

Updated March 15, 2012

Essential Plan (PDP)

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.

For alternate formats or languages other than English please call our Customer Service at 1-855-737-4347.

Esta informacion esta disponible gratis en otros idiomas. Por favor, llamenos al numero del servicio al cliente 1-855-737-4347 si necesita asistencia.

A stand-alone prescription drug plan with a Medicare contract.

Formulary ID 00012186, Version 8

What is the Health First Essential Prescription Drug Plan (Essential Plan (PDP))'s Formulary?

A formulary is a list of covered drugs selected by Essential Plan (PDP) 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. Essential Plan (PDP) will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Essential Plan (PDP)'s 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 Essential Plan (PDP) please visit our Web site at www.HealthFirstHealthPlans.org or call Customer Service at 1-855-737-4347. Between October 15 and February 14, our Customer Service hours are: 8 am–8 pm, 7 days a week. From February 15 to October 14, our Customer Service hours are: Monday–Friday 8 am–8 pm, and Saturday 8 am–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. TTY/TDD users should call 1-800-955-8771. Print formularies are updated via errata sheets in the event of amid-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 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 37. 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?

The Essential Plan (PDP) 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:** The Essential Plan (PDP) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from the Essential Plan (PDP) before you fill your prescriptions. If you don’t get approval,

The Essential Plan (PDP) may not cover the drug.

- **Quantity Limits:** For certain drugs the Essential Plan (PDP) limits the amount of the drug that the Essential Plan (PDP) will cover. For example, The Essential Plan (PDP) 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, The Essential Plan (PDP) 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, The Essential Plan (PDP) may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Essential Plan (PDP) 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 5. 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 the Essential Plan (PDP) to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Health First Essential

Prescription Drug Plan formulary?” on page 3 for information about how to request an exception.

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 the Essential Plan (PDP) does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by the Essential Plan (PDP). When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by the Essential Plan (PDP)
- You can ask the Essential Plan (PDP) 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 Essential Plan (PDP)’s Formulary?

You can ask the Essential Plan (PDP) 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, the Essential Plan (PDP) limits 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, the Essential Plan (PDP) 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 Essential Plan (PDP) prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Essential Plan (PDP), please call Customer Service at 1-855-737-4347, Between October 15 and February 14, our Customer Service hours are: 8 am–8 pm, 7 days a week. From February 15 to October 14, our Customer Service hours are: Monday–Friday 8 am–8 pm, and Saturday 8 am–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. TTY/TDD users should call 1-800-955-8771.) Or visit www.HealthFirstHealthPlans.org.

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.

Essential Plan (PDP)'s Formulary

The formulary that begins on the next page provides coverage information about some of the drugs covered by the Essential Plan (PDP). If you have trouble finding your drug in the list, turn to the Index that begins on page 37.

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 Essential Plan (PDP) 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.)
- **B/D:** This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- **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 provided on the cover of this document.
- **ST: Step Therapy** is required — treatment with certain drugs is required before these drugs will be approved for coverage.

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Your costs

The amounts you pay for covered drugs are explained here:

Level 1: Deductible Period

You begin in this payment stage when you fill your first prescription of the year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid \$320 for your drugs (\$320 is the amount of your deductible), **Level 2** coverage begins.

Level 2: Initial Coverage Period

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 3** coverage begins.

	At a retail pharmacy	
	30-day supply	90-day supply
Tier 1	\$2	\$6
Tier 2	\$10	\$30
Tier 3	\$42.50	\$127.50
Tier 4	\$95	\$285
Tier 5	25%	N/A

Level 3: Coverage Gap Period

You pay these amounts after the total cost for your covered drugs reaches \$2,930 (including what you pay and what we pay). ***During this period, the Essential Plan (PDP) has no coverage in the gap unless you qualify for Extra Help and the coverage gap doesn't apply to you.***

When you have paid \$4,700 out-of-pocket for covered drugs, **Level 4** coverage begins.

	At a retail pharmacy	
	30-day supply	90-day supply
Tier 1	86%	86%
Tier 2	86%	86%
Tier 3	100% (you may receive a 50% manufacturer discount)	
Tier 4		
Tier 5		

Level 4: Catastrophic Coverage Period

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 (*whichever is greater*).

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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)
<i>codeine sulfate</i>	2	QL (240 per 30 days)
<i>endocet tabs 650mg; 10mg</i>	2	QL (180 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<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)
<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)

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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	
<i>oxycodone hcl tabs</i>	2	QL (240 per 30 days)
<i>oxycodone/acetaminophen caps</i>	2	QL (240 per 30 days)
<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	

Drug Name	Drug Tier	Requirements /Limits
<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	
<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	
VIMOVO	3	ST
Antibacterials		
Aminoglycosides		
<i>amikacin sulfate</i>	2	
<i>gentamicin sulfate</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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	
<i>gentamicin sulfate/sodium chloride</i>	2	
<i>isotonic gentamicin</i>	2	
<i>neomycin sulfate</i>	2	
<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 add-vantage</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	

Drug Name	Drug Tier	Requirements /Limits
<i>nitrofurantoin macrocrystalline</i>	2	
<i>nitrofurantoin monohydrate</i>	2	
PRIMSOL	4	
<i>silver sulfadiazine</i>	2	
<i>trimethoprim</i>	2	
TYGACIL	3	
VANOCIN 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	
CEPHALEXIN TABS	3	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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	
<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		

Drug Name	Drug Tier	Requirements /Limits
<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	
levofloxacin	2	
MOXEZA	3	
<i>ofloxacin soln, tabs</i>	2	
Sulfonamides		
<i>sodium sulfacetamide</i>	2	
SULFADIAZINE	3	
<i>sulfamethoxazole/trimethoprim ds</i>	1	
SULFAMETHOXAZOLE/TRIMETHOPRIM 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	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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	3	
KEPPRA TABS 1000MG	3	
<i>levetiracetam</i>	2	
<i>levetiracetam er</i>	2	
VIMPAT	4	PA
Calcium Channel Modifying Agents		
CELONTIN	3	
<i>ethosuximide</i>	2	
LYRICA	4	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
DEPACON	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)

Drug Name	Drug Tier	Requirements /Limits
<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	
<i>zonisamide</i>	2	
Glutamate Reducing Agents		
<i>felbamate</i>	2	
FELBATOL	4	
LAMICTAL ODT	3	
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	3	
LAMICTAL STARTER/TAKING VALPROATE	3	
LAMICTAL XR	3	
<i>lamotrigine</i>	2	
<i>topiramate</i>	2	
Sodium Channel Inhibitors		
<i>carbamazepine</i>	2	
<i>carbamazepine caps, tabs er</i>	2	
CARBATROL	3	
DILANTIN INFATABS	3	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
DILANTIN CAPS 30MG	3	
<i>fosphenytoin sodium</i>	2	
<i>oxcarbazepine</i>	2	
PEGANONE	3	
<i>phenytoin</i>	2	
<i>phenytoin sodium</i>	2	
<i>phenytoin sodium extended</i>	2	
Antidementia Agents		
Antidementia Agents, Other		
<i>ergoloid mesylates</i>	2	
Cholinesterase Inhibitors		
ARICEPT TABS 23MG	3	QL (30 per 30 days)
<i>donepezil hcl</i>	2	
<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	
<i>galantamine hydrobromide tabs 12mg, 4mg</i>	2	QL (30 per 30 days)
<i>rivastigmine tartrate caps 3mg</i>	2	QL (120 per 30 days)
<i>rivastigmine tartrate caps 1.5mg</i>	2	QL (240 per 30 days)
<i>rivastigmine tartrate caps 4.5mg, 6mg</i>	2	QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
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	QL (60 per 30 days)
<i>budeprion xl</i>	2	QL (30 per 30 days)
<i>bupropion hcl</i>	2	
<i>bupropion hcl sr</i>	2	QL (60 per 30 days)
<i>mirtazapine odt</i>	2	QL (30 per 30 days)
<i>mirtazapine tbdp</i>	2	QL (30 per 30 days)
<i>mirtazapine tabs 30mg, 45mg</i>	2	QL (30 per 30 days)
<i>mirtazapine tabs 15mg, 7.5mg</i>	2	QL (45 per 30 days)
<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

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
MARPLAN	3	
NARDIL	3	
<i>tranylcypromine sulfate</i>	2	
Serotonin/ Norepinephrine Reuptake Inhibitors		
<i>citalopram hydrobromide</i>	1	
CYMBALTA	3	QL (30 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	
<i>fluoxetine hcl tabs 10mg</i>	1	QL (45 per 30 days)
<i>fluvoxamine maleate</i>	2	
LEXAPRO SOLN	3	
LEXAPRO TABS 20MG	3	
LEXAPRO TABS 10MG, 5MG	3	QL (45 per 30 days)
<i>paroxetine hcl</i>	2	
<i>paroxetine hcl er</i>	2	
PRISTIQ TB24 100MG	3	
PRISTIQ TB24 50MG	3	QL (30 per 30 days)
SAVELLA	3	QL (60 per 30 days)
SAVELLA TITRATION PACK	3	QL (55 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>sertraline hcl conc</i>	2	
<i>sertraline hcl tabs 100mg</i>	2	
<i>sertraline hcl tabs 25mg, 50mg</i>	2	QL (45 per 30 days)
<i>venlafaxine hcl er</i>	2	
VIIBRYD	4	
Tricyclics		
<i>amitriptyline hcl</i>	1	
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	
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	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
SYPRINE	4	
Deterrents		
ANTABUSE	3	
CHANTIX	3	
NICOTROL INHALER	3	
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	B/D
EMEND CAPS 125MG	3	QL (2 per 30 days) B/D
EMEND CAPS 0	3	QL (4 per 30 days) B/D
<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	QL (30 per 30 days)
<i>ondansetron hcl tabs 4mg, 8mg</i>	2	QL (60 per 30 days)
<i>ondansetron odt</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>prochlorperazine</i>	2	
<i>prochlorperazine edisylate</i>	2	
<i>prochlorperazine maleate</i>	2	
<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	
MYCAMINE	4	
NAFTIN	4	
<i>nystatin</i>	2	
<i>nystatin/triamcinolone</i>	1	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<i>nystop</i>	2	
<i>terbinafine hcl</i>	2	QL (30 per 30 days)
<i>terconazole crea</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)
<i>sumatriptan succinate inj 6mg/0.5ml</i>	2	QL (24 per 30 days)
Antimyasthenic Agents		
Parasympathomimetics		

