

Updated March 15, 2012

Employer Group Plans
(HMO and HMO-POS)

Health First Medicare Plans 2012 Formulary (List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

A Medicare Advantage organization with a Medicare contract.

This information may be available in an alternate format such as Braille, larger print or audio. This information is available for free in other languages. If you need this information in another format or language, please call our Customer Service Department at 321-434-5665 or 1-800-716-7737. Our customer service hours are:

- February 15–October 14: Monday through Friday from 8 am to 8 pm. Saturday from 8 am to Noon. You may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.
- October 15–February 14: Seven days a week from 8 am to 8 pm. TTY/TDD users should call 1-800-955-8771 during customer service hours.

What is the Health First Medicare Plans Formulary?

A formulary is a list of covered drugs selected by Health First Medicare Plans 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. Health First Medicare Plans will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Health First Medicare Plans network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

Can the Formulary change?

Generally, if you are taking a drug on our 2012 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2012 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our

plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before 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. The enclosed formulary is current as of **March 15, 2012**. To get updated information about the drugs covered by Health First Medicare Plans, please visit our Web site at www.HealthFirstHealthPlans.org or call Customer Service at 1-800-716-7737. Our customer service hours are:

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- October 15–February 14: Seven days a week from 8 am to 8 pm.

TTY/TDD users should call 1-800-955-8771. Print formularies are updated via

errata sheets in the event of mid-year non-maintenance formulary changes.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition—The formulary begins on page 5. 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 number 7. Then look under the category name for your drug.

Alphabetical Listing—If you are not sure what category to look under, you should look for your drug in the Index that begins on page 42. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Health First Medicare Plans covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the

brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Health First Medicare Plans requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Health First Medicare Plans before you fill your prescriptions. If you don't get approval, Health First Medicare Plans may not cover the drug.
- **Quantity Limits:** For certain drugs, Health First Medicare Plans limits the amount of the drug that Health First Medicare Plans will cover. For example, Health First Medicare Plans provides 10 patches per prescription for fentanyl patches. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, Health First Medicare Plans requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Health First Medicare Plans may not cover Drug B unless you try Drug A first. If Drug A does not work

for you, Health First Medicare Plans 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 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at www.HealthFirstHealthPlans.org.

You can ask Health First Medicare Plans to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Health First Medicare Plans Formulary?" on this page for information about how to request an exception.

What are over-the counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Health First Medicare Plans does not pay for OTC drugs.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Customer Service and confirm that your drug is not covered. If you learn that Health First Medicare Plans does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Health First Medicare Plans. When you receive the list, show it to your doctor and ask

him or her to prescribe a similar drug that is covered by Health First Medicare Plans.

- You can ask Health First Medicare Plans to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Health First Medicare Plans Formulary?

You can ask Health First Medicare Plans to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Health First Medicare Plans limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of

coverage for drugs that are in the specialty tier.

Generally, Health First Medicare Plans will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.**

Generally, we must make our decision within 72 hours of getting your prescriber's or prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber's or prescribing physician's supporting statement.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it

is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 91-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Additionally, we understand that if you have been enrolled in the plan for more than 90 days, there may be other situations in which you are prescribed non-formulary medications. These circumstances usually involve a change from one treatment setting to another, including but not limited to:

- Discharge from a hospital to home,
- Discharge from a skilled nursing facility to home,
- Ending a long-term care facility stay and returning to the community.

As a current member, if you have been prescribed non-formulary medications as a result of changing from one treatment setting to another, you may be eligible to receive a one-time temporary 30-day supply of your non-formulary drugs. During this transition period you can talk to your doctor to decide if you should switch to an appropriate drug that we cover, or request a formulary exception so we will cover the drug(s) you take. You can contact our Customer Service to ask for a temporary supply if the above circumstances apply to you. Our Customer Service contact information is listed below.

For more information

For more detailed information about your Health First Medicare Plans prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Health First Medicare Plans, please call Customer

Service at 1-800-716-7737. Our customer service hours are:

- **February 15–October 14:** Monday through Friday from 8 am to 8 pm. Saturday from 8 am to Noon. You may receive a messaging service on weekends and holidays. Please leave a message and

your call will be returned the next business day.

- **October 15–February 14:** Seven days a week from 8 am to 8 pm.

TTY/TDD users should call 1-800-955-8771.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

Health First Medicare Plans Formulary

The formulary that begins on the next page provides coverage information about some of the drugs covered by Health First Medicare Plans. If you have trouble finding your drug in the list, turn to the Index that begins on page 39.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., LOTREL) and generic drugs are listed in lower-case italics (e.g., *lisinopril*).

The information in the Requirements/Limits column tells you if Health First Medicare Plans has any special requirements for coverage of your drug.

- **PA: Prior Authorization** is required — your doctor must obtain prior authorization for this drug.

- **QL: Quantity Limits** may also be listed. (For example, “10/30 days” would mean your coverage of this drug is limited to 10 patches every 30 days.) Prescriptions written for more than the suggested Quantity Limits will only be honored up to the listed amount. (For example, a prescription written for a 90-day supply will only process for up to 30 days.)
- $\frac{1}{2}$ — You may be able to split these pills in half. Begin by asking your doctor if pill-splitting is right for you. If so, ask your doctor to write your prescription for half the number of pills and double the strength you normally need. For example, instead of 30 pills of 20 mg, you’d get a prescription for 15 pills of 40 mg. Then

you (or the pharmacy) can split them in half for the correct dose. This way, you save 50 percent of the cost. Call our Customer Service Department for details.

- * — Health First Medicare Plans provides coverage of this prescription drug in the coverage gap.
- **LA: Limited Access** available — applies to prescriptions that may only be available at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at the numbers listed above.
- **ST: Step Therapy** is required — treatment with certain drugs is required before these drugs will be approved for coverage.

Your costs

The amounts you pay for covered drugs are explained here:

Level 1: Initial Coverage Period (for the Group Plus A (HMO), Group Plus B (HMO), and Group (HMO-POS) plans)				
<p>Group Plus B (HMO) and Group (HMO-POS): You pay these amounts beginning January 1, 2012, or when you first enroll. When the total cost for your covered drugs reaches \$2,930 (including what you pay and what we pay), Level 2 coverage begins.</p> <p>Group Plus A (HMO) plan: You pay these costs the entire year or until you have paid \$4,700 out-of-pocket for covered drugs — then you qualify for Level 3 (catastrophic coverage). Level 2 does not apply to you.</p>		At a retail pharmacy		Mail order
		30-day supply	90-day supply	90-day supply
	Tier 1	\$2	\$6	\$6
	Tier 2	\$10	\$30	\$20
	Tier 3	\$25 (Group Plus A HMO) \$45 (Group Plus B HMO) \$45 (Group HMO-POS)	\$75 (Group Plus A HMO) \$135 (Group Plus B HMO) \$135 (Group HMO-POS)	\$50 (Group Plus A HMO) \$90 (Group Plus B HMO) \$90 (Group HMO-POS)
	Tier 4	\$45 (Group Plus A HMO) \$90 (Group Plus B HMO) \$90 (Group HMO-POS)	\$135 (Group Plus A HMO) \$270 (Group Plus B HMO) \$270 (Group HMO-POS)	\$90 (Group Plus A HMO) \$180 (Group Plus B HMO) \$180 (Group HMO-POS)
Tier 5	\$90 (Group Plus A HMO) 33% (Group Plus B HMO) 33% (Group HMO-POS)	\$270 (Group Plus A HMO) 33% (Group Plus B HMO) 33% (Group HMO-POS)	\$180 (Group Plus A HMO) 33% (Group Plus B HMO) 33% (Group HMO-POS)	
Level 2: Coverage Gap Period (for the Group Plus B (HMO) and Group (HMO-POS) plans)				
<p>You pay these amounts after the total cost for your covered drugs reaches \$2,930 (including what you pay and what we pay). <i>During this period, only Tier 1 and Tier 2 drugs are covered, unless you qualify for Extra Help and the coverage gap doesn't apply.</i></p> <p>When you have paid \$4,700 out-of-pocket for covered drugs, Level 3 coverage begins.</p>		At a retail pharmacy		Mail order
		30-day supply	90-day supply	90-day supply
	Tier 1	\$2	\$6	\$6
	Tier 2	\$10	\$30	\$20
Level 3: Catastrophic Coverage Period (for the Group Plus A (HMO), Group Plus B (HMO), and Group (HMO-POS) plans)				
<p>After your yearly out-of-pocket drug costs reach \$4,700, you pay a \$2.60 copay for generic and a \$6.50 copay for all other drugs, or 5% coinsurance (<i>whichever is greater</i>).</p>				

Covered drugs

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
Analgesics					
Nonsteroidal Anti-inflammatory Drugs					
<i>etodolac</i>	2		*	*	*
<i>etodolac er</i>	2		*	*	*
<i>indomethacin</i>	2		*	*	*
<i>ketoprofen</i>	2		*	*	*
<i>ketorolac tromethamine inj</i>	2	QL (40 per 30 days)	*	*	*
<i>naproxen sodium</i>	1		*	*	*
<i>oxaprozin</i>	2		*	*	*
<i>sulindac</i>	1		*	*	*
TREXIMET	3		*		
VOLTAREN	3		*		
Opioid Analgesics					
<i>acetaminophen/codeine #3</i>	2	QL (240 per 30 days)	*	*	*
<i>acetaminophen/codeine #4</i>	2	QL (240 per 30 days)	*	*	*
<i>acetaminophen/codeine soln</i>	2		*	*	*
<i>acetaminophen/codeine tabs</i>	2	QL (240 per 30 days)	*	*	*
<i>buprenorphine hcl inj</i>	2		*	*	*
<i>co-gesic</i>	2	QL (240 per 30 days)	*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>codeine sulfate</i>	2	QL (240 per 30 days)	*	*	*
<i>endocet tabs 650mg; 10mg</i>	2	QL (180 per 30 days)	*	*	*
<i>endocet tabs 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg, 500mg; 7.5mg</i>	2	QL (240 per 30 days)	*	*	*
<i>fentanyl</i>	2	QL (20 per 30 days)	*	*	*
<i>fentanyl citrate</i>	2		*	*	*
<i>fentanyl citrate oral transmucosal</i>	2		*	*	*
<i>hydrocodone bitartrate/acetaminophen tabs 750mg; 10mg</i>	2	QL (150 per 30 days)	*	*	*
<i>hydrocodone/acetaminophen soln</i>	2		*	*	*
<i>hydrocodone/acetaminophen tabs 660mg; 10mg, 750mg; 7.5mg</i>	2	QL (150 per 30 days)	*	*	*
<i>hydrocodone/acetaminophen tabs 650mg; 10mg, 650mg; 7.5mg</i>	2	QL (180 per 30 days)	*	*	*
<i>hydrocodone/acetaminophen tabs 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg, 500mg; 10mg, 500mg; 2.5mg, 500mg; 5mg, 500mg; 7.5mg</i>	2	QL (240 per 30 days)	*	*	*

PA=Prior Authorization required

ST=Step Therapy

LA=Limited Access

½=Qualifies for pill splitting

*We provide additional coverage of this prescription drug in the coverage gap. Refer to our *Evidence of Coverage* for more information about this coverage.

