



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](http://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.)

<b>Tier</b>	<b>Description</b>	<b>Cost</b>
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](http://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 JANUARY 11, 2010**

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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  
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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
<b>ANESTHETICS</b>			
<b>TOPICAL ANESTHETICS</b>			
lidocaine hcl	Xylocaine	1	
lidocaine hcl viscous	Xylocaine	1	
lidocaine-prilocaine	Emla	1	
<b>ANTIINFECTIVES</b>			
<b>CEPHALOSPORINS</b>			
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
<b>CLINDAMYCINS</b>			
clindamycin	Cleocin	1	
<b>ERYTHROMYCINS</b>			
ERY-TAB		2	
erythromycin	Eryc	1	
erythromycin ethylsuccinate	E.E.S.	1	
erythromycin w/sulfisoxazole	Pediazole	1	
<b>OTHER MACROLIDES</b>			
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
<b>PENICILLINS</b>			
amox tr-potassium clavulanate	Augmentin	1	QLL=28/30 days
amoxicillin	Amoxil	1	
ampicillin	Principen	1	
dicloxacillin		1	
penicillin v potassium	Veetids	1	
<b>SULFONAMIDES</b>			
GANTRISIN (SUSPENSION)		2	
sulfamethoxazole/trimethoprim	Septra	1	
sulfadiazine		1	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
<b>TETRACYCLINES</b>			
demeclocycline		1	
doxycycline	Vibramycin	1	
minocycline hcl	Dynacin	1	
tetracycline hcl	Sumycin	1	
<b>URINARY ANTIINFECTIVES</b>			
<b>FURADANTIN (25 MG/5 ML SUSPENSION)</b>		2	
<b>MACRODANTIN (25 MG ONLY)</b>		2	
methenamine hippurate		1	
nitrofurantoin macrocrystal	Macrochantin	1	
trimethoprim		1	
<b>QUINOLONES</b>			
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
<b>TOPICAL ANTIBACTERIAL DRUGS</b>			
<b>BACTROBAN CREAM</b>		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	
<b>ORAL ANTIFUNGAL DRUGS</b>			
clotrimazole	Mycelex	1	
fluconazole	Diflucan	1	150 MG QLL=1 tab/Rx
<b>GRIFULVIN V</b>		2	
<b>GRIS-PEG</b>		2	
itraconazole	Sporanox	1	
ketoconazole	Nizoral	1	
nystatin	Mycostatin	1	
<b>SPORANOX (ORAL SOLUTION)</b>		2	
terbinafine	Lamisil	1	
<b>VAGINAL ANTIFUNGALS</b>			
nystatin	Mycostatin	1	
terconazole	Terazol	1	
<b>OTHER TOPICAL ANTIFUNGALS</b>			
ciclopirox	Loprox/Penlac	1	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
econazole nitrate	Spectazole	1	
ketoconazole	Nizoral	1	
nystatin	Mycostatin	1	
<b>TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.</b>			
clotrimazole/betamethasone	Lotrisone	1	
nystatin w/triamcinolone	Mycolog II	1	
<b>ANTIRETROVIRALS &amp; PROTEASE INHIBITORS</b>			
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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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
			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	
<b>OTHER ANTIINFECTIVE DRUGS</b>			
CLEOCIN (100 MG VAGINAL OVULE)		2	
dapsone		1	
MEPRON		2	COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
VANCOICIN PULVULES		2	QLL=40 caps/30 days
<b>OTHER ANTIVIRAL DRUGS</b>			
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; OTHER SPECIALISTS REQUIRE PA
VALCYTE		2	PA

