



Mercy Healthcare **Group**

Preferred Drug List

What is the Mercy Healthcare Group Formulary?

A formulary is a list of drugs selected by Mercy Healthcare Group in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Mercy Healthcare Group will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Mercy Healthcare Group network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions or about covered services, please review your Member Handbook and Group Service Agreement. **Note: Medicines which are not listed on the formulary are not covered by Mercy Healthcare Group; there are no exceptions.**

The formulary begins on page 6. It gives you information about the drugs covered by Mercy Healthcare Group. The first column of the chart lists the drug that is covered by the plan. Brand name drugs are capitalized (e.g., AMOXIL). Generic drugs are listed in lower case italics (e.g., *amoxicillin*). The second column serves as a reference for providing the brand name of the drug when a generic is covered by the plan. The third column lists the “Covered Drug Tier” or the amount you pay depending on which tier your covered drug is in under the plan (see page 3 for more information). The fourth column lists any requirements for the drug such as prior authorization (PA), quantity limits (QLL), or step therapy (ST).

Can the Formulary change?

Yes, Mercy Healthcare Group may add or remove drugs from our formulary during the year. To get updated information about the drugs covered by Mercy Healthcare Group, please visit our Web site at www.MercyHealthcareGroup.com or call Member Services at (602) 798-2800 or (800) 780-2300. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we will notify members who take the drug at least 60 days before the date that the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

How do I use the Formulary?

The formulary begins on page 6. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents.” If you know what your drug is used for, look for the category name in the list that begins on page 6. Then look under the category name for your drug.

How much will I pay for Mercy Healthcare Group Covered Drugs?

The amount you pay depends on which drug tier your drug is in under our plan and whether you fill your prescription at a network pharmacy. (You can find out which drug tier your drug is in by looking at the third column labeled “Covered Drug Tier” of the formulary that begins on page 6.)

| Tier | Description | Cost |
|-------------|---------------------|-------------|
| 1 | Generic | \$10 |
| 2 | Preferred Brand | \$35 |
| 3 | Non-preferred Brand | \$55 |

Are there any other restrictions on coverage?

Medicines which are not listed on the formulary are not covered by Mercy Healthcare Group; there are no exceptions.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Mercy Healthcare Group requires you to get prior authorization for certain drugs. (You may need prior authorization for drugs that are on the formulary.) This means that you will need to get approval from Mercy Healthcare Group before you fill some of your prescriptions. If you don't get approval, Mercy Healthcare Group will not cover the drug.
- **Quantity Limits:** For certain drugs, Mercy Healthcare Group limits the amount of the drug that Mercy Healthcare Group will cover. For example, Mercy Healthcare Group provides 90 pills in 30 days per prescription for Oxycontin.
- **Step Therapy:** In some cases, Mercy Healthcare Group requires you to first try certain drugs to treat your medical conditions before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Mercy Healthcare Group may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Mercy Healthcare Group will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 6.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, it will not be covered; no exceptions. If you learn that Mercy Healthcare Group does not cover your drug, you can ask your doctor to prescribe a similar drug that is covered by Mercy Healthcare Group.



**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

What are generic drugs?

Mercy Healthcare Group covers both brand-name drugs and generic drugs. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are approved by the Food and Drug Administration (FDA).

Generic drugs are listed in lower-case italics (e.g., amoxicillin) within the formulary. Brand-name drugs are capitalized in the formulary (e.g., AMOXIL).

Mail Order

A mail order pharmacy program is also available. Using the mail order pharmacy, Mercy Healthcare Group members can request multiple-month refills of a maintenance medication at a cost savings over retail pharmacies; instead of paying three separate co-pays for a 90-day refill, a member will only pay two co-pays for a 90-day refill.

To start using mail order services, your doctor should write two prescriptions for you. One prescription should allow you to get a 30-day supply while you are waiting for your mail order supply. The other prescription should be written for 90-days with appropriate refills. Once you have both prescriptions, mail your 90-day prescription to:

P.O. Box 52151
Phoenix, AZ 85072-2151

Contact Center number: (866) 777-7077

For more information

For more detailed information about your Mercy Healthcare Group prescription drug coverage, please review your Member Handbook and Group Service Agreement.

If you have questions about Mercy Healthcare Group, please call Member Services at (602) 798-2800 or (800) 780-2300. Or visit www.MercyHealthcareGroup.com.

MERCY HEALTHCARE GROUP'S FORMULARY

The formulary that begins on the next page provides coverage information about some of the drugs covered by Mercy Healthcare Group. The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., AMOXIL) and generic drugs are listed in lower-case italics (e.g., amoxicillin).



**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

The information in the Requirements/Limits column tells you if Mercy Healthcare Group has any special requirements for coverage of your drug.

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|-------------------------------|----------------------------|--------------------------|---|
| ANESTHETICS | | | |
| TOPICAL ANESTHETICS | | | |
| lidocaine hcl | Xylocaine | 1 | |
| lidocaine hcl viscous | Xylocaine | 1 | |
| lidocaine-prilocaine | Emla | 1 | |
| ANTIINFECTIVES | | | |
| CEPHALOSPORINS | | | |
| cefaclor | Ceclor | 1 | |
| cefaclor er | Ceclor | 1 | |
| cefadroxil | Duricef | 1 | |
| cefdinir | Omnicef | 1 | |
| cefpodoxime proxetil | Vantin | 1 | |
| cefprozil | Cefzil | 1 | |
| cefuroxime | Ceftin | 1 | |
| cephalexin | Keflex | 1 | |
| cefuroxime axetil | Ceftin | 1 | |
| SUPRAX | | 2 | QLL= 1 tab/Rx |
| CLINDAMYCINS | | | |
| clindamycin | Cleocin | 1 | |
| ERYTHROMYCINS | | | |
| ERY-TAB | | 2 | |
| erythromycin | Eryc | 1 | |
| erythromycin ethylsuccinate | E.E.S. | 1 | |
| erythromycin w/sulfisoxazole | Pediazole | 1 | |
| OTHER MACROLIDES | | | |
| azithromycin | Zithromax | 1 | QLL for 250 mg=12 tabs/30 days QLL for 600 mg=8 tabs/30 days |
| clarithromycin, er | Biaxin, Biaxin XL | 1 | QLL=14 tabs/30 days for extended-release; QLL=28 tabs/30 days for immediate-release |
| PENICILLINS | | | |
| amox tr-potassium clavulanate | Augmentin | 1 | QLL=28/30 days |
| amoxicillin | Amoxil | 1 | |
| ampicillin | Principen | 1 | |
| dicloxacillin | | 1 | |
| penicillin v potassium | Veetids | 1 | |
| SULFONAMIDES | | | |
| GANTRISIN (SUSPENSION) | | 2 | |
| sulfamethoxazole/trimethoprim | Septra | 1 | |
| sulfadiazine | | 1 | |