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>hydrocodone/ibuprofen</i>	2	QL (150 per 30 days)	*	*	*
<i>hydromorphone hcl inj</i>	2		*	*	*
<i>hydromorphone hcl tabs</i>	2	QL (240 per 30 days)	*	*	*
<i>levorphanol tartrate</i>	2		*	*	*
<i>margesic-h</i>	2		*	*	*
METHADONE HCL INJ, ORAL SOLN	3		*		
<i>methadone hcl conc</i>	2		*	*	*
<i>methadone hcl tabs</i>	2	QL (240 per 30 days)	*	*	*
<i>morphine sulfate er tb12 200mg</i>	2	QL (60 per 30 days)	*	*	*
<i>morphine sulfate er tb12 100mg, 15mg, 30mg, 60mg</i>	2	QL (90 per 30 days)	*	*	*
<i>morphine sulfate tabs</i>	2	QL (240 per 30 days)	*	*	*
MORPHINE SULFATE INJ 5MG/ML	3		*		
<i>morphine sulfate inj 0.5mg/ml, 1mg/ml</i>	2		*	*	*
OPANA ER TB12 10MG, 20MG, 40MG, 5MG	3		*		
<i>oxycodone hcl tabs</i>	2	QL (240 per 30 days)	*	*	*
<i>oxycodone/acetaminophen caps</i>	2	QL (240 per 30 days)	*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>oxycodone/acetaminophen tabs 650mg; 10mg</i>	2	QL (180 per 30 days)	*	*	*
<i>oxycodone/acetaminophen tabs 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg, 500mg; 7.5mg</i>	2	QL (240 per 30 days)	*	*	*
<i>pentazocine/acetaminophen</i>	2		*	*	*
<i>pentazocine/naloxone hcl</i>	2		*	*	*
<i>stagesic</i>	2		*	*	*
SUBOXONE	3		*		
SUBUTEX	4		*		
<i>tramadol hcl</i>	2	QL (240 per 30 days)	*	*	*
Anesthetics					
Local Anesthetics					
<i>lidocaine</i>	2		*	*	*
<i>lidocaine hcl jelly</i>	2		*	*	*
<i>lidocaine hcl inj, external soln</i>	2		*	*	*
<i>lidocaine/prilocaine</i>	2		*	*	*
LIDODERM	3	QL (90 per 30 days)	*		
Anti-inflammatory Agents					
Nonsteroidal Anti-inflammatory Drugs					
<i>diclofenac potassium</i>	2		*	*	*
<i>diclofenac sodium</i>	2		*	*	*
DICLOFENAC SODIUM EC TBEC 25MG	3		*		

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ST=Step Therapy

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½=Qualifies for pill splitting

*We provide additional coverage of this prescription drug in the coverage gap. Refer to our *Evidence of Coverage* for more information about this coverage.

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>diclofenac sodium ec tbec 50mg</i>	2		*	*	*
<i>diclofenac sodium xr</i>	2		*	*	*
<i>flurbiprofen</i>	2		*	*	*
<i>ibuprofen</i>	1		*	*	*
<i>ketorolac tromethamine inj</i>	2	QL (20 per 30 days)	*	*	*
MELOXICAM SUSP	4		*		
<i>meloxicam tabs</i>	2		*	*	*
<i>nabumetone</i>	2		*	*	*
<i>naproxen</i>	1		*	*	*
<i>naproxen dr</i>	1		*	*	*
<i>piroxicam</i>	2		*	*	*
Antibacterials					
Aminoglycosides					
<i>amikacin sulfate</i>	2		*	*	*
<i>gentamicin sulfate</i>	2		*	*	*
GENTAMICIN SULFATE/0.9% SODIUM CHLORIDE INJ 0.9MG/ML; 0.9%, 1.4MG/ML; 0.9%	3		*		
<i>gentamicin sulfate/0.9% sodium chloride inj 1.6mg/ml; 0.9%, 1mg/ml; 0.9%</i>	2		*	*	*
gentamicin sulfate/sodium chloride	2		*	*	*
<i>isotonic gentamicin</i>	2		*	*	*
<i>neomycin sulfate</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>paromomycin sulfate</i>	2		*	*	*
STREPTOMYCIN SULFATE	3		*		
TOBI	5		*		
<i>tobramycin sulfate</i>	2		*	*	*
Antibacterials, Other					
BACITRACIN	3		*		
BACTROBAN NASAL	3		*		
CLEOCIN GALAXY	3		*		
CLEOCIN PEDIATRIC GRANULES	3		*		
CLEOCIN CREA, SUPP	3		*		
<i>clindamycin hcl</i>	2		*	*	*
<i>clindamycin phosphate advantage</i>	2		*	*	*
<i>clindamycin phosphate crea</i>	2		*	*	*
COLY-MYCIN M	3		*		
CUBICIN	5		*		
LINCOCIN	4		*		
<i>metronidazole vaginal</i>	2		*	*	*
<i>metronidazole tabs</i>	1		*	*	*
<i>metronidazole caps, crea</i>	2		*	*	*
<i>mupirocin</i>	2		*	*	*
<i>nitrofurantoin macrocrystalline</i>	2		*	*	*
<i>nitrofurantoin monohydrate</i>	2		*	*	*
PRIMSOL	4		*		

PA=Prior Authorization required

ST=Step Therapy

LA=Limited Access

½=Qualifies for pill splitting

*We provide additional coverage of this prescription drug in the coverage gap. Refer to our *Evidence of Coverage* for more information about this coverage.

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>silver sulfadiazine</i>	2		*	*	*
<i>trimethoprim</i>	2		*	*	*
TYGACIL	3		*		
VANCOGIN HCL	4	PA	*		
VANCOMYCIN HCL INJ 10GM	3		*		
VANCOMYCIN HCL INJ 500MG	3	PA	*		
<i>vancomycin hcl inj 1000mg</i>	2		*	*	*
XIFAXAN TABS 200MG	4	QL (42 per 30 days) PA	*		
ZYVOX TABS	4		*		
ZYVOX INJ, SUSR	5		*		
Beta-lactam, Cephalosporins					
<i>cefaclor</i>	2		*	*	*
<i>cefaclor er</i>	2		*	*	*
<i>cefadroxil</i>	2		*	*	*
CEFAZOLIN SODIUM INJ 1GM; 5%, 20GM	3		*		
<i>cefazolin sodium inj 1gm, 500mg</i>	2		*	*	*
<i>cefdinir</i>	2		*	*	*
<i>cefepime</i>	2		*	*	*
<i>cefpodoxime proxetil tabs</i>	2		*	*	*
<i>ceftriaxone sodium inj 10gm, 1gm, 2gm</i>	2		*	*	*
<i>cefuroxime axetil tabs</i>	2		*	*	*
<i>cefuroxime sodium</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
CEPHALEXIN TABS	3		*		
<i>cephalexin caps, susr</i>	1		*	*	*
FORTAZ	3		*		
SUPRAX SUSR 100MG/5ML	4		*		
<i>tazicef</i>	2		*	*	*
Beta-lactam, Other					
<i>meropenem</i>	2		*	*	*
PRIMAXIN I.M.	4		*		
PRIMAXIN IV	3		*		
Beta-lactam, Penicillins					
<i>amoxicillin</i>	1		*	*	*
<i>amoxicillin/clavulanate potassium chew, tabs</i>	2		*	*	*
<i>amoxicillin/clavulanate potassium susr 200mg/5ml; 28.5mg/5ml, 400mg/5ml; 57mg/5ml, 600mg/5ml; 42.9mg/5ml</i>	2		*	*	*
<i>amoxicillin/potassium clavulanate</i>	2		*	*	*
AMPICILLIN SODIUM INJ 125MG	3		*		
<i>ampicillin sodium inj 10gm, 1gm</i>	2		*	*	*
AMPICILLIN SUSR	3		*		
<i>ampicillin caps</i>	2		*	*	*
BACTOCILL IN DEXTROSE	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>dicloxacillin sodium</i>	2		*	*	*
<i>nafcillin sodium inj 1gm</i>	2		*	*	*
<i>penicillin g potassium</i>	2		*	*	*
<i>penicillin v potassium</i>	1		*	*	*
TIMENTIN	3		*		
ZOSYN	3		*		
Macrolides					
<i>azithromycin</i>	2		*	*	*
<i>clarithromycin</i>	2		*	*	*
<i>e.e.s. 400</i>	2		*	*	*
<i>ery</i>	2		*	*	*
ERYTHROCIN LACTOBIONATE	3		*		
<i>erythromycin</i>	2		*	*	*
<i>erythromycin base</i>	2		*	*	*
Quinolones					
<i>ciprofloxacin</i>	2		*	*	*
<i>ciprofloxacin hcl</i>	1		*	*	*
LEVAQUIN ORAL SOLN, TABS	4		*		
LEVAQUIN INJ 5%; 750MG/150ML	4		*		
<i>levofloxacin</i>	2		*	*	*
MOXEZA	3		*		
<i>ofloxacin soln, tabs</i>	2		*	*	*
ZYMAR	3		*		
ZYMAXID	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
Sulfonamides					
<i>sodium sulfacetamide</i>	2		*	*	*
SULFADIAZINE	3		*		
<i>sulfamethoxazole/trimethoprim ds</i>	1		*	*	*
SULFAMETHOXAZOLE/T RIMETHOPRIM INJ	3		*		
<i>sulfamethoxazole/ trimethoprim susp, tabs</i>	1		*	*	*
Tetracyclines					
DOXYCYCLINE HYCLATE CPEP 75MG	3		*		
<i>doxycycline hyclate caps, tabs</i>	1		*	*	*
<i>doxycycline hyclate inj</i>	2		*	*	*
<i>doxycycline monohydrate tabs 50mg, 75mg</i>	2		*	*	*
<i>minocycline hcl</i>	2		*	*	*
<i>tetracycline hcl</i>	1		*	*	*
Anticonvulsants					
Anticonvulsants, Other					
BANZEL SUSP	4		*		
BANZEL TABS	4	PA	*		
KEPPRA XR	3		*		
KEPPRA INJ, TABS	3		*		
<i>levetiracetam</i>	2		*	*	*
<i>levetiracetam er</i>	2		*	*	*
VIMPAT	4	PA	*		
Calcium Channel Modifying Agents					

