

[Date]

[Member Address]

Dear State of Ohio Member:

As your pharmacy benefit manager, Catamaran, along with your plan sponsor, wants to let you know about upcoming changes to your prescription plan beginning January 1, 2016.

Our records show that you recently filled a prescription for a medication listed in this letter. If you are still taking this medication, **action may be required to continue to be able to have your prescription covered under your plan on or after January 1, 2016.**

We are providing you with advance notice of these changes to make sure that you have time to **discuss your treatment plan with your doctor** and start the prior authorization process if needed. Please review the medications below carefully.

Medications that will require Step Therapy

Step Therapy Programs require the use of one or more specific medications (often a more affordable generic medication, known as Step 1) that have been proven effective for most people with your condition before you can get a similar, more expensive, brand-name medication covered.

Beginning January 1, 2016, the Step 2 drugs listed below **will not be covered under your drug benefit** until Step One prescription drugs are tried or your doctor contacts Catamaran to obtain a prior authorization. Your doctor may also request authorization for any quantity of the drug that is more than what is listed in the table below.

- If you are currently taking a Step 2 medication and have already tried a Step 1 medication, approval to fill your Step 2 medication after January 1, 2016 may be automatically granted, provided you tried the Step 1 medication within the last three years and we have a record of it in our prescription history. To find out if you meet this criteria, contact member services at 1-866-854-8850.
- If your doctor has already completed a prior authorization request for the quantity you are currently prescribed for a Step 2 drug, no action is needed at this time.
- If you require a prior authorization for a Step 2 drug or for a quantity of drug that is above the quantity limit, your doctor should contact Catamaran two weeks before your first refill on or after January 1, 2016 to request a prior authorization. We will begin accepting prior authorization requests for January 1, 2016 and later beginning December 1, 2015.

| THERAPEUTIC CATEGORY | STEP 2 DRUGS | STEP 1 DRUGS | QUANTITY LIMITS |
|----------------------|--|---|--|
| Cardiovascular | | | |
| Statins | Altoprev Lipitor Liptruzet Livalo | One preferred brand AND one preferred generic | Brands: Crestor Vytorin |
| | | | Altoprev Lipitor Liptruzet Livalo |
| | | | 1 tab/day 1 tab/day 1 tab/day 1 tab/day |

| | | | | | |
|---|--|--------------------------------------|--|---|---|
| | Lescol Lescol XL Mevacor Pravachol Zocor | | Generics: atorvastatin fluvastatin lovastatin pravastatin simvastatin | Lescol 20 mg Lescol 40 mg Lescol XL Zocor 5 and 80 mg Zocor 20 and 40 mg | 1 cap/day 2 caps/day 1 tab/day 1 tab/day 1.5 tabs/day |
| Diabetes | | | | | |
| Dipeptidyl Peptidase-4 Inhibitors & Combinations | Janumet Janumet XR Januvia Kombiglyze XR Onglyza | One preferred brand OR generic | Brands: Bydureon Byetta Victoza Generics: metformin sulfonylurea thiazolidinedione insulin | Janumet Janumet XR 100-1000 mg Janumet XR 50-500 mg Janumet XR 50-1000 mg Januvia Kombiglyze 2.5-1000 mg Kombiglyze 5-500 mg Kombiglyze 5-1000 mg Onglyza | 2 tabs/day 1 tab/day 2 tabs/day 2 tabs/day 1 tab/day 2 tabs/day 1 tab/day 1 tab/day 1 tab/day |
| | Jentadueto Kazano Nesina Oseni Tradjenta | Two preferred brands | Janumet* Janumet XR* Januvia* Kombiglyze XR* Onglyza* | Jentadueto Kazano Nesina Oseni Tradjenta | 2 tabs/day 2 tabs/day 1 tab/day 1 tab/day 1 tab/day |
| Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors | Invokana Invokamet Jardiance | One preferred brand OR generic | Brands: Bydureon Byetta Victoza Generics: metformin sulfonylurea thiazolidinedione insulin | Invokana Invokamet Jardiance | 1 tab/day 2 tabs/day 1 tab/day |
| | Farxiga Xigduo XR | One preferred brand | Invokana* Invokamet* Jardiance* | Farxiga Xigduo XR 5-1000 mg Xigduo XR 5-500 mg Xigduo XR 10-500 mg Xigduo XR 10-1000 mg | 1 tab/day 2 tabs/day 1 tab/day 1 tab/day 1 tab/day |
| Glucagon-Like Peptide-1 Agonists | Byetta Bydureon Victoza | One generic | metformin sulfonylurea thiazolidinedione insulin | Byetta Bydureon Victoza | 1 syringe/30 days 4 pens/vials/28 days 3 pens/30 days |
| | Trulicity Tanzeum | One preferred brand | Byetta* Bydureon* Victoza* | Trulicity Tanzeum | 4 pens/28 days 4 syringes/28 days |
| Blood Glucose Strips ** | Abbott Acon At Last Bayer Embrace EPS Fora Care Glucocard Gmate Liberty Neutek | One preferred brand | Accu-Chek One Touch | Blood Glucose Test Strips | 300 strips/30 days |