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REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|---|----------------------------|--------------------------|-----------------------------|
| TETRACYCLINES | | | |
| demeclocycline | | 1 | |
| doxycycline | Vibramycin | 1 | |
| minocycline hcl | Dynacin | 1 | |
| tetracycline hcl | Sumycin | 1 | |
| URINARY ANTIINFECTIVES | | | |
| FURADANTIN (25 MG/5 ML SUSPENSION) | | 2 | |
| MACRODANTIN (25 MG ONLY) | | 2 | |
| methenamine hippurate | | 1 | |
| nitrofurantoin macrocrystal | Macrochantin | 1 | |
| trimethoprim | | 1 | |
| QUINOLONES | | | |
| ciprofloxacin er | Cipro XR | 1 | QLL=3 tabs/Rx |
| ciprofloxacin hcl | Cipro | 1 | QLL=28 tabs/30 days |
| ofloxacin | Floxin | 1 | |
| LEVAQUIN | | 2 | QLL=14 tabs/90 days |
| TOPICAL ANTIBACTERIAL DRUGS | | | |
| BACTROBAN CREAM | | 2 | |
| chlorhexidine gluconate | Peridex | 2 | |
| erythromycin | Eryderm | 1 | |
| gentamicin sulfate | Genoptic | 1 | |
| mupirocin ointment | Bactroban | 1 | |
| permethrin cream | Elimite | 1 | |
| silver sulfadiazine | Silvadene | 1 | |
| sulfacetamide sodium | Ovace | 1 | |
| ORAL ANTIFUNGAL DRUGS | | | |
| clotrimazole | Mycelex | 1 | |
| fluconazole | Diflucan | 1 | 150 MG QLL=1 tab/Rx |
| GRIFULVIN V | | 2 | |
| GRIS-PEG | | 2 | |
| itraconazole | Sporanox | 1 | |
| ketoconazole | Nizoral | 1 | |
| nystatin | Mycostatin | 1 | |
| SPORANOX (ORAL SOLUTION) | | 2 | |
| terbinafine | Lamisil | 1 | |
| VAGINAL ANTIFUNGALS | | | |
| nystatin | Mycostatin | 1 | |
| terconazole | Terazol | 1 | |
| OTHER TOPICAL ANTIFUNGALS | | | |
| ciclopirox | Loprox/Penlac | 1 | |

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REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|--|----------------------------|--------------------------|--|
| econazole nitrate | Spectazole | 1 | |
| ketoconazole | Nizoral | 1 | |
| nystatin | Mycostatin | 1 | |
| TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB. | | | |
| clotrimazole/betamethasone | Lotrisone | 1 | |
| nystatin w/triamcinolone | Mycolog II | 1 | |
| ANTIRETROVIRALS & PROTEASE INHIBITORS | | | |
| APTIVUS | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| ATRIPLA | | 2 | |
| COMBIVIR | | 2 | |
| CRIXIVAN | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| didanosine | | 1 | |
| EMTRIVA | | 2 | |
| EPIVIR, EPIVIR HBV | | 2 | |
| EPZICOM | | 2 | |
| FORTOVASE | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| FUZEON | | 3 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| INTELENCE | | 2 | PA |
| INVIRASE | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| KALETRA | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| LEXIVA | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| NORVIR | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| PREZISTA | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| RESCRIPTOR | | 2 | |
| REYATAZ | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE |

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REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|-----------------------------------|----------------------------|--------------------------|---|
| | | | PA |
| stavudine | Zerit | 1 | |
| SUSTIVA | | 2 | |
| TRIZIR | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| TRUVADA | | 2 | |
| VIDEX SOLUTION | | 2 | |
| VIRACEPT | | | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| VIRAMUNE | | 2 | |
| VIREAD | | 2 | |
| ZIAGEN | | 2 | |
| zidovudine | | 1 | |
| OTHER ANTIINFECTIVE DRUGS | | | |
| CLEOCIN (100 MG VAGINAL OVULE) | | 2 | |
| dapsone | | 1 | |
| MEPRON | | 2 | COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA |
| malathion 0.5% lotion | Ovide | 1 | |
| VANCOGIN PULVULES | | 2 | QLL=40 caps/30 days |
| OTHER ANTIVIRAL DRUGS | | | |
| acyclovir | Zovirax | 1 | QLL=60 caps or tabs/30 days |
| amantadine hcl | Symmetrel | 1 | |
| BARACLUDE | | 3 | |
| famciclovir | Famvir | 1 | QLL=30 tabs/30 days |
| ISENTRESS | | 2 | |
| rimantadine | Flumadine | 1 | QLL=7 tabs/30 days |
| RELENZA | | 2 | QLL=1 pkg (pkg size=20)/180 days and QLL/Rx=20 inhalation diskus/Rx |
| SELZENTRY | | 2 | |
| TAMIFLU | | 2 | QLL=1 Rx/180 days and QLL/Rx= 75mg 10 capsules /Rx 45mg 10 capsules /Rx 30mg 20 capsules/Rx 12mg/ml oral suspension 3 bottles/Rx |
| TYZEKA | | 2 | COVERED FOR GASTROENTEROLOGISTS OR ID SPECIALISTS; OTHER |

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REVISED SEPTEMBER 22, 2009**

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|---|---------------------|-------------------|------------------------|
| | | | SPECIALISTS REQUIRE PA |
| VALCYTE | | 2 | PA |
| VALTREX (1 GRAM TABLET ONLY) | | 2 | QLL=30 tabs/30 days |
| ZOVIRAX (5% OINTMENT) | | 2 | |
| ANTITUBERCULOSIS DRUGS | | | |
| ethambutol | Myambutol | 1 | |
| isoniazid | Nydrazid | 1 | |
| MYCOBUTIN | | 2 | |
| PRIFTIN | | 2 | |
| pyrazinamide | | 1 | |
| rifampin | Rifadin | 1 | |
| AMEBICIDES | | | |
| YODOXIN | | 2 | |
| ANTHELMINTICS | | | |
| mebendazole | | 1 | |
| PLASMODICIDES | | | |
| chloroquine phosphate | | 1 | |
| DARAPRIM | | 2 | |
| hydroxychloroquine sulfate | Plaquenil | 1 | |
| primaquine | | 1 | |
| TRICHOMONOCIDES | | | |
| metronidazole | Flagyl | 1 | |
| AMINOGLYCOSIDES | | | |
| neomycin | | 1 | |
| paromomycin | | 1 | |
| ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS | | | |
| <p>MEDICATIONS WITHIN THIS CLASS ARE COVERED FOR FDA APPROVED INDICATIONS AND MAY REQUIRE PRIOR AUTHORIZATION. ALL INJECTABLE MEDICATIONS WITHIN THIS CLASS REQUIRE PRIOR AUTHORIZATION.</p> | | | |
| ARIMIDEX | | 2 | |
| azathioprine | Imuran | 1 | |
| bicalutamide | Casodex | 1 | |
| CELLCEPT | | 2 | PA (ALL DOSAGE FORMS) |
| cyclophosphamide | Cytoxan | 1 | PA (INJECTABLE ONLY) |
| cyclosporine | Neoral | 1 | PA (INJECTABLE ONLY) |
| ELIGARD (INJ) | | 2 | PA |
| FEMARA | | 2 | |
| fluorouracil | Adrucil | 1 | PA (INJECTABLE ONLY) |
| flutamide | | 1 | |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|--------------------------------------|---------------------|-------------------|---|
| hydroxyurea | Hydrea | 1 | |
| IRESSA | | 2 | PA |
| leflunomide | Arava | 1 | COVERED FOR RHEUMATOLOGIST; OTHER SPECIALISTS REQUIRE PA |
| megestrol acetate | Megace | 1 | |
| mercaptopurine | Purinethol | 1 | |
| MESNEX TABLETS ONLY | | 2 | |
| methotrexate | Trexall | 1 | |
| MYFORTIC | | 2 | PA |
| NOVANTRONE [INJ] | | 2 | PA |
| octreotide | Sandostatin | 1 | PA |
| RAPAMUNE | | 2 | PA |
| TABLOID | | 2 | |
| tacrolimus | Prograf | 1 | |
| tamoxifen citrate | Nolvadex | 1 | |
| TARCEVA | | 2 | |
| tretinoin | Vesinoid | 1 | |
| ZOLADEX [INJ] | | 2 | PA |
| ZOLINZA | | 2 | COVERED FOR ONCOLOGIST; OTHER SPECIALISTS REQUIRE PA |
| AUTONOMIC AND CNS MEDICATIONS | | | |
| ANALGESICS | | | |
| tramadol hcl | Ultram | 1 | QLL=180 tabs/30 days |
| tramadol hcl-acetaminophen | Ultracet | 1 | QLL= 4 grams APAP/day |
| CLASS II NARCOTICS | | | |
| fentanyl patches | Duragesic | 1 | QLL=30 patches/30 days |
| fentanyl lozenges | Actiq | 1 | PA; QLL=90 lozenges /30 days |
| hydromorphone hcl | Dilaudid | 1 | QLL for 8 mg=120 tabs/30 days |
| methadone hcl | Dolophine | 1 | QLL=540 tabs/30 days |
| morphine sulfate | MS Contin | 1 | |
| oxycodone-acetaminophen | Percocet | 1 | QLL=240 tabs/30 days |
| oxycodone-aspirin | | 1 | QLL=240 tabs/30 days |
| oxycodone hcl | Oxyir | 1 | QLL for 5 mg=240 tabs/30 days, 10 mg, 15 mg, 20 mg, or 30 mg=150 tabs/30 days |
| OXYCONTIN | | 2 | PA/QLL=90 tabs/30 days |
| CLASS III NARCOTICS | | | |
| acetaminophen-codeine | Tylenol #3 | 1 | QLL= 4 grams APAP/day |
| hydrocodone-acetaminophen | Vicodin | 1 | QLL= 4 grams APAP/day |
| hydrocodone bit-ibuprofen | Vicoprofen | 1 | QLL=240 tabs/30 days |

