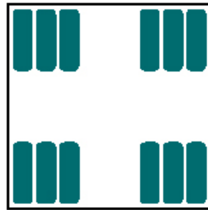

Mercy Healthcare Group

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.

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).

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

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, zpack, susp= 2 Rxs/60 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=2 Rxs/60 days
amoxicillin	Amoxil	1	
ampicillin	Principen	1	
dicloxacillin		1	
penicillin v potassium	Veetids	1	
SULFONAMIDES			
GANTRISIN (SUSPENSION)		2	
sulfamethoxazole/ trimethoprim	Septra	1	
sulfadiazine		1	

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	Macrodantin	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	
silver sulfadiazine	Silvadene	1	
sulfacetamide sodium	Ovace	1	
ORAL ANTIFUNGAL DRUGS			
clotrimazole	Mycelex	1	
fluconazole	Diflucan	1	
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	
econazole nitrate	Spectazole	1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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; ALL OTHERS REQUIRE PA
ATRIPLA		2	
COMBIVIR		2	
CRIXIVAN		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
didanosine		1	
EMTRIVA		2	
EPIVIR, EPIVIR HBV		2	
EPZICOM		2	
FUZEON		3	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
INTELENCE		2	PA
INVIRASE		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
KALETRA		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
LEXIVA		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
NORVIR		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
PREZISTA		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
RESCRIPTOR		2	
REYATAZ		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
stavudine	Zerit	1	
SUSTIVA		2	
TRIZIR		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
TRUVADA		2	
VIDEX SOLUTION		2	
VIRACEPT			COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
VIRAMUNE, -XR		2	
VIREAD		2	
ZIAGEN		2	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
zidovudine		1	
OTHER ANTIINFECTIVE DRUGS			
CLEOCIN (100 MG VAGINAL OVULE)		2	
dapsone		1	
MEPRON		2	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
VANCOCIN 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/Rx=20 inhalation diskus/Rx
SELZENTRY		2	
TAMIFLU		2	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; ALL OTHERS REQUIRE PA
valacyclovir	Valtrex	1	500 mg tablet=60 tabs/30 days 1 gram tablet QLL=30 tabs/30 days
VALCYTE		2	PA
ZOVIRAX (5% CREAM, 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			

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
chloroquine phosphate		1	
DARAPRIM		2	
hydroxychloroquine sulfate	Plaquentil	1	
primaquine		1	
TRICHOMONOCIDES			
metronidazole	Flagyl	1	
AMINOGLYCOSIDES			
neomycin		1	
paromomycin		1	
ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS MEDICATIONS WITHIN THIS CLASS ARE COVERED FOR FDA APPROVED INDICATIONS AND MAY REQUIRE PRIOR AUTHORIZATION. ALL INJECTABLE MEDICATIONS WITHIN THIS CLASS REQUIRE PRIOR AUTHORIZATION.			
anastrozole	Arimidex	1	
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	
GLEEVEC		2	PA
hydroxyurea	Hydrea	1	
IRESSA		2	PA
leflunomide	Arava	1	COVERED FOR RHEUMATOLOGIST; ALL OTHERS 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	PA

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
tretinoin	Vesinoid	1	
VOTRIENT		2	PA
XELODA		2	PA
ZOLADEX [INJ]		2	PA
ZOLINZA		2	COVERED FOR ONCOLOGIST; ALL OTHERS REQUIRE PA
AUTONOMIC AND CNS MEDICATIONS			
ANALGESICS			
tramadol hcl	Ultram	1	QLL=240 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, -ER	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
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	
buspirone hcl	Buspar	1	QLL=90 tabs/30 days
chlordiazepoxide hcl	Librium	1	
clorazepate dipotassium	Tranxene T-Tab	1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
diazepam	Valium	1	
lorazepam	Ativan	1	
oxazepam	Serax	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; ALL OTHERS REQUIRE PA
ANTICONVULSANT/BENZODIAZEPINES			
clonazepam	Klonopin	1	
HYDANTOINS			
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; ALL OTHERS REQUIRE PA
gabapentin	Neurontin	1	QLL=180 units/30 days