Drug Name	Drug Tier	Requirements /Limits
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	
TRECTOR	4	
Antineoplastics		
Alkylating Agents		
BICNU	3	
BUSULFEX	3	
CEENU	3	
HEXALEN	3	
<i>ifosfamide</i>	2	
<i>ifosfamide/mesna</i>	2	
LEUKERAN	3	
MATULANE	4	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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 INJ 20MG/ML	3	
<i>cytarabine aqueous inj 100mg/ml</i>	2	
DROXIA	3	
ELITEK	3	PA
FLUOROURACIL	3	
GEMZAR	5	PA
<i>hydroxyurea</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<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	B/D
DOCEFREZ	5	
DOCETAXEL CONC, SOLN	4	
ETHYOL	5	PA
<i>etoposide</i>	2	B/D
GEMCITABINE	5	PA
HALAVEN	5	PA
HYCAMTIN	4	
IXEMPRA KIT	5	PA
JAKAFI	5	PA
MESNEX	3	
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

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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
Monoclonal Antibodies		
ARZERRA	5	PA
AVASTIN	5	
CAMPATH	4	PA
RITUXAN	5	
YERVOY	5	B/D
Retinoids		
PANRETIN	3	
TARGRETIN	4	
TRETINOIN	5	

Drug Name	Drug Tier	Requirements /Limits
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	
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	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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	
<i>ropinirole hcl</i>	2	
SELEGILINE HCL TABS	3	
<i>selegiline hcl caps</i>	2	
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	

Drug Name	Drug Tier	Requirements /Limits
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	
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	QL (120 per 30 days)
<i>risperidone soln</i>	2	
<i>risperidone tabs 4mg</i>	2	
<i>risperidone tabs 1mg, 2mg, 3mg</i>	2	QL (60 per 30 days)
<i>risperidone tabs 0.25mg, 0.5mg</i>	2	QL (90 per 30 days)
SEROQUEL XR TB24 200MG	3	QL (30 per 30 days)

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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)
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	

Drug Name	Drug Tier	Requirements /Limits
<i>loxapine succinate</i>	2	
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>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	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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	
ISENTRESS	3	QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
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	
Antihepatitis Agents		
BARACLUDE	3	
HEPSERA	4	
INCIVEK	5	
<i>ribasphere</i>	2	
<i>ribavirin</i>	2	
TYZEKA	3	
Antiherpetic Agents		

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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>bupirone 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 150mg, 300mg</i>	2	
<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	

Drug Name	Drug Tier	Requirements /Limits
Blood Glucose Regulators		
Antidiabetic Agents		
<i>acarbose</i>	2	
ACTOPLUS MET	3	QL (90 per 30 days)
ACTOS	3	QL (30 per 30 days)
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	
<i>glyburide micronized tabs 6mg</i>	1	
<i>glyburide tabs 2.5mg</i>	1	
<i>glyburide tabs 1.25mg, 5mg</i>	2	
GLYSET	3	
JANUMET	3	QL (60 per 30 days)
JANUVIA	3	QL (60 per 30 days)
JUVISYNC	3	
KOMBIGLYZE	3	
<i>metformin hcl</i>	1	
<i>metformin hcl er</i>	1	
<i>nateglinide</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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)
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)

Drug Name	Drug Tier	Requirements /Limits
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)
FRAGMIN INJ 2500UNIT/0.2ML, 5000UNIT/0.2ML	3	QL (30 per 180 days)
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)

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
		days)
Blood Formation Products		
EPOGEN	4	
LEUKINE	5	PA
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		
<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	
PLAVIX TABS 75MG	3	QL (30 per 30 days)
<i>ticlopidine hcl</i>	2	

Drug Name	Drug Tier	Requirements /Limits
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	
<i>verapamil hcl er</i>	2	
Beta-adrenergic Blocking Agents		
<i>acebutolol hcl</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<i>atenolol</i>	1	
<i>atenolol/chlorthalidone</i>	1	
<i>betaxolol hcl</i>	2	
<i>carvedilol</i>	1	
<i>labetalol hcl</i>	2	
<i>metoprolol succinate er</i>	2	QL (60 per 30 days)
<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	
<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	
<i>felodipine er</i>	2	
<i>nifediac cc</i>	2	
<i>nifedical xl</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>nifedipine er</i>	2	
NIFEDIPINE CAPS 20MG	3	
<i>nifedipine caps 10mg</i>	2	
<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	
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

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<i>torseamide tabs</i>	2	
<i>triamterene/hydrochlorothiazide</i>	1	
Dyslipidemics		
<i>cholestyramine light</i>	1	
<i>colestipol hcl</i>	2	
CRESTOR	3	
<i>fenofibrate micronized</i>	2	
<i>fenofibrate tabs 54mg</i>	2	
<i>gemfibrozil</i>	1	
<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	
VYTORIN	3	
WELCHOL	3	
ZETIA	3	
Renin-angiotensin-aldosterone System Inhibitors		
<i>amlodipine besylate/benazepril hydrochloride</i>	2	QL (30 per 30 days)
<i>benazepril hcl</i>	2	
<i>benazepril hcl/hydrochlorothiazide</i>	2	
BENICAR	3	
BENICAR HCT	3	

Drug Name	Drug Tier	Requirements /Limits
<i>captopril</i>	1	
<i>captopril/hydrochlorothiazide</i>	1	
DIOVAN	3	
DIOVAN HCT TABS	3	
<i>enalapril maleate/hydrochlorothiazide</i>	1	
<i>enalapril maleate tabs</i>	1	
<i>lisinopril</i>	1	
<i>lisinopril/hydrochlorothiazide</i>	1	
<i>losartan potassium</i>	2	
<i>losartan potassium/hydrochlorothiazide</i>	2	
<i>quinapril hcl</i>	2	
<i>quinapril/hydrochlorothiazide</i>	2	
<i>ramipril</i>	2	
<i>spironolactone</i>	2	
TEKAMLO	3	
TEKTURNA	3	
TEKTURNA HCT	3	
VALTURNA	3	
Vasodilators		
BIDIL	3	
<i>hydralazine hcl</i>	2	
<i>isosorbide dinitrate</i>	1	
<i>isosorbide dinitrate er</i>	1	
<i>isosorbide mononitrate</i>	2	
<i>isosorbide mononitrate er</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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
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	

Drug Name	Drug Tier	Requirements /Limits
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
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		

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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
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		

Drug Name	Drug Tier	Requirements /Limits
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		
<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		
<i>misoprostol</i>	2	
<i>sucralfate</i>	2	
Proton Pump Inhibitors		
<i>lansoprazole</i>	2	
<i>lansoprazole odt</i>	2	
<i>omeprazole cpdr</i>	2	
<i>pantoprazole sodium</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
PROTONIX INJ	3	
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)
<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 caps, tabs</i>	2	
RENVELA TABS	3	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
Glucocorticoids/ Mineralocorticoids		

Drug Name	Drug Tier	Requirements /Limits
<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	
<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 acetonide 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 acetonide</i>	2	
TRIAMCINOLONE ACETONIDE IN ABSORBASE	3	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
<i>chorionic gonadotropin</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<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
<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	
Progestins		
<i>apri</i>	2	

Drug Name	Drug Tier	Requirements /Limits
DEPO-PROVERA	3	
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)		

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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	
Immunological Agents		
Immune Suppressants		

Drug Name	Drug Tier	Requirements /Limits
ACTEMRA	4	
AZASAN	3	
<i>azathioprine</i>	2	B/D
AZATHIOPRINE SODIUM	3	B/D
BENLYSTA	5	PA
CELLCEPT INTRAVENOUS	3	B/D
CELLCEPT SUSR	3	B/D
CELLCEPT CAPS, TABS	4	B/D
<i>cyclosporine</i>	2	B/D
CYCLOSPORINE MODIFIED CAPS 50MG	3	B/D
<i>cyclosporine modified caps 100mg</i>	2	B/D
<i>cyclosporine modified soln</i>	2	B/D
ENBREL	5	QL (200 per 30 days)
<i>gengraf</i>	2	
HUMIRA	5	
HUMIRA PEN-CROHNS DISEASESTARTER	5	
<i>methotrexate</i>	2	B/D
<i>methotrexate sodium</i>	2	B/D
<i>mycophenolate mofetil</i>	2	B/D
NULOJIX	5	PA
ORENCIA	5	
PROGRAF	3	B/D
RAPAMUNE SOLN	3	B/D
RAPAMUNE TABS 1MG, 2MG	3	B/D
REMICADE	5	PA
ZORTRESS	3	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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)
PEGASYS PROCLICK	5	QL (720 per 30 days)
RIDAURA	3	
Vaccines		
ACTHIB	3	
ADACEL	3	
BOOSTRIX	3	
CERVARIX	3	
COMVAX	3	