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REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|---|----------------------------|--------------------------|--|
| DRUGS TO PREVENT AND TREAT HEADACHES | | | |
| butalbital/acetaminophen/caffeine | Esgic/Fioricet/Triad | 1 | |
| butalbital/aspirin/caffeine | Fiorinal, Fortabs | 1 | |
| ERGOMAR | | 2 | |
| sumatriptan nasal spray | Imitrex | 2 | QLL=6 nasal sprays/30 days; |
| sumatriptan tabs | Imitrex | 1 | QLL=9 tabs/30 days |
| sumatriptan (inj) | Imitrex | 1 | QLL=4 vials/30 days; 1 kit/30 days |
| MIGRANAL | | 2 | QLL=8 units/30 days |
| RELPAX | | 2 | QLL=6 tabs/30 days |
| ANXIOLYTICS | | | |
| alprazolam, -XR, intensol solution | Xanax, XR | 1 | |
| bupirone hcl | Buspar | 1 | QLL=60 tabs/30 days |
| chlordiazepoxide hcl | Librium | 1 | |
| clorazepate dipotassium | Tranxene T-Tab | 1 | |
| diazepam | Valium | 1 | |
| lorazepam | Ativan | 1 | |
| oxazepam | Ativan | 1 | |
| SEDATIVE/HYPNOTIC DRUGS | | | |
| chloral hydrate | | 1 | |
| estazolam | | 1 | QLL=30 tabs/30 days |
| flurazepam hcl | Dalmane | 1 | QLL=30 caps/30 days |
| temazepam | Restoril | 1 | QLL=30 caps/30 days |
| ROZEREM | | 2 | QLL=30 tabs/30 days |
| zaleplon | Sonata | 1 | QLL=30 caps/30 days |
| ANTIMANIA DRUGS | | | |
| lithium carbonate | Eskalith/CR | 1 | |
| lithium citrate | | 1 | |
| CARBAMAZEPINES | | | |
| carbamazepine, ER | Tegretol Tegretol XR | 1 | QLL for Extended-Release=120 tabs/30 days |
| CARBATROL | | 2 | |
| oxcarbazepine | Trileptal | 1 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| TRILEPTAL SUSPENSION | | 2 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| ANTICONVULSANT/BENZODIAZEPINES | | | |
| clonazepam | Klonopin | 1 | |
| HYDANTOINS | | | |

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REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|--|-------------------------------|--------------------------|--|
| phenytoin sodium, extended | Dilantin, ER | 1 | |
| DILANTIN INFATABS, DILANTIN 30 MG EXTENDED RELEASE | | 2 | |
| PHENYTEK | | 2 | |
| VALPROIC ACID AND DERIVATIVES | | | |
| DEPAKOTE ER, DELAYED RELEASE,SPRINKLE | | 2 | |
| divalproex sodium ER, delayed-release | Depakote, ER, Delayed-Release | 1 | |
| valproic acid | Depakene | 1 | |
| ANTICONVULSANT BARBITURATES | | | |
| mephobarbital | Mebaral | 1 | |
| phenobarbital | | 1 | |
| primidone | Mysoline | 1 | |
| OTHER ANTICONVULSANTS | | | |
| CELONTIN | | 2 | |
| ethosuximide | | 1 | |
| FELBATOL | | 2 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| gabapentin | Neurontin | 1 | QLL=180 units/30 days |
| GABITRIL | | 2 | QLL=60 tabs/30 days |
| levetiracetam | Keppra | 1 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| lamotrigine | Lamictal | 1 | |
| NEURONTIN SOLUTION | | 2 | |
| topiramate | Topamax | 1 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=120 units/30 days |
| zonisamide | Zonegran | 1 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=180 units/30 days |
| TERTIARY AMINES | | | |
| amitriptyline hcl | Elavil | 1 | |
| doxepin hcl | Sinequan | 1 | |
| imipramine hcl | Tofranil | 1 | |
| trimipramine | Surmontil | 1 | |
| SECONDARY AMINES | | | |
| amoxapine | Norpramin | 1 | |
| desipramine hcl | Norpramin | 1 | |
| nortriptyline hcl | Pamelor | 1 | |
| SELECTIVE SEROTONIN REUPTAKE INHIBITORS | | | |

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REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|--|----------------------------|--------------------------|--|
| citalopram | Celexa | 1 | PA < 18 YEARS OF AGE; QLL=30 tabs/30 days or 300 ml/30 days |
| fluoxetine hcl | Prozac | 1 | PA < 18 YEARS OF AGE; QLL for 10 mg=30 caps/30 days; 20 mg, 40 mg= 60 tabs/caps/ 30 days Soln=150 ml/30 days |
| fluvoxamine maleate | Luvox | 1 | PA < 18 YEARS OF AGE; QLL for 100 mg=90 tabs/30 days; 50 mg=60 tabs/30 days; 25 mg= 30 tabs/30 days |
| paroxetine hcl | Paxil | 1 | PA < 18 YEARS OF AGE; QLL=30 tabs/30 days; soln=300 ml/30 days |
| sertraline hcl | Zoloft | 1 | PA < 18 YEARS OF AGE; QLL for 25 mg=30 tabs/30 days; 50 mg or 100 mg=60 tabs/30 days; soln=75 ml/30 days |
| OTHER ANTIDEPRESSANTS | | | |
| amitriptyline/ chlordiazepoxide | | 1 | |
| budeprion sr | Wellbutrin SR | 1 | QLL=60 tabs/30 days |
| bupropion hcl | Wellbutrin | 1 | QLL=90 tabs/30 days |
| maprotiline | | 1 | |
| mirtazapine | Remeron | 1 | QLL=30 tabs/30 days |
| trazodone hcl | Desyrel | 1 | |
| EFFEXOR XR | | 2 | STEP; QLL=30 caps/30 days |
| tranylcypromine | | 1 | |
| venlafaxine | Effexor | 1 | |
| ANTIVERTIGO AND ANTIEMETIC DRUGS | | | |
| granisetron | Kytril | 1 | COVERED FOR ONCOLOGISTS; OTHER SPECIALISTS REQUIRE PA; QLL=2 tabs/Rx |
| meclizine | | 1 | |
| ondansetron, ODT | Zofran, ODT | 1 | COVERED FOR ONCOLOGISTS; OTHER SPECIALISTS REQUIRE PA |
| prochlorperazine maleate | Compazine | 1 | |
| promethazine hcl | Phenergan | 1 | |
| EMEND | | 2 | PA |
| ANTIPARKINSON ANTICHOLINERGIC DRUGS | | | |
| benztropine mesylate | | 1 | |
| trihexyphenidyl | | 1 | |
| OTHER ANTIPARKINSON DRUGS | | | |

