you may not ask AdvantraRx Premier to provide a higher level of coverage for the drug.

Generally, AdvantraRx Premier will only approve your request for an exception if the alternative drugs included on the plan's formulary, the low-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 Customer Service to ask 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, AdvantraRx Premier must make a decision within 72 hours of your request.

What are generic drugs?

AdvantraRx Premier covers both brand name drugs and generic drugs. A generic drug has the same active-ingredient formula as the brand name drug. Generic drugs usually cost less than brand name drugs and are approved by the Food and Drug Administration (FDA).

Generic drugs are listed in lower-case italics (e.g., *digoxin*) within the formulary on page 34. Brand name drugs are capitalized in the formulary (e.g., CLARINEX).

For more information

For more detailed information about your AdvantraRx Premier prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about AdvantraRx Premier, please call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548. Or visit www.AdvantraRx.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.

AdvantraRx Premier's formulary

The formulary that begins on page 34 provides coverage information about some of the drugs covered by AdvantraRx Premier. If you have trouble finding your drug in the list, turn to the Index that begins on page 39. Remember: This is only a partial list of drugs covered by AdvantraRx Premier. If your prescription is not in this partial formulary, please visit our website at www.AdvantraRx.com or call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548 for additional help.

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

The information in the Requirements/Limits column tells you if AdvantraRx Premier has any special requirements for coverage of your drug.

The following abbreviations may be used in the Requirements/Limits column:

- **PA–Prior Authorization:** AdvantraRx Premier requires you to get prior authorization for certain drugs. (You may need prior authorization for drugs that are on the formulary or drugs that are not on the formulary and were approved

for coverage through our exceptions process.) This means that you will need to get approval from AdvantraRx Premier before you fill your prescriptions. If you don't get approval, AdvantraRx Premier may not cover the drug.

- **QL–Quantity Limits:** For certain drugs, AdvantraRx Premier limits the amount of the drug that AdvantraRx Premier will cover. For example, AdvantraRx Premier provides 4 units per prescription for FOSAMAX per 30 days. This may be in addition to a standard 30- or 90-day supply.
- **ST–Step Therapy:** In some cases, AdvantraRx Premier requires you to first try certain drugs to treat your medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, AdvantraRx Premier may not cover Drug B unless you try Drug A first. If Drug A does not work for you, AdvantraRx Premier will then cover Drug B.
- *–Drugs marked with an asterisk "*" do not count towards your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.

