
Pharmacy Services



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At a Glance

UPMC Health Plan's Pharmacy Services Department helps to monitor appropriate utilization and manage health care dollars spent on prescription medications as well as the benefit plans for all lines of business. The department also works with Medical Management to coordinate member care regarding medications.

The Health Plan offers four prescription programs to commercial members—Your Choice, a four-tier formulary, Value Choice, a three-tier formulary, First Choice, a two-tier formulary, and Open Choice Preferred Formulary, a two-tier open formulary. There also are separate formularies for UPMC *for Kids* (Children's Health Insurance Program), UPMC *for You* (Medical Assistance), UPMC *for Life* (Medicare), and UPMC *for Life* Specialty Plan members.

Each of the formulary programs includes the following features:

- Mandatory generics
- Once-daily dosing initiatives to improve patient compliance
- Lists of preferred drugs, otherwise known as formulary medications
- Prior authorization or step-therapy requirements for selected medications
- Quantity limits (based on FDA guidelines and accepted standards of care)

The Health Plan's formularies are developed by the physicians and clinical pharmacists on the Pharmacy and Therapeutics Committee.

The Health Plan's clinical pharmacists also:

- Answer medication-related questions from providers and network pharmacies
- Develop and conduct prospective and retrospective drug utilization reviews
- Educate providers, network pharmacies, and members on pharmacy changes
- Serve as a clinical resource for the provider network
- Conduct a medication therapy management (MTM) program
- Provides physician and patient education materials to network practices to support drug selection and use based on the best objective and clinical evidence.

The Health Plan encourages providers to contact the **Pharmacy Services Department** at **1-800-396-4139** from 8 a.m. to 5 p.m., Monday through Friday with comments or questions about a member's medication history, duplicate medications, or compliance. Physicians may fax in requests for prior authorizations or non-formulary medications to 412-454-7722.

To obtain authorization for a medication requiring a prior authorization or quantity limits, or a non-formulary medication, providers should:

- Go online at www.upmchealthplan.com and submit a prior authorization form by fax to 412-454-7722.
- UPMC Health Plan will immediately communicate all coverage determinations and prior authorization decisions via fax to the physician's office once the review process is complete. If a fax number is not available, UPMC Health Plan will communicate decisions via telephone and will mail a copy of any decision documentation to the provider's office.
- Physicians are to notify the patient of all pharmacy prior authorization decisions rendered by the Health Plan. If a request is denied, the member will be mailed a letter by the Health Plan fully explaining the rationale for the denial of coverage.

Pharmacy Policies

Mandatory Generics

Most formularies include the concept of mandatory generics, which requires that a brand-name medication with an A-rated generic equivalent be filled as a generic for the lowest copayment.

Your Choice and First Choice:

If a generic is available but a member chooses to use a brand-name medication, the member must pay the brand-name (second-tier) copayment plus the difference in retail price between the brand-name drug and the generic drug.

If a provider believes and offers evidence that a brand-name medication is “medically necessary,” the provider may request a medical necessity review through Pharmacy Services. If the request is approved, the member will pay the third-tier copayment for Your Choice and the second-tier copayment for First Choice.

Value Choice:

If a generic is available but a member or physician chooses to use a brand-name medication, the member must pay 100 percent of the contracted rate for the brand-name medication. The contracted rate is a special rate negotiated by UPMC Health Plan and should offer a cost savings over standard retail rate.

Open Choice Preferred Formulary:

Follows same policy as Your Choice and First Choice

A limited number of medications require authorization before they are dispensed to members. Authorizations may be required for the following reasons:

- To submit for a medication with a prior authorization requirement
 - To write any prescription that exceeds Health Plan quantity limits
 - To request a non-formulary medication
 - To request early refills
- ▶ Please reference website, www.upmchealthplan.com, for a complete list of medications.

These guidelines help promote safe and effective use of medications. In some cases, clinical documentation is necessary in order to review these medication requests. All requests will be reviewed promptly, and the decision will be communicated to the physician or member when applicable.