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REVISED SEPTEMBER 22, 2009**

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|------------------------------|----------------------------|--------------------------|---|
| bromocriptine mesylate | Parlodel | 1 | |
| carbidopa/levodopa COMTAN | Sinemet | 1 2 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=120 tabs/30 days |
| KEMADRIN | | 2 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=120 tabs/30 days |
| MIRAPEX | | 2 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| ropinirole | Requip | 1 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=90 tabs/30 days |
| selegiline | | 1 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| STALEVO | | 2 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=270 tabs/30 days |
| ANTIPSYCHOTIC DRUGS | | | |
| ABILIFY | | 3 | PA; QLL=30 tabs/30 days |
| chlorpromazine tablets | | 1 | |
| clozapine | | 1 | |
| GEODON | | 3 | PA; QLL=30 caps/30 days |
| haloperidol | | 1 | |
| loxapine | | 1 | |
| prochlorperazine maleate | | 1 | |
| risperidone | Risperdal | 1 | QLL=30 tabs/30 days |
| SEROQUEL | | 2 | QLL=90 tabs/30 days; 300 mg=60 tabs/30 days |
| thioridazine | | 1 | |
| trifluoperazine | | 1 | |
| ZYPREXA | | 2 | QLL=30 tabs/30 days |
| CNS STIMULANT DRUGS | | | |
| amphetamine salt combo | Adderall | 1 | QLL=90 tabs/30 days |
| dextroamphetamine | | 1 | |
| methylin tabs | Ritalin | 1 | QLL=120 tabs/30 days |
| methylphenidate er | Ritalin-SR | 1 | |
| methylphenidate hcl | Ritalin | 1 | QLL=120 tabs/30 days |
| METADATE CD | | 2 | QLL=60 caps/30 days |
| ADDERALL XR | | 2 | QLL=30 caps/30 days |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|------------------------------------|----------------------------|--------------------------|--|
| ANTIDEMENTIA DRUGS | | | |
| ARICEPT, ODT | | 2 | PA; QLL=30 tabs/30 days |
| galantamine, ER | Razadyne, Razadyne ER | 1 | galantamine QLL=60 tabs/30 days galantamine ER= 30 caps/30 days |
| OTHER CNS DRUGS | | | |
| caffeine citrate oral solution | | 1 | |
| naltrexone | | 1 | |
| pyridostigmine | | 1 | |
| CARDIOVASCULAR MEDICATIONS | | | |
| CARDIAC GLYCOSIDES | | | |
| digoxin | Lanoxin | 1 | |
| LANOXIN | | 2 | |
| CALCIUM ANTAGONISTS | | | |
| amlodipine | Norvasc | 1 | QLL= 30 tabs/30 days |
| cartia xt | Cardizem CD | 1 | |
| diltiazem er | Tiazac/Taztia XT | 1 | QLL=30 caps or tabs/30 days |
| diltiazem hcl | Cardizem | 1 | QLL=30 tabs/30 days |
| diltia xt | Cardizem CD | 1 | |
| dilt-CD | Cardizem CD | 1 | |
| felodipine er | Plendil | 1 | |
| nicardipine hcl | Cardene | 1 | |
| nifedipine, er | Procardia, Procardia XL | 1 | QLL=30/30 days |
| verapamil, er | Verelan/Calan/ Calan SR | 1 | QLL=30 untis/30days |
| LOOP DIURETICS | | | |
| bumetanide | Bumex | 1 | |
| furosemide | Lasix | 1 | |
| torseamide | Demadex | 1 | |
| THIAZIDE AND RELATED DRUGS | | | |
| chlorthalidone | | 1 | |
| chlorothiazide | | 1 | |
| hydrochlorothiazide | Microzide | 1 | |
| indapamide | Lozol | 1 | |
| metolazone | Zaroxolyn | 1 | |
| POTASSIUM SPARING DIURETICS | | | |
| amiloride | | 1 | |
| amiloride hcl w/hctz | Midamor | 1 | |
| spironolactone | Aldactone | 1 | |
| spironolactone w/hctz | Aldactazide | 1 | |
| triamterene w/hctz | Maxzide/Diazide | 1 | |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|---|----------------------------|--------------------------|---|
| BETA-ADRENERGIC ANTAGONIST DRUGS | | | |
| acebutolol | | 1 | |
| atenolol | Tenormin | 1 | |
| bisoprolol fumarate | Zebeta | 1 | |
| carvedilol | Coreg | 1 | |
| labetalol hcl | Normodyne/Trandate | 1 | |
| metoprolol succinate | Toprol XL | 1 | |
| metoprolol tartrate | Lopressor | 1 | |
| nadolol | Corgard | 1 | |
| pindolol | | 1 | |
| propranolol, er | Inderal/LA | 1 | |
| timolol maleate | | 1 | |
| TOPROL XL | | 2 | |
| VASODILATOR ANTIHYPERTENSIVES | | | |
| doxazosin mesylate | Cardura | 1 | QLL=30 tabs/30 days |
| hydralazine hcl | Apresoline | 1 | |
| minoxidil | | 1 | |
| prazosin hcl | Minipress | 1 | |
| terazosin hcl | Hytrin | 1 | QLL=30 units/30 days |
| CENTRALLY ACTING ANTIHYPERTENSIVES | | | |
| clonidine hcl tablets | Catapres | 1 | |
| methyldopa | | 1 | |
| ANGIOTENSIN CONVERTING ENZYME INHIBITORS | | | |
| benazepril hcl | Lotensin | 1 | |
| captopril | Capoten | 1 | |
| enalapril maleate | Vasotec | 1 | |
| fosinopril sodium | Monopril | 1 | |
| lisinopril | Prinivil/Zestril | 1 | QLL=30 tabs/30 days; 40 mg=60 tabs/30 days |
| moexipril hcl | Univasc | 1 | |
| quinapril hcl | Accupril | 1 | |
| trandolapril | Mavik | 1 | |
| ANGIOTENSIN II RECEPTOR ANTAGONISTS | | | |
| BENICAR | | 2 | STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days |
| DIOVAN | | 2 | STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days; |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

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|--|----------------------------|--------------------------|---|
| OTHER ANTIHYPERTENSIVES | | | |
| atenolol w/chlorthalidone | Tenoretic | 1 | |
| benazepril hcl w/hctz | Lotensin HCT | 1 | |
| bisoprolol fumarate w/hctz | Ziac | 1 | |
| captopril w/hctz | Capozide | 1 | |
| enalapril maleate w/hctz | Vaseretic | 1 | |
| fosinopril w/hctz | Monopril HCT | 1 | |
| hydra-zide | | 1 | |
| lisinopril w/hctz | Prinzide/Zestoretic | 1 | |
| metoprolol w/hctz | Lopressor HCT | 1 | |
| methyl dopa w/hctz | | 1 | |
| moexipril w/hctz | Uniretic | 1 | |
| propranolol hcl w/hctz | Inderide | 1 | |
| quinapril w/hctz | Quinaretic | 1 | |
| BENICAR HCT | | 2 | STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days |
| DIOVAN HCT | | 2 | STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days |
| NITRATES | | | |
| isosorbide dinitrate | Isochron/Isordil | 1 | |
| isosorbide mononitrate | Imdur/Ismo/ Monoket | 1 | |
| nitro-bid ointment | | 1 | |
| nitroglycerin (patch, sublingual tablet, extended-release capsule) | Nitro-Dur/Nitrostat | 1 | |
| OTHER VASODILATING DRUGS | | | |
| REVATIO | | 2 | PA/QLL=90 tabs/30 days |
| CLASS 1A ANTIARRHYTHMICS | | | |
| disopyramide | Norpace | 1 | |
| procainamide | | 1 | |
| quinidine gluconate | | 1 | |
| quinidine sulfate | | 1 | |
| CLASS 1B ANTIARRHYTHMICS | | | |
| mexiletine | Mexitil | 1 | COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA |
| CLASS 1C ANTIARRHYTHMICS | | | |
| flecainide acetate | Tambocor | 1 | |
| propafenone hcl | Rythmol | 1 | COVERED FOR CARDIOLOGIST; |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

