City of Amarillo
Summary of Drug Coverage
Exhibit C

Created: 10/01/11 Revised: 12/26/24

COVERED ITEMS

- Accutane
- Agents for weight loss- Rx only (**100% copay at discounted reimbursement rate**)
- Allergy serum/extracts
- Anaphylactic Kits
- Anti-sera/immune globulins
- Anti-wrinkle agents (ex. Renova)- Rx only (**100% copay at discounted reimbursement rate**)
- Aspirin
- Blood, blood factors, blood plasma or biological sera
- Compounded medications of which at least one ingredient is a legend drug
- Continuous Glucose Monitors (CGMs) – Added 08/22/2022
- Contraceptives– oral, devices, female OTC, implants, injectable, intravaginal, and transdermal
- Cosmetic hair removal products (ex. Vaniqa) Rx only (**100% copay at discounted reimbursement rate**)
- Dental products for periodontal disease
- Depigmenting agents (ex. Hydroxyquinone)
- DESI Drugs
- Devices, appliances, or supplies, including support garments & non-medicinal substances- Rx only (**100% copay at discounted reimbursement rate, except for CGM & Omnipod Products – applicable copay will apply**)
- Diabetic supplies – Insulin pens/syringes/needles, test strips/tape/tabs, lancets
- Drugs for ADD/ADHD/Narcolepsy
- Drugs for Erectile Dysfunction (**100% copay at discounted reimbursement rate**)
- Fertility agents- all (oral and injectable) (**100% copay at discounted reimbursement rate**)
- Growth hormones (PA required)
- Fluoride supplements (**100% copay at discounted reimbursement rate**)
- Folic acid and Foltx– Rx and OTC
- Hair growth stimulants- Rx only (**100% copay at discounted reimbursement rate**)
- Homeopathic/natural legend products
- Immunizations/Vaccines/Toxoids (only those listed below under Preventative care)
- Injectables-not listed under exclusions (PA required on all, except list below**)
- Insulin
- Iron supplements (Rx and OTC)
- Legend drugs, except for drugs listed as exclusions
- Non-Sedating Antihistamines (**100% copay at discounted reimbursement rate**)
- Nutritional Supplements- Rx only (**100% copay at discounted reimbursement rate**)
- Omnipod Products – Added 08/22/2022
- Prenatal vitamins – Rx only
- Proton Pump Inhibitors (**100% copay at discounted reimbursement rate**)
- Smoking deterrents- (Rx and OTC)
- State Restricted Drugs (i.e., DEA Schedule V)
- Syringes/needles, other than insulin type – Rx only (**100% copay at discounted reimbursement rate**)
- Topical tretinoins (ex. Avita, Retin-A) (PA required for ages 40 and up)

- Vitamins – Rx only (**100% copay at discounted reimbursement rate**)

**** The following injectables do not require PA Imitrex, Depo-Provera, dexamethasone, DHE, anaphylaxis kits, Glucagon, heparin lock, Insulin, Sandostatin, Symlin, Immunizations and Vaccines**

EXCLUDED ITEMS

- Alcohol Swabs
- Brand Nasal Steroids
- Extended-Release Hydrocodone (ex. Zohydro)
- Glucometers
- Glucose Tabs
- Immunizations/Vaccines/Toxoids except those listed below under Preventative
- MaxorPlus "Me Too" Drug List
- Non-legend drugs (OTC's), except as listed above
- Please see medications listed above at 100% discounted rate; these medications are only listed under covered, so the members will obtain the discounted rate at the pharmacy.

Co-Payments

Wal-Mart/Sam's Retail Pharmacies and Maxor Mail Order:

	1-30 Day Supply	31-90 Day Supply
Generic:	$10	$20
Preferred:	$35	$70
Non-preferred:	$50	$100

Retail Pharmacies (other than Wal-Mart/Sam's):

	1-30 Day Supply	31-90 Day Supply
Generic:	$15	N/A
Preferred:	$35	N/A
Non-preferred:	$50	N/A

Specialty day supply 1-30:
50% copay with a maximum patient pay of $65* (Effective 09/05/19)

**Specialty copay of $65 will only apply if the member does NOT have copay assistance available or has exhausted current available copay assistance.*

ACA Preventative List $0 Copay for Medications Listed Below

Preventive Medications: $0 copay (List updated 01/01/2025)

- Generic aspirin for cardiovascular & colorectal cancer prevention for patients 50 and older.
- Generic aspirin for women at high risk of pre-eclampsia.
- Bowel prep generic medications for patients ages 45-75.
- Breast cancer prevention: generic tamoxifen, raloxifene, or aromatase inhibitors for women who are at increased risk for breast cancer.
- Generic, over the counter (OTC), and prescription folic acid medications for women up to the age of 55.
- Generic fluoride oral supplements up to the age of 6.
- Tobacco deterrents: annual limit of 2 cycles of treatment (12 weeks/cycle). Generics and brands with no generics only.