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COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/LIMITS
VALTREX (1 GRAM TABLET ONLY)		2	QLL=30 tabs/30 days
ZOVIRAX (5% OINTMENT)		2	
<b>ANTITUBERCULOSIS DRUGS</b>			
ethambutol	Myambutol	1	
isoniazid	Nydravid	1	
MYCOBUTIN		2	
PRIFTIN		2	
pyrazinamide		1	
rifampin	Rifadin	1	
<b>AMEBICIDES</b>			
YODOXIN		2	
<b>ANTHELMINTICS</b>			
mebendazole		1	
<b>PLASMODICIDES</b>			
chloroquine phosphate		1	
DARAPRIM		2	
hydroxychloroquine sulfate	Plaquentil	1	
primaquine		1	
<b>TRICHOMONOCIDES</b>			
metronidazole	Flagyl	1	
<b>AMINOGLYCOSIDES</b>			
neomycin		1	
paromomycin		1	
<b>ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS</b>			
<b>MEDICATIONS WITHIN THIS CLASS ARE COVERED FOR FDA APPROVED INDICATIONS AND MAY REQUIRE PRIOR AUTHORIZATION. ALL INJECTABLE MEDICATIONS WITHIN THIS CLASS REQUIRE PRIOR AUTHORIZATION.</b>			
ARIMIDEX		2	
azathioprine	Imuran	1	
bicalutamide	Casodex	1	
CELLCEPT		2	PA (ALL DOSAGE FORMS)
cyclophosphamide	Cytosan	1	PA (INJECTABLE ONLY)
cyclosporine	Neoral	1	PA (INJECTABLE ONLY)
ELIGARD (INJ)		2	PA
FEMARA		2	
fluorouracil	Adrucil	1	PA (INJECTABLE ONLY)
flutamide		1	
hydroxyurea	Hydrea	1	
IRESSA		2	PA
leflunomide	Arava	1	COVERED FOR

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COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
			RHEUMATOLOGIST; OTHER SPECIALISTS REQUIRE PA
megestrol acetate	Megace	1	
mercaptopurine	Purinethol	1	
<b>MESNEX TABLETS ONLY</b>		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
<b>AUTONOMIC AND CNS MEDICATIONS</b>			
<b>ANALGESICS</b>			
tramadol hcl	Ultram	1	QLL=240 tabs/30 days
tramadol hcl-acetaminophen	Ultracet	1	QLL= 4 grams APAP/day
<b>CLASS II NARCOTICS</b>			
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
<b>CLASS III NARCOTICS</b>			
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
<b>DRUGS TO PREVENT AND TREAT HEADACHES</b>			
butalbital/acetaminophen/ caffeine	Esgic/Fioricet/Triad	1	

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butalbital/aspirin/caffeine	Fiorinal, Fortabs	1	
<b>ERGOMAR</b>		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
<b>MIGRANAL</b>		2	QLL=8 units/30 days
<b>RELPAK</b>		2	QLL=6 tabs/30 days
<b>ANXIOLYTICS</b>			
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	
<b>SEDATIVE/HYPNOTIC DRUGS</b>			
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
<b>ROZEREM</b>		2	QLL=30 tabs/30 days
zaleplon	Sonata	1	QLL=30 caps/30 days
<b>ANTIMANIA DRUGS</b>			
lithium carbonate	Eskalith/CR	1	
lithium citrate		1	
<b>CARBAMAZEPINES</b>			
carbamazepine, ER	Tegretol Tegretol XR	1	QLL for Extended-Release=120 tabs/30 days
<b>CARBATROL</b>		2	
oxcarbazepine	Trileptal	1	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
<b>TRILEPTAL SUSPENSION</b>		2	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
<b>ANTICONVULSANT/BENZODIAZEPINES</b>			
clonazepam	Klonopin	1	
<b>HYDANTOINS</b>			
phenytoin sodium, extended	Dilantin, ER	1	
<b>DILANTIN INFATABS, DILANTIN 30 MG EXTENDED RELEASE</b>		2	

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PHENYTEK		2	
<b>VALPROIC ACID AND DERIVATIVES</b>			
DEPAKOTE ER, DELAYED RELEASE, SPRINKLE		2	
divalproex sodium ER, delayed-release	Depakote, ER, Delayed-Release	1	
valproic acid	Depakene	1	
<b>ANTICONVULSANT BARBITURATES</b>			
mephobarbital	Mebaral	1	
phenobarbital		1	
primidone	Mysoline	1	
<b>OTHER ANTICONVULSANTS</b>			
CELONTIN		2	
ethosuximide		1	
FELBATOL		2	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
gabapentin	Neurontin	1	QLL=180 units/30 days
GABTRIL		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
<b>TERTIARY AMINES</b>			
amitriptyline hcl	Elavil	1	
doxepin hcl	Sinequan	1	
imipramine hcl	Tofranil	1	
trimipramine	Surmontil	1	
<b>SECONDARY AMINES</b>			
amoxapine	Norpramin	1	
desipramine hcl	Norpramin	1	
nortriptyline hcl	Pamelor	1	
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS</b>			
citalopram	Celexa	1	PA < 18 YEARS OF AGE; QLL=30 tabs/30 days or 300 ml/30 days

