



Regence

*Life and Health Insurance Company*

Independent Licensee of the Blue Cross and Blue Shield Association

# Regence Life and Health Medicare Script™ Regence Life and Health Medicare Script Enhanced™

Medicare Prescription Drug Plan  
**2009 Abridged Formulary**  
(Partial List of Covered Drugs)

Please review—This booklet contains information about some of the prescription drugs covered by this plan. This is not a complete list of covered drugs.

## **Welcome!**

This document includes a partial list of covered drugs on our formulary as of October 1, 2009. For a complete listing of all of the drugs we cover and/or updated information on the drugs we cover, please visit our website at the address on the back cover or call our Customer Service Department at 1-800-541-8981, 8 a.m. to 8 p.m., seven days a week for additional information. (TTY/TDD users should call 1-800-382-1003.)

**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.

## **What is the Formulary?**

A formulary is a list of drugs selected 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. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a 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 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 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, or add prior authorization, and/or quantity limits on a drug or move a drug to a higher cost-sharing tier, we must notify members who take the drug at least 60 days *before* the date that the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

To get updated information about the drugs we cover, please visit our website at the address on the back cover or call our Customer Service Department at 1-800-541-8981, 8 a.m. to 8 p.m., seven days a week for additional information. (TTY/TDD users should call 1-800-382-1003.)

## **How do I use the Formulary?**

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

### **Medical Condition**

The formulary begins on page 7. 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 45. 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?**

We provide coverage for both brand-name drugs and generic drugs. A generic drug has the same active-ingredient formula as the brand name drug. Generic drugs usually cost less than brand name drugs.

Generic drugs are listed in lower-case italics (for example *captopril*) within the formulary that begins on page 7. Brand-name drugs are capitalized in the formulary (for example VYTORIN).

## **Are there any other restrictions on coverage?**

Some covered drugs may have additional requirements or limits on coverage, including:

- **Prior Authorization:** Certain drugs require you to get prior authorization. (You may need prior authorization for drugs on the formulary or for drugs that are not on the formulary **and** were approved for coverage through our exceptions process.) This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, there is a limit on the amount of the drug we will cover. For example, we provide coverage for 12 tablets per a 30-day prescription for Imitrex. If your doctor wants to prescribe more than what is listed in the Notes column of the formulary, he/she must get an approval from us before we will cover the additional quantity.

You can find out if your drug has any additional requirements or limits by looking in the Notes column of the formulary that begins on page 7. You can ask us to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Formulary?", 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 ask if your drug is covered. This document includes only a partial list of covered drugs, so we may cover your drug but not list it in this document. You can contact our Customer Service Department at 1-800-541-8981 for additional information. (TTY/TDD users should call 1-800-382-1003.)

If you learn that we don't cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by us. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.
- You can ask us to make an exception and cover your drug. See the information below about how to request an exception.

## How do I request an exception to the Formulary?

You can ask us 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, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred brand drug, you can ask us to cover it as a preferred brand 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 Tier 5 (Specialty Medications) or Tier 2 (Preferred Brand Medications).

Generally, we will only approve your request for an exception for one of the following reasons:

- If the alternative drugs included on our formulary or additional utilization restrictions would not be as effective in treating your condition or cause you to have adverse medical effects.
- If the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition or 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 an exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your 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 prescribing physician's supporting statement.

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

If you are currently taking a medication that requires prior authorization or requires a greater quantity, we realize that you may need time to work with your healthcare provider in considering formulary alternatives or requesting authorization for coverage. Partnering with your doctor or healthcare provider is your best way of getting the most value from your Medicare Part D prescription benefit. You'll avoid expensive prescription costs by considering formulary options that have been proven to be equally effective and safe, but less expensive.

During your transition period (first 90 days of eligibility):

- For **new members and current members affected by formulary changes from one contract year to the next**, you can fill a temporary supply, (up to a 30-day supply) for the prescribed Part D medication during the first 90 days of eligibility, (unless the prescription is written by the prescriber for less than 30 days). After your first 30 day supply, we will not pay for these drugs even if you have been a member of our plan less than 90 days.

- For enrollees in **long-term care** facilities, you can fill a temporary supply, (up to a 31-day supply) for the prescribed Part D medication during the first 90 days of eligibility, (unless the prescription is written by the prescriber for less than 31 days). Also, additional refills during your 90-day transition may be provided, so you can work with your healthcare provider to find formulary medication options or request prior authorization.

If you are an enrollee in a **long-term care** facility and you are past the first 90 days of eligibility with our plan and you need a drug that is not on our formulary or if your ability to get your drugs is limited, 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.

- If you receive coverage for a temporary medication fill, we will notify you if prior authorization is needed for continued coverage of your medication.
- If you are a **current member** and have a change in treatment setting due to a change in the level of care you require, you can ask us to make an exception for these types of unplanned transitions.

Such transitions include:

- Discharge from a hospital to home;
- Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and you now need to use your Part D plan;
- Changing from Hospice Status and reverting back to standard Medicare Part A and B coverage;
- Discharges from chronic psychiatric hospitals with highly individualized drug regimens,

For these unplanned transitions, you can ask us to make an exception or appeal for continued coverage of your drug. In addition we will review requests for continuation of therapy on a case-by-case basis for members that have had a change in their level of care and are stabilized on drug regimens that if altered, are known to have risks.