Drug Name	Drug Tier	Requirements /Limits
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	
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	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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	
<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		
<i>balsalazide disodium</i>	2	
<i>mesalamine</i>	2	
Sulfonamides		

Drug Name	Drug Tier	Requirements /Limits
<i>sulfasalazine</i>	2	
<i>sulfazine ec</i>	2	
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	QL (4 per 28 days)
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		

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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	
<i>intralipid inj 2.25%; 20%</i>	2	
<i>sterile water irrigation</i>	2	
XENAZINE	5	PA
Ophthalmic Agents		
Ophthalmic Agents, Other		
<i>ak-con</i>	2	
<i>bacitracin</i>	2	
LACRISERT	4	
NATACYN	3	
RESTASIS	3	
<i>romycin</i>	2	
<i>trifluridine</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>trimethoprim sulfate/polymyxin b sulfate</i>	2	
Ophthalmic Anti-allergy Agents		
<i>cromolyn sodium</i>	2	
ELESTAT	3	
LASTACAPT	4	
OPTIVAR	3	
Ophthalmic Anti-inflammatories		
BLEPHAMIDE S.O.P.	3	
<i>dexamethasone sodium phosphate</i>	2	
<i>diclofenac sodium</i>	2	
<i>flurbiprofen sodium</i>	2	
<i>ketorolac tromethamine</i>	2	
LOTEMAX	4	
<i>neomycin/polymyxin/dexamethasone</i>	2	
<i>neomycin/polymyxin/hydrocortisone</i>	2	
<i>prednisolone acetate</i>	2	
PREDNISOLONE SODIUM PHOSPHATE	3	
TOBRADEX	3	
VOLTAREN	3	
Ophthalmic Antiglaucoma Agents		
ALPHAGAN P	3	
AZOPT	3	
BETAXOLOL HCL	3	
<i>brimonidine tartrate</i>	2	
<i>carteolol hcl</i>	2	
<i>dorzolamide hcl</i>	2	
<i>dorzolamide hcl/timolol maleate</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<i>levobunolol hcl</i>	2	
<i>methazolamide</i>	2	
PHOSPHOLINE IODIDE	3	
PILOPINE HS	3	
<i>timolol maleate</i>	1	
Ophthalmic Prostaglandin and Prostanamide Analogs		
<i>latanoprost</i>	2	
LUMIGAN SOLN 0.01%	3	QL (5 per 30 days)
LUMIGAN SOLN 0.03%	3	QL (7.5 per 30 days)
TRAVATAN Z	3	QL (5 per 30 days)
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	

Drug Name	Drug Tier	Requirements /Limits
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)
<i>flunisolide</i>	2	QL (50 per 30 days)
<i>fluticasone propionate</i>	2	QL (16 per 30 days)
OMNARIS	4	
SYMBICORT	3	
Antihistamines		
<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	
<i>zafirlukast</i>	2	
ZYFLO CR	4	
Bronchodilators, Anticholinergic		
ATROVENT	3	
ATROVENT HFA	3	QL (26 per 30 days)
<i>ipratropium bromide</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
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 syrp, 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 syrp</i>	2	
SEREVENT DISKUS	3	QL (60 per 30 days)
VENTOLIN HFA	3	QL (36 per 30 days)
Mast Cell Stabilizers		
<i>cromolyn sodium</i>	2	
Pulmonary Antihypertensives		
ADCIRCA	3	
KUVAN	5	
LETAIRIS	5	
REVATIO TABS	3	
TRACLEER	4	LA
VENTAVIS	5	PA
Respiratory Tract Agents, Other		

Drug Name	Drug Tier	Requirements /Limits
<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	QL (90 per 30 days)
<i>methocarbamol</i>	2	
Therapeutic Nutrients/Minerals/ Electrolytes		
Electrolytes/Minerals		
AMINOSYN	3	
<i>aminosyn 8.5%/electrolytes</i>	2	
<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	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Drug Name	Drug Tier	Requirements /Limits
<i>leucovorin calcium inj</i>	2	
LEUCOVORIN CALCIUM 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% d5w/nacl 0.45%</i>	1	
<i>potassium chloride 0.224%/d5w</i>	1	
POTASSIUM CHLORIDE 0.224%D5W/NACL 0.33%	3	

Drug Name	Drug Tier	Requirements /Limits
POTASSIUM CHLORIDE 0.3%/ NACL 0.9%	3	
<i>potassium chloride 0.3%/d5w</i>	1	
<i>potassium chloride er cpcr 10meq</i>	1	
<i>potassium chloride er tbcr</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>potassium citrate extended-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		
<i>tolnaftate</i>	2	
<i>tolnaftate 1% antifungal</i>	2	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Index of drugs

8

8-MOP.....26

A

ABILIFY DISCMELT.....18
 ABILIFY INJ, ORAL SOLN.....18
 ABILIFY TABS 10MG, 15MG, 5MG18
 ABILIFY TABS 20MG, 2MG, 30MG18
Abortive15
acarbose.....21
acebutolol hcl.....23
acetaminophen/codeine #3.....7
acetaminophen/codeine #4.....7
acetaminophen/codeine soln.....7
acetaminophen/codeine tabs.....7
 ACETAZOLAMIDE SODIUM.....24
acetazolamide tabs.....24
acetylcysteine35
 ACTEMRA30
 ACTHIB.....31
acticin.....17
 ACTIMMUNE.....31
 ACTIVELLA TABS 1MG; 0.5MG.....29
 ACTONEL.....32
 ACTOPLUS MET21
 ACTOS21
acyclovir.....21
acyclovir sodium21
 ADACEL31
 ADAGEN.....27
 ADCIRCA.....35

ADVAIR DISKUS34
 ADVAIR HFA.....34
afeditab cr.....24
 AFINITOR17
 AGGRENOX.....23
ak-con33
 ALBENZA17
*albuterol sulfate nebu 0.083%, 0.5%,
 1.25mg/3ml*35
albuterol sulfate syrp, tabs35
 ALCOHOL PREPS33
 ALDURAZYME27
alendronate sodium tabs 10mg, 40mg, 5mg 32
alendronate sodium tabs 35mg, 70mg.....32
 ALIMTA.....16
 ALINIA SUSR17
 ALINIA TABS17
Alkylating Agents15
allopurinol15
allopurinol sodium.....15
Alpha-adrenergic Agonists23
Alpha-adrenergic Blocking Agents23
 ALPHAGAN P33
amantadine hcl caps17
amantadine hcl tabs.....20
amcinonide crea28
amikacin sulfate8
 AMILORIDE HCL.....24
amiloride/hydrochlorothiazide24
Aminoglycosides8
aminophylline35
 AMINOSYN.....35
aminosyn 8.5%/electrolytes35
amiodarone hcl.....23

AMITIZA CAPS 24MCG.....27
amitriptyline hcl13
amlodipine besylate.....24
amlodipine besylate/benazepril hydrochloride
25
ammonium lactate26
 AMOXAPINE.....13
amoxicillin.....10
amoxicillin/clavulanate potassium chew, tabs
10
*amoxicillin/clavulanate potassium susr
 200mg/5ml; 28.5mg/5ml, 400mg/5ml;
 57mg/5ml, 600mg/5ml; 42.9mg/5ml* 10
amoxicillin/potassium clavulanate 10
amphetamine/dextroamphetamine 26
Amphetamines, ADHD26
amphotericin b14
ampicillin caps10
ampicillin sodium inj 10gm, 1gm 10
 AMPICILLIN SODIUM INJ 125MG.....10
 AMPICILLIN SUSR.....10
Anabolic Steroids29
 ANADROL-50.....29
anagrelide hydrochloride33
Analgesics7
anastrozole17
 ANCOBON14
 ANDROGEL.....29
 ANDROGEL PUMP.....29
Androgens29
 ANDROXY29
Anesthetics8
 ANTABUSE14
Anthelmintics.....17

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Antiandrogens	30	Antimetabolites	16	ATROPINE SULFATE INJ 0.05MG/ML ..	27
Antiangiogenic Agents	16	Antimigraine Agents	15	<i>atropine sulfate inj 0.1mg/ml</i>	27
Antiarrhythmics	23	Antimyasthenic Agents	15	ATROVENT	34
Antibacterials	8	Antimycobacterials	15	ATROVENT HFA	34
Antibacterials, Other	9	Antimycobacterials, Other	15	Atypicals	18
Anticoagulants	22	Antineoplastics	15	<i>augmented betamethasone dipropionate lotn</i>	28
Anticonvulsants	11	Antineoplastics, Other	16	AVANDIA	21
Anticonvulsants, Other	11	Antiparasitics	17	AVASTIN	17
Anti-cytomegalovirus (CMV) Agents	19	Antiparkinson Agents	17	AVODART	28
Antidementia Agents	12	Antiprotozoals	17	AVONEX	31
Antidementia Agents, Other	12	Antipsychotics	18	AZASAN	30
Antidepressants	12	Antispasmodics, Gastrointestinal	27	<i>azathioprine</i>	30
Antidepressants, Other	12	Antispasmodics, Urinary	28	AZATHIOPRINE SODIUM	30
Antidiabetic Agents	21	Antispasticity Agents	19	AZILECT	17
Antidotes	13	Antithyroid Agents	30	<i>azithromycin</i>	10
Antidotes, Deterrents, and Toxicologic Agents	13	Antituberculars	15	AZOPT	33
Antiemetics	14	Antivirals	19		
Antiestrogens/Modifiers	16	ANTIZOL	13	B	
Antifungals	14, 36	Anxiolytics	21	<i>bacitracin</i>	33
Antigout Agents	15	Anxiolytics, Other	21	BACITRACIN	9
Antihepatitis Agents	20	APIDRA	22	<i>baclofen</i>	19
Antiherpetic Agents	20	APIDRA SOLOSTAR	22	BACTOCILL IN DEXTROSE	10
Antihistamines	34	APOKYN	17	BACTROBAN NASAL	9
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors	19	<i>apri</i>	29	<i>balsalazide disodium</i>	32
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors	20	APTIVUS	20	BANZEL SUSP	11
Anti-HIV Agents, Other	20	ARCALYST	31	BANZEL TABS	11
Anti-HIV Agents, Protease Inhibitors	20	ARICEPT TABS 23MG	12	BARACLUDGE	20
Anti-inflammatories, Inhaled Corticosteroids	34	ARIXTRA INJ 10MG/0.8ML	22	BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	33
Anti-inflammatory Agents	8	ARIXTRA INJ 2.5MG/0.5ML, 5MG/0.4ML, 7.5MG/0.6ML	22	BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	33
Anti-influenza Agents	20	AROMASIN	17	BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	33
Antileukotrienes	34	Aromatase Inhibitors, 3rd Generation	17	BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	33
		ARZERRA	17		
		<i>atenolol</i>	24		
		<i>atenolol/chlorthalidone</i>	24		
		ATRIPLA	20		