Drug Name	Drug Tier	Requirements/ Limits
ANALGESICS–PAIN		
acetaminophen w/codeine	1	
fentanyl patches	1	
hydrocodone/apap	1	
morphine	1	
oxycodone	1	
oxycodone er	1	PA
oxycodone/apap	1	
propoxyphene/apap	1	
tramadol	1	
ANTIBACTERIALS–INFECTION		
amoxicillin	1	
amoxil/clavulanate	1	
AVELOX	2	QL
cefaclor	1	
cefuroxime	1	
CEFZIL	2	
ciprofloxacin	1	
clarithromycin	1	QL
doxycycline	1	
erythromycin base	1	
OMNICEF	2	
PCE	2	
penicillin	1	
smz-tmp ds	1	
ZITHROMAX	2	QL
ANTI-CONVULSANTS–SEIZURE		
carbamazepine	1	
DEPAKOTE	2	
DILANTIN	2	
gabapentin	1	
KEPPRA	2	QL
LAMICTAL	2	PA
phenytoin	1	
TEGRETOL XR	2	
TOPAMAX	3	PA
ANTIDEMENTIA AGENTS–ALZHEIMER'S DISEASE		
ARICEPT	2	QL
NAMENDA	2	QL
RAZADYNE	2	QL
ANTIDEPRESSANTS–DEPRESSION		
amitriptyline	1	
bupropion sr	1	
citalopram	1	QL
EFFEXOR XR	3	QL, ST
fluoxetine	1	
LEXAPRO	2	QL
mirtazapine tablets	1	QL
paroxetine	1	QL
trazodone	1	
ZOLOFT	3	QL
ANTIEMETICS–NAUSEA/VOMITING		
ZOFRAN	3	PA, QL
ANTIFUNGALS–FUNGAL INFECTION		
fluconazole	1	PA, QL
itraconazole	1	PA
LAMISIL	2	PA, QL
nystatin	1	
terconazole	1	
ANTIGOUT AGENTS–GOUT		
allopurinol	1	
colchicine	1	
probenecid	1	
ANTIHISTAMINES–ALLERGY		
ALLEGRA	3	QL
CLARINEX	2	QL
*loratadine**	1	QL
promethazine	1	
ZYRTEC	3	QL
ANTI-INFLAMMATORIES–ARTHRITIS/PAIN		
CELEBREX	2	ST, PA, QL
diclofenac	1	
etodolac	1	
ibuprofen	1	
indomethacin	1	
ketoprofen	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
naproxen	1	
ANTIMALARIALS–MALARIA		
quinine	1	
ANTIMIGRAINE AGENTS–MIGRAINE		
DEPAKOTE ER	2	
MAXALT	2	QL
RELPAX	2	QL
ANTINEOPLASTICS–CANCER		
ARIMIDEX	2	QL
AROMASIN	2	QL
FASLODEX	2	PA
FEMARA	2	
flutamide	1	
LUPRON	2	PA
megestrol	1	
tamoxifen	1	
ANTIPARKINSON AGENTS–PARKINSON'S DISEASE		
amantadine	1	
benztropine	1	
bromocriptine	1	
carbidopa/levodopa	1	
COMTAN	2	
MIRAPEX	2	
pergolide	1	
REQUIP	3	
selegiline	1	
trihexyphenidyl	1	
ANTIPSYCHOTICS–BEHAVIORAL HEALTH		
ESKALITH	2	
haloperidol	1	
lithium carbonate	1	
RISPERDAL	2	QL
SEROQUEL	2	QL
thiothixene	1	
ANTIRHEUMATIC AGENTS–ARTHRITIS		
ENBREL	2	PA
methotrexate	1	

Drug Name	Drug Tier	Requirements/ Limits
ANTIVIRALS–VIRAL INFECTION		
acyclovir	1	
FAMVIR	3	QL
HEPSERA	2	ST, PA, QL
PEGASYS	2	PA
ribavirin	1	PA
rimantadine	1	
VALTREX	3	QL
ANXIOLYTICS–ANXIETY		
buspirone	1	
hydroxyzine hcl	1	
BLOOD GLUCOSE REGULATORS–DIABETES		
ACTOS	2	PA, QL
glipizide	1	
glyburide	1	
HUMALOG	3	
HUMALOG MIX VIAL	3	
HUMULIN VIAL	3	
INSULIN SYRINGE	2	
LANTUS	2	
metformin	1	
NOVOLIN 70/30	2	
NOVOLIN VIAL	2	
NOVOLOG	2	
NOVOLOG MIX VIAL	2	
PRECOSE	2	
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS–BLOOD THINNERS		
AGGRENOX	3	
cilostazol	1	
COUMADIN	2	
dipyridamole	1	
heparin sodium	1	
pentoxifylline	1	
PLAVIX	2	QL
warfarin	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
CARDIOVASCULAR AGENTS–HEART/BLOOD PRESSURE		
ADVICOR	3	
ALTOPREV	1	QL
amiodarone	1	
atenolol	1	
AVALIDE	2	QL
AVAPRO	2	QL
benazepril	1	QL
bisoprolol	1	
bumetanide	1	
CARDIZEM CD	3	QL
CARDIZEM LA	2	QL
cholestyramine	1	
clonidine	1	
COREG	3	
CRESTOR	3	QL
digoxin	1	
diltiazem cd	1	QL
DIOVAN	3	QL
doxazosin	1	QL
enalapril	1	
felodipine	1	
fosinopril	1	QL
furosemide	1	
gemfibrozil	1	
hydralazine	1	
hydrochlorothiazide	1	
indapamide	1	
INNOPRAN XL	2	QL
isosorbide mononitrate	1	QL
labetalol	1	
LANOXIN	2	
LIPITOR	3	QL
lisinopril	1	
LOFIBRA	2	
MAVIK	3	QL
methyldopa	1	
metolazone	1	
metoprolol	1	
MICARDIS	2	QL
nadolol	1	
NIASPAN ER	2	
nifedipine xl	1	QL
NITRO-DUR	1	QL
nitroglycerin caps	1	
NITROSTAT SL	3	
PRAVACHOL	3	QL
prazosin	1	
procainamide	1	
propranolol	1	
quinapril	1	QL
quinidine sulfate	1	
spironolactone	1	
terazosin	1	QL
TOPROL XL	2	QL
torsemide	1	
triamterene/hctz	1	
verapamil	1	
VYTORIN	2	QL
ZOCOR	2	QL
DERMATOLOGICAL AGENTS–SKIN PREPARATIONS		
betamethasone val	1	
clobetasol	1	
clotrimazole/betamethasone	1	
DENAVIR	2	QL
ELIDEL	3	ST, PA, QL
fluocinolone	1	
fluocinonide	1	
LAMISIL	2	PA, QL
METROGEL VAG	2	
METROLOTION	2	
mometasone	1	
tretinoin	1	
triamcinolone	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
GASTROINTESTINAL AGENTS–STOMACH		
ASACOL	2	
cimetidine	1	
dicyclomine	1	
Diphenoxylate/atropine	1	
famotidine	1	
glycolax	1	
hyoscyamine	1	
lactulose	1	
metoclopramide	1	
NEXIUM	3	ST, PA, QL
PREVACID SOLTAB	3	ST, PA, QL
PRILOSEC OTC*	1	QL
PROTONIX	2	PA, QL
ranitidiine tablets	1	
sucralfate	1	
sulfasalazine	1	
ursodiol	1	
GENITOURINARY AGENTS		
bethanechol	1	
DETROL LA	3	QL
DITROPAN XL	3	QL
ENABLEX	2	QL
FLOMAX	3	QL
LEVITRA	2	QL
nitrofurantn	1	
oxybutynin	1	
PROSCAR	2	QL
SANCTURA	2	
VIAGRA	3	QL
HORMONAL AGENTS–HORMONES		
ACTONEL	3	QL
dexamethasone	1	
ESTRACE VAG	2	
ESTRADERM	3	QL
estradiol	1	QL
estropipate	1	
EVISTA	2	