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
GABITRIL		2	QLL=60 tabs/30 days
levetiracetam	Keppra	1	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA
lamotrigine	Lamictal	1	
NEURONTIN SOLUTION		2	
topiramate	Topamax	1	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA; QLL=120 units/30 days
zonisamide	Zonegran	1	COVERED FOR NEUROLOGIST; ALL OTHERS 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		1	
desipramine hcl	Norpramin	1	
nortriptyline hcl	Pamelor	1	
SELECTIVE SEROTONIN REUPTAKE INHIBITORS			
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; 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, xl, sr	Wellbutrin, Wellbutrin XL	1	QLL=90 tabs/30 days

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
maprotiline		1	
mirtazapine, ODT	Remeron	1	QLL=30 tabs/30 days
trazodone hcl	Desyrel	1	
tranylcypromine		1	
venlafaxine	Effexor	1	
venlafaxine XR capsules	Effexor XR	1	STEP; QLL=30 caps/30 days
ANTIVERTIGO AND ANTIEMETIC DRUGS			
granisetron	Kytril	1	COVERED FOR ONCOLOGISTS; ALL OTHERS REQUIRE PA
meclizine		1	
ondansetron, ODT	Zofran, ODT	1	COVERED FOR ONCOLOGISTS; ALL OTHERS REQUIRE PA
prochlorperazine maleate	Compazine	1	
promethazine hcl	Phenergan	1	
EMEND		2	PA
ANTIPARKINSON ANTICHOLINERGIC DRUGS			
benztropine mesylate		1	
trihexyphenidyl		1	
OTHER ANTIPARKINSON DRUGS			
bromocriptine mesylate	Parlodel	1	
carbidopa/levodopa	Sinemet	1	
COMTAN		2	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA ; QLL=120 tabs/30 days
KEMADRIN		2	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA; QLL=120 tabs/30 days
pramipexole	Mirapex	1	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA
ropinirole	Requip	1	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA; QLL=90 tabs/30 days
selegiline		1	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA
STALEVO		2	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA; QLL=270 tabs/30 days
ANTIPSYCHOTIC DRUGS			
ABILIFY		3	PA; QLL=30 tabs/30 days
chlorpromazine tablets		1	
clozapine		1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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/ dextroamphetamine	Adderall, Adderall XR	1	Immediate release QLL=90 tabs/30 days; Extended release QLL=30 caps/30 days
dextroamphetamine		1	
methylin, -er tabs, methylin suspension	Ritalin	1	QLL=120 tabs/30 days
methylphenidate er, sr (methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg are not covered)	Ritalin-SR	1	
methylphenidate hcl	Ritalin	1	QLL=120 tabs/30 days
METADATE CD		2	QLL=60 caps/30 days
ANTIDEMENTIA DRUGS			
donepezil 5MG, 10 MG (23 MG IS NON-FORMULARY)	Aricept	1	PA; QLL=30 tabs/30 days
donepezil ODT	Aricept ODT	1	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=120 tabs/30 days

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
diltia xt	Cardizem CD	1	
dilt-CD	Cardizem CD	1	
felodipine er	Plendil	1	
nicardipine hcl	Cardene	1	
nifediac cc		1	
nifedical xl		1	QLL=90 tabs/30 days
nifedipine, er	Procardia, Procardia XL	1	Extended Release QLL=90/30 days
nisoldipine	Sular	1	QLL=60 tabs/30 days
verapamil, er	Verelan/Calan/ Calan SR	1	QLL for Immediate Release=120 units/30days; QLL for Extended Release=60 units/30 days
CARBONIC ANHYDRASE INHIBITORS			
acetazolamide, -ER	Diamox	1	
LOOP DIURETICS			
bumetanide	Bumex	1	
furosemide	Lasix	1	
torsemide	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	
BETA-ADRENERGIC ANTAGONIST DRUGS			
acebutolol		1	
atenolol	Tenormin	1	
bisoprolol fumarate	Zebeta	1	
carvedilol	Coreg	1	
labetalol hcl	Normodyne/Tranda te	1	
metoprolol succinate	Toprol XL	1	
metoprolol tartrate	Lopressor	1	
nadolol	Corgard	1	
pindolol		1	
propranolol, er	Inderal/LA	1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
timolol maleate		1	
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 1mg, 2mg, 5mg=30/30 days; QLL 10 mg=60/30 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	
perindopril	Aceon	1	
quinapril hcl	Accupril	1	
ramipril	Altace	1	
trandolapril	Mavik	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS			
BENICAR		2	STEP; COVERED FOR CARDIOLOGIST; ALL OTHERS REQUIRE PA; QLL=30 tabs/30 days
DIOVAN		2	STEP; COVERED FOR CARDIOLOGIST; ALL OTHERS REQUIRE PA; QLL=60 tabs/30 days;
losartan	Cozaar	1	
OTHER ANTIHYPERTENSIVES			
amlodipine/benazepril	Lotrel	1	
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	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
metoprolol w/hctz	Lopressor HCT	1	
methyldopa 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; ALL OTHERS REQUIRE PA; QLL=30 tabs/30 days
DIOVAN HCT		2	STEP; COVERED FOR CARDIOLOGIST; ALL OTHERS REQUIRE PA; QLL=30 tabs/30 days
losartan HCTZ	Hyzaar	1	
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	
NITROSTAT		2	
OTHER VASODILATING DRUGS			
REVATIO		2	COVERED FOR CARDIOLOGISTS AND PULMONOLOGISTS; ALL OTHERS REQUIRE 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; ALL OTHERS REQUIRE PA
CLASS 1C ANTIARRHYTHMICS			
flecainide acetate	Tambocor	1	
propafenone hcl	Rythmol	1	COVERED FOR CARDIOLOGIST; ALL OTHERS REQUIRE PA
OTHER ANTIARRHYTHMICS			
amiodarone	Pacerone	1	COVERED FOR CARDIOLOGIST; ALL OTHERS REQUIRE PA
MULTAQ		2	COVERED FOR CARDIOLOGIST; ALL OTHERS REQUIRE PA

