NATIONAL IAM
BENEFIT TRUST FUND
Better Benefits · Better Life

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To: **All Medical Plan Participants**
From: **Connie DeFrance, Managing Director**
Date: **October 20, 2014**
Re: **Summary of Material Modifications - 2015 Changes to the Prescription Drug Formulary, Generic Step Therapy, and Prior Authorization of Compounds**

THIS IS AN IMPORTANT NOTICE ABOUT CHANGES TO YOUR PRESCRIPTION DRUG COVERAGE THROUGH CVS CAREMARK EFFECTIVE JANUARY 1, 2015.

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 2015. It also includes a comprehensive list of all prescription drug products that now require prior authorization for coverage under the National IAM Benefit Trust Fund prescription drug program through CVS Caremark.

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, 2015, or have your Physician request a prior authorization review to determine whether continued coverage is clinically appropriate; otherwise, coverage of these products will be denied. CVS Caremark will notify you and your Physician of 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 Physician 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 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 Physician 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.

Diabetic Testing Equipment

The new formulary limits glucose monitors and related test strips to OneTouch devices. OneTouch blood glucose meters will be provided at no charge by the manufacturer to those individuals currently using a meter other than OneTouch. For more information on how to obtain a blood glucose meter, call **1-800-588-4456**.

GENERIC STEP THERAPY

Effective **January 1, 2015**, the Plan has implemented the CVS Caremark generic step therapy program that requires participants to try one or more generic equivalent alternatives in most drug classes before the Plan will provide coverage for a brand name drug. Prior to January 2015, CVS Caremark will review the prescription drug history for all participants who utilize brand name drugs to determine whether generics or generic equivalent alternatives have been tried.

If the record shows that generics or generic equivalent alternatives were used or attempted during the prior 12 month period, that participant ***will be allowed to continue the brand name drug without disruption***. CVS Caremark may also notify the prescribing Physician of other generic alternatives that could be tried, but any change would be with your Physician's approval.

If you have not tried a generic or generic equivalent to the brand name drug, your Physician will be offered generic alternative options, and will be required to select one. Your brand name prescription will be changed to the generic alternative chosen by your Physician. The Plan will not continue coverage for brand name drugs in 2015 until you try one or more generic alternatives, except as noted below.

Exceptions to Generic Alternatives

If there is no record of generic or generic equivalent alternative use in the most recent 12 month period, your Physician can provide CVS Caremark with further historic information about alternatives you tried earlier, if applicable, and request approval for continued coverage of the brand name drug. Your Physician can also provide a statement of medical necessity that explains clinical reasons why the brand name drug is required, and the brand name drug will be allowed if medical necessity is confirmed by CVS Caremark.

This review and exception process will be handled between CVS Caremark and your Physician before 2015, so your Physician will be able to explain any changes to your prescriptions before they occur. However, **we suggest you inform your Physician about this impending change now**, and ask to be moved to a generic drug or generic equivalent, if possible. Your Physician can also call CVS Caremark directly at **1-800-294-5979** to request prior approval for continued coverage of the current medication.

When You Get New Prescriptions

THIS IS VERY IMPORTANT! If you need new prescriptions on or after January 1, 2015, **be sure to inform your Physician that the Plan requires you to try generics or generic equivalents**, whenever possible, before the Plan will cover a brand name drug. If a brand name drug is required, it must be specifically ordered, and the Physician will be required to verify medical necessity through the CVS Caremark prior authorization process. If you have not tried a generic alternative, and do not have prior authorization approval of medical necessity, **you will be responsible for full payment of the brand name drug** even if the prescription is marked "dispense as written".

To avoid any confusion at the pharmacy, we suggest that you ask **your Physician to call CVS Caremark at 1-800-294-5979** in advance to see if your brand name drug is covered by the Plan, what alternatives are available, and to initiate the medical necessity review process where appropriate.

PRIOR AUTHORIZATION OF COMPOUNDED MEDICATIONS

A compounded medication is a medication that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.

Effective **January 1, 2015**, any medication classified as a compounded medication that costs more than $300.00 will require prior authorization before coverage is provided under the Plan. Bulk powders and high cost proprietary bases are excluded from coverage. One fill for a compound medication is allowed in a 34 day period.

If your Physician or other Allied Health Professional prescribes a compound medication for you or your Dependent, you should ask him or her to call CVS Caremark at **1-800-294-5979** to request prior authorization before you fill the prescription.

OUT-OF-POCKET MAXIMUM FOR PRESCRIPTION DRUG COVERAGE

We are pleased to inform you that the Plan is being improved effective **January 1, 2015** to include an out-of-pocket limit on the prescription drug program administered by CVS Caremark. The limit was established to comply with the Patient Protection and Affordable Care Act (PPACA), and it varies based on benefit design. Please refer to the Summary of Benefits and Coverage (SBC) for information on the out-of-pocket limit that will apply for you. When you have paid prescription drug copayments to meet the limit during any calendar year, your copayments will be waived for the balance of that calendar year.