Drug Name	Drug Tier	Requirements/ Limits
FORTEO	2	PA
FOSAMAX	2	QL
LEVOTHROID	2	
levothyroxine	1	
levoxyl	1	
MIACALCIN	2	
prednisolone	1	
prednisone	1	
PREMARIN	2	QL
PREMPHASE	2	QL
PREMPRO	2	QL
propylthiouracil	1	
SYNTHROID	2	
thyroid	1	
IMMUNOLOGICAL AGENTS		
azathioprine	1	PA
INFLAMMATORY BOWEL DISEASE AGENTS–RECTAL		
anucort-hc	1	
PROCTOCORT	2	
proctosol	1	
OPHTHALMIC AGENTS–EYE		
ALOCRIL	3	
AZOPT	2	
betaxolol	1	
BETOPTIC-S	3	
BLEPHAMIDE	3	
brimonidine	1	
erythromycin	1	
IOPIDINE	3	
levobunolol	1	
LUMIGAN	2	
pilocarpine	1	
timolol	1	
TIMOPTIC-XE	3	
TRAVATAN	2	
VOLTAREN	2	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
RESPIRATORY AGENTS–BREATHING		
ADVAIR	3	QL
albuterol	1	QL
ASMANEX	2	QL
ASTELIN NASAL	2	
COMBIVENT	2	QL
FLONASE	3	
FLOVENT	3	QL
FORADIL	2	
INTAL INHALER	3	
ipratropium neb sol	1	
MAXAIR AUTOHALER	3	QL
NASACORT AQ	2	QL
NASONEX	2	QL
PROVENTIL HFA	2	
PULMICORT RESPULE	3	QL
QVAR	2	
SEREVENT	3	
SINGULAIR	2	ST, PA, QL

Drug Name	Drug Tier	Requirements/ Limits
SPIRIVA	2	QL
theophylline	1	
TILADE	3	
SEDATIVES/HYPNOTICS–SLEEP		
AMBIEN	2	QL
LUNESTA	3	QL
SKELETAL MUSCLE RELAXANTS–MUSCLE RELAXER		
baclofen	1	
carisoprodol	1	
cyclobenzaprine	1	
tizanidine	1	
THERAPEUTIC NUTRIENTS / MINERALS / ELECTROLYTES–VITAMINS/MINERALS		
k+ potassium	1	
KLOR-CON	2	
K-LYTE/CL	2	
MICRO-K	2	
pot chloride	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

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Advantra®Rx Premier Plus

Formulary
(List of Covered Drugs)

This document includes AdvantraRx Premier Plus's partial formulary as of September 21, 2005.
For a complete, updated formulary, please visit our website at www.AdvantraRx.com or call 1-800-882-3822,
8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

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What is the AdvantraRx Premier Plus formulary?