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
CELONTIN	3		*		
<i>ethosuximide</i>	2		*	*	*
LYRICA	4		*		
Gamma-aminobutyric Acid (GABA) Augmenting Agents					
DEPACON	3		*		
DEPAKOTE	3		*		
DEPAKOTE ER	3		*		
DEPAKOTE SPRINKLES	3		*		
<i>divalproex sodium</i>	2		*	*	*
<i>divalproex sodium er</i>	2		*	*	*
<i>gabapentin caps 100mg</i>	2	QL (1080 per 30 days)	*	*	*
<i>gabapentin caps 400mg</i>	2	QL (270 per 30 days)	*	*	*
<i>gabapentin caps 300mg</i>	2	QL (360 per 30 days)	*	*	*
<i>gabapentin soln</i>	2	QL (2350 per 30 days)	*	*	*
<i>gabapentin tabs 800mg</i>	2	QL (120 per 30 days)	*	*	*
<i>gabapentin tabs 600mg</i>	2	QL (180 per 30 days)	*	*	*
GABITRIL	4		*		
<i>primidone</i>	2		*	*	*
SABRIL	5	PA	*		
STAVZOR	4		*		
<i>valproate sodium</i>	2		*	*	*
<i>valproic acid</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>zonisamide</i>	2		*	*	*
Glutamate Reducing Agents					
<i>felbamate</i>	2		*	*	*
FELBATOL	4		*		
LAMICTAL CHEWABLE DISPERSIBLE	3		*		
LAMICTAL ODT	3		*		
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	3		*		
LAMICTAL STARTER/TAKING VALPROATE	3		*		
LAMICTAL XR	3		*		
<i>lamotrigine</i>	2		*	*	*
TOPAMAX	4		*		
TOPAMAX SPRINKLE	3		*		
<i>topiramate</i>	2		*	*	*
Sodium Channel Inhibitors					
<i>carbamazepine</i>	2		*	*	*
<i>carbamazepine er</i>	2		*	*	*
CARBATROL	3		*		
DILANTIN INFATABS	3		*		
DILANTIN SUSP	3		*		
DILANTIN CAPS 100MG	3		*		
<i>dilantin caps 30mg</i>	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>epitol</i>	2		*	*	*
<i>fosphenytoin sodium</i>	2		*	*	*
<i>oxcarbazepine</i>	2		*	*	*
PEGANONE	3		*		
PHENYTEK	3		*		
<i>phenytoin</i>	2		*	*	*
<i>phenytoin sodium</i>	2		*	*	*
<i>phenytoin sodium extended</i>	2		*	*	*
TRILEPTAL	3		*		
Antidementia Agents					
Antidementia Agents, Other					
<i>ergoloid mesylates</i>	2		*	*	*
Cholinesterase Inhibitors					
ARICEPT	3	QL (30 per 30 days)	*		
<i>donepezil hcl</i>	2		*	*	*
EXELON SOLN	3		*		
EXELON PT24	3	QL (30 per 30 days)	*		
<i>galantamine hydrobromide cp24 16mg, 24mg</i>	2		*	*	*
<i>galantamine hydrobromide cp24 8mg</i>	2	QL (30 per 30 days)	*	*	*
<i>galantamine hydrobromide soln</i>	2		*	*	*
<i>galantamine hydrobromide tabs 8mg</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>galantamine hydrobromide tabs 12mg, 4mg</i>	2	QL (30 per 30 days)	*	*	*
<i>rivastigmine tartrate caps 3mg</i>	2		*	*	*
<i>rivastigmine tartrate caps 1.5mg</i>	2		*	*	*
<i>rivastigmine tartrate caps 4.5mg, 6mg</i>	2		*	*	*
Glutamate Pathway Modifiers					
NAMENDA TITRATION PAK	3		*		
NAMENDA SOLN	3		*		
NAMENDA TABS	3	QL (60 per 30 days)	*		
Antidepressants					
Antidepressants, Other					
<i>budeprion sr</i>	2		*	*	*
<i>budeprion xl</i>	2		*	*	*
<i>bupropion hcl</i>	2		*	*	*
<i>bupropion hcl sr</i>	2		*	*	*
EFFEXOR XR	3		*		
<i>mirtazapine odt</i>	2		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>mirtazapine tbdp</i>	2		*	*	*
<i>mirtazapine tabs 30mg, 45mg</i>	2		*	*	*
<i>mirtazapine tabs 15mg, 7.5mg</i>	2		*	*	*
<i>nefazodone hcl</i>	2		*	*	*
<i>trazodone hcl</i>	1		*	*	*
<i>venlafaxine hcl</i>	2		*	*	*
Monoamine Oxidase Inhibitors					
EMSAM	4	QL (30 per 30 days) PA	*		
MARPLAN	3		*		
NARDIL	3		*		
PARNATE	3		*		
<i>tranylcypromine sulfate</i>	2		*	*	*
Serotonin/Norepinephrine Reuptake Inhibitors					
<i>citalopram hydrobromide</i>	1		*	*	*
CYMBALTA	3	QL (60 per 30 days)	*		
<i>fluoxetine hcl caps 10mg, 20mg</i>	1	QL (30 per 30 days)	*	*	*
<i>fluoxetine hcl caps 40mg</i>	2		*	*	*
<i>fluoxetine hcl soln</i>	1		*	*	*
<i>fluoxetine hcl tabs 20mg</i>	1		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>fluoxetine hcl tabs 10mg</i>	1	QL (45 per 30 days)	*	*	*
<i>fluvoxamine maleate</i>	2		*	*	*
LEXAPRO SOLN	3		*		
LEXAPRO TABS 20MG	3	1/2	*		
LEXAPRO TABS 10MG, 5MG	3	QL (45 per 30 days); 1/2	*		
<i>paroxetine hcl</i>	2		*	*	*
<i>paroxetine hcl er</i>	2		*	*	*
PAXIL SUSP	4		*		
PRISTIQ TB24 100MG	3		*		
PRISTIQ TB24 50MG	3	QL (30 per 30 days)	*		
RAPIFLUX	3		*		
SAVELLA	3	QL (60 per 30 days)	*		
SAVELLA TITRATION PACK	3	QL (55 per 30 days)	*		
<i>sertraline hcl conc</i>	2		*	*	*
<i>sertraline hcl tabs 100mg</i>	2		*	*	*
<i>sertraline hcl tabs 25mg, 50mg</i>	2		*	*	*
<i>venlafaxine hcl er</i>	2		*	*	*
VIIBRYD	4		*		
Tricyclics					
<i>amitriptyline hcl</i>	1		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
AMOXAPINE	3		*		
<i>clomipramine hcl</i>	2		*	*	*
<i>desipramine hcl</i>	2		*	*	*
<i>doxepin hcl caps 100mg, 10mg, 25mg, 50mg, 75mg</i>	2		*	*	*
<i>doxepin hcl conc</i>	2		*	*	*
<i>imipramine hcl</i>	2		*	*	*
MAPROTILINE HCL	3		*		
<i>nortriptyline hcl</i>	2		*	*	*
<i>protriptyline hcl</i>	2		*	*	*
SURMONTIL	4		*		
VIVACTIL	3		*		
Antidotes, Deterrents, and Toxicologic Agents					
Antidotes					
ANTIZOL	3	PA	*		
CUPRIMINE	4		*		
DEPEN TITRATABS	3		*		
EXJADE	3	PA	*		
RELISTOR	4	PA	*		
<i>sodium polystyrene sulfonate</i>	2		*	*	*
SYPRINE	4		*		
Deterrents					
ANTABUSE	3		*		
CAMPRAL	3		*		
CHANTIX	3		*		
NICOTROL INHALER	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
NICOTROL NS	3		*		
Toxicologic Agents					
<i>naloxone hcl</i>	2		*	*	*
<i>naltrexone hcl</i>	2		*	*	*
SUBOXONE SUBL	3		*		
Antiemetics					
Antiemetics					
<i>dronabinol</i>	2	QL (60 per 30 days)	*	*	*
EMEND CAPS 40MG, 80MG	3		*		
EMEND CAPS 125MG	3	QL (2 per 30 days) PA	*		
EMEND CAPS 0	3	QL (4 per 30 days) PA	*		
<i>granisetron hcl</i>	2		*	*	*
<i>granisol</i>	2		*	*	*
<i>metoclopramide hcl</i>	1		*	*	*
<i>ondansetron hcl inj, oral soln</i>	2		*	*	*
<i>ondansetron hcl tabs 24mg</i>	2		*	*	*
<i>ondansetron hcl tabs 4mg, 8mg</i>	2		*	*	*
<i>ondansetron odt</i>	2		*	*	*
<i>prochlorperazine</i>	2		*	*	*
<i>prochlorperazine edisylate</i>	2		*	*	*
<i>prochlorperazine maleate</i>	2		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>promethazine hcl tabs</i>	1		*	*	*
<i>promethazine hcl supp, syrpf</i>	2		*	*	*
<i>promethegan</i>	2		*	*	*
Antifungals					
Antifungals					
<i>amphotericin b</i>	2		*	*	*
ANCOBON	3		*		
CANCIDAS	5	PA	*		
<i>ciclopirox</i>	2		*	*	*
<i>ciclopirox nail lacquer</i>	2		*	*	*
<i>ciclopirox olamine</i>	2		*	*	*
<i>clotrimazole</i>	2		*	*	*
<i>clotrimazole/betamethasone dipropionate</i>	2		*	*	*
<i>fluconazole</i>	2		*	*	*
<i>fluconazole in dextrose</i>	2		*	*	*
GRIFULVIN V	4		*		
<i>griseofulvin microsize</i>	2		*	*	*
<i>itraconazole</i>	2		*	*	*
<i>ketoconazole</i>	2		*	*	*
LAMISIL SOLN	3		*		
LOTRISONE	3		*		
MYCAMINE	4		*		
NAFTIN	4		*		
<i>nystatin</i>	2		*	*	*
<i>nystatin/triamcinolone</i>	1		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>nystop</i>	2		*	*	*
<i>terbinafine hcl</i>	2	QL (30 per 30 days)	*	*	*
<i>terconazole crea</i>	2		**	*	*
<i>zazole</i>	2		**	*	*
Antigout Agents					
Antigout Agents					
<i>allopurinol</i>	1		*	*	*
<i>allopurinol sodium</i>	2		*	*	*
COLCRYS	3		*		
<i>probenecid</i>	2		*	*	*
<i>probenecid/colchicine</i>	2		*	*	*
ULORIC	3	ST	*		
Antimigraine Agents					
Abortive					
<i>dihydroergotamine mesylate</i>	2		*	*	*
ERGOMAR	3		*		
<i>ergotamine tartrate/caffeine</i>	2		*	*	*
MAXALT	3	QL (12 per 30 days)	*		
MAXALT-MLT	3	QL (12 per 30 days)	*		
MIGRANAL	4		*		
<i>sumatriptan succinate tabs</i>	2	QL (12 per 30 days)	*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>sumatriptan succinate inj 6mg/0.5ml</i>	2	QL (24 per 30 days)	*	*	*
Antimyasthenic Agents					
Parasympathomimetics					
GUANIDINE HCL	3		*		
<i>pyridostigmine bromide</i>	2		*	*	*
Antimycobacterials					
Antimycobacterials, Other					
DAPSONE	3		*		
MYCOBUTIN	4		*		
Antituberculars					
CAPASTAT SULFATE	3		*		
<i>ethambutol hcl</i>	2		*	*	*
ISONIAZID SYRP	3		*		
<i>isoniazid tabs</i>	2		*	*	*
PASER	4		*		
PRIFTIN	3		*		
<i>pyrazinamide</i>	2		*	*	*
<i>rifampin</i>	2		*	*	*
SEROMYCIN	3		*		
TRECATOR	4		*		
Antineoplastics					
Alkylating Agents					
BICNU	3		*		
BUSULFEX	3		*		
CEENU	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
HEXALEN	3		*		
<i>ifosfamide</i>	2		*	*	*
<i>ifosfamide/mesna</i>	2		*	*	*
LEUKERAN	3		*		
MATULANE	4		*		
<i>melphalan hydrochloride</i>	2		*	*	*
MUSTARGEN	5		**		
<i>thiotepa</i>	2		**	*	*
TREANDA	5		*		
ZANOSAR	5		*		
*					
Antiangiogenic Agents					
CAPRELSA	5				
REVLIMID	5	LA	*		
THALOMID	5		*		
VANDETANIB	5		*		
VOTRIENT	5	PA	*		
Antiestrogens/Modifiers					
EMCYT	4	PA	*		
FARESTON	4		*		
FASLODEX	4		*		
<i>tamoxifen citrate</i>	2		*	*	*
*					
Antimetabolites					
<i>cladribine</i>	2		**	*	*
CLOLAR	5		*		
<i>cytarabine</i>	2		*	*	*
CYTARABINE AQUEOUS	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
INJ 20MG/ML					
<i>cytarabine aqueous inj 100mg/ml</i>	2		*	*	*
DROXIA	3		*		
ELITEK	3	PA	*		
FLUOROURACIL	3		*		
GEMZAR	5	PA	*		
<i>hydroxyurea</i>	2		*	*	*
<i>mercaptopurine</i>	2		*	*	*
<i>pentostatin</i>	2		*	*	*
TABLOID	3		*		
Antineoplastics, Other					
ALIMTA	5		*		
<i>bleomycin sulfate</i>	2		*	*	*
<i>cisplatin</i>	2		*	*	*
<i>cyclophosphamide</i>	2		*	*	*
DOCEFREZ	5		*		
DOCETAXEL	4		*		
ETHYOL	5	PA	*		
<i>etoposide</i>	2		*	*	*
GEMCITABINE	5	PA	*		
HALAVEN	5	PA	*		
HYCAMTIN	4		*		
IXEMPRA KIT	5	PA	*		
JAKAFI	5	PA	*		
MESNEX	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
NOVANTRONE	3	PA	*		
ONTAK	4	PA	*		
PROLEUKIN	3		*		
SYLATRON	5	PA	*		
TRISENOX	3	PA	*		
TYKERB	5	QL (150 per 30 days) PA	*		
VELCADE	4	PA	*		
VIDAZA	4	PA	*		
ZOLINZA	4		*		
ZYTIGA	5		*		
Aromatase Inhibitors, 3rd Generation					
<i>anastrozole</i>	2		*	*	*
AROMASIN	3		*		
FEMARA	3		*		
Molecular Target Inhibitors					
AFINITOR	5		*		
GLEEVEC	5		*		
IRESSA	3	PA	*		
NEXAVAR	5	PA	*		
SPRYCEL	5		*		
SUTENT	5	PA	*		
TARCEVA	5		*		
TASIGNA	5	PA	*		
XALKORI	5	PA	*		
ZELBORAF	5	PA	*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
Monoclonal Antibodies					
ARZERRA	5	PA	*		
AVASTIN	5		*		
CAMPATH	4	PA	*		
RITUXAN	5		*		
YERVOY	5	PA	*		
Retinoids					
PANRETIN	3		*		
TARGRETIN	4		*		
TRETINOIN	5		*		
Antiparasitics					
Anthelmintics					
ALBENZA	3		*		
<i>mebendazole</i>	2		*	*	*
Antiprotozoals					
ALINIA SUSR	3	PA	*		
ALINIA TABS	3	QL (12 per 30 days) PA	*		
<i>chloroquine phosphate</i>	2		*	*	*
DARAPRIM	3		*		
<i>hydroxychloroquine sulfate</i>	2		*	*	*
MALARONE	3		*		
<i>mefloquine hcl</i>	2		*	*	*
MEPRON	5		*		
PRIMAQUINE PHOSPHATE	3		*		
QUALAQUIN	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
Pediculicides/Scabicides *					
<i>acticin</i>	2		*	*	*
<i>lindane</i>	2		*	*	*
OVIDE	3		*		
<i>permethrin</i>	2		*	*	*
Antiparkinson Agents					
Antiparkinson Agents *					
<i>amantadine hcl caps</i>	2		*	*	*
APOKYN	5	PA	*		
AZILECT	3		*		
<i>benztropine mesylate tabs</i>	2		**	*	*
<i>bromocriptine mesylate</i>	2		**	*	*
<i>carbidopa/levodopa</i>	2		*	*	*
<i>carbidopa/levodopa cr</i>	2		*	*	*
<i>carbidopa/levodopa sr</i>	2		**	*	*
COMTAN	3		*		
LODOSYN	4		*		
<i>pramipexole dihydrochloride tabs 0.125mg, 0.25mg, 0.5mg, 1.5mg, 1mg</i>	2		*	*	*
REQUIP XL	3		*		
<i>ropinirole hcl</i>	2		*	*	*
SELEGILINE HCL TABS	3		*		
<i>selegiline hcl caps</i>	2		*	*	*
STALEVO 100	3		*		
STALEVO 150	3		*		
STALEVO 50	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
TASMAR	4		*		
<i>trihexyphenidyl hcl</i>	2		*	*	*
ZELAPAR	4		*		
Antipsychotics					
Atypicals					
ABILIFY DISCMELT	3		*		
ABILIFY INJ, ORAL SOLN	3		*		
ABILIFY TABS 20MG, 2MG, 30MG	3		*		
ABILIFY TABS 10MG, 15MG, 5MG	3	QL (30 per 30 days)	*		
CLOZAPINE TABS 200MG	3		*		
<i>clozapine tabs 100mg, 25mg, 50mg</i>	2		*	*	*
FANAPT	3	ST	*		
FANAPT TITRATION PACK	3	ST	*		
FAZACLO	3		*		
GEODON INJ	3		*		
GEODON CAPS 40MG	3	QL (120 per 30 days)	*		
GEODON CAPS 20MG	3	QL (240 per 30 days)	*		
GEODON CAPS 60MG, 80MG	3	QL (60 per 30 days)	*		
INVEGA SUSTENNA	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
INVEGA TB24 1.5MG, 3MG, 9MG	3	QL (30 per 30 days)	*		
INVEGA TB24 6MG	3	QL (60 per 30 days)	*		
LATUDA	3		**		
<i>olanzapine</i>	2		*	*	*
RISPERDAL CONSTA	4	QL (4 per 28 days)	*		
<i>risperidone odt tbdp 0.5mg, 1mg, 2mg, 3mg, 4mg</i>	2		*	*	*
<i>risperidone odt tbdp 0.25mg</i>	2		*	*	*
<i>risperidone soln</i>	2		*	*	*
<i>risperidone tabs 4mg</i>	2		*	*	*
<i>risperidone tabs 1mg, 2mg, 3mg</i>	2		*	*	*
<i>risperidone tabs 0.25mg, 0.5mg</i>	2		*	*	*
SEROQUEL XR TB24 200MG	3	QL (30 per 30 days)	*		
SEROQUEL XR TB24 300MG, 400MG	3	QL (60 per 30 days)	*		
SEROQUEL TABS 200MG	3	QL (120 per 30 days)	*		
SEROQUEL TABS 100MG	3	QL (240 per 30 days)	*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
SEROQUEL TABS 50MG	3	QL (480 per 30 days)	*		
SEROQUEL TABS 300MG, 400MG	3	QL (60 per 30 days)	*		
SEROQUEL TABS 25MG	3	QL (960 per 30 days)	*		
ZYPREXA ZYDIS TBDP 10MG, 15MG, 20MG	3		*		
ZYPREXA ZYDIS TBDP 5MG	3	QL (30 per 30 days)	*		
ZYPREXA INJ	3		*		
ZYPREXA TABS 10MG, 15MG, 20MG	3		*		
ZYPREXA TABS 2.5MG, 5MG, 7.5MG	3	QL (30 per 30 days)	*		
Conventional					
CHLORPROMAZINE HCL INJ	3		*		
<i>chlorpromazine hcl tabs</i>	2		*	*	*
<i>fluphenazine decanoate</i>	2		*	*	*
FLUPHENAZINE HCL CONC, ELIX, INJ	3		*		
<i>fluphenazine hcl tabs</i>	2		*	*	*
<i>haloperidol</i>	2		*	*	*
<i>haloperidol decanoate</i>	2		*	*	*
<i>haloperidol lactate</i>	2		*	*	*
<i>loxapine succinate</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
ORAP	3		*		
<i>perphenazine</i>	2		*	*	*
<i>perphenazine/amitriptyline</i>	2		*	*	*