To obtain authorization for a medication requiring a prior authorization or quantity limits, or a non-formulary medication, providers should:

- ▶ Go online at **www.upmchealthplan.com** and submit a prior authorization form by fax to 412-454-7722

Step Therapy

Step therapy is a process to ensure that Health Plan preferred medications are used as the first course of treatment. If the preferred medication is not clinically effective or if the member has side effects, another medication may be used as the second course of treatment.

The rules for each step therapy medication are built into the pharmacy computer files. These medications are automatically approved if there is a record that the member has already tried a preferred medication. If there is no record of a preferred medication in the member's medication history, the physician must submit clinical information to the Health Plan. Once that information is received, the Health Plan will make a decision regarding payment for the requested medication.

- ▶ Please reference website, www.upmchealthplan.com, for a complete list of medications.

Once-Daily Dosing

To improve adherence to medication regimens, the Health Plan requires once-daily dosing for certain medications. A provider who feels a member needs multiple daily doses may call **Pharmacy Services** at **1-800-396-4139** from 8 a.m. to 5 p.m., Monday through Friday.

Quantity Limits

The United States Food and Drug Administration (FDA) publishes guidelines on the safest and most efficient ways to use certain medications. For these medications, the Health Plan's Pharmacy and Therapeutics Committee follows the FDA and manufacturer's recommended dosing guidelines and limits how much of the medication the member may receive in a certain time period. Providers are encouraged to incorporate these quantity limits into their prescribing patterns.

- ▶ Please reference website, www.upmchealthplan.com, for a complete list of medications.

For medical exceptions, call **Pharmacy Services** at **1-800-396-4139** from 8 a.m. to 5 p.m., Monday through Friday.

UPMC Health Plan (Commercial) Pharmacy Programs

Your Choice (Four-Tier) Pharmacy Program

Your Choice is for commercial members and features a four-tier formulary. Many medications, unless they require prior authorization or are benefit exclusions, are reimbursed under this program. This allows for accessibility of all medications within a class and permits members and providers to determine the medication that is best for the individual member.

▶ *See Medications Requiring Prior Authorization, chapter J.*

The first tier, which has the lowest copayment, is for generic medications that are A-rated by the FDA. These are therapeutically equivalent to the branded product. When a generic medication is available, providers are encouraged to prescribe the generic medication to their patients.

The second tier, which has a slightly higher copayment, includes those brand-name drugs for which generics are not available. The Health Plan has designated these agents “preferred” based on clinical efficacy, safety profile, and cost effectiveness.

The third tier includes medications that are not preferred but which the member may purchase at a higher copayment.

The fourth tier includes high-cost medications and biologicals regardless of how the medication is administered (injectable, oral, transdermal or inhalant). These medications may require close management due to potential for side effects and frequent dose adjustments for effectiveness. These medications are often used to treat complex clinical conditions. Special methods for administration and specific storage and handling provisions also are often needed for appropriate use of these medications.

Your Choice includes a few restrictions that allow us to provide members with a wide range of options at an affordable cost. Your Choice requires **the member** to use a generic version of the drug if one is available. If **members** have a mandatory generic plan and receive a brand-name drug when a generic is available, **the member** must pay the preferred brand (second-tier) copayment in addition to the retail cost difference between the brand-name and generic forms of the drug. Also, quantities are limited to a 30-day supply from retail locations, controlled substances and for medications defined as specialty. A 90-day supply of most drugs is available

from the mail-order pharmacy, Express Scripts, Inc. (ESI). ESI customer service center is available 24/7 at 1-877-787-6279 (TTY: 1-800-899-2114) or by logging in to request refills online.

Your Choice drugs are listed alphabetically in the [Pharmacy Benefit Guide](#). This is a listing of the most commonly prescribed drugs and represents an abbreviated drug formulary that is at the core of our pharmacy benefit plan. Please remember that there are many other drug categories and drugs that Your Choice covers besides the ones listed in the table.