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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
<b>OTHER ANTIDEPRESSANTS</b>			
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	
<b>ANTIVERTIGO AND ANTIEMETIC DRUGS</b>			
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
<b>ANTIPARKINSON ANTICHOLINERGIC DRUGS</b>			
benztropine mesylate		1	
trihexyphenidyl		1	
<b>OTHER ANTIPARKINSON DRUGS</b>			
bromocriptine mesylate	Parlodel	1	
carbidopa/levodopa	Sinemet	1	

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COMTAN		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
<b>ANTIPSYCHOTIC DRUGS</b>			
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
<b>CNS STIMULANT DRUGS</b>			
amphetamine/ dextroamphetamine	Adderall, Adderall XR	1	Immediate release QLL=90 tabs/30 days; Extended release QLL=30 caps/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
<b>ANTIDEMENTIA DRUGS</b>			
ARICEPT, ODT		2	PA; QLL=30 tabs/30 days

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
galantamine, ER	Razadyne, Razadyne ER	1	galantamine QLL=60 tabs/30 days galantamine ER= 30 caps/30 days
<b>OTHER CNS DRUGS</b>			
caffeine citrate oral solution		1	
naltrexone		1	
pyridostigmine		1	
<b>CARDIOVASCULAR MEDICATIONS</b>			
<b>CARDIAC GLYCOSIDES</b>			
digoxin	Lanoxin	1	
LANOXIN		2	
<b>CALCIUM ANTAGONISTS</b>			
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
<b>LOOP DIURETICS</b>			
bumetanide	Bumex	1	
furosemide	Lasix	1	
torseamide	Demadex	1	
<b>THIAZIDE AND RELATED DRUGS</b>			
chlorthalidone		1	
chlorothiazide		1	
hydrochlorothiazide	Microzide	1	
indapamide	Lozol	1	
metolazone	Zaroxolyn	1	
<b>POTASSIUM SPARING DIURETICS</b>			
amiloride		1	
amiloride hcl w/hctz	Midamor	1	
spironolactone	Aldactone	1	
spironolactone w/hctz	Aldactazide	1	
triamterene w/hctz	Maxzide/Diazide	1	
<b>BETA-ADRENERGIC ANTAGONIST DRUGS</b>			
acebutolol		1	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
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	
<b>VASODILATOR ANTIHYPERTENSIVES</b>			
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
<b>CENTRALLY ACTING ANTIHYPERTENSIVES</b>			
clonidine hcl tablets	Catapres	1	
methyl dopa		1	
<b>ANGIOTENSIN CONVERTING ENZYME INHIBITORS</b>			
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	
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>			
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=60 tabs/30 days;
<b>OTHER ANTIHYPERTENSIVES</b>			
atenolol w/chlorthalidone	Tenoretic	1	
benazepril hcl w/hctz	Lotensin HCT	1	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
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	
methyldopa w/hctz		1	
moexipril w/hctz	Uniretic	1	
propranolol hcl w/hctz	Inderide	1	
quinapril w/hctz	Quinaretic	1	
<b>BENICAR HCT</b>		2	STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days
<b>DIOVAN HCT</b>		2	STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days
<b><i>NITRATES</i></b>			
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	
<b><i>OTHER VASODILATING DRUGS</i></b>			
<b>REVATIO</b>		2	PA/QLL=90 tabs/30 days
<b><i>CLASS 1A ANTIARRHYTHMICS</i></b>			
disopyramide	Norpace	1	
procainamide		1	
quinidine gluconate		1	
quinidine sulfate		1	
<b><i>CLASS 1B ANTIARRHYTHMICS</i></b>			
mexiletine	Mexitil	1	COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA
<b><i>CLASS 1C ANTIARRHYTHMICS</i></b>			
flecainide acetate	Tambocor	1	
propafenone hcl	Rythmol	1	COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA
<b><i>OTHER ANTIARRHYTHMICS</i></b>			