<i>thioridazine hcl</i>	2		*	*	*
<i>thiothixene</i>	2		*	*	*
<i>trifluoperazine hcl</i>	2		*	*	*
Antispasticity Agents					
Antispasticity Agents					
<i>baclofen</i>	2		*	*	*
<i>dantrolene sodium</i>	2		*	*	*
<i>tizanidine hcl</i>	2		*	*	*
Antivirals					
Anti-cytomegalovirus (CMV) Agents					
CYTOVENE	4		*		
FOSCARNET SODIUM	3		*	*	
GANCICLOVIR	3		*		
VALCYTE	5		*		
ZIRGAN	4		*		
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors					
COMPLERA	4		*		
EDURANT	4		*		
INTELENCE TABS 200MG	4		*		
INTELENCE TABS 100MG	4	QL (120 per 30 days)	*		
RESCRIPTOR	3		*		
SUSTIVA	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
VIRAMUNE	3		*		
VIRAMUNE XR	3		*		
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors					
ATRIPLA	5		*		
COMBIVIR	3		*		
<i>didanosine</i>	2		*	*	*
EMTRIVA	3		*		
EPIVIR	3		*		
EPIVIR HBV	3		*		
EPZICOM	4		*		
<i>lamivudine</i>	2		*	*	*
<i>lamivudine/zidovudine tabs</i>	2		*	*	*
RETROVIR	3		*		
RETROVIR IV INFUSION	3		*		
<i>stavudine</i>	2		*	*	*
TRIZIVIR	4		*		
TRUVADA	4		*		
VIDEX EC	3		*		
VIDEX PEDIATRIC	3		*		
VIREAD	3		*		
ZERIT	3		*		
ZIAGEN	3		*		
<i>zidovudine</i>	2		*	*	
Anti-HIV Agents, Other					
FUZEON	5		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
ISENTRESS	3	QL (60 per 30 days)	*		
SELZENTRY	4	QL (123 per 30 days)	**		
Anti-HIV Agents, Protease Inhibitors					
APTIVUS	5		*		
CRIXIVAN	3		*		
INVIRASE	4		*		
KALETRA	3		*		
LEXIVA	3		*		
NORVIR	3		*		
PREZISTA TABS 150MG	3		*		
PREZISTA TABS 400MG, 600MG, 75MG	4		*		
REYATAZ	4		*		
VICTRELIS	5		*		
VIRACEPT	3		*		
Anti-influenza Agents					
<i>amantadine hcl tabs</i>	2		*	*	*
FLUMADINE	3		*		
RELENZA DISKHALER	3		*		
<i>rimantadine hcl</i>	2		*	*	*
Antih hepatitis Agents					
BARACLUDE	3		*		
HEPSERA	4		**		
INCIVEK	5	PA	*		
<i>ribasphere</i>	2		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>ribavirin</i>	2		*	*	*
TYZEKA	3		*		
Antitherpetic Agents					
<i>acyclovir</i>	2		*	*	*
<i>acyclovir sodium</i>	2		*	*	*
DENAVIR	3		*		
<i>famciclovir</i>	2		*	*	*
<i>valacyclovir hcl</i>	2	QL (60 per 30 days)	*	*	*
VIROPTIC	3		*		
ZOVIRAX	3		*		
Anxiolytics					
Anxiolytics, Other					
<i>buspirone hcl</i>	2		*	*	*
<i>chlordiazepoxide /amitriptyline</i>	2		*	*	*
<i>meprobamate</i>	2		*	*	
Bipolar Agents					
Bipolar Agents					
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	3		*		
<i>lithium carbonate er</i>	2		*	*	*
LITHIUM CARBONATE TABS	3		*		
LITHIUM CARBONATE CAPS 600MG	3		*		
<i>lithium carbonate caps</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>150mg, 300mg</i>					
<i>lithium citrate</i>	2		*	*	*
SAPHRIS	3		**		
SEROQUEL XR TB24 50MG	3	QL (120 per 30 days)	*		
SEROQUEL XR TB24 150MG	3	QL (30 per 30 days)	*		
SYMBYAX	3		*		
Blood Glucose Regulators					
Antidiabetic Agents					
<i>acarbose</i>	2		*	*	*
ACTOPLUS MET	3	QL (90 per 30 days)	**		
ACTOS	3	QL (30 per 30 days)	*		
AVANDAMET	3		*		
AVANDARYL TABS 1MG; 4MG, 2MG; 4MG, 4MG; 4MG	3		**		
AVANDIA	3		*		
BYETTA INJ 10MCG/0.04ML	3		*		
DUETACT	3	QL (30 per 30 days)	*		
<i>glimepiride</i>	2		*	*	*
<i>glipizide</i>	1		*	*	*
<i>glipizide er</i>	2		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
glyburide micronized tabs 6mg	1		*	*	*
glyburide tabs 2.5mg	1		*	*	*
glyburide tabs 1.25mg, 5mg	2		*	*	*
GLYSET	3		*		
JANUMET	3	QL (60 per 30 days)	*		
JANUVIA	3	QL (60 per 30 days)	*		
JUVISYNC	3		*		
KOMBIGLYZE	3		*		
metformin hcl	1		*	*	*
metformin hcl er	1		*	*	*
nateglinide	2		*	*	*
ONGLYZA	3		*		
PRANDIN	3		*		
PRECOSE	3		*		
STARLIX	3		*		
SYMLIN	3		*		
SYMLINPEN 60	3		*		
TRADJENTA	3		*		
Glycemic Agents					
GLUCAGEN HYPOKIT	3		*		
PROGLYCEM	3		*		
Insulins					
APIDRA	3	QL (60 per 30 days)	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
APIDRA SOLOSTAR	3	QL (60 per 30 days)	*		
LANTUS	3	QL (60 per 30 days)	*		
LEVEMIR	3	QL (60 per 30 days)	*		
NOVOLIN 70/30	3	QL (60 per 30 days)	*		
NOVOLIN N	3	QL (60 per 30 days)	*		
NOVOLIN R	3	QL (60 per 30 days)	*		
NOVOLOG	3	QL (60 per 30 days)	*		
NOVOLOG MIX 70/30	3	QL (60 per 30 days)	*		
Blood Products/Modifiers/ Volume Expanders					
Anticoagulants					
ARIXTRA INJ 10MG/0.8ML	3	QL (20 per 180 days)	*		
ARIXTRA INJ 2.5MG/0.5ML, 5MG/0.4ML, 7.5MG/0.6ML	3	QL (30 per 180 days)	*		
COUMADIN	3		*		
FRAGMIN INJ 2500UNIT/0.2ML, 5000UNIT/0.2ML	3	QL (30 per 180 days)	**		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
FRAGMIN INJ 25000UNIT/ML	4		*		
FRAGMIN INJ 10000UNIT/ML, 7500UNIT/0.3ML	5	QL (30 per 180 days)	*		
HEPARIN SODIUM INJ 20000UNIT/ML, 2000UNIT/ML, 2500UNIT/ML	3		*		
<i>heparin sodium inj 10000unit/ml, 1000unit/ml, 5000unit/ml</i>	2		*	*	*
<i>jantoven</i>	2		*	*	*
LOVENOX INJ 30MG/0.3ML	4	QL (18 per 180 days) PA	*		
LOVENOX INJ 150MG/ML, 300MG/3ML, 40MG/0.4ML, 60MG/0.6ML	4	QL (60 per 180 days) PA	*		
LOVENOX INJ 100MG/ML, 120MG/0.8ML, 80MG/0.8ML	5	QL (60 per 180 days) PA	*		
PRADAXA	3		*		
<i>warfarin sodium</i>	2		*	*	*
XARELTO 10 MG	3	QL (34 per 34 days)	*		
Blood Formation Products					
EPOGEN	4		*		
LEUKINE	5	PA	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
NEULASTA	5	PA	*		
NEUMEGA	5	PA	*		
NEUPOGEN	5		*		
PROCRIT INJ 3000UNIT/ML, 4000UNIT/ML	3	QL (12 per 30 days) PA	*		
PROCRIT INJ 10000UNIT/ML, 2000UNIT/ML	4	QL (12 per 30 days) PA	*		
PROCRIT INJ 20000UNIT/ML	5	QL (12 per 30 days) PA	*		
PROCRIT INJ 40000UNIT/ML	5	QL (6 per 30 days) PA	*		
Blood Products/Modifiers/ Volume Expanders					
CINRYZE	5	PA	*		
<i>pentoxifylline er</i>	2		*	*	*
PROMACTA	5		*		
Coagulants					
CYKLOKAPRON	3	PA	*		
Platelet Aggregation Inhibitors					
AGGRENOX	3	QL (60 per 30 days)	*		
<i>cilostazol</i>	2		*	*	*
<i>dipyridamole</i>	2		*	*	*
EFFIENT	3		* *		
PLAVIX TABS 75MG	3	QL (30 per 30 days)	*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>ticlopidine hcl</i>	2		*	*	*
Cardiovascular Agents					
Alpha-adrenergic Agonists					
<i>clonidine hcl tabs</i>	1		*	*	*
<i>guanfacine hcl</i>	2		*	*	*
<i>methyldopa</i>	2		*	*	*
<i>methyldopa/hydrochlorothiazide</i>	2		*	*	*
<i>midodrine hcl</i>	2		*	*	*
Alpha-adrenergic Blocking Agents					
<i>prazosin hcl</i>	2		*	*	*
<i>terazosin hcl</i>	2		*	*	*
Antiarrhythmics					
<i>amiodarone hcl</i>	2		*	*	*
<i>disopyramide phosphate</i>	2		*	*	*
<i>flecainide acetate</i>	2		*	*	*
MULTAQ	3		*		
PACERONE TABS 100MG, 400MG	3		*		
<i>pacerone tabs 200mg</i>	2		*	*	*
PROCAINAMIDE HCL	3		*		
<i>propafenone hcl</i>	2		*	*	*
<i>quinidine gluconate er</i>	2		*	*	*
<i>quinidine sulfate</i>	2		*	*	*
QUINIDINE SULFATE ER	3		*		
<i>sotalol hcl</i>	2		*	*	*
TIKOSYN	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>verapamil hcl er</i>	2		*	*	*
Beta-adrenergic Blocking Agents					
<i>acebutolol hcl</i>	2		**	*	*
<i>atenolol</i>	1		*	*	*
<i>atenolol/chlorthalidone</i>	1		*	*	*
<i>betaxolol hcl</i>	2		*	*	*
BYSTOLIC TABS 10MG, 2.5MG, 5MG	3		*		
<i>carvedilol</i>	1		*	*	*
COREG CR	3		**		
<i>labetalol hcl</i>	2		*	*	*
			*	*	*
<i>metoprolol succinate er</i>	2		*		
<i>metoprolol tartrate</i>	1		*	*	*
<i>nadolol</i>	2		*	*	*
PROPRANOLOL HCL ORAL SOLN	3		*		
<i>propranolol hcl inj, tabs</i>	1		*	*	*
PROPRANOLOL/HYDROCHLOROTHIAZIDE TABS 25MG; 80MG	3		*		
<i>propranolol/hydrochlorothiazide tabs 25mg; 40mg</i>	1		*	*	*
<i>timolol maleate</i>	2		*	*	*
Calcium Channel Blocking Agents					
<i>afeditab cr</i>	2		*	*	*
<i>amlodipine besylate</i>	1		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>cartia xt</i>	2		*	*	*
<i>diltiazem cd</i>	2		*	*	*
<i>diltiazem hcl er</i>	2		*	*	*
<i>diltiazem hcl tabs</i>	2		*	*	*
DILTIAZEM HCL INJ 100MG	3		*		
<i>diltiazem hcl inj 25mg/5ml</i>	2		*	*	*
EXFORGE HCT	3		*		
<i>felodipine er</i>	2		*	*	*
<i>nifediac cc</i>	2		*	*	*
<i>nifedical xl</i>	2		*	*	*
<i>nifedipine er</i>	2		*	*	*
NIFEDIPINE CAPS 20MG	3		*		
<i>nifedipine caps 10mg</i>	2		*	*	*
SULAR	3		*		
<i>verapamil hcl</i>	2		*	*	*
<i>verapamil hcl er</i>	2		*	*	*
Cardiovascular Agents, Other					
DIGOXIN ORAL SOLN	3		*		
<i>digoxin tabs</i>	1		*	*	*
<i>digoxin inj</i>	2		*	*	*
LANOXIN INJ 0.1MG/ML	3		*		
RANEXA	3		*		
Diuretics					
ACETAZOLAMIDE SODIUM	3		*		
<i>acetazolamide tabs</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
AMILORIDE HCL	3		*		
<i>amiloride/ hydrochlorothiazide</i>	2		*	*	*
<i>bumetanide</i>	2		*	*	*
<i>chlorthalidone</i>	2		*	*	*
DYRENIUM	3		*		
<i>furosemide inj, tabs</i>	1		*	*	*
FUROSEMIDE ORAL SOLN 8MG/ML	3		*		
<i>furosemide oral soln 10mg/ml</i>	1		*	*	*
<i>hydrochlorothiazide caps</i>	1		*	*	*
<i>hydrochlorothiazide tabs 25mg, 50mg</i>	1		*	*	*
<i>indapamide</i>	2		*	*	*
<i>metolazone</i>	2		*	*	*
SAMSCA	5	PA	*		
<i>toremide tabs</i>	2		*	*	*
<i>triamterene/ hydrochlorothiazide</i>	1		*	*	*
Dyslipidemics					
<i>cholestyramine light</i>	1		*	*	*
<i>colestipol hcl</i>	2		*	*	*
CRESTOR	3	1/2	*		
<i>fenofibrate micronized</i>	2		*	*	*
<i>fenofibrate tabs 54mg</i>	2		* *	*	*
<i>gemfibrozil</i>	1		*	*	*
LESCOL XL	4		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>lovastatin</i>	2		*	*	*
LOVAZA	3		*		
<i>niacor</i>	2		*	*	*
NIASPAN	3		*		
<i>pravastatin sodium tabs</i>	2		*	*	*
<i>prevalite</i>	1		*	*	*
<i>simvastatin</i>	1		*	*	*
TRICOR	3		*		
TRILIPIX	3		*		
VYTORIN	3		*		
WELCHOL	3		*		
ZETIA	3		*		
Renin-angiotensin-aldosterone System Inhibitors					
<i>amlodipine besylate/benazepril hydrochloride</i>	2		*	*	*
AZOR	3		*		
<i>benazepril hcl</i>	2		*	*	*
<i>benazepril hcl/hydrochlorothiazide</i>	2		*	*	*
BENICAR	3	1/2	*		
BENICAR HCT	3	1/2	*		
<i>captopril</i>	1		*	*	*
<i>captopril/hydrochlorothiazide</i>	1		*	*	*
DIOVAN	3	1/2	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
DIOVAN HCT TABS	3	1/2	*		
<i>enalapril maleate/hydrochlorothiazide</i>	1		*	*	*
<i>enalapril maleate tabs</i>	1		*	*	*
EXFORGE	3		*		
<i>lisinopril</i>	1		*	*	*
<i>lisinopril/hydrochlorothiazide</i>	1		*	*	*
<i>losartan potassium</i>	2		*	*	*
<i>losartan potassium/hydrochlorothiazide</i>	2		*	*	*
LOTREL CAPS 10MG; 20MG, 2.5MG; 10MG, 5MG; 10MG, 5MG; 20MG	3		*		
<i>quinapril hcl</i>	2		*	*	*
<i>quinapril/hydrochlorothiazide</i>	2		*	*	*
<i>ramipril</i>	2		*	*	*
<i>spironolactone</i>	2		*	*	*
TEKAMLO	3		*		
TEKURNA	3		*		
TEKURNA HCT	3		*		
VALTURNA	3		*		
Vasodilators					
BIDIL	3		*		
<i>hydralazine hcl</i>	2		*	*	*
<i>isosorbide dinitrate</i>	1		*	*	*
<i>isosorbide dinitrate er</i>	1		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>isosorbide mononitrate</i>	2		*	*	*
<i>isosorbide mononitrate er</i>	2		*	*	*
<i>minoxidil</i>	2		*	*	*
<i>nitroglycerin</i>	2		*	*	*
<i>nitroglycerin transdermal</i>	2		*	*	*
NITROLINGUAL PUMPSPRAY	3		*		
NITROSTAT	3		*		
Central Nervous System Agents					
Amphetamines, ADHD					
<i>amphetamine /dextroamphetamine</i>	2		*	*	*
<i>dextroamphetamine sulfate</i>	2		*	*	*
<i>dextroamphetamine sulfate er</i>	2		*	*	*
Non-amphetamines, ADHD					
<i>dexmethylphenidate hcl</i>	2		*	*	*
<i>methylin er</i>	2		*	*	*
<i>methylin tabs</i>	1		*	*	*
<i>methylphenidate hcl</i>	1		*	*	*
<i>methylphenidate hcl sr</i>	2		*	*	*
Non-amphetamines, Other					
NUVIGIL	3	QL (30 per 30 days) PA	*		
PROVIGIL TABS 200MG	3	QL (30 per 30 days) PA	*		
PROVIGIL TABS 100MG	3	QL (60 per 30 days) PA	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
RILUTEK	5		*		
XYREM	3	PA LA	*		
Dental and Oral Agents					
Dental and Oral Agents					
<i>chlorhexidine gluconate oral rinse</i>	2		*	*	*
<i>pilocarpine hcl</i>	2		*	*	*
<i>pilocarpine hydrochloride</i>	2		*	*	*
<i>triamcinolone in orabase</i>	2		**	*	*
Dermatological Agents					
Dermatological Agents					
8-MOP	3		*		
<i>ammonium lactate</i>	2		*	*	*
<i>calcipotriene soln</i>	2		*	*	*
CLARAVIS	3		**		
<i>clindamycin phosphate</i>	2		*	*	*
CONDYLOX	4		*		
DOVONEX	3		*		
ELIDEL	3		*		
<i>fluorouracil</i>	2		*	*	*
<i>imiquimod</i>	2		**	*	*
OXSORALEN	3		*		
OXSORALEN ULTRA	5		*		
<i>podofilox</i>	2		*	*	*
PROTOPIC	3	PA	*		
REGRANEX	4	PA	*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
SANTYL	3		*		
<i>selenium sulfide</i>	2		*	*	*
SELSUN SHAMPOO	3		*		
SOLARAZE	4		*		
TAZORAC	3		*		
<i>tretinoin</i>	2		*	*	*
VECTICAL	4	PA	*		
VEREGEN	3		*		
ZONALON	3		*		
Enzyme Replacements/Modifiers					
Enzyme Replacements/Modifiers					
ADAGEN	5		*		
ALDURAZYME	5	PA	*		
BUPHENYL	5	PA	*		
CEREDASE	3	PA	*		
CEREZYME	5		*		
CREON	3		*		
CYSTADANE	3		*		
CYSTAGON	3		*		
ELAPRASE	5		*		
FABRAZYME	3		*		
LUMIZYME	5	PA	*		
NAGLAZYME	5	PA	*		
ORFADIN	3		*		
PULMOZYME	5	QL (75 per 30 days) PA	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
SUCRAID	3		*		
VPRIV	3		*		
ZAVESCA	5	PA	*		
Gastrointestinal Agents					
Antispasmodics, Gastrointestinal					
ATROPINE SULFATE INJ 0.05MG/ML	3		*		
<i>atropine sulfate inj 0.1mg/ml</i>	2		*	*	*
<i>dicyclomine hcl caps, tabs</i>	1		*	*	*
<i>dicyclomine hcl inj, oral soln</i>	2		* *	*	*
<i>glycopyrrolate</i>	2		* *	*	*
Gastrointestinal Agents, Other					
AMITIZA CAPS 24MCG	3	QL (60 per 30 days)	*		
<i>diphenoxylate/atropine</i>	2		*	*	*
GASTROCROM	3		*		
GOLYTELY SOLR 236GM; 2.97GM; 6.74GM; 5.86GM; 22.74GM	3		*		
<i>lactulose</i>	2		*	*	*
<i>loperamide hcl</i>	2		*	*	*
<i>metoclopramide hcl tabs</i>	1		*	*	*
<i>metoclopramide hcl inj, oral soln</i>	2		*	*	*
<i>ursodiol caps</i>	2		*	*	*
VISICOL	3		*		
Histamine2 (H2) Blocking Agents					