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|-------------------------------------|-------------------------------|-------------------|---|
| | | | OTHER SPECIALISTS REQUIRE PA |
| OTHER ANTIARRHYTHMICS | | | |
| amiodarone | Pacerone | 1 | COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA |
| sotalol | Betapace | 1 | |
| HYPOLIPOPROTEINEMICS | | | |
| cholestyramine | | 1 | |
| colestipol hcl | Colestid | 1 | |
| fenofibrate | Lofibra | 1 | |
| gemfibrozil | Lopid | 1 | QLL=60 tabs/30 days |
| TRILIPIX | | 2 | |
| ZETIA | | 2 | STEP |
| HMG-COA REDUCTASE INHIBITORS | | | |
| lovastatin | Mevacor | 1 | QLL=30 tabs/30 days; 40 mg=60 tabs/30 days |
| pravastatin | Pravachol | 1 | QLL=30 tabs/30 days |
| simvastatin | Zocor | 1 | QLL=30 tabs/30 days |
| LESCOL | | 2 | QLL=30 caps/30 days |
| LESCOL XL | | 2 | QLL=30 tabs/30 days |
| OTHER CARDIOVASCULAR DRUGS | | | |
| midodrine | ProAmatine | 1 | |
| pentoxifylline | Trental | 1 | |
| DERMATOLOGICAL MEDICATIONS | | | |
| TOPICAL CORTICOSTEROID DRUGS | | | |
| alclometasone dipropionate | Aclovate | 1 | |
| amcinonide | | 1 | |
| betamethasone dipropionate | Diprolene | 1 | |
| betamethasone valerate | Beta-Val | 1 | |
| clobetasol propionate | Clobevate/Temovate | 1 | |
| desonide | Desowen/Lokara | 1 | |
| desoximetasone | Topicort | 1 | |
| diflorasone diacetate | Apexicon/Maxiflor/ Psorcon | 1 | |
| fluocinolone | | 1 | |
| fluocinonide | | 1 | |
| fluticasone propionate | Cutivate | 1 | |
| halobetasol | Ultravate | 1 | |
| hydrocortisone butyrate | Locoid | 1 | |
| hydrocortisone valerate | Westcort | 1 | |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|---|-----------------------------|--------------------------|---|
| mometasone furoate | Elocon | 1 | |
| prednicarbate | Dermatop | 1 | |
| triamcinolone acetonide | Kenalog | 1 | |
| ANTIPRURITIC DRUGS | | | |
| hydroxyzine hcl | | 1 | |
| hydroxyzine pamoate | | 1 | |
| ANTIACNE DRUGS | | | |
| amnestem | Accutane | 1 | |
| claravis | Accutane | 1 | |
| clindamycin phosphate | Cleocin T/Clindamax | 1 | |
| erythromycin | A/T/S / Emgel/Erycette | 1 | |
| metronidazole | Metrocream/ Metro lotion | 1 | |
| sod.sulfacetamide/sulfur tf | Avar/Plexion | 1 | |
| sotret | Accutane | 1 | |
| tretinoin | Avita/Retin-A | 1 | QLL=20 gram tube/30 days |
| KERATOLYTIC DRUGS | | | |
| CONDYLOX GEL | | 2 | |
| podofilox solution | Condylox | 1 | |
| ANTIPSORIASIS AND ANTIECZEMA DRUGS | | | |
| calcipotriene scalp solution | Dovonex | 1 | |
| DOAK TAR DISTILLATE | | 2 | |
| DRITHO-SCALP | | 2 | |
| DOVONEX CREAM | | 2 | |
| selenium sulfide | Selseb | 1 | |
| sulfacetamide sodium | Carmol Scalp | 1 | |
| VECTICAL OINTMENT | | 2 | |
| TOPICAL DERMATOLOGICAL DRUGS | | | |
| FLUOROPLEX | | 2 | |
| fluorouracil | Efudex | 1 | |
| ALDARA | | 2 | |
| CARAC | | 2 | |
| ELIDEL | | 2 | PA REQUIRED FOR AGE < 2 AND > 10;QLL=30 gm/30 days |
| SANTYL | | 2 | |
| SCABICIDES | | | |
| permethrin | Elimite | 1 | |
| EAR-NOSE-THROAT MEDICATIONS | | | |
| DRUGS AFFECTING THE EAR | | | |
| antipyrine/benzocaine otic | Benzotic/Otogesic | 1 | |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

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|---|----------------------------|--------------------------|-----------------------------|
| acetic acid otic | | 1 | |
| CIPRO HC | | 2 | |
| CIPRODEX OTIC | | 2 | |
| neomycin/polymixin/ hydrocortisone | | 1 | |
| ofloxacin | | 1 | |
| DRUGS AFFECTING THE NOSE | | | |
| flunisolide | Nasarel | 1 | |
| fluticasone propionate | Flonase | 1 | |
| ipratropium bromide | Atrovent | 1 | |
| NASONEX | | 2 | STEP/QLL=2 bottles/30 days |
| DRUGS AFFECTING THE THROAT AND MOUTH | | | |
| chlorhexidine gluconate | Peridex | 2 | |
| doxycycline hyclate | Periostat | 1 | |
| pilocarpine hcl | Salagen | 1 | |
| triamcinolone acetonide | Kenalog | 1 | |
| ENDOCRINE MEDICATIONS | | | |
| ORAL HYPOGLYCEMIC DRUGS | | | |
| acarbose | Precose | 1 | |
| chlorpropamide | Diabinese | 1 | |
| glimepiride | Amaryl | 1 | |
| glipizide, er | Glucotrol, XL | 1 | |
| glipizide-metformin | Metaglip | 1 | |
| glyburide | Diabeta/Micronase | 1 | |
| glyburide-metformin | Glucovance | 1 | |
| metformin, er | Glucophage, XR | 1 | |
| nateglinide | Starlix | 1 | |
| PRANDIN | | 2 | |
| PRANDIMET | | 2 | |
| tolazamide | | 1 | |
| tolbutamide | | 1 | |
| INSULIN SENSITIZERS | | | |
| ACTOPLUS MET | | 2 | QLL=90 tabs/30 days |
| ACTOS | | 2 | QLL=30 tabs/30 days |
| AVANDAMET | | 2 | QLL=60 tabs/30 days |
| AVANDARYL | | 2 | QLL=60 tabs/30 days |
| AVANDIA | | 2 | QLL=30 tabs/30 days |
| DUETACT | | 2 | QLL=30 tabs/30 days |
| INSULIN (VIALS ONLY) | | | |
| HUMULIN 50/50 | | 2 | |
| HUMULIN R (500 U/ML VIAL) | | 2 | |

PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|--------------------------------|---------------------|-------------------|--|
| HUMULIN 70/30 | | 2 | |
| NOVOLIN 70/30 | | 2 | |
| NOVOLIN R | | 2 | |
| NOVOLIN N | | 2 | |
| NOVOLOG | | 2 | |
| NOVOLOG MIX 70/30 | | 2 | |
| LANTUS | | 2 | |
| LEVEMIR | | 2 | |
| GLUCOSE ELEVATING DRUGS | | | |
| GLUCAGON | | 2 | |
| GLUCOCORTICOID DRUGS | | | |
| cortisone | | 1 | |
| dexamethasone | | 1 | |
| hydrocortisone | Cortef | 1 | |
| methylprednisolone | Medrol | 1 | |
| prednisolone | Prelone | 1 | |
| prednisone | Sterapred | 1 | |
| ORAPRED, -ODT | | 2 | |
| MINERALOCORTICOID DRUGS | | | |
| fludrocortisone acetate | Florinef | 1 | |
| THYROID SUPPLEMENTS | | | |
| ARMOUR THYROID | | 2 | |
| levothyroid | | 1 | |
| levothyroxine sodium | Synthroid | 1 | |
| levoxyl | Synthroid | 1 | |
| liothyronine | Cytomel | 1 | |
| thyroid, dessicated | Armour Thyroid | 1 | |
| unithroid | Synthroid | 1 | |
| ANTITHYROID DRUGS | | | |
| methimazole | Tapazole | 1 | |
| propylthiouracil | | 1 | |
| ANDROGEN DRUGS | | | |
| danazol | | 1 | |
| methyltestosterone | | 1 | |
| OTHER ENDOCRINE DRUGS | | | |
| alendronate sodium | Fosamax | 1 | QLL 35 mg or 70 mg=4 tabs/30 days; QLL 5 mg,10 mg, 40 mg=30 tabs/30 days |
| BYETTA | | 3 | PA |
| calcitonin-salmon nasal | | 1 | |
| desmopressin acetate | DDAVP/Minirin | 1 | COVERED FOR ENDO/NEURO; |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

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|--|---------------------|-------------------|--|
| | | | OTHER SPECIALISTS REQUIRE PA; QLL=1 bottle/30 days; QLL=90 tabs/30 days |
| CYTADREN | | 2 | |
| etidronate | Didronel | 1 | |
| fortical nasal spray | | 1 | |
| KUVAN | | 2 | PA |
| SENSIPAR | | 2 | COVERED FOR NEPHROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| SYMLIN | | 3 | PA |
| GASTROINTESTINAL MEDICATIONS | | | |
| ANTIDIARRHEAL DRUGS | | | |
| diphenoxylate w/atropine | Lomotil | 1 | |
| ANTISPASMODICS/DRUGS AFFECT GI MOTILITY | | | |
| dicyclomine hcl | Bentyl | 1 | |
| hyoscyamine | Nulev/Levbrel | 1 | |
| metoclopramide hcl | Reglan | 1 | |
| ANTIULCER DRUGS | | | |
| cimetidine | Tagamet | 1 | |
| famotidine | Pepcid | 1 | |
| nizatidine | Axid | 1 | |
| ranitidine | Zantac | 1 | |
| OTHER ANTIULCER DRUGS | | | |
| misoprostol | Cytotec | 1 | |
| sucralfate | Carafate | 1 | |
| CARAFATE SUSPENSION | | 2 | |
| PROTON PUMP INHIBITORS | | | |
| PREVACID SOLUTAB | | 2 | COVERED FOR PULMONOLOGISTS (INCLUDING PEDIATRIC PULMONOLOGISTS) AND PEDIATRIC GASTROENTEROLOGISTS FOR CHILDREN 17 YEARS OF AGE AND YOUNGER |
| omeprazole | Prilosec | 1 | COVERED FOR GASTROENTEROLOGIST; OTHER SPECIALISTS REQUIRE PA; STEP/QLL=120 caps/30 days |
| pantoprazole | Protonix | 1 | PA/QLL=30 tabs/30 days |
| OTHER GI DRUGS | | | |
| AMITIZA | | 2 | QLL=60 caps/30 days |

PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|--|------------------------------------|-------------------|-----------------------|
| ASACOL, ASACOL HD | | 2 | |
| belladonna alkaloids-opium | | 1 | |
| CANASA | | 2 | |
| CREON | | 2 | |
| DIPENTUM | | 2 | |
| hydrocortisone rectal formulations | AnusolHC/Colocort/ Proctosol-HC | 1 | |
| mesalamine enema | | 1 | |
| NULYTELY WITH FLAVOR PACKS | | 2 | |
| PANCREASE MT 4 | | 2 | |
| PANCRELIPASE | | 2 | |
| peg 3350 electrolyte solution | | 1 | |
| PENTASA | | 2 | |
| polyethylene glycol 3350 | | 1 | |
| PROCTOFOAM-HC | | 2 | |
| propantheline | | 1 | |
| sulfasalazine | Azulfidine | 1 | |
| ultracaps MT 20 | Ultrase MT 20 | 1 | |
| ULTRASE | | 2 | |
| ursodiol | Actigall | 1 | |
| VIOKASE | | 2 | |
| IMMUNOLOGICALS AND VACCINES | | | |
| FLUMIST | | 2 | PA FOR AGES <2 OR >49 |
| ROTARIX | | 2 | |
| ROTATEQ | | 2 | |
| MUSCULOSKELETAL MEDICATIONS | | | |
| SALICYLATES AND RELATED DRUGS | | | |
| choline magnesium trisalicylate | | 1 | |
| diflunisal | Dolobid | 1 | |
| salsalate | Disalcid | 1 | |
| NON-STEROIDAL ANTIINFLAMMATORY AGENTS | | | |
| diclofenac sodium | Voltaren | 1 | |
| etodolac | Lodine/Lodine XL | 1 | |
| fenoprofen | | 1 | |
| flurbiprofen | Anasaid | 1 | |
| ibuprofen (prescription-strength only) | Motrin | 1 | |
| indomethacin | Indocin SR | 1 | |
| ketoprofen | Orudis/Oruvail | 1 | |
| ketorolac | Toradol | 1 | QLL=20 tabs/30 days |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|---|----------------------------|--------------------------|---|
| meclofenamate | | 1 | |
| meloxicam | Mobic | 1 | |
| nabumetone | Relafen | 1 | |
| naproxen | Naprosyn | 1 | |
| naproxen sodium (prescription-strength only) | Anaprox | 1 | |
| oxaprozin | Daypro | 1 | |
| piroxicam | Feldene | 1 | |
| sulindac | Clinoril | 1 | |
| tolmetin | | 1 | |
| OTHER DRUGS FOR ARTHRITIS | | | |
| CELEBREX | | 2 | QLL=60 caps/30 days |
| DRUGS TO PREVENT AND TREAT GOUT | | | |
| allopurinol | Zyloprim | 1 | |
| colchicine | | 1 | |
| colchicine / probenecid | | 1 | |
| probenecid | | 1 | |
| DIRECT MUSCLE RELAXANTS | | | |
| baclofen | | 1 | |
| tizanidine hcl | Zanaflex | 1 | |
| CNS MUSCLE RELAXANTS | | | |
| carisoprodol | Soma | 1 | QLL=120 tabs/30 days |
| cyclobenzaprine hcl | Flexeril | 1 | QLL=120 tabs/30 days |
| dantrolene capsule | Dantrium | 1 | |
| methocarbamol | Robaxin | 1 | QLL=120 tabs/30 days |
| SKELAXIN | | 2 | QLL=120 tabs/30 days |
| OTHER MUSCULOSKELETAL MEDICATIONS | | | |
| RILUTEK | | 2 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| NUTRITION, BLOOD MODIFIERS, ELECTROLYTES | | | |
| THERAPEUTIC VITAMINS & MINERALS (PRESCRIPTION-STRENGTH ONLY) | | | |
| calcitriol | Calcijex/Rocaltrol | 1 | |
| calcium acetate | Phoslo | 1 | |
| cyanocobalamin [inj] | | 1 | PA REQUIRED |
| ergocalciferol | Vitamin D | 1 | |
| folic acid | | 1 | |
| levocarnitine | | 1 | COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| NEPHROCAPS | | 2 | |
| sodium fluoride | | 1 | |