A formulary is a list of drugs selected by AdvantraRx Premier Plus 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. AdvantraRx Premier Plus will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at an AdvantraRx Premier Plus network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by AdvantraRx Premier Plus. For a complete listing of all prescription drugs covered by AdvantraRx Premier Plus, please visit our website at www.AdvantraRx.com or call 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

Can the formulary change?

Yes, AdvantraRx Premier Plus may add or remove drugs from the formulary during the year. The enclosed formulary is current as of September 21, 2005. To get updated information about the drugs covered by AdvantraRx Premier Plus, please visit our website at www.AdvantraRx.com or call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548. If we remove drugs from the formulary, or 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 members who take the drug that it will be removed at least 60 days before the date that 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 the formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from the formulary and provide notice to members who take the drug.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 46. The drugs in the 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 Agents." If you know what your drug is used for, look for the category name in the list that begins on page 46. 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 51. The Index provides an alphabetical list of all 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.

How much will I pay for AdvantraRx Premier Plus covered drugs?

If you qualified for extra help with your drug costs, your costs for your drugs may be different than those described below. Please refer to your Evidence of Coverage or call Customer Service to find out what your cost are.

The amount you pay depends on which drug tier your drug is in under our plan. (You can find out which drug tier your drug is in by looking in the formulary that begins on page 46.)

The amount you pay depends on whether you fill your prescription at a retail pharmacy or at a mail-order pharmacy. Generally, when you go to a retail pharmacy you will pay for a 30-day supply. In addition, if you fill your prescription through the mail-order pharmacy, you can get a 90-day supply.

You will pay a copayment for your drugs until your total drug costs (the amount you paid, plus the amount AdvantraRx Premier Plus has paid) reach $2,250. Once your total drug costs reach $2,250, there is a gap in your coverage. This means you have to pay the full amount for your drugs. You pay the full amount until you have paid $3,600 out of pocket. After you have paid $3,600 out of pocket, you will generally pay the greater of:

- $2 for generic or a preferred brand drug that is a multi-source drug and $5 for all other drugs, or
- 5% coinsurance

You can ask AdvantraRx Premier Plus to make an exception to your drug's tier placement. See the section "How do I request an exception to AdvantraRx Premier Plus's formulary?" for information about how to request an exception.

Are there any other restrictions on coverage?

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

- **Prior Authorization:** AdvantraRx Premier Plus requires you to get prior authorization for certain drugs. (You may need prior authorization for drugs that are on the formulary or drugs that are not on the formulary **and** were approved for coverage through the exceptions process.) This means that you will need to get approval from AdvantraRx Premier Plus before you fill your prescriptions. If you don't get approval, AdvantraRx Premier Plus may not cover the drug.
- **Quantity Limits:** For certain drugs, AdvantraRx Premier Plus limits the amount of the drug that AdvantraRx Premier Plus will cover. For example, AdvantraRx Premier Plus provides 4 units per prescription for FOSAMAX per 30 days. This **may** be in addition to a standard 30- or 90-day supply.
- **Step Therapy:** In some cases, AdvantraRx Premier Plus requires you to first try certain drugs to treat your medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, AdvantraRx Premier Plus may not cover Drug B unless you try Drug A first. If Drug A does not work for you, AdvantraRx Premier Plus 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 46.

You can ask AdvantraRx Premier Plus to make an exception to these restrictions or limits. See the section "How do I request an exception to AdvantraRx Premier Plus's formulary?" below 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 Customer Service and ask if your drug is covered. This document includes only a partial list of covered drugs, so AdvantraRx Premier Plus may cover your drug. You can contact Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548.