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

BD PEN NEEDLE/ULTRAFINE/29G X 12.7MM	33	<i>budeprion sr</i>	12	<i>carvedilol</i>	24	
<i>benazepril hcl</i>	25	<i>budeprion xl</i>	12	CEENU	15	
<i>benazepril hcl/hydrochlorothiazide</i>	25	<i>bumetanide</i>	24	<i>cefaclor</i>	9	
BENICAR.....	25	BUPHENYL.....	27	<i>cefaclor er</i>	9	
BENICAR HCT.....	25	<i>buprenorphine hcl inj</i>	7	<i>cefadroxil</i>	9	
Benign Prostatic Hypertrophy Agents	28	<i>bupropion hcl</i>	12	<i>cefazolin sodium inj 1gm, 500mg</i>	9	
BENLYSTA.....	30	<i>bupropion hcl sr</i>	12	CEFAZOLIN SODIUM INJ 1GM; 5%, 20GM	9	
<i>benztropine mesylate tabs</i>	17	<i>buspironone hcl</i>	21	<i>cefdinir</i>	9	
Beta-adrenergic Blocking Agents	23	BUSULFEX	15	<i>cefepime</i>	9	
Beta-lactam, Cephalosporins	9	BYETTA INJ 10MCG/0.04ML	21	<i>cefpodoxime proxetil tabs</i>	9	
Beta-lactam, Other	10	C			<i>ceftriaxone sodium inj 10gm, 1gm, 2gm</i>	9
Beta-lactam, Penicillins	10	<i>cabergoline</i>	30	<i>cefuroxime axetil tabs</i>	9	
<i>betamethasone dipropionate crea, oint</i>	28	<i>calcipotriene soln</i>	26	<i>cefuroxime sodium</i>	9	
BETASERON	31	<i>calcitriol</i>	32	CELLCEPT CAPS, TABS.....	30	
<i>betaxolol hcl</i>	24	<i>calcium acetate caps, tabs</i>	28	CELLCEPT INTRAVENOUS.....	30	
BETAXOLOL HCL.....	33	Calcium Channel Blocking Agents	24	CELLCEPT SUSR	30	
<i>bethanechol chloride</i>	28	Calcium Channel Modifying Agents	11	CELONTIN.....	11	
<i>bicalutamide</i>	30	CAMPATH.....	17	Central Nervous System Agents	26	
BICNU	15	CANCIDAS.....	14	<i>cephalexin caps, susr</i>	10	
BIDIL.....	25	CAPASTAT SULFATE.....	15	CEPHALEXIN TABS	9	
Bipolar Agents	21	CAPRELSA.....	16	CEREDASE	27	
<i>bleomycin sulfate</i>	16	<i>captopril</i>	25	CEREZYME	27	
BLEPHAMIDE S.O.P.	33	<i>captopril/hydrochlorothiazide</i>	25	CERVARIX	31	
Blood Formation Products	23	<i>carbamazepine</i>	11	CHANTIX.....	14	
Blood Glucose Regulators	21	<i>carbamazepine caps, tabs er</i>	11	<i>chlordiazepoxide/amitriptyline</i>	21	
Blood Products/Modifiers/ Volume		CARBATROL.....	11	<i>chlorhexidine gluconate oral rinse</i>	26	
Expanders	22, 23	<i>carbidopa/levodopa</i>	18	<i>chloroquine phosphate</i>	17	
BONIVA TABS.....	32	<i>carbidopa/levodopa cr</i>	18	CHLORPROMAZINE HCL INJ	19	
BOOSTRIX.....	31	<i>carbidopa/levodopa sr</i>	18	<i>chlorpromazine hcl tabs</i>	19	
<i>brimonidine tartrate</i>	33	Cardiovascular Agents	23	<i>chlorthalidone</i>	24	
<i>bromocriptine mesylate</i>	18	Cardiovascular Agents, Other	24	<i>cholestyramine light</i>	25	
Bronchodilators, Anticholinergic	34	CARIMUNE NANOFILTERED	31	Cholinesterase Inhibitors	12	
Bronchodilators, Phosphodiesterase		<i>carisoprodol</i>	35	<i>chorionic gonadotropin</i>	28	
Inhibitors (Xanthines)	35	<i>carteolol hcl</i>	33	<i>ciclopirox</i>	14	
Bronchodilators, Sympathomimetic	35	<i>cartia xt</i>	24	<i>ciclopirox nail lacquer</i>	14	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

<i>ciclopirox olamine</i>	14	COMBIVIR	20	DARAPRIM.....	17
<i>cilostazol</i>	23	COMPLERA	19	<i>ddavp soln 0.01%</i>	29
<i>cimetidine hcl</i>	27	COMTAN.....	18	DECAVAC	31
CIPRO HC	34	COMVAX	31	DENAVIR.....	21
CIPRODEX.....	34	CONDYLOX.....	26	Dental and Oral Agents	26
<i>ciprofloxacin</i>	10	Conventional	19	DEPACon	11
<i>ciprofloxacin hcl</i>	10	COPAXONE	31	DEPEN TITRATABS	13
<i>cisplatin</i>	16	<i>cortisone acetate</i>	32	DEPO-PROVERA	29
<i>citalopram hydrobromide</i>	13	CREON.....	27	DEPO-TESTOSTERONE.....	29
<i>cladribine</i>	16	CRESTOR	25	DERMA-SMOOTH/FS BODY OIL	28
CLARAVIS.....	26	CRIXIVAN.....	20	Dermatological Agents	26
<i>clarithromycin</i>	10	<i>cromolyn sodium</i>	33, 35	DERMOTIC.....	34
<i>clemastine fumarate</i>	34	CUBICIN.....	9	<i>desipramine hcl</i>	13
CLEOCIN CREA, SUPP	9	CUPRIMINE	13	<i>desmopressin acetate inj, tabs</i>	29
CLEOCIN GALAXY	9	CURITY GAUZE PADS 2"X2"	33	<i>desmopressin acetate nasal soln 0.01%</i>	29
CLEOCIN PEDIATRIC GRANULES	9	<i>cyclobenzaprine hcl</i>	35	<i>desonide</i>	28
<i>clindamycin hcl</i>	9	<i>cyclophosphamide</i>	16	<i>desoximetasone crea 0.25%</i>	28
<i>clindamycin phosphate</i>	26	<i>cyclosporine</i>	30	<i>desoximetasone gel, oint</i>	28
<i>clindamycin phosphate add-vantage</i>	9	<i>cyclosporine modified caps 100mg</i>	30	Deterrents	14
<i>clindamycin phosphate crea</i>	9	CYCLOSPORINE MODIFIED CAPS 50MG	30	DETROL LA CP24 2MG	28
<i>clobetasol propionate</i>	28	.....	30	DETROL LA CP24 4MG	28
<i>clobetasol propionate e</i>	28	<i>cyclosporine modified soln</i>	30	DEXAMETHASONE ELIX.....	32
CLOLAR.....	16	CYKLOKAPRON.....	23	<i>dexamethasone sodium phosphate</i>	32, 33
<i>clomipramine hcl</i>	13	CYMBALTA.....	13	DEXAMETHASONE TABS 0.5MG, 0.75MG, 1MG, 2MG	32
<i>clonidine hcl tabs</i>	23	CYSTADANE.....	27	<i>dexamethasone tabs 1.5mg, 4mg, 6mg</i>	32
<i>clotrimazole</i>	14	CYSTAGON	27	<i>dexamethylphenidate hcl</i>	26
<i>clotrimazole/betamethasone dipropionate</i> ...14		<i>cytarabine</i>	16	<i>dextroamphetamine sulfate</i>	26
<i>clozapine tabs 100mg, 25mg, 50mg</i>	18	<i>cytarabine aqueous inj 100mg/ml</i>	16	<i>dextroamphetamine sulfate er</i>	26
CLOZAPINE TABS 200MG.....	18	CYTARABINE AQUEOUS INJ 20MG/ML	16	<i>dextrose 10% flex container</i>	33
Coagulants	23	.....	16	<i>dextrose 10%/nacl 0.2%</i>	35
<i>codeine sulfate</i>	7	CYTOVENE.....	19	<i>dextrose 2.5%/sodium chloride 0.45%</i>	35
<i>co-gesic</i>	7			<i>dextrose 5%</i>	33
COLCRYS	15	D			
<i>colestipol hcl</i>	25	<i>danazol</i>	29	<i>diclofenac potassium</i>	8
<i>colocort</i>	32	DAPSONE.....	15	<i>diclofenac sodium</i>	8, 33
COLY-MYCIN M	9	DAPTACEL	31	DICLOFENAC SODIUM EC TBEC 25MG 8	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