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>cimetidine hcl</i>	2		*	*	*
<i>famotidine inj, tabs</i>	2		*	*	*
<i>ranitidine hcl caps, tabs</i>	1		*	*	*
<i>ranitidine hcl inj</i>	2		*	*	*
Irritable Bowel Syndrome Agents					
LOTRONEX	3	QL (60 per 30 days) PA	*		
Protectants					
CARAFATE SUSP	3		*		
<i>misoprostol</i>	2		*	*	*
<i>sucralfate</i>	2		*	*	*
Proton Pump Inhibitors					
DEXILANT	3		*		
<i>lansoprazole</i>	2		*	*	*
<i>lansoprazole odt</i>	2		*	*	*
<i>omeprazole cpdr</i>	2		*	*	*
<i>pantoprazole sodium</i>	2		*	*	*
PROTONIX INJ	3		*		
ZEGERID CAPS	4		*		
Genitourinary Agents					
Antispasmodics, Urinary					
DETROL LA CP24 4MG	4		*		
DETROL LA CP24 2MG	4	QL (30 per 30 days)	*		
ENABLEX TB24 15MG	3		*		
ENABLEX TB24 7.5MG	3	QL (30 per 30 days)	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>oxybutynin chloride er</i>	2		*	*	*
<i>oxybutynin chloride tabs</i>	1		*	*	*
SANCTURA XR	3		*		
VESICARE	3		*		
Benign Prostatic Hypertrophy Agents					
AVODART	3		*		
<i>doxazosin mesylate</i>	2		*	*	*
<i>finasteride</i>	2		**	*	*
JALYN	3		*		
<i>tamsulosin hcl</i>	2		*	*	*
Genitourinary Agents, Other					
<i>bethanechol chloride</i>	2		*	*	*
ELMIRON	3		*		
Phosphate Binders					
<i>calcium acetate</i>	2		*	*	*
REVELA TABS	3		*		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)					
Glucocorticoids/Mineralocorticoids					
<i>amcinonide crea</i>	2		*	*	*
<i>augmented betamethasone dipropionate lotn</i>	2		**	*	*
<i>betamethasone dipropionate crea, oint</i>	2		*	*	*
<i>clobetasol propionate</i>	2		*	*	*
<i>clobetasol propionate e</i>	2		*	*	*
DERMA-SMOOTH/FS BODY OIL	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>desonide</i>	2		*	*	*
<i>desoximetasone crea 0.25%</i>	2		*	*	*
<i>desoximetasone gel, oint</i>	2		*	*	*
DIPROLENE AF	3		*		
<i>fludrocortisone acetate</i>	2		*	*	*
FLUOCINOLONE ACETONIDE OINT, SOLN	3		*		
FLUOCINOLONE ACETONIDE CREA 0.025%	3		*		
<i>fluocinolone acetate crea 0.01%</i>	2		*	*	*
<i>fluticasone propionate</i>	2		*	*	*
<i>hydrocortisone</i>	2		*	*	*
LOCOID LIPOCREAM	3		*		
<i>mometasone furoate</i>	2		*	*	*
<i>proctocream hc</i>	2		*	*	*
<i>triamcinolone acetate</i>	2		*	*	*
TRIAMCINOLONE ACETONIDE IN ABSORBASE	3		*		
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)					
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)					
<i>chorionic gonadotropin</i>	2		*	*	*
<i>ddavp soln 0.01%</i>	2		*	*	*
<i>desmopressin acetate inj, tabs</i>	2		*	*	*
<i>desmopressin acetate nasal soln 0.01%</i>	2		*	*	*
INCRELEX	5	PA	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>novarel</i>	2	PA	*	*	*
SEROSTIM	5	PA	*		
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/ Modifiers)					
Anabolic Steroids					
ANADROL-50	3		*		
<i>oxandrolone</i>	2	QL (60 per 30 days)	*	*	*
Androgens					
ANDROGEL	3		*		
ANDROGEL PUMP	3		*		
ANDROXY	3		*		
<i>danazol</i>	2		*	*	*
DEPO-TESTOSTERONE	3		*		
<i>testosterone cypionate</i>	2		*	*	*
<i>testosterone enanthate</i>	2		*	*	*
Estrogens					
ACTIVELLA TABS 1MG; 0.5MG	3		*		
<i>estradiol</i>	2		*	*	*
PREMARIN	3		*		
PREMARIN W/APPLICATOR	3		*		
VAGIFEM	3		*		
Progestins					
<i>apri</i>	2		*	*	*
DEPO-PROVERA	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
ELLA	3		*		
<i>kariva</i>	2		*	*	*
<i>medroxyprogesterone acetate</i>	2		*	*	*
<i>megestrol acetate</i>	2		*	*	*
<i>next choice</i>	2		*	*	*
PREMPHASE	3		*		
PREMPRO	3		*		
<i>solia</i>	2		*	*	*
<i>trinessa</i>	2		*	*	*
<i>zovia 1/35e</i>	2		*	*	*
<i>zovia 1/50e</i>	2		*	*	*
Selective Estrogen Receptor Modifying Agents					
EVISTA	3		*		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)					
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)					
<i>levothroid</i>	2		*	*	*
<i>levothyroxine sodium</i>	2		*	*	*
<i>levoxyl</i>	2		*	*	*
<i>liothyronine sodium</i>	2		*	*	*
SYNTHROID	3		*		
THYROLAR-1	3		*		
THYROLAR-1/4	3		*		
THYROLAR-2	3		*		
THYROLAR-3	3		*		
<i>unithroid</i>	2		*	*	*
Hormonal Agents, Suppressant (Adrenal)					