If a provider believes and offers evidence that a brand-name medication is “medically necessary,” the provider may request a prior authorization through Pharmacy Services.

▶ [See Medications Requiring Prior Authorization, chapter J.](#)

Your Choice Pharmacy Program Guide

Please select the link below to view the Your Choice Prescription Drug Formulary.

▶ [See Your Choice Prescription Drug Formulary.](#)

Value Choice (Three -Tier) Pharmacy Program

The UPMC Health Plan’s *Value Choice* pharmacy program provides good value by offering a variety of high-quality, cost-effective generic and select brand-name prescription drugs. When a [member requires](#) a prescription medication, [providers have the opportunity to](#) select from a wide range of generic drugs. In addition, when generic drugs are not available, providers can choose from certain brand-name medications. Specialty medications are also available through this plan. *Value Choice* allows [our members](#) to take full advantage of the savings offered by generic drugs over their higher-priced brand-name alternatives.

The first tier, which has the lowest copayment, is for generic medications that are A-rated by the FDA. These are therapeutically equivalent to the branded product. When a generic medication is available, providers are encouraged to prescribe the generic medication to their patients.

The second tier, which has a slightly higher copayment, includes those brand-name drugs for which generics are not available. The Health Plan has designated these agents “preferred” based on clinical efficacy, safety profile, and cost effectiveness.

The third tier includes specialty medications. This tier includes high-cost medications and biologicals, regardless of how the medication is administered (injectable, oral, transdermal, or inhalant). These medications are often used to treat complex clinical conditions and usually require close management by a physician because of their potential

side effects and the need for frequent dosage adjustments. These drugs have the highest copayment.

The *Value Choice* program requires a member to use a generic version of the drug if one is available. This means that if a member receives a brand-name drug when a generic is available, the member must pay 100% of the contracted rate for the brand-name drug. The contracted rate is a special rate negotiated by UPMC Health Plan and should offer a cost savings over the standard retail rate. Also, quantities are limited to a 30-day supply from retail locations, controlled substances and for specialty medications. A 90-day supply of most drugs, are available from ESI.

If a member needs a generic prescription drug that is not listed in the table, the member will pay the lowest copayment for the medication. If the member requires a brand-name drug that is not listed on the table, the member will pay 100% of the contracted rate for that drug. Benefit exclusions are listed in the "Medications Not Covered by *Value Choice*" table.

All of the brand-name and specialty medications covered by *Value Choice* are listed in the [Pharmacy Benefit Guide](#). This list includes some commonly prescribed generic drugs. Please note that there are many other generic drugs that *Value Choice* covers besides the ones listed in the table.

Value Choice Pharmacy Program Guide

Please select the link below to view the Value Choice Prescription Drug Formulary.

▶ [See Value Choice Prescription Drug Formulary.](#)

First Choice Pharmacy Program

The First Choice program for commercial members features a two-tiered copayment scale for covered prescription medications—one for brand-name medications with a higher copayment and the other for generic medications with a lower copayment.

The first tier, which has the lower copayment, is for generic medications. These are therapeutically equivalent to the branded product. When a generic medication is available, providers are encouraged to prescribe the generic medication to their patients.

The second tier, which has a slightly higher copayment, is for preferred brand-name drugs. The Health Plan has designated these agents “preferred” based on clinical efficacy, safety profile, and cost effectiveness.

The specialty segment includes high-cost medications and biologicals regardless of how the medication is administered (injectable, oral, transdermal or inhalant). These medications are often used to treat complex clinical conditions and usually require close management by a physician because of their potential side effects and the need for frequent dosage adjustments. These drugs have the higher copayment.

The Non-First Choice segment includes medications that are not typically covered by First Choice. If you have previously taken a First Choice drug and it was not successful in treating your condition, your doctor may contact UPMC Health Plan for approval for a specific Non-First Choice drug. These drugs have the higher copayment.