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
amiodarone	Pacerone	1	COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA
sotalol	Betapace	1	
<b>HYPOLIPOPROTEINEMICS</b>			
cholestyramine		1	
colestipol hcl	Colestid	1	
fenofibrate	Lofibra	1	
gemfibrozil	Lopid	1	QLL=60 tabs/30 days
TRILIPIX		2	
ZETIA		2	STEP
<b>HMG-COA REDUCTASE INHIBITORS</b>			
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
<b>OTHER CARDIOVASCULAR DRUGS</b>			
midodrine	ProAmatine	1	
pentoxifylline	Trental	1	
<b>DERMATOLOGICAL MEDICATIONS</b>			
<b>TOPICAL CORTICOSTEROID DRUGS</b>			
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	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
<b>ANTIPRURITIC DRUGS</b>			
hydroxyzine hcl		1	
hydroxyzine pamoate		1	
<b>ANTIACNE DRUGS</b>			
amnesteam	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
<b>KERATOLYTIC DRUGS</b>			
CONDYLOX GEL		2	
podofilox solution	Condylox	1	
<b>ANTIPSORIASIS AND ANTIECZEMA DRUGS</b>			
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	
<b>TOPICAL DERMATOLOGICAL DRUGS</b>			
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	
<b>SCABICIDES</b>			
malathion 0.5% lotion	Ovide	1	
permethrin	Elimite	1	
ULESFIA LOTION		2	
<b>EAR-NOSE-THROAT MEDICATIONS</b>			
<b>DRUGS AFFECTING THE EAR</b>			
antipyrine/benzocaine otic	Benzotic/Otogesic	1	
acetic acid otic		1	

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CIPRO HC		2	
CIPRODEX OTIC		2	
neomycin/polymixin/ hydrocortisone		1	
ofloxacin		1	
<b>DRUGS AFFECTING THE NOSE</b>			
flunisolide	Nasarel	1	
fluticasone propionate	Flonase	1	
ipratropium bromide	Atrovent	1	
NASONEX		2	STEP/QLL=2 bottles/30 days
<b>DRUGS AFFECTING THE THROAT AND MOUTH</b>			
chlorhexidine gluconate	Peridex	2	
doxycycline hyclate	Periostat	1	
pilocarpine hcl	Salagen	1	
triamcinolone acetonide	Kenalog	1	
<b>ENDOCRINE MEDICATIONS</b>			
<b>ORAL HYPOGLYCEMIC DRUGS</b>			
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	
<b>INSULIN SENSITIZERS</b>			
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
<b>INSULIN (VIALS ONLY)</b>			
HUMULIN 50/50		2	
HUMULIN R (500 U/ML VIAL)		2	
HUMULIN 70/30		2	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
NOVOLIN 70/30		2	
NOVOLIN R		2	
NOVOLIN N		2	
NOVOLOG		2	
NOVOLOG MIX 70/30		2	
LANTUS		2	
LEVEMIR		2	
<b>GLUCOSE ELEVATING DRUGS</b>			
GLUCAGON		2	
<b>GLUCOCORTICOID DRUGS</b>			
cortisone		1	
dexamethasone		1	
hydrocortisone	Cortef	1	
methylprednisolone	Medrol	1	
prednisolone	Prelone	1	
prednisone	Sterapred	1	
ORAPRED, -ODT		2	
<b>MINERALOCORTICOID DRUGS</b>			
fludrocortisone acetate	Florinef	1	
<b>THYROID SUPPLEMENTS</b>			
ARMOUR THYROID		2	
levothyroid		1	
levothyroxine sodium	Synthroid	1	
levoxyl	Synthroid	1	
liothyronine	Cytomel	1	
thyroid, dessicated	Armour Thyroid	1	
unithroid	Synthroid	1	
<b>ANTITHYROID DRUGS</b>			
methimazole	Tapazole	1	
propylthiouracil		1	
<b>ANDROGEN DRUGS</b>			
danazol		1	
<b>OTHER ENDOCRINE DRUGS</b>			
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; OTHER SPECIALISTS REQUIRE PA; QLL=1 bottle/30 days;

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COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
			QLL=90 tabs/30 days
etidronate	Didronel	1	
fortical nasal spray		1	
KUVAN		2	PA
SENSIPAR		2	COVERED FOR NEPHROLOGIST; OTHER SPECIALISTS REQUIRE PA
SYMLIN		3	PA
<b>GASTROINTESTINAL MEDICATIONS</b>			
<b>ANTIDIARRHEAL DRUGS</b>			
diphenoxylate w/atropine	Lomotil	1	
<b>ANTISPASMODICS/DRUGS AFFECT GI MOTILITY</b>			
dicyclomine hcl	Bentyl	1	
hyoscyamine	Nulev/Levbrel	1	
metoclopramide hcl	Reglan	1	
<b>ANTIULCER DRUGS</b>			
cimetidine	Tagamet	1	
famotidine	Pepcid	1	
nizatidine	Axid	1	
ranitidine	Zantac	1	
<b>OTHER ANTIULCER DRUGS</b>			
misoprostol	Cytotec	1	
sucralfate	Carafate	1	
CARAFATE SUSPENSION		2	
<b>PROTON PUMP INHIBITORS</b>			
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
<b>OTHER GI DRUGS</b>			
AMITIZA		2	QLL=60 caps/30 days
ASACOL, ASACOL HD		2	
belladonna alkaloids-opium		1	
CANASA		2	
CREON		2	