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
Hormonal Agents, Suppressant (Adrenal)					
LYSODREN	3		*		
Hormonal Agents, Suppressant (Parathyroid)					
Hormonal Agents, Suppressant (Parathyroid)					
SENSIPAR	3		*		
Hormonal Agents, Suppressant (Pituitary)					
Hormonal Agents, Suppressant (Pituitary)					
<i>cabergoline</i>	2		*	*	*
<i>leuprolide acetate</i>	2		*	*	*
LUPRON DEPOT	3	PA	*		
LUPRON DEPOT-PED	3	PA	*		
<i>octreotide acetate</i>	2		*	*	*
SANDOSTATIN LAR DEPOT	5	PA	*		
SOMATULINE DEPOT	5	PA	**		
SOMAVERT	3		*		
SYNAREL	5		*		
Hormonal Agents, Suppressant (Sex Hormones/Modifiers)					
Antiandrogens					
<i>bicalutamide</i>	2		*	*	*
<i>flutamide</i>	2		*	*	*
NILANDRON	3		*		
Hormonal Agents, Suppressant (Thyroid)					
Antithyroid Agents					
<i>methimazole</i>	2		*	*	*
<i>propylthiouracil</i>	2		**	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
Immunological Agents					
Immune Suppressants					
ACTEMRA	4		*		
AZASAN	3		*		
<i>azathioprine</i>	2		*	*	*
AZATHIOPRINE SODIUM	3		*		
BENLYSTA	5	PA	*		
CELLCEPT INTRAVENOUS	3		*		
CELLCEPT SUSR	3		*		
CELLCEPT CAPS, TABS	4		*		
<i>cyclosporine</i>	2		*	*	*
CYCLOSPORINE MODIFIED CAPS 50MG	3		*		
<i>cyclosporine modified caps 100mg</i>	2		*	*	*
<i>cyclosporine modified soln</i>	2		*	*	*
ENBREL	5	QL (200 per 30 days)	*		
<i>engraf</i>	2		*	*	*
HUMIRA	5		*		
HUMIRA PEN-CROHNS DISEASESTARTER	5		*		
<i>methotrexate</i>	2		*	*	*
<i>methotrexate sodium</i>	2		*	*	*
<i>mycophenolate mofetil</i>	2		*	*	*
NULOJIX	5	PA	*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
ORENCIA	5		**		
PROGRAF	3		**		
RAPAMUNE SOLN	3		*		
RAPAMUNE TABS 1MG, 2MG	3		*		
REMICADE	5	PA	*		
ZORTRESS	3		*		
Immunizing Agents, Passive					
CARIMUNE NANOFILTERED	3		*		
GAMMAGARD LIQUID	5		*		
GAMUNEX	5		*		
Immunomodulators					
ACTIMMUNE	5	PA	*		
ARCALYST	5	PA	*		
AVONEX	5		*		
BETASERON	3		*		
COPAXONE	3		*		
GILENYA	5	PA	*		
ILARIS	5	PA	*		
INTRON-A	3		*		
INTRON-A W/DILUENT	3		*		
KINERET	5		*		
<i>leflunomide</i>	2	QL (30 per 30 days)	*	*	*
PEGASYS INJ 180MCG/0.5ML	5	QL (720 per 30 days)	*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
PEGASYS PROCLICK	5	QL (720 per 30 days)	*		
RIDAURA	3		*		
Vaccines					
ACTHIB	3		*		
ADACEL	3		*		
BOOSTRIX	3		*		
CERVARIX	3		*		
COMVAX	3		*		
DAPTACEL	3		*		
DECAVAC	3		*		
DIPHThERIA/TETANUS TOXOID PEDIATRIC	3		*		
ENGERIX-B	3		*		
GARDASIL	3	PA	*		
HAVRIX	3		*		
IMOVAX RABIES (H.D.C.V.)	3		*		
INFANRIX	3		*		
IPOL INACTIVATED IPV	3		*		
IXIARO	3		*		
JE-VAX	3		*		
M-M-R II W/DILUENT 10 DOSE	3		*		
MENACTRA	3		*		
MENOMUNE-A/C/Y/W-135	3		*		
MENVEO	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
PEDVAX HIB	3		*		
PROQUAD	3		*		
RABAVERT	3		*		
RECOMBIVAX HB	3		*		
ROTATEQ	3		*		
TETANUS TOXOID ADSORBED	3		*		
TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT	3		*		
TRIHIBIT	3		*		
TRIPEDIA	3		*		
TWINRIX	3		*		
TYPHIM VI	3		*		
VAQTA	3		*		
VARIVAX	3		*		
YF-VAX	3		*		
ZOSTAVAX	3		*		
Inflammatory Bowel Disease Agents					
Glucocorticoids					
<i>colocort</i>	2		*	*	*
<i>cortisone acetate</i>	2		*	*	*
<i>dexamethasone sodium phosphate</i>	2		*	*	*
DEXAMETHASONE ELIX	3		*		
DEXAMETHASONE TABS 0.5MG, 0.75MG, 1MG, 2MG	3		*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>dexamethasone tabs 1.5mg, 4mg, 6mg</i>	2		*	*	*
ENTOCORT EC	4		*		
<i>hydrocortisone</i>	2		*	*	*
<i>methylprednisolone acetate</i>	2		*	*	*
<i>methylprednisolone sodiumsuccinate</i>	2		*	*	*
<i>methylprednisolone tabs 4mg, 8mg</i>	2		*	*	*
ORAPRED ODT	3		*		
<i>prednisolone sodium phosphate</i>	2		*	*	*
PREDNISON SOLN	3		*		
PREDNISON TABS 50MG	3		*		
<i>prednisone tabs 10mg, 1mg, 2.5mg, 20mg, 5mg</i>	1		*	*	*
Salicylates					
ASACOL	3	QL (360 per 30 days)	*		
ASACOL HD	3	QL (180 per 30 days)	*		
<i>balsalazide disodium</i>	2		*	*	*
<i>mesalamine</i>	2		*	*	*
PENTASA CPR 500MG	3		*		
Sulfonamides					
<i>sulfasalazine</i>	2		*	*	
<i>sulfazine ec</i>	2		*	*	

