

**UnitedHealthcare – RItE Care
Provider Information for Generic Only Formulary Program**

As of February 1, 2009, RItE Care Member’s prescription drug benefit will cover Generic Drugs Only. Exceptions will be made for a limited number of brand name drugs in certain therapeutic classes. Exceptions were identified in cases where a specific brand name drug does not have a generic or therapeutic alternative. These exceptions were determined by the Department of Human Services. There will be exceptions to this list based on Medical Necessity.

Listed below are drug categories in which certain brand name drugs may be authorized. Please refer to the UnitedHealthcare’s RItE Care February 2009 Preferred Drug List.

RItE Care - Allowed Brand Name Therapeutic Classes /Single Agents	
Antidementia Agents	Inhaled Corticosteroids (including combo products)
Anti-Parasitics/Antihelminthics	Insulins (ALL)
Anti-TNF Agents (Humira and Enbrel only)	Insulin Syringes (ALL)
Antivirals (HIV/AIDs only)	Leukotriene Modulators
Atypical Antipsychotics	Low Molecular Weight Heparins
Beta-Agonist Inhalers (including combo products)	Mesalamine Related Products (Asacol, Pentasa, Dipentum, Lialda only)
Contraceptives (oral, transdermal, injectable, intravaginal)	Multiple Sclerosis Agents
Dapsone	Ophthalmic Prostaglandins
Dilantin Only	Oral Antineoplastic Agents (ALL)
Erythropoietin Products	Pancreatic Enzymes
Estrogen Replacement (Premarin, Prempro, Premphase only)	Plan B (Rx and OTC)
GCSF Agents (Neulasta, Neupogen, Leukine)	Platelet Aggregation Agents
Glucometers, lancets, test strips, misc. supplies	Pulmozyme
Growth Hormones (ALL)	Substance Abuse (Campral, Antabuse, Suboxone, Subutex)
Hepatitis B Agents (all routes)	Tracleer, Revatio, Ventavis (only)
Hepatitis C Agents (all routes)	Vfend
Immunosuppressants (Prograf, Cellcept, Rapamune)	

Formulary:

Each Health Plan will continue to have its own formulary program; therefore, certain generic and brand name drugs will still require a prior authorization.

The Department of Human Services established the review criteria for Prior Authorizations by the Health Plans, as indicated below:

Criteria to be used for the evaluation of brand name drug coverage due to medical necessity and/or demonstrated lack of efficacy of generic drugs are outlined below:

- Patient has experienced an inadequate therapeutic response following a trial, within the last six (6) months, with at least two (2) different, if available, either generic or Formulary

agents. Trial requires appropriate does of generic agent of Formulary (up to maximum recommended does) and minimum duration therapy.

- Patient has experienced a documented side effect and/or intolerance to trial, with at least two (2) different, if available, either generic or Formulary agents. Documentation of side effect and/or intolerance to generic or Formulary agent must be noted in the patient's medical record. Trial requires appropriate does of generic agent of Formulary (up to maximum recommended does) and minimum duration therapy.
- Documentation, within the last six (6) months, of a generic trial that the patient cannot be stabilized on a generic agent.
- Use of all generic and Formulary agent(s) of a brand name drug is contraindicated for a patient's specific condition.

UnitedHealthcare RItE Care Therapeutic Class Alternatives

Below is a list of SOME of the major classes of medications that the Department of Human Services has excluded from the RItE Care Pharmacy benefit. This table will provide you with a selection of therapeutic alternatives available on the UnitedHealthcare RItE Care Preferred Drug List. Some may, at this time, require prior authorization as indicated with an asterisk (*)

Therapeutic Class	Drugs Excluded by State	Available Alternatives
Proton Pump Inhibitors	Aciphex Nexium Prevacid	Prilosec OTC Omeprazole Pantaprozole *
TZDs	Actos/Actoplusmet Avandia/Avandaryl/Avandamet	Glyburide Glipizide Metformin Insulin
ARBs	Cozaar/Hyzaar Benicar/HCT Diovan/HCT	Captopril Enalapril Lisinopril Benazopril Fosinipril
Statins	Lipitor Crestor Lescol	Simvastatin Pravastatin Lovastatin
Fibrates	Tricor Antara	Gemfibrizol Fibrate, Micronized* Niacin
Anticonvulsants	Topamax Depakote ER Tegretol XR	Lamotrigine* Oxcarbazine* Divalproex Sodium Carbamazepine
DPP-4 Inhibitor	Januvia Janumet	Glyburide Glipizide

Therapeutic Class	Drugs Excluded by State	Available Alternatives
		Metformin Insulin
CNS Stimulants (ADHD)	Adderall XR Concerta Strattera Focalin XR Vyvanse Daytrana Metadate CD Ritalin LA	Methylphenidate SR** Amphetamine salts combo** Dextroamphetamine**
Antidepressants	Lexapro Effexor XL Cymbalta	Fluoxetine Sertraline Citalopram* Venlafaxine
5-HT	Maxalt Frova Zomig Relpax	Sumatriptan
Antivirals	Valtrex	Acyclovir
Pain medications	Oxycontin Percocet Lidoderm Lyrica Cymbalta	Morphine LA Hydrocodone/APAP Oxycodone/APAP Fentanyl* Methadone Neurontin Lidocaine topical
Smoking Cessation	Chantix	Nicotine patches Bupropion 150mg ER

* May require prior authorization

** Require prior authorization > 23 years of age

To Contact UnitedHealthcare's Rite Care Pharmacy Prior Notification - Authorization:

Phone	(800) 310-6826
Fax	(877) 265-4976
Fax Request Form Enclosed	
Injectable Drugs Fax	(800) 764-4388



Pharmacy Prior Notification

Phone: (800)310-6826 • Fax: (877)265-4976 • INJECTABLE DRUGS FAX: (800)764-4388

Recipient/Patient ID #:	Physician Name:
Patient Name:	Address:
Date of Birth:	City/State/Zip Code:
Address:	Phone #:
City/State/Zip Code:	Fax #:
Office Contact:	

Drug (Name & Strength): _____ **Quantity (or dosing):** _____

Please provide the following information

A. Diagnosis (Please be specific & provide as much information as possible):

B. Formulary Drugs Tried/Previous Therapy (include strength, frequency and duration):

(Note: State Protocol requires trial of formulary medications in the prior 6 months)

C. Additional Treatment/Therapies (diet, exercise, physical therapy):

D. Pertinent Patient Data and Lab Values (if applicable):

E. Reasons for choosing a non-formulary medications, including documentation of any adverse events that occurred with the use of formulary and/or generic alternatives

Physician Signature: _____ **Date:** _____

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PLEASE DO NOT USE COVER SHEET

Appeals Rights:

UnitedHealthcare RItE Care Members and providers have the right to appeal any decision made by the Health Plans. Those appeals will be reviewed based on Medical Necessity.

Providers may appeal any adverse determination by contacting UnitedHealthcare's RItE Care Member Services at:

1. 1-800-587-5187
2. hit the "Member Services Prompts and
3. Indicate you would like to file an appeal **on behalf of the member**.