If a medication featured in the First Choice program is ineffective or causes an adverse reaction, providers, at their discretion, may prescribe the non-First Choice medication without seeking prior authorization if use of the First Choice medication is indicated in the member's pharmacy profile.

First Choice includes a few restrictions which allow the Health Plan to offer members a wide range of options at an affordable cost. First Choice requires [the member](#) to use a generic version of the drug if one is available. If [a member](#) has a mandatory generic plan and [receives](#) a brand-name drug when a generic is available, [the member](#) must pay the preferred brand (second-tier) copayment in addition to the retail cost difference between the brand-name and generic forms of the drug. Also, quantities are limited to a 30-day supply from retail locations, for controlled substances and for medications defined as specialty. A 90-day supply of most drugs is available from ESI.

First Choice drugs are listed alphabetically [in our Pharmacy Benefit Guide](#). This is a listing of the most commonly prescribed drugs and represents an abbreviated drug formulary that is at the core of [our](#) pharmacy benefit plan. Please remember that there are many other drug categories and drugs that First Choice covers besides the ones listed in the table.

Lifestyle enhancement and cosmetic medications are not covered.

- ▶ [See Medications Requiring Prior Authorization, chapter J.](#)
- ▶ [See Benefit Exclusions, chapter J.](#)

Prescription drugs not covered are listed in the “Medications Not Covered” and “Non-Covered Medications with Covered Alternatives” sections.

First Choice Pharmacy Program Guide

Please select the link below to view the First Choice Prescription Drug Formulary.

- ▶ [See First Choice Prescription Drug Formulary.](#)

UPMC for Kids Pharmacy Program

UPMC for Kids Pharmacy Program (Two-Tier)

The UPMC *for Kids* pharmacy program features a closed, two-tiered formulary for covered prescription medications—one tier for generic medications and the other for preferred brand-name medications. The program requires mandatory generic utilization when available. Members must fill prescriptions at a participating pharmacy.

Some copayments may apply. The UPMC *for Kids* member identification (ID) card has copayment information printed on the front. Members are responsible for copayments when the prescription is picked up at the pharmacy or when ordering a medication through the mail-order program. If a medication is ordered through the mail-order program and a 90-day supply is provided, the member will only have to pay two copayments instead of three. Specialty medications, controlled substances and over-the-counter medications cannot be ordered through the mail-order program. UPMC for Kids uses the Express Scripts (ESI) Company for the mail-order program and can be reached at 1-877-787-6279, (TTY: 1-800-899-2114). See copayment chart below:

Pharmacy including diabetic supplies	Free CHIP	Low-Cost CHIP	Full-Cost CHIP
Retail			
Generic Drug	\$0	\$6 for 30-day supply	\$10 for 30-day supply
Brand Drug	\$0	\$9 for 30-day supply	\$18 for 30-day supply
Mail-Order			
Generic Drug		\$12 for 90-day supply	\$20 for 90-day supply
Brand Drug		\$18 for 90-day supply	\$36 for 90-day supply

The UPMC *for Kids* pharmacy program utilizes prior authorization programs, step therapy, quantity limits, once-daily dosing, and benefit exclusions.

- ▶ See *Medications Requiring Prior Authorization*, chapter J.
- ▶ See *Quantity Limits*, chapter J.
- ▶ See *Benefit Exclusions*, chapter J.

Step Therapy

The rules for each step therapy medication are built into the pharmacy computer files. These medications are automatically approved if there is a record that the member has already tried a preferred medication. If there is no record of a preferred medication in the member's

medication history, the Health Plan will request clinical information from the member's physician. Once that information is received, the Health Plan will make a decision on payment for the requested medication. Step therapy medications include:

- Singulair
- Lexapro
- Ranexa
- Effexor XR
- Byetta
- Ramipril

Medications not covered by UPMC *for Kids*

Medications that are considered to be benefit exclusions by the Pennsylvania Children's Health Insurance Program (CHIP) will not be covered. These include the following:

- Drugs used for cosmetic purposes
- Drug Efficacy Study Implementation (DESI) drugs
- Experimental drugs
- Infertility agents
- Weight loss drugs
- Anabolic steroids
- Biological
- Blood or blood plasma
- Drugs labeled for investigational use
- Drugs used for hair growth
- Impotency drugs
- Urine strips

There is no coverage for lost, stolen, or destroyed medications and for prescriptions that are over refilled or dispensed after one year from the date that the prescription was written.