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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	
mometasone furoate	Elocon	1	
prednicarbate	Dermatop	1	
triamcinolone acetonide	Kenalog	1	
ANTIPRURITIC DRUGS			
hydroxyzine hcl		1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
hydroxyzine pamoate		1	
ANTIACNE DRUGS			
adapalene cream, gel	Differin	1	
amnesteem	Accutane	1	
claravis	Accutane	1	
clindamycin phosphate	Cleocin T/Clindamax	1	
erythromycin	A/T/S / Emgel/Erycette	1	
metronidazole	Metrocream/ Metrolotion	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 ointment, 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			
CARAC		2	
ELIDEL		2	PA REQUIRED FOR AGE < 2 AND > 10;QLL=30 gm/30 days
FLUOROPLEX		2	
fluorouracil	Efudex	1	
imiquimod 5% cream	Aldara	1	
SANTYL		2	
SCABICIDES			
malathion 0.5% lotion	Ovide	1	
permethrin	Elimite	1	
ULESFIA LOTION		2	
EAR-NOSE-THROAT MEDICATIONS			
DRUGS AFFECTING THE EAR			
antipyrine/benzocaine otic	Benzotic/Otogesic	1	
acetic acid otic		1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
CIPRO HC		2	
CIPRODEX OTIC		2	
neomycin/polymixin/ hydrocortisone		1	
ofloxacin		1	
DRUGS AFFECTING THE NOSE			
azelastine		1	
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	

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	
levothroid		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	
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; ALL OTHERS REQUIRE PA; QLL= 4 fills/180 days;