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
Metabolic Bone Disease Agents					
Metabolic Bone Disease Agents					
ACTONEL	4		*		
<i>alendronate sodium tabs 10mg, 40mg, 5mg</i>	2		*	*	*
<i>alendronate sodium tabs 35mg, 70mg</i>	2		*	*	*
BONIVA TABS	4	QL (1 per 28 days)	*		
<i>calcitriol</i>	2		*	*	*
FORTEO	4	QL (750 per 30 days)	*		
FOSAMAX SOLN	3		*		
HECTOROL INJ	4		*		
HECTOROL CAPS 0.5MCG, 2.5MCG	4		*		
MIACALCIN INJ	3		**		
MIACALCIN NASAL SOLN	3	QL (3.7 per 30 days)	*		
PAMIDRONATE DISODIUM INJ 6MG/ML	3		*		
<i>pamidronate disodium inj 30mg/10ml, 90mg/10ml</i>	2		*	*	*
PROLIA	4	PA	*		
RECLAST	4		*		
ZOMETA	5	PA	**		
Miscellaneous Therapeutic Agents					
Miscellaneous Therapeutic Agents					

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
ALCOHOL PREPS	3	QL (100 per 30 days)	*		
<i>anagrelide hydrochloride</i>	2		*	*	*
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	3	QL (100 per 30 days)	*		
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	3	QL (100 per 30 days)	*		
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	3	QL (100 per 30 days)	*		
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	3	QL (100 per 30 days)	*		
BD PEN NEEDLE/ULTRAFINE/29G X 12.7MM	3		*		
CURITY GAUZE PADS 2"X2"	3		*		
<i>dextrose 10% flex container</i>	2		*	*	*
<i>dextrose 5%</i>	2		*	*	*
FIRAZYR	5	PA	*		
<i>intralipid inj 2.25%; 20%</i>	2		*	*	*
<i>sterile water irrigation</i>	2		*	*	*
XENAZINE	5	PA	*		
Ophthalmic Agents					
Ophthalmic Agents, Other					
<i>con</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>bacitracin</i>	2		*	*	*
LACRISERT	4		*		
NATACYN	3		*		
RESTASIS	3		*		
<i>romycin</i>	2		*	*	*
<i>trifluridine</i>	2		*	*	*
<i>trimethoprim sulfate/polymyxin b sulfate</i>	2		*	*	*
VIGAMOX	3		*		
Anti-allergy Agents					
<i>cromolyn sodium</i>	2		*	*	*
ELESTAT	3		*		
LASTACAFT	4		*		
OPTIVAR	3		*		
PATADAY	3		*		
Anti-inflammatories					
ACULAR	3		*		
ACULAR LS	3		*		
BLEPHAMIDE S.O.P.	3		*		
<i>dexamethasone sodium phosphate</i>	2		*	*	*
<i>diclofenac sodium</i>	2		*	*	*
DUREZOL	3		*		
<i>flurbiprofen sodium</i>	2		*	*	*
<i>ketorolac tromethamine</i>	2		**	*	*
LOTEMAX	4		**		
<i>neomycin/polymyxin/dexamet</i>	2		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>hasone</i>					
<i>neomycin/polymyxin/hydrocortisone</i>	2		*	*	*
NEVANAC	3		*		
PRED FORTE	3		*		
<i>prednisolone acetate</i>	2		*	*	*
PREDNISOLONE SODIUM PHOSPHATE	3		*		
TOBRADEX	3		*		
VIMOVO	3	ST	*		
VOLTAREN	3		*		
Ophthalmic Antiglaucoma Agents					
ALPHAGAN P	3		*		
AZOPT	3		*		
BETAXOLOL HCL	3		*		
BETOPTIC-S	3		*		
<i>brimonidine tartrate</i>	2		*	*	*
<i>carteolol hcl</i>	2		*	*	*
COMBIGAN	3		*		
<i>dorzolamide hcl</i>	2		*	*	*
<i>dorzolamide hcl/timolol maleate</i>	2		*	*	*
ISTALOL	3		*		
<i>levobunolol hcl</i>	2		*	*	*
<i>methazolamide</i>	2		*	*	*
PHOSPHOLINE IODIDE	3		*		
PILOPINE HS	3		*		