If you learn that AdvantraRx Premier Plus does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by AdvantraRx Premier Plus. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by AdvantraRx Premier Plus.
- You can ask AdvantraRx Premier Plus 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 AdvantraRx Premier Plus's formulary?

You can ask AdvantraRx Premier Plus to make an exception to its coverage rules. There are several types of exceptions that you can request.

- You can ask AdvantraRx Premier Plus to cover your drug even if it is not on the formulary.
- You can ask AdvantraRx Premier Plus to waive coverage restrictions or limits on your drug. For example, for certain drugs, AdvantraRx Premier Plus limits the amount of the drug that it will cover. If your drug has a quantity limit, you can ask for the limit to be waived and cover more.
- You can ask AdvantraRx Premier Plus to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Tier 2 drug, you can ask AdvantraRx Premier Plus to cover it as a Tier 1 drug instead. This would lower the amount you must pay for your drug. Please note, if your request to cover a drug that is not on the formulary is granted, you may not ask AdvantraRx Premier Plus to provide a higher level of coverage for the drug.

Generally, AdvantraRx Premier Plus will only approve your request for an exception if the alternative drugs included on the plan's formulary, the low-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 Customer Service to ask 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, AdvantraRx Premier Plus must make a decision within 72 hours of your request.

What are generic drugs?

AdvantraRx Premier Plus covers both brand name drugs and generic drugs. A generic drug has the same active-ingredient formula as the brand name drug. Generic drugs usually cost less than brand name drugs and are approved by the Food and Drug Administration (FDA).

Generic drugs are listed in lower-case italics (e.g., *digoxin*) within the formulary on page 46. Brand name drugs are capitalized in the formulary (e.g., CLARINEX).

For more information

For more detailed information about your AdvantraRx Premier Plus prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about AdvantraRx Premier Plus, please call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548. Or visit www.AdvantraRx.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.

AdvantraRx Premier Plus's formulary

The formulary that begins on page 46 provides coverage information about some of the drugs covered by AdvantraRx Premier Plus. If you have trouble finding your drug in the list, turn to the Index that begins on page 51. Remember: This is only a partial list of drugs covered by AdvantraRx Premier Plus. If your prescription is not in this partial formulary, please visit our website at www.AdvantraRx.com or call Customer Service at 1-800-882-3822, 8 a.m.–8 p.m., local time, and 8 a.m.–5 p.m. in Hawaii, 7 days a week. TTY/TDD users should call 1-800-508-9548 for additional help.

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

The information in the Requirements/Limits column tells you if AdvantraRx Premier Plus has any special requirements for coverage of your drug.

The following abbreviations may be used in the Requirements/Limits column:

- **PA–Prior Authorization:** AdvantraRx Premier Plus requires you to get prior authorization for

certain drugs. (You may need prior authorization for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through the exceptions process.) This means that you will need to get approval from AdvantraRx Premier Plus before you fill your prescriptions. If you don't get approval, AdvantraRx Premier Plus may not cover the drug.

- **QL–Quantity Limits:** For certain drugs, AdvantraRx Premier Plus limits the amount of the drug that AdvantraRx Premier Plus will cover. For example, AdvantraRx Premier Plus provides 4 units per prescription for FOSAMAX per 30 days. This may be in addition to a standard 30- or 90-day supply.
- **ST–Step Therapy:** In some cases, AdvantraRx Premier Plus requires you to first try certain drugs to treat your medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, AdvantraRx Premier Plus may not cover Drug B unless you try Drug A first. If Drug A does not work for you, AdvantraRx Premier Plus will then cover Drug B.
- *–Drugs marked with an asterisk "*" do not count towards your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.

Drug Name	Drug Tier	Requirements/ Limits
ANALGESICS–PAIN		
acetaminophen w/codeine	1	
fentanyl patches	1	
hydrocodone/apap	1	
morphine	1	
oxycodone	1	
oxycodone er	1	PA
oxycodone/apap	1	
propoxyphene/apap	1	
tramadol	1	
ANTIBACTERIALS–INFECTION		
amoxicillin	1	
amoxil/clavulanate	1	
AVELOX	2	QL
cefaclor	1	
cefuroxime	1	
CEFZIL	2	
ciprofloxacin	1	
clarithromycin	1	QL
doxycycline	1	
erythromycin base	1	
OMNICEF	2	
PCE	2	
penicillin	1	
smz-tmp ds	1	
ZITHROMAX	2	QL
ANTI-CONVULSANTS–SEIZURE		
carbamazepine	1	
DEPAKOTE	2	
DILANTIN	2	
gabapentin	1	
KEPPRA	3	QL
LAMICTAL	3	PA
phenytoin	1	
TEGRETOL XR	2	
TOPAMAX	3	PA
ANTIDEMENTIA AGENTS–ALZHEIMER'S DISEASE		
ARICEPT	2	QL