UPMC *for Kids* Pharmacy Program Guide

Please select the link below to view the UPMC *for Kids* Prescription Drug Formulary.

- ▶ [See UPMC *for Kids* Prescription Drug Formulary.](#)

UPMC for You (Medical Assistance) Pharmacy Program

UPMC for You Pharmacy Program (Two-Tier)

The UPMC *for You* pharmacy program features a closed, two-tiered formulary for covered prescription medications—one tier for generic medications and the other for preferred brand-name medications.

The program requires mandatory generic utilization when available and includes limited over-the-counter products when written on a prescription. The program covers smoking cessation aides and birth control.

Pharmacy copayments will apply to members in the adult and general assistance benefit categories, as well as members 18 to 20 years of age. Copayments are as follows:

- Brand-name prescription and over-the-counter pharmaceutical drugs: \$3 per prescription
- Generic prescription and over-the-counter pharmaceutical drugs: \$1 per prescription
- If a 90-day supply of medication is approved, then the member will be responsible for only 1 co-payment.

For members in the **general assistance** benefit category:

If pharmacy copayments between January and June or between July and December are more than \$180, UPMC *for You* will automatically refund the amount that is over \$180.

For members in the **adult** benefit category:

If pharmacy copayments between January and June or between July and December are more than \$90, UPMC *for You* will automatically refund the amount that is over \$90.

UPMC *for You* will issue rebate checks within 4 to 6 weeks following each six-month period.

Providers (including pharmacies) are responsible for the collection of applicable copayments for rendered services. According to State and Federal law; however, if a member cannot afford to pay the copayment, providers must render covered services to the member despite non-payment of the copayment. Providers may bill the member for the amount of the copayment after rendering services.

The following prescription drug classes are excluded from copayments for members in the adult benefit category and members 18 to 20 years of age:

- Antihypertensives
- Antidiabetics
- Anticonvulsants
- Cardiovascular preparations
- Antipsychotics
- Antineoplastics
- Antiglaucoma drugs
- Anti-Parkinson's drugs
- AIDS drugs
- Antidepressants

Pharmacy copayments do not apply to:

- Pregnant women (including the postpartum period, which ends 60 days after delivery)
- Recipients under the age of 18
- Nursing facility residents
- Emergency supplies
- Family planning supplies
- Intermediate care facility for the mentally retarded and other related conditions (ICF/MR/ORCs)
- Drugs, including immunizations, when dispensed by a physician
- Breast and Cervical Cancer Prevention Treatment (BCCPT)
- Foster Care Adoption Assistance

The UPMC *for You* pharmacy program utilizes prior authorization programs, step therapy, quantity limits, once-daily dosing, and benefit exclusions.

- ▶ [See Medications Not Covered by UPMC for You, chapter J.](#)

Step Therapy

Step therapy is a process to ensure that Health Plan preferred medications are used as the first course of treatment. If the preferred medication is not clinically effective or if the member has side effects, another medication may be used as the second course of treatment.

The rules for each step therapy medication are built into the pharmacy computer files. These medications are automatically approved if there is a record that the member has already tried a preferred medication. If there is no record of a preferred medication in the member's medication history, the Health Plan will request clinical information from the member's physician. Once that information is received, the Health Plan will make a decision on payment for the requested medication.