<i>diclofenac sodium ec tbec 50mg</i>	8	<i>doxepin hcl caps 100mg, 10mg, 25mg, 50mg,</i> <i>75mg</i>	13	<i>325mg; 7.5mg, 500mg; 7.5mg</i>	7	
<i>diclofenac sodium xr</i>	8	<i>doxepin hcl conc</i>	13	<i>endocet tabs 650mg; 10mg</i>	7	
<i>dicloxacillin sodium</i>	10	<i>doxycycline hyclate caps, tabs</i>	10	ENGERIX-B	31	
<i>dicyclomine hcl caps, tabs</i>	27	DOXYCYCLINE HYCLATE CPEP 75MG		ENTOCORT EC	32	
<i>dicyclomine hcl inj, oral soln</i>	27	.....	10	Enzyme Replacements/ Modifiers	26, 27
<i>didanosine</i>	20	<i>doxycycline hyclate inj</i>	10	EIPEN 2-PAK	35	
<i>digoxin inj</i>	24	<i>doxycycline monohydrate tabs 50mg, 75mg</i>	10	EIPEN-JR 2-PAK	35	
DIGOXIN ORAL SOLN	24	<i>dronabinol</i>	14	EPIVIR	20	
<i>digoxin tabs</i>	24	DROXIA.....	16	EPIVIR HBV	20	
<i>dihydroergotamine mesylate</i>	15	DUETACT	21	EPOGEN	23	
DILANTIN CAPS 30MG	12	DULERA.....	34	EPZICOM	20	
DILANTIN INFATABS	11	DYRENIUM.....	24	<i>ergoloid mesylates</i>	12	
<i>diltiazem cd</i>	24	Dyslipidemics	25	ERGOMAR.....	15	
<i>diltiazem hcl er</i>	24			<i>ergotamine tartrate/caffeine</i>	15	
DILTIAZEM HCL INJ 100MG.....	24	E			<i>ery</i>	10
<i>diltiazem hcl inj 25mg/5ml</i>	24	<i>e.e.s. 400</i>	10	ERYTHROCIN LACTOBIONATE	10	
<i>diltiazem hcl tabs</i>	24	EDURANT	19	<i>erythromycin</i>	10	
DIOVAN.....	25	ELAPRASE.....	27	<i>erythromycin base</i>	10	
DIOVAN HCT.....	25	Electrolytes/Minerals	35	<i>estradiol</i>	29	
<i>diphenhydramine hcl</i>	34	ELESTAT	33	Estrogens	29	
<i>diphenoxylate/atropine</i>	27	ELIDEL	26	<i>ethambutol hcl</i>	15	
DIPHThERIA/TETANUS TOXOID		ELITEK	16	<i>ethosuximide</i>	11	
PEDIATRIC.....	31	ELLA	29	ETHYOL.....	16	
DIPROLENE AF	28	ELMIRON.....	28	<i>etodolac</i>	7	
<i>dipyridamole</i>	23	EMCYT	16	<i>etodolac er</i>	7	
<i>disopyramide phosphate</i>	23	EMEND CAPS 0.....	14	<i>etoposide</i>	16	
Diuretics	24	EMEND CAPS 125MG	14	EVISTA.....	29	
<i>divalproex sodium</i>	11	EMEND CAPS 40MG, 80MG	14	EXJADE.....	13	
<i>divalproex sodium er</i>	11	EMSAM	12	F		
DOCEFREZ.....	16	EMTRIVA.....	20	FABRAZYME	27	
DOCETAXEL CONC, SOLN	16	ENABLEX TB24 15MG.....	28	<i>famciclovir</i>	21	
<i>donepezil hcl</i>	12	ENABLEX TB24 7.5MG.....	28	<i>famotidine inj, tabs</i>	27	
<i>dorzolamide hcl</i>	33	<i>enalapril maleate/hydrochlorothiazide</i>	25	FANAPT	18	
<i>dorzolamide hcl/timolol maleate</i>	33	ENBREL.....	30	FANAPT TITRATION PACK	18	
DOVONEX.....	26	<i>endocet tabs 325mg; 10mg, 325mg; 5mg,</i>		FARESTON	16	
<i>doxazosin mesylate</i>	28					

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

FASLODEX.....	16	<i>fluphenazine decanoate</i>	19	<i>galantamine hydrobromide tabs 12mg, 4mg</i>	12	
FAZACLO.....	18	FLUPHENAZINE HCL CONC, ELIX, INJ	19	<i>galantamine hydrobromide tabs 8mg</i>	12	
<i>felbamate</i>	11	<i>fluphenazine hcl tabs</i>	19	Gamma-aminobutyric Acid (GABA)		
FELBATOL.....	11	<i>flurbiprofen</i>	8	Augmenting Agents	11	
<i>felodipine er</i>	24	<i>flurbiprofen sodium</i>	33	GAMMAGARD LIQUID.....	31	
FEMARA.....	17	<i>flutamide</i>	30	GAMUNEX	31	
<i>fenofibrate micronized</i>	25	<i>fluticasone propionate</i>	28, 34	GANCICLOVIR	19	
<i>fenofibrate tabs 54mg</i>	25	<i>fluvoxamine maleate</i>	13	GARDASIL.....	31	
<i>fentanyl</i>	7	FORTAZ.....	10	GASTROCROM.....	27	
<i>fentanyl citrate</i>	7	FORTEO.....	32	Gastrointestinal Agents	27	
<i>fentanyl citrate oral transmucosal</i>	7	FOSAMAX SOLN	32	Gastrointestinal Agents, Other	27	
<i>fexofenadine hcl</i>	34	FOSCARNET SODIUM.....	19	GEMCITABINE	16	
<i>finasteride</i>	28	<i>fosphenytoin sodium</i>	12	<i>gemfibrozil</i>	25	
<i>flecainide acetate</i>	23	FRAGMIN INJ 10000UNIT/ML, 7500UNIT/0.3ML	22	GEMZAR.....	16	
FLOVENT DISKUS AEPB 100MCG/BLIST, 250MCG/BLIST	34	FRAGMIN INJ 25000UNIT/ML	22	<i>gengraf</i>	30	
FLOVENT DISKUS AEPB 50MCG/BLIST	34	FRAGMIN INJ 2500UNIT/0.2ML, 5000UNIT/0.2ML	22	Genitourinary Agents	28	
FLOVENT HFA	34	<i>furosemide inj, tabs</i>	24	Genitourinary Agents, Other	28	
<i>fluconazole</i>	14	<i>furosemide oral soln 10mg/ml</i>	24	<i>gentamicin sulfate</i>	8	
<i>fluconazole in dextrose</i>	14	FUROSEMIDE ORAL SOLN 8MG/ML....	24	GENTAMICIN SULFATE/0.9% SODIUM CHLORIDE INJ 0.9MG/ML; 0.9%, 1.4MG/ML; 0.9%	9	
<i>fludrocortisone acetate</i>	28	FUSILEV.....	36	<i>gentamicin sulfate/0.9% sodium chloride inj</i> <i>1.6mg/ml; 0.9%, 1mg/ml; 0.9%</i>	9	
FLUMADINE.....	20	FUZEON	20	<i>gentamicin sulfate/sodium chloride</i>	9	
<i>flunisolide</i>	34	G			GEODON CAPS 20MG	18
<i>fluocinolone acetonide crea 0.01%</i>	28	<i>gabapentin caps 100mg</i>	11	GEODON CAPS 40MG	18	
FLUOCINOLONE ACETONIDE CREA 0.025%	28	<i>gabapentin caps 300mg</i>	11	GEODON CAPS 60MG, 80MG	18	
FLUOCINOLONE ACETONIDE OINT, SOLN.....	28	<i>gabapentin caps 400mg</i>	11	GEODON INJ	18	
<i>fluorouracil</i>	26	<i>gabapentin soln</i>	11	GILENYA	31	
FLUOROURACIL.....	16	<i>gabapentin tabs 600mg</i>	11	GLEEVEC.....	17	
<i>fluoxetine hcl caps 10mg, 20mg</i>	13	<i>gabapentin tabs 800mg</i>	11	<i>glimepiride</i>	21	
<i>fluoxetine hcl caps 40mg</i>	13	GABITRIL	11	<i>glipizide</i>	21	
<i>fluoxetine hcl soln</i>	13	<i>galantamine hydrobromide cp24 16mg, 24mg</i>	12	<i>glipizide er</i>	21	
<i>fluoxetine hcl tabs 10mg</i>	13	<i>galantamine hydrobromide cp24 8mg</i>	12	GLUCAGEN HYPOKIT	22	
<i>fluoxetine hcl tabs 20mg</i>	13	<i>galantamine hydrobromide soln</i>	12	Glucocorticoids	32	
				Glucocorticoids/ Mineralocorticoids	28	