Drug Name	Drug Tier	Requirements/ Limits
NAMENDA	2	QL
RAZADYNE	2	QL
ANTIDEPRESSANTS–DEPRESSION		
amitriptyline	1	
bupropion sr	1	
citalopram	1	QL
EFFEXOR XR	2	QL, ST
fluoxetine	1	
LEXAPRO	2	QL
mirtazapine tablets	1	QL
paroxetine	1	QL
trazodone	1	
ZOLOFT	2	QL
ANTIEMETICS–NAUSEA/VOMITING		
ZOFRAN	2	PA, QL
ANTIFUNGALS–FUNGAL INFECTION		
fluconazole	1	PA, QL
itraconazole	1	PA
LAMISIL	2	PA, QL
nystatin	1	
terconazole	1	
ANTIGOUT AGENTS–GOUT		
allopurinol	1	
colchicine	1	
probenecid	1	
ANTIHISTAMINES–ALLERGY		
ALLEGRA	3	QL
CLARINEX	2	QL
*loratadine**	1	QL
promethazine	1	
ZYRTEC	3	QL
ANTI-INFLAMMATORIES–ARTHRITIS/PAIN		
CELEBREX	3	ST, PA, QL
diclofenac	1	
etodolac	1	
ibuprofen	1	
indomethacin	1	
ketoprofen	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
naproxen	1	
ANTIMALARIALS–MALARIA		
quinine	1	
ANTIMIGRAINE AGENTS–MIGRAINE		
DEPAKOTE ER	2	
MAXALT	2	QL
RELPAX	2	QL
ANTINEOPLASTICS–CANCER		
ARIMIDEX	2	QL
AROMASIN	2	QL
FASLODEX	2	PA
FEMARA	2	
flutamide	1	
LUPRON	2	PA
megestrol	1	
tamoxifen	1	
ANTIPARKINSON AGENTS–PARKINSON'S DISEASE		
amantadine	1	
benztropine	1	
bromocriptine	1	
carbidopa/levodopa	1	
COMTAN	2	
MIRAPEX	2	
pergolide	1	
REQUIP	2	
selegiline	1	
trihexyphenidyl	1	
ANTIPSYCHOTICS–BEHAVIORAL HEALTH		
ESKALITH	2	
haloperidol	1	
lithium carbonate	1	
RISPERDAL	2	QL
SEROQUEL	2	QL
thiothixene	1	
ANTIRHEUMATIC AGENTS–ARTHRITIS		
ENBREL	2	PA
methotrexate	1	

Drug Name	Drug Tier	Requirements/ Limits
ANTIVIRALS–VIRAL INFECTION		
acyclovir	1	
FAMVIR	2	QL
HEPSERA	2	ST, PA, QL
PEGASYS	2	PA
ribavirin	1	PA
rimantadine	1	
VALTREX	3	QL
ANXIOLYTICS–ANXIETY		
buspirone	1	
hydroxyzine hcl	1	
BLOOD GLUCOSE REGULATORS–DIABETES		
ACTOS	2	PA, QL
glipizide	1	
glyburide	1	
HUMALOG	3	
HUMALOG MIX VIAL	3	
HUMULIN VIAL	3	
INSULIN SYRINGE	2	
LANTUS	2	
metformin	1	
NOVOLIN 70/30	2	
NOVOLIN VIAL	2	
NOVOLOG	2	
NOVOLOG MIX VIAL	2	
PRECOSE	2	
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS–BLOOD THINNERS		
AGGRENOX	2	
cilostazol	1	
COUMADIN	2	
dipyridamole	1	
heparin sodium	1	
pentoxifylline	1	
PLAVIX	2	QL
warfarin	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

