

The following drugs have a Dispensing Limitation (quantity limit per 30 days unless otherwise specified)

Prescription Drug	Quantity Limits	Comments
Ambien/Sonata 5/10mg AmbienCR	30 tablets	Limitation applies to drugs either singularly or in combination
Amerge 1/2.5mg	9 tablets	Limitation applies to drugs either singularly or in combination
Axert 6.5/12.5mg	12 tablets	Limitation applies to drugs either singularly or in combination
Caverject/Edex/Muse	6 vials or pellets	Limitation applies to drugs either singularly or in combination
Celebrex 100/200/400mg	68 tablets	
Cialis (Males Only)	6 tablets	Limitation applies to drugs either singularly or in combination
Diflucan 150mg	2 tablets	
Frova 2.5mg	9 tablets	
Imitrex 25/50/100mg	9 tablets	Limitation applies to drugs either singularly or in combination
Imitrex Injection	3 kits	
Imitrex Nasal Spray	1 – 6 unit package	
Lamisil	90 tablets per calendar year (30 tablets maximum per 30 days)	
Levitra 5/10/20mg (Males Only)	6 tablets	Limitation applies to drugs either singularly or in combination
Lunesta 1/2/3mg	30 tablets	
Maxalt/Maxalt MLT 5/10mg	12 tablets	Limitation applies to drugs either singularly or in combination
Migranal Nasal Spray	1 kit – 16 mg	
Monurol	1 packet	
Oxycontin	120 tablets	
Plan B	1 treatment per calendar year	Limitation applies to drugs either singularly or in combination
Relenza/Tamiflu Capsules & Suspension	1 fill every 180 days	Limitation applies to drugs either singularly or in combination
Relpax	6 tablets	
Rozerem	30 tablets	Limitation applies to drugs either singularly or in combination
Sporanox	180 tablets per calendar year	
Sporanox Liquid	300ml per fill	
Stadol Nasal Spray	2 bottles (3ml each)	
Toradol 10mg	20 tablets	
Treximet 85mg	9 tablets	Limitation applies to drugs either singularly or in combination
Viagra 25/50/100mg (Males Only)	6 tablets	Limitation applies to drugs either singularly or in combination

Prescription Drug	Quantity Limits	Comments
Zomig 5mg	6 tablets	
Zomig 2.5mg	12 tablets	
Zomig Nasal Spray	1-6 pack units	

Also applies to Generic Medications

Prior Authorization Drugs

Acne Agents for individuals 31 years of age and older

Actinic Kerasotes (Solaraze)

Antihyperglycemic (Symlin, Byetta) for individuals 18 years of age and older

Benign Prostatic Hypertrophy (Avodart, Proscar, finasteride)

Blood Modifiers (Aranesp, Epogen, Leukine, Neulasta, Neupogen, Procrit) – Specialty Rx Benefit

Crohne's Disease (Cimzia) – Specialty Rx Benefit

Erectile Dysfunction (Viagra, Cialis, Levitra) for males through the age of 49 years

Growth Hormones - Specialty Rx Benefit

Hepatitis C (Infergen, Intron A, Pegasys, Peg-Intron, Redipen, Rebetron, Roferon-A) - Specialty Rx Benefit

Irritable Bowel Syndrome (Lotronex, Zelnorm)

IVIG Medications – Specialty Rx Benefit

Lupron, Lupron Depot Ped, leuprolide acetate - for diagnosis other than infertility - Specialty Rx Benefit

Miscellaneous (Actimmune, Alferon N, Botox, Forteo, Myobloc, Prialt, Progesterone in Oil, Synagis, Viadur, Xolair) – Specialty Rx Benefit

Multiple Sclerosis (Avonex, Betaseron, Copaxone, Novantrone, Rebif, Tysabri, mitoxantrone) – Specialty Rx Benefit

Metabolic Modifier-(Kuvan)-Specialty Rx Benefit

Narcolepsy (Provigil)

Narcotic Analgesics (Actiq, fentanyl citrate, Fentora)

Oncology (Arimidex, Aromasin, Femara, Gleevac, Iressa, Nexavar, Revlimid, Sprycel, Sutent, Tarceva, Temodar, Tykerb, Xeloda, Zolanza)

Oncology (Rituxan, Tasigna, Trelstar) – Specialty Rx Benefit

Osteo-Arthritis (Euflexxa, Hyalgan, Orthovisc, Supartz, Synvisc) – Specialty Rx Benefit

Other (Anabolic Steroids (oral only), Progesterone, Micronized (Crinone and Prochieve), Testosterone (Androgel)

Psoriasis (Amevive, Raptiva) – Specialty Rx Benefit

Pulmonary Arterial Hypertension (Revatio all Genders, Viagra Females only)

Rheumatoid Arthritis (Arava, leflunomide)

Rheumatology (Enbrel, Humira, Kineret, Orencia, Remicade) – Specialty Rx Benefit

Secondary Hyperparathyroidism and Hypercalcemia (Sensipar)

Transplant/Anti-Rejection (Cellcept, Myfortic)

Additional drugs may be added to the prior authorization or quantity limit list throughout the year. Your specific benefit design may not cover certain drugs, even though they appear on this list.

This document is a summary reference and may not necessarily reflect all coverage and exclusions of the plan benefit system. Please contact your account team for any questions.

Prior Authorization Process

For the medications on this form that indicate a prior authorization is required, please follow the process below.

1. Bring your prescription to a pharmacist.
2. If not approved, the pharmacist will receive a prompt stating that the physician must contact or call 888-413-2723 for preauthorization.
3. The pharmacist should advise the member to have their physician call the number given above.
4. This means that either your doctor will have to call the number or FAX a letter of medical necessity to CVSCaremark.
Physician prior authorization number 888-413-2723
Physician prior authorization FAX number 888-836-0730
5. CVSCaremark will evaluate the information received based on our internally developed clinical criteria. The decision will be an approval, denial, or review for more information.

Approval

After a claim is approved, an override is applied so that the claim will process electronically at the pharmacy and a letter will be sent to the member and the physician indicating the approval and the time period it is valid for.

Denial

If the medication is denied, then a letter is sent to both the physician and the member. The denial letter will outline directions on how to appeal the decision.

Missing Information

If more information is required, the physician's office will be contacted. Once the physician's office provides CVSCaremark with the required information then a review will be completed within 24 – 48 hours.