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>timolol maleate</i>	1		*	*	*
Ophthalmic Prostaglandin and Prostanamide Analogs					
<i>latanoprost</i>	2		*	*	*
LUMIGAN SOLN	3		*		
TRAVATAN Z	3		*		
Otic Agents					
Otic Agents					
CIPRO HC	3		*		
CIPRODEX	3		*		
DERMOTIC	3		*		
<i>neomycin/polymyxin/hc</i>	2		*	*	*
<i>neomycin/polymyxin/hydrocortisone</i>	2		*	*	*
Respiratory Tract Agents					
Anti-inflammatories, Inhaled Corticosteroids					
ADVAIR DISKUS	3	QL (120 per 30 days)	*		
ADVAIR HFA	3	QL (12 per 30 days)	*		
DULERA	3		*		
FLOVENT DISKUS AEPB 100MCG/BLIST, 250MCG/BLIST	3		*		
FLOVENT DISKUS AEPB 50MCG/BLIST	3	QL (120 per 30 days)	*		
FLOVENT HFA	3	QL (24 per 30 days)	*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>flunisolide</i>	2		*	*	*
<i>fluticasone propionate</i>	2	QL (16 per 30 days)	*	*	*
OMNARIS	4		*		
SYMBICORT	3		*		
VERAMYST	3		*		
Antihistamines					
ASTELIN	3		*		
CLARINEX TABS	3		*		
<i>clemastine fumarate</i>	2		*	*	*
<i>diphenhydramine hcl</i>	2		*	*	*
<i>fexofenadine hcl</i>	2		*	*	*
<i>meclizine hcl</i>	2		*	*	*
<i>promethazine hcl tabs</i>	1		*	*	*
<i>promethazine hcl inj 25mg/ml</i>	2		*	*	*
Antileukotrienes					
SINGULAIR	3		*		
zafirlukast	2		*	*	*
ZYFLO CR	4		*		
Bronchodilators, Anticholinergic					
ATROVENT	3		*		
ATROVENT HFA	3	QL (26 per 30 days)	*		
<i>ipratropium bromide</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
SPIRIVA HANDIHALER	3	QL (30 per 30 days)	*		
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)					
<i>aminophylline</i>	2		*	*	*
<i>theophylline er tb12</i>	2		*	*	*
Bronchodilators, Sympathomimetic					
<i>albuterol sulfate syrpl, tabs</i>	2		*	*	*
<i>albuterol sulfate nebu 0.083%, 0.5%, 1.25mg/3ml</i>	2		**	*	*
EPIPEN 2-PAK	3		*		
EPIPEN-JR 2-PAK	3		*		
METAPROTERENOL SULFATE TABS	3		*		
<i>metaproterenol sulfate syrpl</i>	2		*	*	*
SEREVENT DISKUS	3	QL (60 per 30 days)	*		
VENTOLIN HFA	3	QL (36 per 30 days)	**		
XOPENEX HFA	3		*		
Mast Cell Stabilizers					
<i>cromolyn sodium</i>	2		*	*	*
Pulmonary Antihypertensives					
ADCIRCA	3		*		
KUVAN	5		*		
LETAIRIS	5		*		
REVATIO TABS	3		*		
TRACLEER	4	LA	*		

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
VENTAVIS	5	PA	*		
Respiratory Tract Agents, Other					
<i>acetylcysteine</i>	2		*	*	*
PROLASTIN	3		*		
TYZINE	3		*		
TYZINE PEDIATRIC NASAL DROPS	3		*		
XOLAIR	4	PA	*		
Sedatives/Hypnotics					
Sedatives/Hypnotics					
SOMNOTE	3		*		
<i>zaleplon</i>	2		*	*	*
<i>zolpidem tartrate</i>	2	QL (30 per 30 days)	*	*	*
Skeletal Muscle Relaxants					
Skeletal Muscle Relaxants					
<i>carisoprodol</i>	2	QL (120 per 30 days)	*	*	*
<i>cyclobenzaprine hcl</i>	2		*	*	*
<i>methocarbamol</i>	2		*	*	*
SKELAXIN	3	QL (120 per 30 days) PA	*		
Therapeutic Nutrients/Minerals/Electrolytes					
Electrolytes/Minerals					
AMINOSYN	3		*		
<i>aminosyn 8.5%/electrolytes</i>	2		*	*	*

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>dextrose 10%/nacl 0.2%</i>	2		*	*	*
<i>dextrose 2.5%/sodium chloride 0.45%</i>	2		**	*	*
<i>kcl 0.3%/d5w/lr iv lac ring</i>	2		*	*	*
<i>lactated ringers</i>	2		*	*	*
<i>lactated ringers irrigation</i>	2		*	*	*
<i>leucovorin calcium inj</i>	2		*	*	*
LEUCOVORIN CA TABS 10MG, 15MG	3		*		
<i>leucovorin calcium tabs 25mg, 5mg</i>	2		**	*	*
<i>magnesium sulfate</i>	2		*	*	*
<i>magnesium sulfate in d5w</i>	2		*	*	*
<i>physiolyte</i>	2		*	*	*
<i>physiosol irrigation</i>	2		*	*	*
<i>potassium chloride 0.075%/d5w/nacl 0.225%</i>	1		*	*	*
POTASSIUM CHLORIDE 0.15% /NACL 0.45% VIAFLEX	3		*		
<i>potassium chloride 0.15% d5w/nacl 0.33%</i>	1		*	*	*
<i>potassium chloride 0.15% d5w/nacl 0.45% viaflex</i>	1		*	*	*
<i>potassium chloride 0.15% nacl 0.9%</i>	1		*	*	*
<i>potassium chloride 0.15%/d5w</i>	1		**	*	*
<i>potassium chloride 0.22%</i>	1		*	*	*

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Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>d5w/nacl 0.45%</i>					
<i>potassium chloride 0.224%/d5w</i>	1		*	*	*
POTASSIUM CHLORIDE 0.224%D5W/NACL 0.33%	3		*		
POTASSIUM CHLORIDE 0.3%/ NACL 0.9%	3		*		
<i>potassium chloride 0.3%/d5w</i>	1		*	*	*
<i>potassium chloride er cpr 10meq</i>	1		*	*	*
<i>potassium chloride er tbc</i>	1		*	*	*
<i>potassium chloride sr</i>	1		*	*	*
POTASSIUM CHLORIDE INJ 10MEQ/50ML	3		*		
<i>potassium chloride inj 0.4meq/ml, 10meq/100ml, 2meq/ml, 30meq/100ml</i>	1		*	*	*
<i>release</i>	2		*	*	*
<i>ringers irrigation</i>	2		*	*	*
<i>Sodium chloride</i>	2		*	*	*
<i>sodium chloride 0.9%</i>	2		*	*	*
<i>sodium fluoride</i>	2		*	*	*
<i>tpn electrolytes</i>	2		*	*	*
Vitamins					
FUSILEV	4		*		
<i>prenatabs obn</i>	2		*	*	*
Antifungals					
Antifungals					

Drug Name	Drug Tier	Requirements /Limits	Coverage During Gap		
			Group Plus A	Group Plus B	Group Plus
			HMO	HMO	HMO POS
<i>tolnaftate</i>	2		*	*	*
<i>tolnaftate 1% antifungal</i>	2		*	*	*

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<i>morphine sulfate er tb12 200mg</i>	8
<i>morphine sulfate inj 0.5mg/ml, 1mg/ml</i>	8
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