NATIONAL IAM
BENEFIT TRUST FUND
Better Benefits · Better Life

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To: **All Medical Plan Participants**
From: **Connie DeFrance, Managing Director**
Date: **August 30, 2013**
Re: **Summary of Material Modifications - 2014 Changes to the Prescription Drug Formulary, and Prior Authorization Requirement for Male Androgens**

THIS IS AN IMPORTANT NOTICE ABOUT CHANGES TO YOUR PRESCRIPTION DRUG COVERAGE EFFECTIVE JANUARY 1, 2014

FORMULARY CHANGES

CVS Caremark has issued its annual notice regarding changes to its covered drug list (formulary), which may impact you or your eligible dependents. The enclosed memorandum lists the changes that apply for 2014. It also includes a comprehensive list of all products that now require prior authorization for coverage under the Fund's Prescription Drug Plan.

If you or your dependents **ARE CURRENTLY USING** any of the products being removed from the formulary, you must transition to a "therapeutic equivalent" alternative by January 1, 2014, or have your doctor request a prior authorization review to determine whether continued coverage is clinically appropriate; otherwise, coverage of these products will be denied. You and your prescribing physician will be sent a notification by CVS Caremark that will, among other things, identify the product(s) in question and provide information about covered therapeutic equivalents. Most of the listed products have both brand name and generic equivalents, with the lowest patient copayment for generics. Your doctor will determine which equivalent product will best meet your needs. Where appropriate, you should ask him or her if a lower cost generic can be used.

Note - A ***therapeutic equivalent*** is a drug that has essentially the same effect in the treatment of a disease or condition as one or more other drugs (i.e., a drug that controls a symptom or condition in the exact same way as another).

If you or your dependents **ARE NOT CURRENTLY USING** any of the products that are being removed from the formulary, you will not be affected by this change. However, you should retain this information and share it with your physician for future reference concerning what products require prior authorization for coverage under the Prescription Drug Program.

Prior Authorization Review: If your physician feels there is a clinical reason why you or your dependent cannot or should not use any of the available therapeutic equivalent alternatives in place of one or more of the excluded products, the physician should call CVS Caremark toll-free at **1-855-240-0536** to request prior authorization review and approval for continued use of the current item. The doctor will be required to support his or her position with clinical information. CVS Caremark will review the information to determine whether coverage should be allowed for the current product as an exception.

If prior authorization review results in approval of the product as a clinical exception, the plan will continue to cover the current product at the brand name copayment level (greatest copayment). However, if prior authorization review is not favorable, and CVS Caremark determines that a therapeutic equivalent can be used, you or your dependent must transition to a covered equivalent to receive coverage under the Plan.

If a prescribed item is not approved for coverage, you can always choose to pay for the non-covered product yourself. On the other hand, the easiest way to ensure that the Plan covers your prescription drugs and devices at the lowest possible out-of-pocket cost is to ask your physician to select generic equivalents for all your prescription needs. Use of generics will always result in the lowest possible expense to you and the greatest possible savings to the Fund.

PRIOR AUTHORIZATION REQUIREMENT FOR MALE ANDROGENS

The Plan provides coverage for medically necessary treatment of erectile dysfunction resulting from an established medical condition. This includes coverage for prescribed male androgens (testosterone and erectile dysfunction drugs). Recently, CVS Caremark indicated that a high percentage of male androgens are used for lifestyle enhancement rather than medical necessity. Since the Plan does not provide coverage unless medications are medically necessary, effective January 1, 2014, prior authorization will be required for coverage of male androgens.

If you or your dependents **ARE CURRENTLY USING** male androgens, you and the prescribing physician will be notified by CVS Caremark of the need for medical necessity review. Your doctor can also call CVS Caremark directly at their toll-free number **1-855-240-0536** to request prior authorization approval for continued use of the current medication. The doctor will be required to provide supporting clinical information, which CVS Caremark will review to determine whether medical necessity has been established.

If medical necessity is confirmed, the plan will continue to cover the current product, subject to the existing 10 pill per month limit for on-demand products, or a 30 pill per month limit for daily use Cialis 2.5mg or 5mg. However, if the review is not favorable, and CVS Caremark determines that the use of a male androgen is not medically necessary, coverage will be denied.

If you or your dependents **ARE NOT CURRENTLY USING** male androgens, you will not be affected by this change. However, you should retain this information and share it with your physician for future reference concerning this prior authorization requirement for coverage under the Prescription Drug Program.

IF YOU HAVE QUESTIONS

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions, please contact the Benefit Trust Fund at 800-457-3481.

cc: Board of Trustees
Fund Director
Contributing Employers
Union Representatives

January 2014

Medications Requiring Prior Authorization for Medical Necessity

Below is a list of medicines by drug class that will not be covered without a prior authorization for medical necessity, effective January 1, 2014. If you continue using one of these drugs after this date without prior approval for medical necessity, you may be required to pay the full cost.