**PREFERRED DRUG LIST
REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|---|----------------------------|--------------------------|---|
| thiamine | | 1 | |
| ZEMPLAR | | 2 | COVERED FOR NEPHROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| POTASSIUM SUPPLEMENTS | | | |
| KLOR-CON, KLOR-CON M | | 1 | |
| potassium chloride | K-Dur/Klotrix | 1 | |
| SHOHL'S MODIFIED | | 2 | |
| POTASSIUM REMOVING RESINS | | | |
| sodium polystyrene sulfonate | Kayexalate | 1 | |
| ORAL ANTICOAGULANTS, VITAMIN K | | | |
| warfarin sodium | Coumadin | 1 | |
| HEPARINS | | | |
| heparin sodium [inj] (heparin lock flush solution not covered) | | 1 | |
| LOW-MOLECULAR WEIGHT HEPARINS (LMWH) | | | |
| FRAGMIN [inj] | | 2 | 10 DAYS W/O PA (10 DAYS=10 SYRINGES) |
| LOVENOX [inj] | | 2 | 10 DAYS W/O PA (10 DAYS=20 SYRINGES) |
| ANTIPLATELET DRUGS | | | |
| cilostazol | Pletal | 1 | |
| dipyridamole | Persantine | 1 | |
| ticlopidine hcl | Ticlid | 1 | |
| PLAVIX | | 2 | QLL=30 tabs/30 days |
| HEMOSTATICS | | | |
| aminocaproic acid | Amicar | 1 | |
| MEPHYTON | | 2 | |
| BLOOD DETOXICANTS | | | |
| lactulose | Enulose | 1 | |
| FOSRENOL | | 2 | COVERED FOR NEPHROLOGIST; OTHER SPECIALISTS REQUIRE PA |
| RENAGEL | | 2 | |
| RENVELA | | 2 | |
| OTHER BLOOD MODIFIERS | | | |
| anagrelide | Agrylin | 1 | |
| OBSTETRICAL & GYNECOLOGICAL MEDICATIONS | | | |
| PRENATAL VITAMINS (COVERED FOR FEMALES AGES 11 to 49) QLL=100 tabs/90 days for all legend prenatal vitamins | | | |
| cal-nate | | 1 | |
| complete natal DHA | | 1 | |

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REVISED SEPTEMBER 22, 2009**

| COVERED DRUG | REFERENCE DRUG NAME | COVERED DRUG TIER | REQUIREMENTS/ LIMITS |
|--|----------------------------|--------------------------|-----------------------------|
| fe plus tablet | | 1 | |
| prenatal advantage (prenatal AD) | | 1 | |
| prenatal low iron | | 1 | |
| prenatal H | | 1 | |
| prenatal U | | 1 | |
| trinate | | 1 | |
| ultra-natal | | 1 | |
| vinatal forte | | 1 | |
| vinate ultra | | 1 | |
| vinate calcium | | 1 | |
| vitafol-ob | | 1 | |
| vitafol-pn | | 1 | |
| OB/GYN TOPICAL ANTIINFECTIVES | | | |
| acidic vaginal jelly | | 1 | |
| CLEOCIN OVULE | | 2 | |
| clindamycin 2% vaginal cream | Clindamax | 1 | |
| metronidazole 0.75% vaginal gel | MetroGel | 1 | |
| ESTROGEN DRUGS | | | |
| estradiol tablets | Estrace | 1 | |
| estradiol transdermal patch | Climara | 1 | QLL=8 patches/30 days |
| estropipate | Ogen/Ortho-Est | 1 | |
| ESTRACE VAGINAL CREAM | | 2 | |
| ESTRING | | 2 | |
| FEMRING | | 2 | |
| MENEST | | 2 | |
| PREMARIN | | 2 | |
| VAGIFEM | | 2 | |
| ESTROGEN/PROGESTIN COMBINATIONS | | | |
| CLIMARA PRO | | 2 | |
| COMBIPATCH | | 2 | |
| FEMHRT | | 2 | |
| PREFEST | | 2 | |
| PREMPHASE | | 2 | |
| PREMPRO | | 2 | |
| SELECTIVE ESTROGEN RECEPTOR MODULATOR | | | |
| EVISTA | | 2 | QLL=30 tabs/30 days |
| PROGESTIN DRUGS | | | |
| camila | Micronor/Nor-Q-D | 1 | |
| errin | Micronor/Nor-Q-D | 1 | |
| jolivette | Micronor/Nor-Q-D | 1 | |
| medroxyprogesterone acetate | Provera | 1 | |

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|---|---------------------|-------------------|----------------------|
| nora-be | Micronor/Nor-Q-D | 1 | |
| norethindrone acetate | Aygestin | 1 | |
| PROMETRIUM | | 2 | |
| OTHER OB/GYN DRUGS | | | |
| METHERGINE TABLETS | | 2 | |
| OPHTHALMIC MEDICATIONS | | | |
| OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS | | | |
| bacitracin ophth ointment | | 1 | |
| ciprofloxacin hcl (ophth drops) | Ciloxan | 1 | |
| CILOXAN OPTHALMIC OINTMENT | | 2 | |
| erythromycin | | 1 | |
| gentamicin sulfate | Garamycin/Gentak | 1 | |
| ofloxacin | Ocuflox | 1 | |
| neomycin/polymyxin/bacitracin | Neosporin | 1 | |
| neomycin/polymyxin/gramicidin | | 1 | |
| polymyxin/trimethoprim | Polytrim | 1 | |
| sulfacetamide sodium | Bleph-10 | 1 | |
| tobramycin sulfate | Tobrex | 1 | |
| TOBEX OINTMENT | | 2 | |
| VIGAMOX | | 2 | |
| ZYMAR | | 2 | |
| OPHTHALMIC CORTICOSTEROID DRUGS | | | |
| dexamethasone | | 1 | |
| PRED MILD | | 2 | |
| prednisolone | Omnipred/Pred Forte | 1 | |
| fluorometholone | | 1 | |
| FML FORTE | | 2 | |
| OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS | | | |
| neomycin/polymyxin/hydrocortisone | Cortisporin | 1 | |
| neomycin/polymyxin/dexamethasone | Methadex/Maxitrol | 1 | |
| prednisolone/sulfacetamide | | 1 | |
| TOBRADEX OINTMENT | | 2 | |
| tobramycin/dexamethasone susp | Tobradex | 1 | |
| ANTIGLAUCOMA DRUGS | | | |
| acetazolamide | | 1 | |
| ALPHAGAN, ALPHAGAN P | | 2 | |
| AZOPT | | 2 | |
| BETOPTIC S | | 2 | |

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|--|----------------------|-------------------|--|
| betaxolol hcl | | 1 | |
| brimonidine tartrate | | 1 | |
| carteolol hcl | | 1 | |
| COMBIGAN | | 2 | |
| dipivefrin hcl | Propine | 1 | |
| dorzolamide | Trusopt | 1 | |
| dorzolamide/timolol | Cosopt | 1 | |
| ISOPTO CARBACHOL | | 2 | |
| levobunolol hcl | Betagan | 1 | |
| LUMIGAN | | 2 | |
| methazolamide | | 1 | |
| metipranolol | Optipranolol | 1 | |
| PHOSPHOLINE IODIDE | | 2 | |
| pilocarpine hcl | Isopto Carpine | 1 | |
| timolol maleate | Timoptic/Timoptic-XE | 1 | |
| TRAVATAN | | 2 | |
| TRAVATAN Z | | 2 | |
| XALATAN | | 3 | |
| OTHER OPHTHALMIC DRUGS | | | |
| ACULAR, ACULAR LS | | 2 | |
| atropine sulfate | Isopto Atropine | 1 | |
| cromolyn sodium | Crolom | 1 | |
| cyclopentolate | Cyclogyl | 1 | |
| diclofenac sodium | Voltaren | 1 | |
| flurbiprofen sodium | Ocufen | 1 | |
| ISOPTO HOMATROPINE | | 2 | |
| ISOPTO HYOSCINE | | 2 | |
| MUROCOLL-2 | | 2 | |
| naphazoline | AK-Con | 1 | |
| NEVANAC | | 2 | |
| PATANOL | | 2 | |
| phenylephrine | | 1 | |
| trifluridine | | 1 | |
| tropicamide | | 1 | |
| RESPIRATORY MEDICATIONS | | | |
| BETA-2 ADRENERGIC DRUGS | | | |
| albuterol sulfate (inhalation soln, syrup, tablet) | | 1 | QLL=375 ml/30 days for inhalation soln |
| ALUPENT (650 MCG INHALER) | | 2 | |
| MAXAIR AUTOHALER | | 2 | |