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Glutamate Pathway Modifiers	12
Glutamate Reducing Agents	11
<i>glyburide micronized tabs 6mg</i>	21
<i>glyburide tabs 1.25mg, 5mg</i>	21
<i>glyburide tabs 2.5mg</i>	21
Glycemic Agents	22
<i>glycopyrrolate</i>	27
GLYSET	21
GOLYTELY SOLR 236GM; 2.97GM; 6.74GM; 5.86GM; 22.74GM.....	27
<i>granisetron hcl</i>	14
<i>granisol</i>	14
GRIFULVIN V	14
<i>griseofulvin microsize</i>	14
<i>guanfacine hcl</i>	23
GUANIDINE HCL	15

H

HALAVEN	16
<i>haloperidol</i>	19
<i>haloperidol decanoate</i>	19
<i>haloperidol lactate</i>	19
HAVRIX.....	31
HECTOROL CAPS 0.5MCG, 2.5MCG	32
HECTOROL INJ	32
<i>heparin sodium inj 10000unit/ml, 1000unit/ml, 5000unit/ml</i>	22
HEPARIN SODIUM INJ 20000UNIT/ML, 2000UNIT/ML, 2500UNIT/ML	22
HEPSERA.....	20
HEXALEN.....	15
Histamine2 (H2) Blocking Agents	27
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	28
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)	28

Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	29
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)	29
Hormonal Agents, Suppressant (Adrenal)	29, 30
Hormonal Agents, Suppressant (Parathyroid)	30
Hormonal Agents, Suppressant (Pituitary)	30
Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)	30
Hormonal Agents, Suppressant (Thyroid)	30
HUMIRA.....	30
HUMIRA PEN-CROHNS DISEASESTARTER	30
HYCAMTIN.....	16
<i>hydralazine hcl</i>	25
<i>hydrochlorothiazide caps</i>	24
<i>hydrochlorothiazide tabs 25mg, 50mg</i>	24
<i>hydrocodone bitartrate/acetaminophen tabs 750mg; 10mg</i>	7
<i>hydrocodone/acetaminophen soln</i>	7
<i>hydrocodone/acetaminophen tabs 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg, 500mg; 10mg, 500mg; 2.5mg, 500mg; 5mg, 500mg; 7.5mg</i>	7
<i>hydrocodone/acetaminophen tabs 650mg; 10mg, 650mg; 7.5mg</i>	7
<i>hydrocodone/acetaminophen tabs 660mg; 10mg, 750mg; 7.5mg</i>	7
<i>hydrocodone/ibuprofen</i>	7
<i>hydrocortisone</i>	28, 32
<i>hydromorphone hcl inj</i>	7

<i>hydromorphone hcl tabs</i>	7
<i>hydroxychloroquine sulfate</i>	17
<i>hydroxyurea</i>	16

I

<i>ibuprofen</i>	8
<i>ifosfamide</i>	15
<i>ifosfamide/mesna</i>	15
ILARIS	31
<i>imipramine hcl</i>	13
<i>imiquimod</i>	26
Immune Suppressants	30
Immunizing Agents, Passive	31
Immunological Agents	30
Immunomodulators	31
IMOVAX RABIES (H.D.C.V.)	31
INCIVEK	20
INCRELEX	29
<i>indapamide</i>	24
<i>indomethacin</i>	7
INFANRIX.....	31
Inflammatory Bowel Disease Agents	32
Insulins	22
INTELENCE TABS 100MG	19
INTELENCE TABS 200MG	19
<i>intralipid inj 2.25%; 20%</i>	33
INTRON-A	31
INTRON-A W/DILUENT	31
INVEGA SUSTENNA.....	18
INVEGA TB24 1.5MG, 3MG, 9MG	18
INVEGA TB24 6MG.....	18
INVIRASE	20
IPOL INACTIVATED IPV	31
<i>ipratropium bromide</i>	34
IRESSA	17
Irritable Bowel Syndrome Agents	27

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

ISENTRESS.....	20
ISONIAZID SYRP	15
<i>isoniazid tabs</i>	15
<i>isosorbide dinitrate</i>	25
<i>isosorbide dinitrate er</i>	25
<i>isosorbide mononitrate</i>	25
<i>isosorbide mononitrate er</i>	25
<i>isotonic gentamicin</i>	9
<i>itraconazole</i>	14
IXEMPRA KIT.....	16
IXIARO.....	31

J

JAKAFI.....	16
JALYN.....	28
<i>jantoven</i>	22
JANUMET.....	21
JANUVIA	21
JE-VAX.....	31
JUVISYNC	21

K

KALETRA.....	20
<i>kariva</i>	29
<i>kcl 0.3%/d5w/lr iv lac ring</i>	35
KEPPRA INJ	11
KEPPRA TABS 1000MG.....	11
KEPPRA XR.....	11
<i>ketoconazole</i>	14
<i>ketoprofen</i>	7
<i>ketorolac tromethamine</i>	33
<i>ketorolac tromethamine inj</i>	7, 8
KINERET	31
KOMBIGLYZE	21
KUVAN.....	35

L

<i>labetalol hcl</i>	24
LACRISERT	33
<i>lactated ringers</i>	35
<i>lactated ringers irrigation</i>	35
<i>lactulose</i>	27
LAMICTAL ODT	11
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	21
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	11
LAMICTAL STARTER/TAKING VALPROATE	11
LAMICTAL XR.....	11
LAMISIL SOLN	14
<i>lamivudine</i>	20
<i>lamivudine/zidovudine tabs</i>	20
<i>lamotrigine</i>	11
LANOXIN INJ 0.1MG/ML.....	24
<i>lansoprazole</i>	27
<i>lansoprazole odt</i>	27
LANTUS	22
LASTACFT	33
<i>latanoprost</i>	34
LATUDA.....	18
<i>leflunomide</i>	31
LETAIRIS	35
<i>leucovorin calcium inj</i>	36
LEUCOVORIN CALCIUM TABS 10MG, 15MG.....	36
<i>leucovorin calcium tabs 25mg, 5mg</i>	36
LEUKERAN.....	15
LEUKINE.....	23
<i>leuprolide acetate</i>	30

LEVAQUIN INJ 5%; 750MG/150ML	10
LEVAQUIN ORAL SOLN, TABS.....	10
LEVEMIR.....	22
<i>levetiracetam</i>	11
<i>levetiracetam er</i>	11
<i>levobunolol hcl</i>	34
levofloxacin.....	10
<i>levorphanol tartrate</i>	7
<i>levothroid</i>	29
<i>levothyroxine sodium</i>	29
<i>levoxyl</i>	29
LEXAPRO SOLN.....	13
LEXAPRO TABS 10MG, 5MG	13
LEXAPRO TABS 20MG.....	13
LEXIVA	20
<i>lidocaine</i>	8
<i>lidocaine hcl inj, external soln</i>	8
<i>lidocaine hcl jelly</i>	8
<i>lidocaine/prilocaine</i>	8
LIDODERM.....	8
LINCOCIN.....	9
<i>lindane</i>	17
<i>liothyronine sodium</i>	29
<i>lisinopril</i>	25
<i>lisinopril/hydrochlorothiazide</i>	25
<i>lithium carbonate caps 150mg, 300mg</i>	21
LITHIUM CARBONATE CAPS 600MG ..	21
<i>lithium carbonate er</i>	21
LITHIUM CARBONATE TABS	21
<i>lithium citrate</i>	21
Local Anesthetics	8
LOCOID LIPOCREAM.....	28
LODOSYN.....	18
<i>loperamide hcl</i>	27
<i>losartan potassium</i>	25
<i>losartan potassium/hydrochlorothiazide</i>	25

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

LOTEMAX.....	33
LOTRONEX.....	27
lovastatin.....	25
LOVAZA.....	25
LOVENOX INJ 100MG/ML, 120MG/0.8ML, 80MG/0.8ML.....	22
LOVENOX INJ 150MG/ML, 300MG/3ML, 40MG/0.4ML, 60MG/0.6ML.....	22
LOVENOX INJ 30MG/0.3ML.....	22
loxapine succinate.....	19
LUMIGAN SOLN 0.01%.....	34
LUMIGAN SOLN 0.03%.....	34
LUMIZYME.....	27
LUPRON DEPOT.....	30
LUPRON DEPOT-PED.....	30
LYRICA.....	11
LYSODREN.....	30

M

Macrolides	10
magnesium sulfate.....	36
magnesium sulfate in d5w.....	36
MALARONE.....	17
MAPROTILINE HCL.....	13
margesic-h.....	7
MARPLAN.....	13
Mast Cell Stabilizers	35
MATULANE.....	15
MAXALT.....	15
MAXALT-MLT.....	15
mebendazole.....	17
meclizine hcl.....	34
medroxyprogesterone acetate.....	29
mefloquine hcl.....	17
megestrol acetate.....	29
MELOXICAM SUSP.....	8

meloxicam tabs.....	8
melphalan hydrochloride.....	16
MENACTRA.....	31
MENOMUNE-A/C/Y/W-135.....	31
MENVEO.....	31
meprobamate.....	21
MEPRON.....	17
mercaptapurine.....	16
meropenem.....	10
mesalamine.....	32
MESNEX.....	16
Metabolic Bone Disease Agents	32
metaproterenol sulfate syrp.....	35
METAPROTERENOL SULFATE TABS.....	35
metformin hcl.....	21
metformin hcl er.....	21
methadone hcl conc.....	7
METHADONE HCL INJ, ORAL SOLN.....	7
methadone hcl tabs.....	7
methazolamide.....	34
methimazole.....	30
methocarbamol.....	35
methotrexate.....	30
methotrexate sodium.....	30
methyl dopa.....	23
methyl dopa/hydrochlorothiazide.....	23
methylin er.....	26
methylin tabs.....	26
methylphenidate hcl.....	26
methylphenidate hcl sr.....	26
methylprednisolone acetate.....	32
methylprednisolone sodiumsuccinate.....	32
methylprednisolone tabs 4mg, 8mg.....	32
metoclopramide hcl.....	14
metoclopramide hcl inj, oral soln.....	27
metoclopramide hcl tabs.....	27