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
			QLL=1 bottle/30 days; QLL=90 tabs/30 days
etidronate	Didronel	1	
fortical nasal spray		1	
KUVAN		2	PA
SENSIPAR		2	COVERED FOR NEPHROLOGIST; ALL OTHERS 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			
lansoprazole oral disintegrating tablet	Prevacid Solu-Tab	1	COVERED FOR PULMONOLOGISTS (INCLUDING PEDIATRIC PULMONOLOGISTS) AND PEDIATRIC GASTROENTEROLOGISTS FOR CHILDREN 17 YEARS OF AGE AND YOUNGER
omeprazole	Prilosec	1	omeprazole 10 mg=30 caps/30 days omeprazole 20 mg=60 caps/30 days omeprazole 40 mg=270 caps/30 days
pantoprazole	Protonix	1	PA/QLL=30 tabs/30 days
LAXATIVES AND CATHARTICS			
constulose		1	
OTHER GI DRUGS			
AMITIZA		2	QLL=60 caps/30 days
ASACOL, ASACOL HD		2	
belladonna alkaloids-opium		1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
CANASA		2	
CREON 5, 10, 15, CREON LIPASE 6,000; 12,000; 24,000 UNITS		2	
DIPENTUM		2	
hydrocortisone rectal enema suspension	Colocort/ Cortenema	1	
LIPRAM 4,500; LIPRAM CR5; LIPRAM PN10, LIPRAM PN16, LIPRAM PN 20, LIPRAM UL20		2	
mesalamine enema		1	
NULYTELY WITH FLAVOR PACKS		2	
PANCREAZE		2	
PANCRELIPASE 5,000 UNITS		2	
peg 3350 electrolyte solution		1	
PENTASA		2	
polyethylene glycol 3350		1	
PROCTOFOAM-HC		2	
propantheline		1	
sulfasalazine	Azulfidine	1	
ULTRASE, ULTRASE MT12, MT18, MT20		2	
ursodiol	Actigall	1	
VIOKASE 8, 16		2	
ZENPEP 5,000U; 10,000U, 15,000U, 20,000U		2	
IMMUNOLOGICALS AND VACCINES			
CERVARIX		2	COVERED FOR FEMALES ONLY PA FOR AGES <10 OR >25 QLL=3 syringes and vials/lifetime
FLUMIST		2	PA FOR AGES <2 OR >49
GARDASIL		2	PA FOR AGES <9 OR >26 QLL=3 syringes and vials/lifetime
ROTARIX		2	
ROTATEQ		2	
ERYTHROID STIMULANTS			
ARANESP		2	ONCOLOGY USE ONLY
EPOGEN		2	ONCOLOGY USE ONLY
PROCRIT		2	ONCOLOGY USE ONLY
MUSCULOSKELETAL MEDICATIONS			
SALICYLATES AND RELATED DRUGS			
choline magnesium trisalicylate		1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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 tablets only	Toradol	1	QLL=20 tabs/30 days
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	
COLCRYS		2	
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	
metaxalone	Skelaxin	1	QLL=120 tabs/30 days
methocarbamol	Robaxin	1	QLL=120 tabs/30 days
OTHER MUSCULOSKELETAL MEDICATIONS			
RILUTEK		2	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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; ALL OTHERS REQUIRE PA
NEPHROCAPS		2	
sodium fluoride		1	
thiamine		1	
ZEMPLAR		2	COVERED FOR NEPHROLOGIST; ALL OTHERS REQUIRE PA
POTASSIUM SUPPLEMENTS			
citric acid/sodium citrate oral soln	Bicitra	1	
klor con, klor con m, klor con effervescent		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)			
enoxaparin [inj]	Lovenox	1	10 DAYS W/O PA (10 DAYS=20 SYRINGES)
FRAGMIN [inj]		2	10 DAYS W/O PA (10 DAYS=10 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			