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 2015

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, 2015. 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 options listed below.

Bolded products represent drugs requiring prior authorization for medical necessity that are new for the 2015 plan year.

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Allergic Reaction (Anaphylaxis) Treatment *	**ADRENACLICK**	AUVI-Q, EPIPEN, EPIPEN JR
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 spray* or PATANASE
Allergies * Ophthalmic	LASTACAFT	*azelastine, cromolyn sodium,* PATADAY, PATANOL
Anti-infectives, Antivirals * Herpes Agents	VALTREX	*acyclovir, valacyclovir*
Asthma * Beta Agonists, Short-Acting	**PROVENTIL HFA** VENTOLIN HFA XOPENEX HFA	PROAIR HFA
Asthma * Steroid Inhalants	**AEROSPAN** ALVESCO	ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR
*Asthma * or Chronic Obstructive Pulmonary Disease (COPD)* * Steroid / Beta Agonist Combinations	**SYMBICORT**	ADVAIR, DULERA
Attention Deficit Hyperactivity Disorder Agents	**ADDERALL XR**	*amphetamine-dextroamphetamine mixed salts ext-rel*
Cardiovascular Antilipemics * Fibrates	TRICOR	*fenofibrate, fenofibric acid*
Cardiovascular Antilipemics * HMG Co-A Reductase Inhibitors (HMGs or Statins) / Combinations	ADVICOR ALTOPREV LESCOL XL LIPITOR LIPTRUZET LIVALO	*atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin,* CRESTOR, SIMCOR, VYTORIN

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Chronic Obstructive Pulmonary Disease (COPD) * Anticholinergics	TUDORZA	SPIRIVA
Dermatology Skin Inflammation and Hives * Corticosteroids	OLUX-E	*clobetasol propionate foam 0.05%*, CLOBEX SPRAY
	APEXICON E	*desoximetasone, fluocinonide*
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** Injectable Incretin Mimetics	**BYETTA**	BYDUREON, VICTOZA
Diabetes * Insulins	**APIDRA** HUMALOG	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 R U-500 concentrate will not be subject to prior authorization and will continue to be covered.*	
Diabetes * Insulin Sensitizers	ACTOS	*pioglitazone*
*Diabetes** Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors	**FARXIGA**	INVOKANA
Diabetes * Supplies	**ACCU-CHEK STRIPS AND KITS** BREEZE 2 STRIPS AND KITS CONTOUR NEXT STRIPS AND KITS CONTOUR STRIPS AND KITS FREESTYLE STRIPS AND KITS **All other test strips that are not ONETOUCH brand**	ONETOUCH ULTRA STRIPS AND KITS [2], ONETOUCH VERIO STRIPS AND KITS [2]
Erectile Dysfunction * Phosphodiesterase Inhibitors	LEVITRA	CIALIS, VIAGRA
Gastrointestinal Agents * Proton Pump Inhibitors (PPIs)	PREVACID PROTONIX	*lansoprazole, omeprazole, omeprazole-sodium bicarbonate capsule, pantoprazole*, DEXILANT, NEXIUM

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Glaucoma * Prostaglandin Analogs	LUMIGAN	*latanoprost, travoprost,* TRAVATAN Z, ZIOPTAN
Growth Hormones *	GENOTROPIN NUTROPIN AQ OMNITROPE SAIZEN TEV-TROPIN	HUMATROPE, NORDITROPIN
Hematologic * Platelet Aggregation Inhibitors	PLAVIX	*clopidogrel,* BRILINTA, EFFIENT
High Blood Pressure * Angiotensin II Receptor Antagonists	ATACAND EDARBI TEVETEN	*candesartan, eprosartan, irbesartan, losartan, telmisartan,* BENICAR, DIOVAN
High Blood Pressure * Angiotensin II Receptor Antagonist / Diuretic Combinations	ATACAND HCT DIOVAN HCT EDARBYCLOR TEVETEN HCT	*candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide,* BENICAR HCT
High Blood Pressure * Calcium Channel Blockers	**NORVASC**	*amlodipine*
Inflammatory Bowel Disease (IBD), Ulcerative Colitis * Aminosalicylates	ASACOL HD DELZICOL	*balsalazide, sulfasalazine, sulfasalazine delayed-rel,* APRISO, LIALDA, PENTASA
*Multiple Sclerosis Agents**	**REBIF**	AVONEX, COPAXONE, EXTAVIA, GILENYA, TECFIDERA
*Musculoskeletal Agents**	**AMRIX**	*cyclobenzaprine*
Opioid Dependence Agents *	SUBOXONE FILM	*buprenorphine-naloxone sublingual tablet,* ZUBSOLV
*Osteoarthritis** Viscosupplements	**EUFLEXXA** **ORTHOVISC**	GEL-ONE, HYALGAN, SUPARTZ
Overactive Bladder / Incontinence * Urinary Antispasmodics	DETROL LA OXYTROL TOVIAZ	*oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel,* GELNIQUE, VESICARE
Pain and Inflammation * Corticosteroids	RAYOS	*dexamethasone, methylprednisolone, prednisone*
Pain and Inflammation * Nonsteroidal Anti-inflammatory Drugs (NSAIDs) / Combinations	ARTHROTEC **DUEXIS** **VIMOVO**	CELEBREX; *diclofenac, meloxicam,* or *naproxen* **WITH** *lansoprazole, omeprazole, omeprazole/sodium bicarbonate, pantoprazole,* DEXILANT, or NEXIUM
	FLECTOR **PENNSAID**	*diclofenac, diclofenac sodium solution, meloxicam, naproxen,* VOLTAREN GEL
	NAPRELAN	*diclofenac, meloxicam, naproxen,* CELEBREX
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 **LUNESTA** ROZEREM	*eszopiclone, zolpidem, zolpidem ext-rel*