metolazone.....	24
metoprolol succinate er.....	24
metoprolol tartrate.....	24
metronidazole caps, crea.....	9
metronidazole tabs.....	9
metronidazole vaginal.....	9
MIACALCIN INJ.....	32
MIACALCIN NASAL SOLN.....	32
midodrine hcl.....	23
MIGRANAL.....	15
minocycline hcl.....	11
minoxidil.....	26
mirtazapine odt.....	12
mirtazapine tabs 15mg, 7.5mg.....	12
mirtazapine tabs 30mg, 45mg.....	12
mirtazapine tbdp.....	12
Miscellaneous Therapeutic Agents	32
misoprostol.....	27
M-M-R II W/DILUENT 10 DOSE.....	31
Molecular Target Inhibitors	17
mometasone furoate.....	28
Monoamine Oxidase Inhibitors	12
Monoclonal Antibodies	17
morphine sulfate er tb12 100mg, 15mg, 30mg, 60mg.....	8
morphine sulfate er tb12 200mg.....	8
morphine sulfate inj 0.5mg/ml, 1mg/ml.....	8
MORPHINE SULFATE INJ 5MG/ML.....	8
morphine sulfate tabs.....	8
MOXEZA.....	10
MULTAQ.....	23
mupirocin.....	9
MUSTARGEN.....	16
MYCAMINE.....	14
MYCOBUTIN.....	15
mycophenolate mofetil.....	30

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

N

nabumetone8
nadolol24
nafcillin sodium inj 1gm.....10
 NAFTIN.....14
 NAGLAZYME27
naloxone hcl.....14
naltrexone hcl.....14
 NAMENDA SOLN.....12
 NAMENDA TABS.....12
 NAMENDA TITRATION PAK.....12
naproxen8
naproxen dr.....8
naproxen sodium.....7
 NARDIL13
 NATACYN33
nateglinide.....21
nefazodone hcl12
neomycin sulfate.....9
neomycin/polymyxin/dexamethasone33
neomycin/polymyxin/hc.....34
neomycin/polymyxin/hydrocortisone33, 34
 NEULASTA23
 NEUMEGA.....23
 NEUPOGEN23
 NEXAVAR17
next choice29
niacor25
 NIASPAN25
 NICOTROL INHALER.....14
 NICOTROL NS14
nifediac cc24
nifedical xl.....24
nifedipine caps 10mg24
 NIFEDIPINE CAPS 20MG24

nifedipine er.....24
 NILANDRON30
nitrofurantoin macrocrystalline9
nitrofurantoin monohydrate9
nitroglycerin26
nitroglycerin transdermal.....26
 NITROLINGUAL PUMPSPRAY26
 NITROSTAT26
Non-amphetamines, ADHD26
Non-amphetamines, Other.....26
Nonsteroidal Anti-inflammatory Drugs 7, 8
nortriptyline hcl.....13
 NORVIR.....20
 NOVANTRONE16
novarel.....29
 NOVOLIN 70/30.....22
 NOVOLIN N22
 NOVOLIN R22
 NOVOLOG22
 NOVOLOG MIX 70/3022
 NULOJIX30
 NUVIGIL26
nystatin14
nystatin/triamcinolone14
nystop.....15

O

octreotide acetate30
ofloxacin soln, tabs.....10
olanzapine.....18
omeprazole cpdr27
 OMNARIS.....34
ondansetron hcl inj, oral soln.....14
ondansetron hcl tabs 24mg.....14
ondansetron hcl tabs 4mg, 8mg.....14
ondansetron odt14

ONGLYZA22
 ONTAK.....16
Ophthalmic Agents.....33
Ophthalmic Agents, Other33
Ophthalmic Anti-allergy Agents.....33
Ophthalmic Antiglaucoma Agents.....33
Ophthalmic Anti-inflammatories33
Ophthalmic Prostaglandin and Prostanoid Analogs.....34
Opioid Analgesics7
 OPTIVAR33
 ORAP19
 ORAPRED ODT.....32
 ORENCIA30
 ORFADIN.....27
Otic Agents.....34
 OVIDE17
oxandrolone.....29
oxaprozin.....7
oxcarbazepine12
 OXSORALEN.....26
 OXSORALEN ULTRA26
oxybutynin chloride er.....28
oxybutynin chloride tabs28
oxycodone hcl tabs8
oxycodone/acetaminophen caps.....8
oxycodone/acetaminophen tabs 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg, 500mg; 7.5mg.....8
oxycodone/acetaminophen tabs 650mg; 10mg8

P

PACERONE TABS 100MG, 400MG.....23
pacerone tabs 200mg23
pamidronate disodium inj 30mg/10ml,

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

90mg/10ml.....	32	PLAVIX TABS 75MG.....	23	.....	33
PAMIDRONATE DISODIUM INJ 6MG/ML		<i>podofilox</i>	26	PREDNISONE SOLN	32
.....	32	<i>potassium chloride 0.075%/d5w/nacl 0.225%</i>		<i>prednisone tabs 10mg, 1mg, 2.5mg, 20mg,</i>	
PANRETIN.....	17	.....	36	5mg.....	32
<i>pantoprazole sodium</i>	27	POTASSIUM CHLORIDE 0.15% /NACL		PREDNISONE TABS 50MG	32
Parasympathomimetics	15	0.45% VIAFLEX.....	36	PREMARIN	29
<i>paromomycin sulfate</i>	9	<i>potassium chloride 0.15% d5w/nacl 0.33%</i>	36	PREMARIN W/APPLICATOR.....	29
<i>paroxetine hcl</i>	13	<i>potassium chloride 0.15% d5w/nacl 0.45%</i>		PREMPHASE	29
<i>paroxetine hcl er</i>	13	<i>viaflex</i>	36	PREMPRO	29
PASER.....	15	<i>potassium chloride 0.15% nacl 0.9%</i>	36	<i>prenatabs obn</i>	36
Pediculicides/ Scabicides	17	<i>potassium chloride 0.15%/d5w</i>	36	<i>prevalite</i>	25
PEDVAX HIB	31	<i>potassium chloride 0.22% d5w/nacl 0.45%</i>	36	PREZISTA TABS 150MG	20
PEGANONE.....	12	<i>potassium chloride 0.224%/d5w</i>	36	PREZISTA TABS 400MG, 600MG, 75MG20	
PEGASYS INJ 180MCG/0.5ML.....	31	POTASSIUM CHLORIDE		PRIFTIN.....	15
PEGASYS PROCLICK.....	31	0.224% D5W/NACL 0.33%	36	PRIMAQUINE PHOSPHATE.....	17
<i>penicillin g potassium</i>	10	POTASSIUM CHLORIDE 0.3%/ NACL		PRIMAXIN I.M.	10
<i>penicillin v potassium</i>	10	0.9%	36	PRIMAXIN IV.....	10
<i>pentazocine/acetaminophen</i>	8	<i>potassium chloride 0.3%/d5w</i>	36	<i>primidone</i>	11
<i>pentazocine/naloxone hcl</i>	8	<i>potassium chloride er cpcr 10meq</i>	36	PRIMSOL	9
<i>pentostatin</i>	16	<i>potassium chloride er tbc</i>	36	PRISTIQ TB24 100MG	13
<i>pentoxifylline er</i>	23	<i>potassium chloride inj 0.4meq/ml,</i>		PRISTIQ TB24 50MG	13
<i>permethrin</i>	17	10meq/100ml, 2meq/ml, 30meq/100ml....	36	<i>probenecid</i>	15
<i>perphenazine</i>	19	POTASSIUM CHLORIDE INJ		<i>probenecid/colchicine</i>	15
<i>perphenazine/amitriptyline</i>	19	10MEQ/50ML	36	PROCAINAMIDE HCL	23
<i>phenytoin</i>	12	<i>potassium chloride sr</i>	36	<i>prochlorperazine</i>	14
<i>phenytoin sodium</i>	12	<i>potassium citrate extended-release</i>	36	<i>prochlorperazine edisylate</i>	14
<i>phenytoin sodium extended</i>	12	PRADAXA.....	22	<i>prochlorperazine maleate</i>	14
Phosphate Binders	28	<i>pramipexole dihydrochloride tabs 0.125mg,</i>		PROCRIT INJ 10000UNIT/ML,	
PHOSPHOLINE IODIDE	34	0.25mg, 0.5mg, 1.5mg, 1mg.....	18	2000UNIT/ML	23
<i>physiolyte</i>	36	PRANDIN	22	PROCRIT INJ 20000UNIT/ML	23
<i>physiosol irrigation</i>	36	<i>pravastatin sodium tabs</i>	25	PROCRIT INJ 3000UNIT/ML,	
<i>pilocarpine hcl</i>	26	<i>prazosin hcl</i>	23	4000UNIT/ML	23
<i>pilocarpine hydrochloride</i>	26	PRECOSE.....	22	PROCRIT INJ 40000UNIT/ML	23
PILOPINE HS.....	34	<i>prednisolone acetate</i>	33	<i>proctocream hc</i>	28
<i>piroxicam</i>	8	<i>prednisolone sodium phosphate</i>	32	Progestins	29
Platelet Aggregation Inhibitors	23	PREDNISOLONE SODIUM PHOSPHATE		PROGLYCEM	22