Drug Name	Drug Tier	Requirements/ Limits
CARDIOVASCULAR AGENTS–HEART/BLOOD PRESSURE		
ADVICOR	2	
ALTOPREV	1	QL
amiodarone	1	
atenolol	1	
AVALIDE	2	QL
AVAPRO	2	QL
benazepril	1	QL
bisoprolol	1	
bumetanide	1	
CARDIZEM CD	2	QL
CARDIZEM LA	2	QL
cholestyramine	1	
clonidine	1	
COREG	2	
CRESTOR	3	QL
digoxin	1	
diltiazem cd	1	QL
DIOVAN	3	QL
doxazosin	1	QL
enalapril	1	
felodipine	1	
fosinopril	1	QL
furosemide	1	
gemfibrozil	1	
hydralazine	1	
hydrochlorothiazide	1	
indapamide	1	
INNOPRAN XL	2	QL
isosorbide mononitrate	1	QL
labetalol	1	
LANOXIN	2	
LIPITOR	2	QL
lisinopril	1	
LOFIBRA	2	
MAVIK	2	QL
methyldopa	1	
metolazone	1	
metoprolol	1	
MICARDIS	2	QL
nadolol	1	
NIASPAN ER	2	
nifedipine xl	1	QL
NITRO-DUR	1	QL
nitroglycerin caps	1	
NITROSTAT SL	2	
PRAVACHOL	3	QL
prazosin	1	
procainamide	1	
propranolol	1	
quinapril	1	QL
quinidine sulfate	1	
spironolactone	1	
terazosin	1	QL
TOPROL XL	2	QL
torsemide	1	
triamterene/hctz	1	
verapamil	1	
VYTORIN	2	QL
ZOCOR	2	QL
DERMATOLOGICAL AGENTS–SKIN PREPARATIONS		
betamethasone val	1	
clobetasol	1	
clotrimazole/betamethasone	1	
DENAVIR	3	QL
ELIDEL	2	ST, PA, QL
fluocinolone	1	
fluocinonide	1	
LAMISIL	2	PA, QL
METROGEL VAG	2	
METROLOTION	2	
mometasone	1	
tretinoin	1	
triamcinolone	1	

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Drug Name	Drug Tier	Requirements/ Limits
GASTROINTESTINAL AGENTS–STOMACH		
ASACOL	2	
cimetidine	1	
dicyclomine	1	
Diphenoxylate/atropine	1	
famotidine	1	
glycolax	1	
hyoscyamine	1	
lactulose	1	
metoclopramide	1	
NEXIUM	3	ST, PA, QL
PREVACID SOLTAB	3	ST, PA, QL
PRILOSEC OTC*	1	QL
PROTONIX	2	PA, QL
ranitidiine tablets	1	
sucralfate	1	
sulfasalazine	1	
ursodiol	1	
GENITOURINARY AGENTS		
bethanechol	1	
DETROL LA	3	QL
DITROPAN XL	3	QL
ENABLEX	3	QL
FLOMAX	3	QL
LEVITRA	2	QL
nitrofurantn	1	
oxybutynin	1	
PROSCAR	2	QL
SANCTURA	3	
VIAGRA	3	QL
HORMONAL AGENTS–HORMONES		
ACTONEL	3	QL
dexamethasone	1	
ESTRACE VAG	2	
ESTRADERM	2	QL
estradiol	1	QL
estropipate	1	
EVISTA	2	
FORTEO	2	PA
FOSAMAX	2	QL
LEVOTHROID	2	
levothyroxine	1	
levoxyl	1	
MIACALCIN	2	
prednisolone	1	
prednisone	1	
PREMARIN	2	QL
PREMPHASE	2	QL
PREMPRO	2	QL
propylthiouracil	1	
SYNTHROID	2	
thyroid	1	
IMMUNOLOGICAL AGENTS		
azathioprine	1	PA
INFLAMMATORY BOWEL DISEASE AGENTS–RECTAL		
anucort-hc	1	
PROCTOCORT	2	
proctosol	1	
OPHTHALMIC AGENTS–EYE		
ALOCRIL	2	
AZOPT	2	
betaxolol	1	
BETOPTIC-S	2	
BLEPHAMIDE	2	
brimonidine	1	
erythromycin	1	
IOPIDINE	2	
levobunolol	1	
LUMIGAN	2	
pilocarpine	1	
timolol	1	
TIMOPTIC-XE	2	
TRAVATAN	2	
VOLTAREN	2	