If you are currently using one of the drugs requiring prior authorization for medical necessity, ask your doctor to choose one of the generic or brand formulary consideration options listed below.

Bolded products represent drugs requiring prior authorization for medical necessity that are new for the 2014 plan year.

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Considerations
Allergies * Nasal Steroids / Combinations	BECONASE AQ OMNARIS QNASL RHINOCORT AQUA VERAMYST **ZETONNA**	*flunisolide spray, fluticasone spray, triamcinolone spray,* NASONEX
	DYMISTA	*flunisolide spray, fluticasone spray, triamcinolone spray,* or NASONEX **WITH** *azelastine* or ASTEPRO
Allergies * Ophthalmic	**LASTACAFT**	*azelastine, cromolyn sodium,* PATADAY, PATANOL
Anti-infectives, Antivirals * Herpes Agents	**VALTREX**	*acyclovir, valacyclovir*
Asthma * Beta Agonists, Short-Acting	MAXAIR **VENTOLIN HFA** XOPENEX HFA	PROAIR HFA, PROVENTIL HFA
Asthma * Steroid Inhalants	**ALVESCO**	ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR
Asthma * *or Chronic Obstructive Pulmonary Disease (COPD)* * Steroid / Beta Agonist Combinations	**BREO ELLIPTA**	ADVAIR, DULERA, SYMBICORT
Cardiovascular Antilipemics * HMG Co-A Reductase Inhibitors (HMGs or Statins) / Combinations	ADVICOR ALTOPREV **LESCOL XL** **LIPITOR** LIVALO **LIPTRUZET**	*atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin,* CRESTOR, SIMCOR, VYTORIN
Cardiovascular Antilipemics * Fibrates	**TRICOR**	*fenofibrate*, ANTARA, LIPOFEN, TRILIPIX
Chronic Obstructive Pulmonary Disease (COPD) * Anticholinergics	**TUDORZA PRESSAIR**	SPIRIVA
Depression * Antidepressants	OLEPTRO	*trazodone*

CVS CAREMARK

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Considerations
Dermatology *Skin Inflammation and Hives* * Corticosteroids	OLUX-E	*clobetasol propionate foam 0.05%*, CLOBEX SPRAY
Diabetes * Biguanides	FORTAMET GLUMETZA RIOMET	*metformin, metformin ext-rel*
Diabetes * Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	**NESINA** ONGLYZA	JANUVIA, TRADJENTA
Diabetes * Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations	**KAZANO** KOMBIGLYZE XR **OSENI**	JANUMET, JANUMET XR, JENTADUETO
Diabetes * Insulins	HUMALOG	APIDRA, NOVOLOG
	HUMALOG MIX 50/50	NOVOLOG MIX 70/30
	HUMALOG MIX 75/25	NOVOLOG MIX 70/30
	HUMULIN 70/30	NOVOLIN 70/30
	HUMULIN N	NOVOLIN N
	HUMULIN R	NOVOLIN R
	NOTE: *Humulin U-500 concentrate will not be subject to removal and will continue to be covered.*	
Diabetes * Supplies [2]	**BREEZE 2 STRIPS AND KITS** **CONTOUR STRIPS AND KITS** **CONTOUR NEXT STRIPS AND KITS** FREESTYLE STRIPS AND KITS	ACCU-CHEK STRIPS AND KITS [2], ONETOUCH STRIPS AND KITS [2]
Diabetes * Insulin Sensitizers	**ACTOS**	*pioglitazone*
Erectile Dysfunction * Phosphodiesterase Inhibitors	LEVITRA	CIALIS, VIAGRA
Gastrointestinal Agents * Proton Pump Inhibitors (PPIs)	**PREVACID** **PROTONIX**	*lansoprazole del-rel, omeprazole del-rel, omeprazole-sodium bicarbonate, pantoprazole del-rel,* DEXILANT, NEXIUM
Glaucoma * Prostaglandin Analogs	LUMIGAN	*latanoprost,* TRAVATAN Z, ZIOPTAN
Growth Hormones *	GENOTROPIN NUTROPIN / NUTROPIN AQ OMNITROPE SAIZEN TEV-TROPIN	HUMATROPE, NORDITROPIN
High Blood Pressure * Angiotensin II Receptor Antagonists	ATACAND EDARBI TEVETEN	*candesartan, eprosartan, irbesartan, losartan,* BENICAR, DIOVAN, MICARDIS

