NWPS
NORTHWEST PHARMACY SERVICES

C T U I R

DAY SUPPLY:

Retail Pharmacy	30 day supply
Mail Service Pharmacy & Yellowhawk Clinic	90 day supply

COPAY: The copay amount as specified below applies to each covered prescription or refill.

Retail Pharmacy Generic	$ 10.00
Retail Pharmacy Formulary Brand	$ 25.00
Retail Pharmacy Non-Formulary Brand	$ 50.00

Mail Service Pharmacy Generic	$ 20.00
Mail Service Pharmacy Formulary Brand	$ 50.00
Mail Service Pharmacy Non-Formulary Brand	$100.00

COVERED ITEMS: The following items are covered under this drug benefit.

- prescription drugs except as listed in excluded items
- diabetic supplies, including insulin, insulin syringes, testing supplies
- prenatal vitamins requiring a prescription
- contraceptives
- fluoride requiring a prescription
- PDE5 inhibitors only when prescribed and approved to treat erectile dysfunction symptoms caused by a medical condition

EXCLUDED ITEMS: The following items are **not** covered under this drug benefit.

- over the counter drugs (except those listed in covered items)
- appetite suppressants and drugs for weight loss
- drugs and medications used for cosmetic purposes (tretinoin (Retin-A) requires authorization for patients over 26 years of age)
- fertility/infertility drugs
- smoking deterrents
- growth hormone
- steroids for body building
- injectable drugs not listed below
- vitamins, except prenatal and preventive items
- drugs to treat impotency (except as listed in covered items)

COVERED INJECTABLE ITEMS: The following injectable items are covered under this drug benefit.

- insulin
- Byetta
- drugs used to treat rheumatoid arthritis
- drugs used to treat muscular sclerosis
- drugs used to treat Hepatitis C
- anaphylaxis therapy agents (i.e.: Epi-Pen)
- glucagon
- drugs used to treat migraines

PREVENTIVE DRUG COVERAGE: please refer to next page

PREVENTIVE DRUG COVERAGE

Under the Patient Protection and Affordable Care Act, most health plans must cover certain preventive services and drugs with no cost-sharing. Listed below are drugs covered that comply with the preventive benefits requirements. Over the counter items also require a prescription from your medical provider.

ITEM	PLAN REQUIREMENTS
CONTRACEPTIVES	
Oral, injectable and patch	Generic only Quantity limits may apply
Over the counter female contraceptives: Conceptrol Gynol II Today Sponge VCF Vaginal Foam VCF Vaginal Film	Generic and select brand-name products Quantity limits may apply Male condoms are not covered
Nuvaring	Quantity limits may apply
ASPIRIN **(over the counter)**	Generic only – 81mg & 325mg For men ages 45 to79 and women ages 55 to 79
FLUORIDE	Generic only – 0.25mg & 0.5mg drops and tablets Children age 6 months to 5 years
FOLIC ACID **(over the counter)**	Generic only – 0.4mg & 0.8mg Females who may become pregnant
IRON **(over the counter)**	Generic only – 15 mg drops Children age 6 to 12 months
VITAMIN D **(over the counter)**	Generic only Adults age 65 or older
SMOKING CESSATION **(over the counter)** Nicotine gum Nicotine lozenge Nicotine patch	Generic only Adults age 18 or older Quantity limits may apply
SMOKING CESSATION Bupropion Chantix Nicotrol, Nicotrol NS	Adults age 18 or older Quantity limits may apply
BREAST CANCER PREVENTION Tamoxifen Raloxifene	Generic only Women age 35 or older Documentation of risk factors Quantity limits may apply