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Testosterone Replacement * Androgens	***testosterone gel*** ANDROGEL **NATESTO** TESTIM **VOGELXO**	ANDRODERM, AXIRON, FORTESTA
Transplant * Immunosuppressants, Calcineurin Inhibitors	Hecoria	*tacrolimus*

*Category** Drug Class	Formulary Options
Hepatitis C Agents*	OLYSIO, SOVALDI and/or other Hepatitis C agents in the pipeline: Evaluation and identification of Drugs Requiring Prior Authorization for Medical Necessity will be made upon approval of the new Hepatitis C agents.
New to Market Agents [1]	New to market products and new variations of products already in the marketplace will be excluded from [or "will not be added to"] the formulary until the product has been evaluated, determined to be clinically appropriate and cost effective, and approved by the CVS/caremark Pharmacy and Therapeutics Committee (or other appropriate reviewing body).

The listed formulary options are subject to change.

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

ACTOS	Hecoria	OSENI
ADVICOR	HUMALOG	OXYTROL
ALTOPREV	HUMALOG MIX 50/50	PLAVIX
ALVESCO	HUMALOG MIX 75/25	PREVACID
ANDROGEL	HUMULIN 70/30	PROTONIX
ARTHROTEC	HUMULIN N	QNASL
ASACOL HD	HUMULIN R	RAYOS
ATACAND	INTERMEZZO	RHINOCORT AQUA
ATACAND HCT	JALYN	RIOMET
BECONASE AQ	KAZANO	ROZEREM
BREEZE 2 STRIPS AND KITS	KOMBIGLYZE XR	SAIZEN
CONTOUR NEXT STRIPS AND KITS	LASTACAFT	SUBOXONE FILM
CONTOUR STRIPS AND KITS	LESCOL XL	TESTIM
DELZICOL	LEVITRA	TEVETEN
DETROL LA	LIPITOR	TEVETEN HCT
DIOVAN HCT	LIPTRUZET	TEV-TROPIN
DYMISTA	LIVALO	TOVIAZ
EDARBI	LUMIGAN	TRICOR
EDARBYCLOR	NESINA	TUDORZA
FLECTOR	NUTROPIN AQ	VALTREX
FORTAMET	OLUX-E	VENTOLIN HFA
FREESTYLE STRIPS AND KITS	OMNARIS	VERAMYST
GENOTROPIN	OMNITROPE	XOPENEX HFA
GLUMETZA	ONGLYZA	ZETONNA

List of Drugs Requiring Prior Authorization for Medical Necessity - *New for 2015*

ACCU-CHEK STRIPS AND KITS +	**DUEXIS**	**PENNSAID**
ADDERALL XR	**EUFLEXXA**	**PROVENTIL HFA**
ADRENACLICK	**FARXIGA**	**REBIF**
AEROSPAN	**LUNESTA**	**SYMBICORT**
AMRIX	**NAPRELAN**	***testosterone gel***
APEXICON E	**NATESTO**	**VIMOVO**
APIDRA	**NORVASC**	**VOGELXO**
BYETTA	**ORTHOVISC**	

+ Also includes all other test strips that are not ONETOUCH brand

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 options. 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 laws and regulations.

* 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 A OneTouch blood glucose meter will be provided at no charge by the manufacturer to those individuals currently using a meter other than 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.

CVS/caremark may receive rebates, discounts and service fees from pharmaceutical manufacturers for certain listed products. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS/caremark. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the doctor.

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CVS/caremark