Medications not covered by UPMC *for You*

The following medications are benefit exclusions and will not be covered:

- Antiobesity medications
- Biologicals, blood, or blood plasma
- DESI drugs
- Drugs labeled for investigational use
- Drugs used for cosmetic purposes or hair growth
- Fertility agents

UPMC *for You* Pharmacy Program Guide

Please select the link below to view the UPMC *for You* Prescription Drug Formulary.

- ▶ [See UPMC for You Prescription Drug Formulary.](#)

UPMC for Life (Medicare)

Pharmacy Program

Beginning January 1, 2006, new Medicare prescription drug coverage called Medicare Part D was offered to everyone with Medicare. The Medicare Part D coverage is intended to help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage.

UPMC Health Plan offers the following plans that include Medicare-approved prescription drug plans:

- UPMC *for Life* HMO RX
- UPMC *for Life* HMO RX Enhanced
- UPMC *for Life* PPO RX Enhanced
- UPMC *for Life* Specialty Plan
- UPMC *for Life* PFFS (Private Fee for Service)
- UPMC *for Life* Prescription Drug Plan
- UPMC *for Life* Prescription Drug Plan Enhanced

The UPMC *for Life* HMO RX, UPMC *for Life* PPO RX, and UPMC *for Life* Specialty Plan are Medicare Advantage Plans. Medicare beneficiaries must have permanent residence within the UPMC *for Life* service area in order to join the plan.

The UPMC *for Life* Prescription Drug Plan, also called a stand-alone prescription drug plan, is offered to Medicare beneficiaries who have permanent residence in the UPMC Health Plan service area. This plan covers the Medicare prescription drug coverage only (it does not cover the medical and hospital portion of Medicare, or Medicare Parts A and B).

With the UPMC *for Life* Prescription Drug Plan, members are required to pay the copayment amounts for medications until the total cost (the total amount the member paid as well as the amount the UPMC *for Life* Prescription Drug Plan has paid) reach \$2,510. Members are then required to pay the full amount for medications until they reach \$4,350 in out-of-pocket costs. After reaching \$4,050, members generally pay a \$2.25 copayment for generic and preferred brand drugs that are multi-source and \$5.60 for all other drugs, or a 5% coinsurance, whichever is greater. These dollar values are based on 2008 values which are adjusted annually by CMS.

The UPMC *for Life* pharmacy program utilizes quantity limits, once-daily dosing, benefit exclusions, and prior authorization requirements.

- ▶ See *Medications Requiring Prior Authorization*, chapter J.
- ▶ See *Once-Daily Dosing*, chapter J.
- ▶ See *Quantity Limits*, chapter J.
- ▶ See *Benefit Exclusions*, chapter J.

Exception Process

An exception is the request for payment for a prescription drug that is not on the formulary or a request to pay differently from the coverage rules. A provider or member may request an exception for any medication. The request may be submitted to the following address:

UPMC *for Life*
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219
Phone: 1-800-396-4139
Fax: 412-454-7722

If a provider deems the generic equivalent has not produced the same clinical results as a brand medication, the doctor must provide written documentation of laboratory or objective values (for example, blood pressure readings), as well as dates of trial of the brand and generic medication if applicable.

If a medical exception is granted, the member will be able to receive the brand medication at the non-preferred 3rd tier co-payment for the 2008 plan year.

Copayment Exception

Copayment exceptions will only be made from tier 3 and 4 agents to tier 2. No exceptions will be made for 5th tier agents to a lower tier. Based upon a letter from the prescribing provider discussing that the member has tried and failed all lower tiered / lower cost similar agents or has significant clinical rationale for lowering the tier placement for an individual member, UPMC Health Plan can review the request.

UPMC Health Plan decisions will be made within 24 hours of receiving all pertinent clinical information from the prescribing doctor. A response will be provided to the doctor via fax within 2 business days of receipt of all pertinent clinical information.

Medication Therapy

UPMC Health Plan has developed a program to assist members with multiple chronic diseases, multiple chronic medications and a high out-of-pocket expense. The program consists of a team approach of internal clinical pharmacists, registered nurses, caseworkers, clinical psychologists and support staff with oversight by the Medicare Medical Director. The program has defined admission criteria for participation.