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DIPENTUM		2	
hydrocortisone rectal enema suspension	Colocort/ Cortenema	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	
VIKASE		2	
<b>IMMUNOLOGICALS AND VACCINES</b>			
FLUMIST		2	PA FOR AGES <2 OR >49
ROTARIX		2	
ROTATEQ		2	
<b>MUSCULOSKELETAL MEDICATIONS</b>			
<b>SALICYLATES AND RELATED DRUGS</b>			
choline magnesium trisalicylate		1	
diflunisal	Dolobid	1	
salsalate	Disalcid	1	
<b>NON-STEROIDAL ANTIINFLAMMATORY AGENTS</b>			
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
meclofenamate		1	
meloxicam	Mobic	1	
nabumetone	Relafen	1	
naproxen	Naprosyn	1	

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naproxen sodium (prescription-strength only)	Anaprox	1	
oxaprozin	Daypro	1	
piroxicam	Feldene	1	
sulindac	Clinoril	1	
tolmetin		1	
<b>OTHER DRUGS FOR ARTHRITIS</b>			
CELEBREX		2	QLL=60 caps/30 days
<b>DRUGS TO PREVENT AND TREAT GOUT</b>			
allopurinol	Zyloprim	1	
colchicine		1	
colchicine / probenecid		1	
probenecid		1	
<b>DIRECT MUSCLE RELAXANTS</b>			
baclofen		1	
tizanidine hcl	Zanaflex	1	
<b>CNS MUSCLE RELAXANTS</b>			
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
<b>OTHER MUSCULOSKELETAL MEDICATIONS</b>			
RILUTEK		2	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
<b>NUTRITION, BLOOD MODIFIERS, ELECTROLYTES</b>			
<b>THERAPEUTIC VITAMINS &amp; MINERALS (PRESCRIPTION-STRENGTH ONLY)</b>			
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	
thiamine		1	
ZEMPLAR		2	COVERED FOR NEPHROLOGIST; OTHER SPECIALISTS REQUIRE PA

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

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prenatal U		1	
trinate		1	
ultra-natal		1	
vinatal forte		1	
vinate ultra		1	
vinate calcium		1	
vitafol-ob		1	
vitafol-pn		1	
<b>OB/GYN TOPICAL ANTIINFECTIVES</b>			
acidic vaginal jelly		1	
<b>CLEOCIN OVULE</b>		2	
clindamycin 2% vaginal cream	Clindamax	1	
metronidazole 0.75% vaginal gel	MetroGel	1	
<b>ESTROGEN DRUGS</b>			
estradiol tablets	Estrace	1	
estradiol transdermal patch	Climara	1	QLL=8 patches/30 days
estropipate	Ogen/Ortho-Est	1	
<b>ESTRACE VAGINAL CREAM</b>		2	
<b>ESTRING</b>		2	
<b>FEMRING</b>		2	
<b>MENEST</b>		2	
<b>PREMARIN</b>		2	
<b>VAGIFEM</b>		2	
<b>ESTROGEN/PROGESTIN COMBINATIONS</b>			
<b>CLIMARA PRO</b>		2	
<b>COMBIPATCH</b>		2	
<b>FEMHRT</b>		2	
<b>PREFEST</b>		2	
<b>PREMPHASE</b>		2	
<b>PREMPRO</b>		2	
<b>SELECTIVE ESTROGEN RECEPTOR MODULATOR</b>			
<b>EVISTA</b>		2	QLL=30 tabs/30 days
<b>PROGESTIN DRUGS</b>			
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	
<b>PROMETRIUM</b>		2	
<b>OTHER OB/GYN DRUGS</b>			