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Drug Name	Drug Tier	Requirements/ Limits
RESPIRATORY AGENTS–BREATHING		
ADVAIR	2	QL
albuterol	1	QL
ASMANEX	2	QL
ASTELIN NASAL	2	
COMBIVENT	2	QL
FLONASE	2	
FLOVENT	2	QL
FORADIL	2	
INTAL INHALER	2	
ipratropium neb sol	1	
MAXAIR AUTOHALER	2	QL
NASACORT AQ	3	QL
NASONEX	2	QL
PROVENTIL HFA	2	
PULMICORT RESPULE	2	QL
QVAR	2	
SEREVENT	3	
SINGULAIR	2	ST, PA, QL
SPIRIVA	2	QL
theophylline	1	
TILADE	2	
SEDATIVES/HYPNOTICS–SLEEP		
AMBIEN	3	QL
LUNESTA	3	QL
SKELETAL MUSCLE RELAXANTS–MUSCLE RELAXER		
baclofen	1	
carisoprodol	1	
cyclobenzaprine	1	
tizanidine	1	
THERAPEUTIC NUTRIENTS / MINERALS / ELECTROLYTES–VITAMINS/MINERALS		
k+ potassium	1	
KLOR-CON	2	
K-LYTE/CL	2	
MICRO-K	2	
pot chloride	1	

**These drugs do not count toward your total out-of-pocket expenditure, and if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these drugs.*

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Advantra®Rx Pharmacy Network

AdvantraRx has a pharmacy network of over 58,000 retail pharmacies, long-term care pharmacies, home infusion pharmacies, and Indian Health Service/Tribal/Urban Indian Program (I/T/U) pharmacies.

Below is a list of some of the large national pharmacy chains in our network to serve your needs. However this is a list of only large chains and a comprehensive list of retail pharmacies and all other contracted pharmacies is available upon request by simply visiting our website at www.AdvantraRx.com through your agent or calling 1-800-882-3822 (TDD for the hearing impaired 1-800-508-9548) 8 a.m. to 8 p.m. and 8 a.m. to 5 p.m. in Hawaii, seven days a week.

Albertson's
A&P
Acme Pharmacy
Bel Air
Bell Pharmacy
Bigg's
BJ's Pharmacy
Brooks Pharmacy
Budget Saver Pharmacies
Buehler's Pharmacy
Carr's Pharmacies
City Market
Costco Pharmacies
Cub
CVS/Pharmacy
Dillon
Drug Basics
Eagle Drugs
Eckerd
Fagen Pharmacy
Farmer Jack
Food City Pharmacy
Food Emporium
Fred Meyer
Frys
GHA Pharmacy (Cincinnati)
Giant Eagle Pharmacy
Giant Foods of Maryland
Giant Food Stores of Pennsylvania
Happy Harry's Pharmacy
Harmons Pharmacy
Harris Teeter Pharmacy
Harvest Foods Pharmacies
H-E-B Pharmacy
Hen House Pharmacy
Keltsch
Kerr Drug
King Sooper
Kmart Pharmacy
Kroger
Longs Drug Stores
Martin's Pharmacy
Nob Hill
Pamida Pharmacies
Park Nicollett Pharmacies
Pathmark Pharmacy
PharMerica, Inc.
Prairie Stone Pharmacies
Price Chopper Pharmacy
Publix
Quality Food Center
Raley's
Ralph's
Rite Aid
Safeway
Schnuck Markets, Inc.
Shop 'N Save Pharmacy
Shoprite Pharmacy
Smiths
Stop & Shop Pharmacy
Super Fresh
Target
The Medicine Shoppe
Thrifty White
Tops Markets
United Supermarkets, Ltd.
Valley Drug
Waldbaum's
Walgreens
Wal-Mart Pharmacies
Weber & Judd/MCBE Company
Wegmans Food Markets
Weis Pharmacy
Mr. Z's Pharmacy
King's Pharmacy
Scot's Lo-Cost Pharmacy
White Drug

AdvantraRx may add or remove pharmacies from our network. This is only a partial list of retail pharmacies and is subject to change.

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