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Considerations
High Blood Pressure * Angiotensin II Receptor Antagonist / Diuretic Combinations	ATACAND HCT **DIOVAN HCT** EDARBYCLOR TEVETEN HCT	*candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, valsartan-hydrochlorothiazide,* BENICAR HCT, MICARDIS HCT
Hematologic * Platelet Aggregation Inhibitor	**PLAVIX**	*clopidogrel*, BRILINTA, EFFIENT
Inflammatory Bowel Disease (IBD), Ulcerative Colitis * Aminosalicylates	**ASACOL HD** **DELZICOL**	*balsalazide, sulfasalazine, sulfasalazine del-rel*, APRISO, LIALDA, PENTASA
Opioid Dependence Agents *	**SUBOXONE FILM**	*buprenorphine/naloxone sublingual tablets*
Overactive Bladder / Incontinence * Urinary Antispasmodics	DETROL LA OXYTROL SANCTURA XR TOVIAZ	*oxybutynin ext-rel*, *tolterodine*, *trospium*, *trospium ext-rel*, GELNIQUE, VESICARE
Pain and Inflammation * Nonsteroidal Anti-inflammatory Drugs (NSAIDs) / Combinations	ARTHROTEC	*diclofenac sodium del-rel/misoprostol*, CELEBREX, VIMOVO
	FLECTOR	*diclofenac, meloxicam, naproxen*
Pain and Inflammation * Corticosteroids	**RAYOS**	*dexamethasone, methylprednisolone, prednisone*
Prostate Condition * Benign Prostatic Hyperplasia Agents / Combinations	JALYN	*finasteride* or AVODART **WITH** *alfuzosin ext-rel, doxazosin, tamsulosin, terazosin* or RAPAFLO
Sleep * Hypnotics, Non-benzodiazepines	INTERMEZZO ROZEREM	*zolpidem, zolpidem ext-rel*
Testosterone Replacement * Androgens	ANDROGEL TESTIM	ANDRODERM, AXIRON, FORTESTA
Transplant * Immunosuppressants, Calcineurin Inhibitors	Hecoria	*tacrolimus*

The listed formulary considerations are subject to change.

List of Drugs Requiring Prior Authorization for Medical Necessity - *Carryover from 2013*

ADVICOR	HUMALOG MIX 50/50	ONGLYZA
ALTOPREV	HUMALOG MIX 75/25	OXYTROL
ANDROGEL	HUMULIN 70/30	QNASL
ARTHROTEC	HUMULIN N	RHINOCORT AQUA
ATACAND	HUMULIN R	RIOMET
ATACAND HCT	INTERMEZZO	ROZEREM
BECONASE AQ	JALYN	SAIZEN
DETROL LA	KOMBIGLYZE XR	SANCTURA XR
EDARBI	LEVITRA	TESTIM
EDARBYCLOR	LIVALO	TEVETEN
FLECTOR	LUMIGAN	TEVETEN HCT
FORTAMET	MAXAIR	TEV-TROPIN
FREESTYLE STRIPS AND KITS	NUTROPIN / NUTROPIN AQ	TOVIAZ
GENOTROPIN	OLEPTRO	VERAMYST
GLUMETZA	OLUX-E	XOPENEX HFA
Hecoria	OMNARIS	
HUMALOG	OMNITROPE	

List of Drugs Requiring Prior Authorization for Medical Necessity - *New for 2014*

ACTOS	**DYMISTA**	**PREVACID**
ALVESCO	**KAZANO**	**PROTONIX**
ASACOL HD	**LASTACAFT**	**RAYOS**
BREEZE 2 STRIPS AND KITS	**LESCOL XL**	**SUBOXONE FILM**
BREO ELLIPTA	**LIPITOR**	**TRICOR**
CONTOUR STRIPS AND KITS	**LIPTRUZET**	**TUDORZA PRESSAIR**
CONTOUR NEXT STRIPS AND KITS	**NESINA**	**VALTREX**
DELZICOL	**OSENI**	**VENTOLIN HFA**
DIOVAN HCT	**PLAVIX**	**ZETONNA**

There may be additional drugs subject to prior authorization or other plan design restrictions. Please consult your plan for further information.

This list represents brand products in CAPS, branded generics in upper- and lowercase, and generic products in lowercase *italics*. This is not an all-inclusive list of available drug alternative considerations. Log in to **www.caremark.com** to check coverage and copay information for a specific drug. Discuss this information with your doctor or health care provider. This information is not a substitute for medical advice or treatment. Talk to your doctor or health care provider about this information and any health-related questions you have. CVS Caremark assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information. This list is subject to change.

Subject to applicable state law restrictions.

* This list indicates the common uses for which the drug is prescribed. Some drugs are prescribed for more than one condition.

1 If your doctor believes you have a specific clinical need for one of these products, he or she should contact the Prior Authorization department toll-free at: 1-855-240-0536.

2 An Accu-Chek or OneTouch blood glucose meter will be provided at no charge by the manufacturer to those individuals currently using a meter other than Accu-Chek or OneTouch. For more information on how to obtain a blood glucose meter, call toll-free: 1-800-588-4456. Members must have CVS Caremark Mail Service Pharmacy benefits to qualify.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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www.caremark.com

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