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| metaproterenol | | 1 | |
| PROAIR HFA | | 2 | QLL= 2 inhalers/30 days |
| PROVENTIL HFA | | 2 | QLL= 2 inhalers/30 days |
| SEREVENT DISKUS | | 2 | |
| terbutaline | | 1 | |
| VENTOLIN HFA | | 1 | QLL= 2 inhalers/30 days |
| INHALED CORTICOSTEROIDS | | | |
| ADVAIR DISKUS | | 2 | |
| ADVAIR HFA | | 2 | |
| AZMACORT | | 2 | |
| FLOVENT DISKUS | | 2 | |
| FLOVENT HFA | | 2 | |
| PULMICORT RESPULES | | 2 | QLL=60 ml/30 days (30 respules/30 days) |
| PULMICORT FLEXHALER/INHALER | | 2 | QLL=1 inhaler or flexhaler/30 days |
| SYMBICORT | | 2 | |
| LEUKOTRIENE MODIFIERS | | | |
| ACCOLATE | | 2 | COVERED FOR MEMBERS WITH DIAGNOSIS OF ASTHMA; NOT FDA-APPROVED FOR ALLERGIC RHINITIS; QLL=60 tabs/30 days |
| SINGULAIR | | 2 | COVERED FOR MEMBERS WITH DIAGNOSIS OF ASTHMA; PA FOR ALLERGIC RHINITIS; QLL=30 tabs/30 days |
| METHYL XANTHINE DRUGS | | | |
| theophylline, er | | 1 | |
| OTHER DRUGS FOR ASTHMA | | | |
| ATROVENT (INHALER) | | 2 | |
| COMBIVENT | | 2 | |
| cromolyn sodium inhalation soln | | 1 | |
| EPIPEN, EPIPEN JR | | 2 | |
| ipratropium bromide | | 1 | |
| ipratropium bromide/albuterol inhalation soln | | 1 | |
| SPIRIVA | | 2 | STEP; QLL=30 caps/30 days (pkg size=30); 6 caps/30 days (pkg size=6); 1 pkg/30 days (pkg size=5); 1/30 days (pkg size=90) |
| sodium chloride 0.9% nebulizer solution | | 1 | |

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|---|----------------------------------|-------------------|---------------------------|
| ANTIHISTAMINES (PRESCRIPTION-STRENGTH ONLY) | | | |
| clemastine fumarate | Tavist | 1 | |
| cyproheptadine hcl | Periactin | 1 | |
| dexchlorpheniramine | | 1 | |
| diphenhydramine hcl | | 1 | |
| hydroxyzine hcl | Atarax, Vistaril | 1 | |
| ANTIHISTAMINE/DECONGESTANT COMBINATIONS | | | |
| andehist nr syrup | Rondec syrup | 1 | |
| bromaxefed rf syrup | Rondec syrup | 1 | |
| chlor-pseudo sr capsule | Deconamine SR | 1 | |
| colfed-a capsule sr | Deconamine SR | 1 | |
| duradryl syrup | | 1 | |
| HISTADE CAPSULE SA | | 2 | |
| p-ephed-cpm 120-8 mg SA | Deconamine SR | 1 | |
| rhinacon a liquid, tablet | | 1 | |
| ANTITUSSIVE AND EXPECTORANT DRUGS (PRESCRIPTION-STRENGTH ONLY) | | | |
| benzonatate | Tessalon | 1 | QLL=90 capsules/30 days |
| ceron dm syrup | Rondec DM syrup | 1 | |
| cphen, cphen dm drops, syrup | Rondec, DM drops, syrup | 1 | |
| guaifenesin-dextromethorphan hbr extended-release | Guaifenex DM, Humibid DM | 1 | |
| guaifenesin | | 1 | |
| guaifenesin w/codeine | Romilar AC/Tussi-Organidin DM NR | 1 | |
| guaifenesin-dm | | 1 | |
| guaifenesin-pseudoephedrine hcl | | 1 | |
| guaifenex pse | Entex PSE/Zephrex-LA | 1 | |
| promethazine vc w/codeine | Phenergan VC w/Codeine | 1 | |
| promethazine vc | Phenergan VC | 1 | |
| promethazine w/dm | Phenergan DM | 1 | |
| TOXICOLOGY MEDICATIONS | | | |
| acetylcysteine | | 1 | |
| CUPRIMINE | | 2 | |
| UROLOGICAL MEDICATIONS | | | |
| ANTICHOLINERGIC ANTISPASMODICS DRUGS | | | |
| flavoxate | Urispas | 1 | |
| oxybutynin chloride | Ditropan | 1 | |
| oxybutynin chloride er | Ditropan XL | 1 | |
| SANCTURA | | 2 | STEP; QLL=60 tabs/30 days |

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| SANCTURA XR | | 2 | STEP |
| CHOLINERGIC STIMULANTS | | | |
| bethanecol | | 1 | |
| URINARY ANESTHETICS | | | |
| phenazopyridine hcl | Pyridium/Urodol | 1 | |
| OTHER GENITOURINARY PRODUCTS | | | |
| cytra-k | | 1 | |
| ELMIRON | | 2 | |
| finasteride | Proscar | 1 | |
| K-PHOS | | 2 | |
| potassium citrate | | 1 | |
| UROXATRAL | | 2 | |
| MEDICAL (MISCELLANEOUS) SUPPLIES | | | |
| DIABETIC SUPPLIES | | | |
| TEST STRIPS COMBINED QLL=204 TEST STRIPS/30 DAYS | | | |
| ACCU-CHEK AVIVA GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| ACCU-CHEK ACTIVE GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| ACCU-CHEK ADVANTAGE GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| ACCU-CHEK COMPACT GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| ACCU-CHEK COMPLETE GLUCOMETER | | 2 | |
| ACCU-CHEK SIMPLICITY | | 2 | |
| ACCU-CHEK COMFORT CURVE TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| ACCU-CHEK MULTICLIX LANCET DEVICE/LANCETS | | 2 | |
| ACCU-CHEK SOFTCLIX LANCET DEVICE/LANCETS | | 2 | |
| BREEZE GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| BREEZE 2 GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| CONTOUR TS GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| ELITE GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| ELITE XL GLUCOMETER/TEST STRIPS | | 2 | Combined QLL for test strips=204 strips/30 days |
| MICROLET LANCING DEVICE/LANCETS | | 2 | |



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| AUTOJECT 2 INJECTION DEVICE | | 2 | |
| GLUCOMETER DEX | | 2 | |
| GLUCOMETER ELITE | | 2 | |
| insulin syringes | | 2 | |
| NOVOFINE 30 | | 2 | |
| NOVA MAX TEST STRIPS | | 2 | PA Required: Member must be on insulin pump |
| SOFT TOUCH LANCETS | | 2 | |
| SOFTCLIX | | 2 | |
| CHEMSTRIP | | 2 | |
| KETOSTIX | | 2 | |
| OTHER SUPPLIES | | | |
| AEROCHAMBER, MICROCHAMBER | | 2 | QLL=1/year |