HIV PrEP (Updated 01/01/2025)
- Generic Truvada (emtricitabine-tenofovir disoproxil) 200-300mg
- Descovy 200-25mg
- Apretude (Specialty drug that requires PA; $0 copay only if the PA is approved)

Contraceptives: $0 Copay
- Generics & single-sourced brands will be $0 copay
- Brands with generics available will be at tiered copays listed above

Statins: $0 Copay
- Generic lovastatin at $0 without PA for ages 40-75*

**Prior Authorizations can be requested for other low-to-moderate dose statins to ensure criteria is met*

Immunizations/Vaccines/Toxoids: $0 Copay
- Diphtheria Toxoid
- Haemophilus Influenza Type B Vaccine
- Hepatitis A vaccine - min 12 months
- Hepatitis B vaccine
- Hepatitis A/Hepatitis B vaccine – min 18 years
- Human Papillomavirus Vaccine – 9 to 26 years
- Influenza Vaccine
- Measles Vaccine - min 12 months to max 65 years old
- Mumps Vaccine - min 12 months to max 65 years old
- Rubella Vaccine - min 12 months to max 65 years old
- MMRV – min 12 months to max 12 years
- Meningococcal Vaccine
- Pertussis
- Pneumonia Vaccine
- Polio Vaccine - max 18 years
- Rotavirus Vaccine
- RSV [Abrysvo (female or min 60 years); Arexvy (min 60 years); Byfortus (max 24 months)]
- Shingles Vaccine - min 50 years
- Tetanus Toxoid
- Varicella Vaccine - min 12 months
- COVID-19
- Smallpox & Monkeypox – min 18 years
- Respiratory Syncytial Virus (RSV) – up to age 2 and 60 plus

Days Supply Allowed

Retail	Up to 30 days
Walmart/Sam's	Up to 90 days
Mail	Up to 90 days

Refill Edit

An edit for 75% usage will be applied at Retail and 75% usage at Mail Order before refills will be allowed.
An edit for 90% usage will be applied at Retail and Mail order before refills on narcotics will be allowed (effective 06/02/21)

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Deductible
None

DAW Copay Differential - DAW1 and DAW2
Brand/Generic copay differential applies**

If the doctor (DAW1) or member (DAW2) requests a brand name prescription drug when a generic equivalent exists, and the doctor allows substitution, the applicable BRAND copay plus the cost difference between the brand and generic will apply.

****Exceptions are Lamictal, Topamax, and Narrow Therapeutic Index medications**

Maximum Out-of-Pocket (Amounts should have been updated, effective 01/01/2017**)**
A combined medical/prescription maximum out-of-pocket amount applies for prescription benefits per calendar year. Brand-Generic copay differentials do not apply to the cost sharing limits.

$5,000 / Individual
$10,000 / Family

This is a real-time claim integration with Aetna.
100% copay drugs will NOT apply towards the maximum out of pocket.

Maximum Allowable Benefits
None

Drugs with Special Quantity Limits
- Smoking deterrents – Limited to two-12 week cycles/year
- Depo Provera: 90 day supply allowed at retail for 3 retail copays
- Estring: 90 day supply allowed at retail for 3 retail copays
- Seasonique/Seasonale: 91 day supply allowed at retail for 3 retail copays

Drugs Requiring Prior Authorization
- MaxorPlus standard Prior Authorization (PA) list applies for specific medications.
- Breast Cancer Preventative generic medications- if approved then $0 copay
- Fentanyl buccal and nasal products
- Injectables unless on the above exempt list **
- Lamisil brand name
- Sporanox
- Topical tretinoins (ex. Avita, Retin-A) (PA required for ages 40 and up)
- All Specialty Medications
- Restasis
- Acthar Gel (only approved for treatment of infantile spasms)
- Tobi
- Retin-A (PA required for ages 40 & over)
- Pulmozyme
- Apretude – if approved, then $0 copay

Prior Authorization Appeals

All Prior Authorization appeal requests will be sent to an Independent Review Organization (IRO). The City of Amarillo will uphold the IRO's decision regarding Prior Authorization Appeals.

Step Therapy Requirements

Statin Step Therapy Program (Effective 01/01/2009)

Step 1	Simvastatin (Note: Pravastatin and Lovastatin will go through without having to have tried simvastatin. However, if a member has been on Pravastatin or lovastatin and wants to try a Step 2 agent, they will have try simvastatin before a step 2 drug can be tried unless prior authorized.)
Step 2	Crestor, Lipitor, Livalo, Mevacor, Pravachol and Zocor Member must have tried and failed simvastatin, before a step 2 drug will process, unless request has gone through the prior authorization process.

Glumetza, Fortamet & generic Fortamet Step Therapy (Effective 07/13/2015)

Step 1	Extended-Release Metformin HCl Metformin extended release (generic Glucophage ® XR)
Step 2	Extended-Release Metformin HCl Medications Member must try and fail or have a contraindication to the Step 1 agent. Step 2 drugs include: Metformin 24hr osmotic (generic Fortamet®), Fortamet®, Glumetza®.

Pharmacy Network

Prescriptions must be filled at a MaxorPlus Select Network Pharmacy*. Prescriptions filled at non-participating pharmacies, except in cases of Medical Emergency, are not covered.

*Prescriptions must be filled at a MaxorPlus EXTENDED DAY SUPPLY (EDS) Pharmacy for 90-day supplies at participating Retail pharmacies.

Dynamic Discount: in collaboration with Sempre Health:

This program is funded by manufactures and provides discounts for members on certain chronic medications when they fill consistently and on time. Members are required to sign up for the program and can receive the discount at any pharmacy. If they do not sign up, they will not receive refill messages with discounts. Copay discounts are provided via text message and members must confirm this when they register.

The following medications are eligible: Diabetes – Farxiga, Glyxambi, Jardiance, Lantus/Lantus Solostar, Ozempic, Rybelsus, Soliqua, Synjardy, Toujeo, Tradjenta, Trijardy XR, Trulicity, Victoza. Blood Thinners – Brilinta, Eloquis, Pradaxa

Drug Formulary

Effective 01/01/20, the MaxorPlus Advantage Formulary will be utilized to determine copay tiers for generic, preferred brand, and non-preferred brand medications.

Specialty Medications

Specialty medications are restricted to be filled at Maxor Specialty Pharmacy.

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Patient assistance will not be considered as true out-of-pocket for members and may not apply to deductible and/or out-of-pocket maximums.

Client Name/Title (printed): Sandy Elliott/HR Assistant Director

Client Signature: Sandy Elliott Date: 12/26/2024