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
enulose		1	
generlac		1	
lactulose		1	
FOSRENOL		2	COVERED FOR NEPHROLOGIST; ALL OTHERS 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	
CONCEPT DHA		2	
fe plus tablet		1	
natalcare glosstabs		1	
natatab Rx		1	
prenafirst		1	
prenatabs FA		1	
prenatabs rx		1	
prenatal advantage (prenatal AD)		1	
prenatal low iron		1	
prenatal H		1	
prenatal U		1	
SELECT-OB, SELECT-OB + DHA		2	
trinate		1	
ultra-natal		1	
vinate II		1	
vinate az		1	
vinatal forte		1	
vinate gt		1	
vinate m		1	
vinate one		1	
vinate ultra		1	
vinate calcium		1	
vitafol-ob		1	
vitafol-pn		1	
OB/GYN TOPICAL ANTIINFECTIVES			
acidic vaginal jelly		1	
CLEOCIN OVULE		2	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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=4 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			
ACTIVELLA 0.5 MG-0.1 MG		2	
CLIMARA PRO		2	
COMBIPATCH		2	
estradiol/norethindrone acetate 1 mg-0.5 mg	Activella 1 mg-0.5mg	1	
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	
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	
bacitracin/polymixin ophth ointment	AK-Poly Bac	1	
ciprofloxacin hcl (ophth drops)	Ciloxan	1	
CILOXAN OPTHALMIC		2	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
OINTMENT			
erythromycin		1	
gentamicin sulfate	Garamycin/Gentak	1	
levofloxacin 0.5% ophth soln	Quixin	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	
TOBREX OINTMENT		2	
VIGAMOX		2	
ZYMAR		2	
ZYMAXID		2	
OPHTHALMIC CORTICOSTEROID DRUGS			
dexamethasone		1	
PRED MILD		2	
prednisolone	Omnipred/Pred Forte	1	
fluorometholone		1	
FML FORTE		2	
OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS			
neomycin/polymixin/ hydrocortisone	Cortisporin	1	
neomycin/polymyxin/ dexamethasone	Methadex/Maxitrol	1	
prednisolone/sulfacetamide		1	
TOBRADEX OINTMENT		2	
tobramycin/dexamethasone susp	Tobradex	1	
ANTIGLAUCOMA DRUGS			
acetazolamide, -ER		1	
AZOPT		2	
BETOPTIC S		2	
betaxolol hcl		1	
brimonidine tartrate	Alphagan, Alphagan P	1	
carteolol hcl		1	
COMBIGAN		2	
dipivefrin hcl	Propine	1	
dorzolamide	Trusopt	1	
dorzolamide/timolol	Cosopt	1	
ISOPTO CARBACHOL		2	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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 Z		2	
XALATAN		3	PA
OTHER OPHTHALMIC DRUGS			
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	
ketorolac tromethamine	Acular, Acular LS	1	
MUROCOLL-2		2	
naphazoline	AK-Con	1	
NEVANAC		2	
PATANOL		2	
phenylephrine		1	
trifluridine		1	
tropicamide	Tropicacyl	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	
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	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
budesonide respules 0.25 mg/2 ml, 0.50 mg/2 ml	Pulmicort Respules	1	QLL=120 ml/30 days (60 respules/30 days)
FLOVENT DISKUS		2	
FLOVENT HFA		2	
PULMICORT 1 MG/2 ML RESPULES		2	QLL=120 ml/30 days (60 respules/30 days)
PULMICORT FLEXHALER/INHALER		2	QLL=1 inhaler or flexhaler/30 days
SYMBICORT		2	
LEUKOTRIENE MODIFIERS			
SINGULAIR		2	COVERED FOR MEMBERS WITH DIAGNOSIS OF ASTHMA; PA FOR ALLERGIC RHINITIS; QLL=30 tabs/30 days
zafirlukast	Accolate	1	COVERED FOR MEMBERS WITH DIAGNOSIS OF ASTHMA; NOT FDA-APPROVED FOR ALLERGIC RHINITIS; QLL=60 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	
sodium chloride 0.9% nebulizer solution		1	
OTHER RESPIRATORY DRUGS			
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)
ANTIHISTAMINES (PRESCRIPTION-STRENGTH ONLY)			
brompheniramine maleate chewable tablets, suspension		1	
clemastine fumarate	Tavist	1	
cyproheptadine hcl	Periactin	1	
dexchlorpheniramine		1	
diphenhydramine hcl		1	
hydroxyzine hcl	Atarax, Vistaril	1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
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	
sildec PE-DM drops, syrup		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 XR		2	STEP
trospium	Sanctura	1	STEP; QLL=60 tabs/30 days
CHOLINERGIC STIMULANTS			
bethanecol		1	
URINARY ANESTHETICS			
phenazopyridine hcl	Pyridium/Urodol	1	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
OTHER GENITOURINARY PRODUCTS			
cytra-k		1	
ELMIRON		2	
finasteride	Proscar	1	
K-PHOS		2	
potassium citrate		1	
tamsulosin	Flomax	1	STEP; QLL=60 tabs/30 days
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 SOFT TOUCH LANCETS		2	
ACCU-CHEK SOFTCLIX LANCET DEVICE/LANCETS		2	
MICROLET LANCING DEVICE/LANCETS		2	
AUTOJECT 2 INJECTION DEVICE		2	
insulin syringes		2	
NOVA MAX TEST STRIPS		2	PA Required: Member must be on insulin pump
ONE TOUCH DELICA LANCETS			
ONE TOUCH SELECT		2	
ONE TOUCH SURESOFT LANCETS		2	
ONE TOUCH TEST STRIPS, CONTROL SOLUTION		2	Combined QLL for test strips=204 strips/30 days
ONE TOUCH ULTRA2, ULTRALINK, ULTRAMINI,		2	

COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
ULTRASMART			
ONE TOUCH ULTRASOFT LANCETS		2	
CHEMSTRIP		2	
KETOSTIX		2	
OTHER SUPPLIES			
AEROCHAMBER, MICROCHAMBER		2	QLL=1/year