All members who meet the admission criteria are reviewed by a clinical pharmacist and referred to case management staff for outreach and/or education on medication regimen. The case manager will make an outbound call to the member or caregiver, and if the member is willing to participate, completes an assessment.

Areas of assistance available through this intervention include, but are not limited to, the following:

- Education
- Coordination of transportation to doctor appointments if needed
- Referral to assistance agencies such as the department of aging and community resources if needed
- Encouragement of compliance with medications
- Assessment of support network
- Teaching coping mechanisms especially with regard to caregivers

Drug Utilization

UPMC Health Plan has developed procedures for the assessment of drug therapy. The purpose of these procedures is to ensure that outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical outcomes. Drug therapy assessments can occur at the point of sale and after dispensing has occurred.

When conducting drug therapy assessments at the point of sale, the pharmacist will use professional opinion and judgment to determine if a prescribed drug may potentially cause adverse medical results. The pharmacist will consult with the patient and/or doctor to take steps in reducing the likelihood that drug therapy will adversely affect the patient's health.

When conducting drug therapy assessments after dispensing has occurred, the clinical pharmacist evaluates the drug therapies to determine whether treatment was appropriate and medically necessary. For treatment that was inappropriate or unnecessary, education of members and providers will be initiated by the Health Plan to impact members' compliance with drug therapies, providers' prescribing and pharmacists' dispensing habits.

UPMC *for Life* Pharmacy Program Guide

Please select the link below to view the UPMC *for Life* Prescription Drug Formulary.

▶ [See UPMC *for Life* Prescription Drug Formulary.](#)

UPMC for Life Specialty Plan Pharmacy Program

- ▶ See *UPMC for Life (Medicare) Pharmacy Program*
- ▶ See *UPMC for Life Prescription Drug Formulary*.

Benefit Exclusions for Medicare

The following medications, products, or services are not included under the pharmacy plan:

- Antiobesity medications including, but not limited to, appetite suppressants and lipase inhibitors
- Biologicals, blood or blood plasma
- Drugs for cosmetic purposes or hair growth
- Drugs labeled for investigational use
- Drugs to treat impotency (prior authorization for *UPMC for You* members only)
- Fertility agents
- Legend vitamins (covered for *UPMC for You*)
- Medications that are lost, stolen, or destroyed
- Non-federal legend drugs
- Over-the-counter medications (covered for *UPMC for You*)
- Prescriptions over-refilled or dispensed after 1 year

*These items may be provided under medical benefits. (Please contact Provider Services at 1-866-918-1595 or *UPMC for You* Provider Services at 1-800-286-4242 for additional information.)

Where to Obtain Prescriptions

In Person

UPMC Health Plan has developed a pharmacy network that includes Giant Eagle, Target, Walgreens, Sams Club, Walmart, K-mart, and Rite-Aid pharmacies in addition to neighborhood and independent pharmacies. When prescriptions are filled at a participating retail pharmacy, commercial or UPMC *for Life* members may receive up to a 30-day (1 month) supply. Medicare members may receive up to a 3-month supply at certain retail pharmacies.

Effective January 1, 2009, UPMC *for You* members have the opportunity to receive a 90-day supply for the cost of 1 copayment through the 90-day retail pharmacy program.

By Mail

UPMC Health Plan offers mail-order prescription services to its members through **Express Scripts**. The mail-order service may be contacted at **1-877-787-6279**. **TTY users** should call **1-800-899-2114**.

Members typically have a lower copayment when filling prescriptions through the mail-order service. Medicaid members are not eligible for mail-order service.

Certain specialty medications must be ordered through the **CuraScript** mail-order service for Commercial and Medicaid members. Specialty medications may be ordered by calling **1-877-787-6279**. **TTY users** should call **1-800-899-2114**.