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

PROGRAF.....	30
PROLASTIN.....	35
PROLEUKIN.....	16
PROLIA.....	32
PROMACTA.....	23
<i>promethazine hcl inj 25mg/ml.....</i>	<i>34</i>
<i>promethazine hcl supp, syrp.....</i>	<i>14</i>
<i>promethazine hcl tabs.....</i>	<i>14, 34</i>
<i>promethegan.....</i>	<i>14</i>
<i>propafenone hcl.....</i>	<i>23</i>
<i>propranolol hcl inj, tabs.....</i>	<i>24</i>
PROPRANOLOL HCL ORAL SOLN.....	24
<i>propranolol/hydrochlorothiazide tabs 25mg;</i>	
<i>40mg.....</i>	<i>24</i>
PROPRANOLOL/HYDROCHLOROTHIAZI	
DE TABS 25MG; 80MG.....	24
<i>propylthiouracil.....</i>	<i>30</i>
PROQUAD.....	31
Protectants.....	27
Proton Pump Inhibitors.....	27
PROTONIX INJ.....	28
PROTOPIC.....	26
<i>protriptyline hcl.....</i>	<i>13</i>
Pulmonary Antihypertensives.....	35
PULMOZYME.....	27
<i>pyrazinamide.....</i>	<i>15</i>
<i>pyridostigmine bromide.....</i>	<i>15</i>

Q

QUALAQUIN.....	17
<i>quinapril hcl.....</i>	<i>25</i>
<i>quinapril/hydrochlorothiazide.....</i>	<i>25</i>
<i>quinidine gluconate er.....</i>	<i>23</i>
<i>quinidine sulfate.....</i>	<i>23</i>
QUINIDINE SULFATE ER.....	23
Quinolones.....	10

R

RABAVERT.....	31
<i>ramipril.....</i>	<i>25</i>
RANEXA.....	24
<i>ranitidine hcl caps, tabs.....</i>	<i>27</i>
<i>ranitidine hcl inj.....</i>	<i>27</i>
RAPAMUNE SOLN.....	30
RAPAMUNE TABS 1MG, 2MG.....	30
RECLAST.....	32
RECOMBIVAX HB.....	31
REGRANEX.....	26
RELENZA DISKHALER.....	20
RELISTOR.....	13
REMICADE.....	30
Renin-angiotensin-aldosterone System	
Inhibitors.....	25
RENVELA TABS.....	28
RESCRIPTOR.....	19
Respiratory Tract Agents.....	34
Respiratory Tract Agents, Other.....	35
RESTASIS.....	33
Retinoids.....	17
RETROVIR.....	20
RETROVIR IV INFUSION.....	20
REVATIO TABS.....	35
REVLIMID.....	16
REYATAZ.....	20
<i>ribasphere.....</i>	<i>20</i>
<i>ribavirin.....</i>	<i>20</i>
RIDAURA.....	31
<i>rifampin.....</i>	<i>15</i>
RILUTEK.....	26
<i>rimantadine hcl.....</i>	<i>20</i>
<i>ringers irrigation.....</i>	<i>36</i>
RISPERDAL CONSTA.....	18

<i>risperidone odt tbdp 0.25mg.....</i>	<i>18</i>
<i>risperidone odt tbdp 0.5mg, 1mg, 2mg, 3mg,</i>	
<i>4mg.....</i>	<i>18</i>
<i>risperidone soln.....</i>	<i>18</i>
<i>risperidone tabs 0.25mg, 0.5mg.....</i>	<i>18</i>
<i>risperidone tabs 1mg, 2mg, 3mg.....</i>	<i>18</i>
<i>risperidone tabs 4mg.....</i>	<i>18</i>
RITUXAN.....	17
<i>rivastigmine tartrate caps 1.5mg.....</i>	<i>12</i>
<i>rivastigmine tartrate caps 3mg.....</i>	<i>12</i>
<i>rivastigmine tartrate caps 4.5mg, 6mg.....</i>	<i>12</i>
<i>romycin.....</i>	<i>33</i>
<i>ropinirole hcl.....</i>	<i>18</i>
ROTATEQ.....	31

S

SABRIL.....	11
Salicylates.....	32
SAMSCA.....	24
SANCTURA XR.....	28
SANDOSTATIN LAR DEPOT.....	30
SANTYL.....	26
SAPHRIS.....	21
SAVELLA.....	13
SAVELLA TITRATION PACK.....	13
Sedatives/Hypnotics.....	35
Selective Estrogen Receptor Modifying	
Agents.....	29
<i>selegiline hcl caps.....</i>	<i>18</i>
SELEGILINE HCL TABS.....	18
<i>selenium sulfide.....</i>	<i>26</i>
SELSUN SHAMPOO.....	26
SELZENTRY.....	20
SENSIPAR.....	30
SEREVENT DISKUS.....	35
SEROMYCIN.....	15

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

TOBI.....	9	TRUVADA.....	20	<i>verapamil hcl</i>	24	
TOBRADEX.....	33	TWINRIX.....	31	<i>verapamil hcl er</i>	23, 24	
<i>tobramycin sulfate</i>	9	TYGACIL.....	9	VEREGEN.....	26	
<i>tolnaftate</i>	36	TYKERB.....	16	VESICARE.....	28	
<i>tolnaftate 1% antifungal</i>	36	TYPHIM VI.....	31	VICTRELIS.....	20	
<i>topiramate</i>	11	TYZEKA.....	20	VIDAZA.....	16	
<i>torsemide tabs</i>	25	TYZINE.....	35	VIDEX EC.....	20	
Toxicologic Agents	14	TYZINE PEDIATRIC NASAL DROPS.....	35	VIDEX PEDIATRIC.....	20	
<i>tpn electrolytes</i>	36			VIIBRYD.....	13	
TRACLEER.....	35	U			VIMOVO.....	8
TRADJENTA.....	22	ULORIC.....	15	VIMPAT.....	11	
<i>tramadol hcl</i>	8	<i>unithroid</i>	29	VIRACEPT.....	20	
<i>tranylcypromine sulfate</i>	13	<i>ursodiol caps</i>	27	VIRAMUNE.....	20	
TRAVATAN Z.....	34			VIRAMUNE XR.....	20	
<i>trazodone hcl</i>	12	V			VIREAD.....	20
TREANDA.....	16	Vaccines	31	VIROPTIC.....	21	
TRECATOR.....	15	<i>valacyclovir hcl</i>	21	VISICOL.....	27	
<i>tretinoin</i>	26	VALCYTE.....	19	Vitamins	36	
TRETINOIN.....	17	<i>valproate sodium</i>	11	VOLTAREN.....	7, 33	
TREXIMET.....	7	<i>valproic acid</i>	11	VOTRIENT.....	16	
<i>triamcinolone acetonide</i>	28	VALTURNA.....	25	VPRIV.....	27	
TRIAMCINOLONE ACETONIDE IN ABSORBASE.....	28	VANCOGIN HCL.....	9	VYTORIN.....	25	
<i>triamcinolone in orabase</i>	26	<i>vancomycin hcl inj 1000mg</i>	9	W		
<i>triamterene/hydrochlorothiazide</i>	25	VANCOMYCIN HCL INJ 10GM.....	9	<i>warfarin sodium</i>	22	
Tricyclics	13	VANCOMYCIN HCL INJ 500MG.....	9	WELCHOL.....	25	
<i>trifluoperazine hcl</i>	19	VANDETANIB.....	16	X		
<i>trifluridine</i>	33	VAQTA.....	32	XALKORI.....	17	
<i>trihexyphenidyl hcl</i>	18	VARIVAX.....	32	XARELTO 10 MG.....	22	
TRIHIBIT.....	31	Vasodilators	25	XENAZINE.....	33	
<i>trimethoprim</i>	9	VECTICAL.....	26	XIFAXAN TABS 200MG.....	9	
<i>trimethoprim sulfate/polymyxin b sulfate</i>	33	VELCADE.....	16	XOLAIR.....	35	
<i>trinessa</i>	29	<i>venlafaxine hcl</i>	12	XYREM.....	26	
TRIPEDIA.....	31	<i>venlafaxine hcl er</i>	13			
TRISENOX.....	16	VENTAVIS.....	35			
TRIZIVIR.....	20	VENTOLIN HFA.....	35			

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances

Y

YERVOY.....	17
YF-VAX	32

Z

<i>zafirlukast</i>	34
<i>zaleplon</i>	35
ZANOSAR.....	16
ZAVESCA	27
ZELAPAR.....	18
ZELBORAF.....	17

ZERIT	20
ZETIA.....	25
ZIAGEN	20
<i>zidovudine</i>	20
ZIRGAN	19
ZOLINZA.....	17
<i>zolpidem tartrate</i>	35
ZOMETA	32
ZONALON.....	26
<i>zonisamide</i>	11
ZORTRESS	30
ZOSTAVAX.....	32
ZOSYN.....	10

<i>zovia 1/35e</i>	29
<i>zovia 1/50e</i>	29
ZOVIRAX.....	21
ZYFLO CR.....	34
ZYPREXA INJ.....	19
ZYPREXA TABS 10MG, 15MG, 20MG...	19
ZYPREXA TABS 2.5MG, 5MG, 7.5MG...	19
ZYPREXA ZYDIS TBDP 10MG, 15MG, 20MG	19
ZYPREXA ZYDIS TBDP 5MG.....	19
ZYTIGA	17
ZYVOX INJ, SUSR	9
ZYVOX TABS.....	9

PA=Prior Authorization required ST=Step Therapy LA=Limited Access QL=Quantity Limit

B/D= This drug may be covered under Medicare Part B or D depending upon the circumstances