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COVERED DRUG	REFERENCE DRUG NAME	COVERED DRUG TIER	REQUIREMENTS/ LIMITS
METHERGINE TABLETS		2	
<b>OPHTHALMIC MEDICATIONS</b>			
<b>OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS</b>			
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	
<b>OPHTHALMIC CORTICOSTEROID DRUGS</b>			
dexamethasone		1	
PRED MILD		2	
prednisolone	Omnipred/Pred Forte	1	
fluorometholone		1	
FML FORTE		2	
<b>OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS</b>			
neomycin/polymixin/ hydrocortisone	Cortisporin	1	
neomycin/polymyxin/ dexamethasone	Methadex/Maxitrol	1	
prednisolone/sulfacetamide		1	
TOBRADEX OINTMENT		2	
tobramycin/dexamethasone susp	Tobradex	1	
<b>ANTIGLAUCOMA DRUGS</b>			
acetazolamide		1	
AZOPT		2	
BETOPTIC S		2	
betaxolol hcl		1	
brimonidine tartrate	Alphagan, Alphagan P	1	
carteolol hcl		1	
COMBIGAN		2	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
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	PA
<b>OTHER OPHTHALMIC DRUGS</b>			
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	
ketoralac tromethamine	Acular, Acular LS	1	
MUROCOLL-2		2	
naphazoline	AK-Con	1	
NEVANAC		2	
PATANOL		2	
phenylephrine		1	
trifluridine		1	
tropicamide		1	
<b>RESPIRATORY MEDICATIONS</b>			
<b>BETA-2 ADRENERGIC DRUGS</b>			
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	

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terbutaline		1	
VENTOLIN HFA		1	QLL= 2 inhalers/30 days
<b>INHALED CORTICOSTEROIDS</b>			
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	
<b>LEUKOTRIENE MODIFIERS</b>			
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
<b>METHYL XANTHINE DRUGS</b>			
theophylline, er		1	
<b>OTHER DRUGS FOR ASTHMA</b>			
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	
<b>OTHER RESPIRATORY DRUGS</b>			
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)
<b>ANTI-HISTAMINES (PRESCRIPTION-STRENGTH ONLY)</b>			
clemastine fumarate	Tavist	1	
cyproheptadine hcl	Periactin	1	

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<b>COVERED DRUG</b>	<b>REFERENCE DRUG NAME</b>	<b>COVERED DRUG TIER</b>	<b>REQUIREMENTS/ LIMITS</b>
dexchlorpheniramine		1	
diphenhydramine hcl		1	
hydroxyzine hcl	Atarax, Vistaril	1	
<b>ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>			
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	
<b>ANTITUSSIVE AND EXPECTORANT DRUGS (PRESCRIPTION-STRENGTH ONLY)</b>			
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	
<b>TOXICOLOGY MEDICATIONS</b>			
acetylcysteine		1	
CUPRIMINE		2	
<b>UROLOGICAL MEDICATIONS</b>			
<b>ANTICHOLINERGIC ANTISPASMODICS DRUGS</b>			
flavoxate	Urispas	1	
oxybutynin chloride	Ditropan	1	
oxybutynin chloride er	Ditropan XL	1	
SANCTURA		2	STEP; QLL=60 tabs/30 days
SANCTURA XR		2	STEP
<b>CHOLINERGIC STIMULANTS</b>			
bethanecol		1	

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<b>URINARY ANESTHETICS</b>			
phenazopyridine hcl	Pyridium/Urodol	1	
<b>OTHER GENITOURINARY PRODUCTS</b>			
cytra-k		1	
ELMIRON		2	
finasteride	Proscar	1	
K-PHOS		2	
potassium citrate		1	
UROXATRAL		2	
<b>MEDICAL (MISCELLANEOUS) SUPPLIES</b>			
<b>DIABETIC SUPPLIES</b>			
<b>TEST STRIPS COMBINED QLL=204 TEST STRIPS/30 DAYS</b>			
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	
MICROLET LANCING DEVICE/LANCETS		2	
AUTOJECT 2 INJECTION DEVICE		2	
insulin syringes		2	
NOVOFINE 30		2	
NOVA MAX TEST STRIPS		2	PA Required: Member must be on insulin pump
ONE TOUCH ULTRA2, UKTRALINK, ULTRAMINI, ULTRASMART		2	
ONE TOUCH SELECT		2	
ONE TOUCH TEST STRIPS, CONTROL SOLUTION		2	Combined QLL for test strips=204 strips/30 days
SOFT TOUCH LANCETS		2	
SOFTCLIX		2	

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CHEMSTRIP		2	
KETOSTIX		2	
<b><i>OTHER SUPPLIES</i></b>			
AEROCHAMBER, MICROCHAMBER		2	QLL=1/year