| | | | | | |
|--|--|----------------------|--|---------------------------------|--|
| | Quintet Relion Reveal Supreme True Metrix Truetest Truetrack Ultima Unistrip | | | | |
| Inflammatory Bowel Disease | | | | | |
| Inflammatory Bowel Disease/ Ulcerative Colitis | Apriso Asacol HD Delzicol | One preferred brand | Lialda | Apriso Asacol HD Delzicol | 4 caps/day 6 tabs/day 6 caps/day |
| Respiratory | | | | | |
| Pulmonary Anti-Inflammatory Inhalers | Asmanex Alvesco | Two preferred brands | Pulmicort Flexhaler Flovent QVAR | Asmanex Alvesco | 1 inhaler/30 days 2 inhalers/30 days |
| Pulmonary Anti-Inflammatory/ Long-Acting Beta Agonist Combination Inhalers | Dulera | Two preferred brands | Advair Diskus Advair HFA Symbicort Breo Ellipta | Dulera | 1 inhaler/30 days |
| Short-Acting Beta-2 Adrenergic Inhalers | Proventil HFA Xopenex HFA | One preferred brand | Ventolin HFA ProAir HFA ProAir Respiclick | Proventil HFA Xopenex HFA | 2 inhalers/30 days 2 inhalers/30 days |
| Cystic Fibrosis Inhaled Anti-Infectives | Tobi Podhaler Tobi Nebulizer Kitabis | Preferred brand | Bethkis | None | |

* These agents are also subject to additional step requirements as indicated in table.

** Patients who require a new One Touch or Accu-Chek blood glucose meter can obtain one for free by contacting one of the following toll free numbers and alerting them that you are a Catamaran member:

- Roche 1-877-411-9833
- Lifescan 1-866-355-9962

Medications that will require a Prior Authorization

Beginning January 1, 2016, a prior authorization may be needed to continue to fill prescriptions for the medications listed below under your plan. This means that before you can have your prescription covered by your plan, your doctor will need to submit a request to Catamaran to confirm safe and appropriate use of the medication and/or that you require a quantity greater than what is listed in the table below.

- If your doctor has already completed a prior authorization request for a medication and quantity listed below, **no action is needed at this time.**
- If you are still taking a medication listed below, your doctor should contact Catamaran two weeks before your first refill on or after January 1, 2016 to request a prior authorization. We will begin accepting prior authorization requests for January 1, 2016 and later beginning December 1, 2015.

| THERAPEUTIC CATEGORY | DRUGS REQUIRING PRIOR AUTHORIZATION | QUANTITY LIMITS | |
|----------------------|---|--|---|
| Growth Hormones | Genotropin Humatrope Norditropin Nutropin Omnitrope Saizen Tev-Tropin Zomacton | None | |
| Hepatitis C | Harvoni Olysio Sovaldi Viekira | Harvoni Olysio Sovaldi Viekira | QL Varies QL Varies QL Varies 4 tabs/day |
| Immunomodulators | Actemra Cimzia Cosentyx Enbrel Humira Kineret Orencia Otezla Rituxan Simponi Stelara Xeljanz | Cimzia Cosentyx Enbrel Humira Orencia Otezla Starter Pack Otezla 10/20/30 mg Otezla 30 mg Simponi | QL Varies QL Varies QL Varies QL Varies QL Varies 1 pack/year 1 pack/year 2 tabs/day QL Varies |
| Multiple Sclerosis | Aubagio Avonex Betaseron Copaxone Extavia Gilenya Lemtrada Plegridy Rebif Tecfidera | Aubagio Avonex Betaseron Copaxone 20 mg Copaxone 40 mg Extavia Gilenya Plegridy Kit Plegridy Rebif Titration Pack Rebif Tecfidera Starter Pack Tecfidera | 1 tab/day 1 kit/28 days 15 vials/30 days 30 syringes/30 days 12 syringes/28 days 15 vials/30 days 1 cap/day 1 kit/28 days 2 pens/syr/28 days 1 pack/year 12 syringes/28 days 1 pack/year 2 caps/day |

Questions?

If you have questions regarding these changes, please call Member Services at 1-866-854-8850. Representatives are available 24 hours a day, seven days a week to assist you.

Sincerely,

Catamaran