Our formulary is an open formulary, meaning all Medicare covered Part D drugs are included within our formulary to provide comprehensive coverage to Medicare members.

### **For more information**

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

If you have questions about our plan, please call our Customer Service Department at 1-800-541-8981, 8 a.m. to 8 p.m., seven days a week for additional information. (TTY/TDD users should call 1-800-382-1003.)

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

## Tier Level Definitions

Regence Life & Health Medicare Script – Plan Benefits			
Tier Name	Tier Level	<sup>2</sup> Retail Cost-Sharing (1-30 day supplies)	<sup>2</sup> Mail Order Cost-Sharing (1-30 day supplies)
Generic	1	\$4	\$4
Preferred Brand	2	\$20	\$20
Non-Preferred Brand	3	\$40	\$40
<sup>1</sup> Miscellaneous Injectables	4	25%	25%
<sup>1</sup> Specialty	5	25%	25%

Regence Life & Health Medicare Script <i>Enhanced</i> – Plan Benefits			
Tier Name	Tier Level	<sup>2</sup> Retail Cost-Sharing (1-30 day supplies)	<sup>2</sup> Mail Order Cost-Sharing (1-30 day supplies)
<sup>3</sup> Generic	1	\$4	\$4
Preferred Brand	2	\$25	\$25
Non-Preferred Brand	3	\$50	\$50
<sup>1</sup> Miscellaneous Injectables	4	25%	25%
<sup>1</sup> Specialty	5	25%	25%

<sup>1</sup>Note – These tiers may contain generic products and are limited to a 30 day supply for retail and mail order (31 day supply for Long-Term care residents).

<sup>2</sup>Up to a 90 day supply of medication is available on most products at network retail pharmacies that agree to dispense up to a 90 day supply and mail order. Cost-sharing for these larger quantities is 2 to 3 times the cost-sharing shown for Tiers 1 through 3.

For example:

- 1-30 day supply of a generic product in Tier 1 would be \$4;
- 31-60 day supply of a generic product in Tier 1 would be \$8;
- 61-90 day supply of a generic product in Tier 1 would be \$12.

To locate a network retail pharmacy that can dispense up to a 90 day supply of medications or for more information regarding our mail order pharmacies, please refer to our pharmacy directory or visit our website at the address listed on the back cover.

<sup>3</sup>For Enhanced members, we provide coverage for Generic medications in Tier 1 during the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

## Our Formulary

The formulary that begins on the following pages provides coverage information about some of the drugs we cover. If you have trouble finding your drug in the list, turn to the index that begins on page 45. Remember: This is only a partial list of drugs we cover. If your prescription is not listed, please visit our website at the address on the back cover or call our Customer Service Department at 1-800-541-8981, 8 a.m. to 8 p.m., seven days a week for additional information. (TTY/TDD users should call 1-800-382-1003.)

The first column of the chart lists the drug name. Brand name drugs are capitalized (for example VYTORIN) and generic drugs are listed in lower-case italics (for example *captopril*).

The information in the “Notes” section tells you if there are any special requirements for coverage of your drug.

## **Formulary Legend**

### **FF** Free First Fill Medications

For our members on Regence Life & Health Medicare Script Enhanced, this prescription drug will be provided at no charge the first time you fill it.

### **GC** Gap Coverage Medications

For our members on Regence Life & Health Medicare Script Enhanced, we provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

### **HI** Home Infusion Therapy Medications

For members on our plans that cover both medical and Rx, this prescription drug may be covered under your medical benefit. For more information, call Customer Service at 1-800-541-8981, 8 a.m. to 8 p.m., seven days a week. (TTY/TDD Users should call 1-800-382-1003.)

### **LA** Limited Access Medications

This prescription drug may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at 1-800-541-8981, 8 a.m. to 8 p.m., seven days a week. (TTY/TDD users should call 1-800-382-1003.)

### **PA** Prior Authorization Medications

Prior Authorization required for coverage. Refer to the Notes section under your prescription drug for additional information.

### **QL** Quantity Level Limit Medications

Quantity Level limits apply. Refer to the Notes section under your prescription drug for additional information.

Drug Name	Drug Tier	Notes
<b>Analgesics</b>		
<b>Nonsteroidal Anti-inflammatory Drugs</b>		
<i>diclofenac potassium</i>	1	GC
<i>diclofenac sodium</i>	1	GC
<i>diclofenac sodium ec</i>	1	GC
<i>diflunisal</i>	1	GC
<i>etodolac</i>	1	FF GC
<i>fenoprofen calcium</i>	1	GC
<i>flurbiprofen</i>	1	GC
<i>ketoprofen</i>	1	GC
<i>ketorolac tromethamine tablet</i>	1	GC
<i>nabumetone</i>	1	FF GC
<i>naproxen dr</i>	1	FF GC
<i>oxaprozin</i>	1	GC
<b>Opioid Analgesics</b>		
<i>acetaminophen/codeine</i>	1	GC
<i>acetaminophen/codeine #2</i>	1	GC
<i>acetaminophen/codeine #3</i>	1	GC
<i>acetaminophen/codeine #4</i>	1	GC
<i>balacet 325</i>	1	GC
<i>butal/asa/caff/cod</i>	1	GC
<i>butalbital /apap /caffeine /codeine</i>	1	GC
<i>butorphanol tartrate solution</i>	1	GC
<i>co-gesic</i>	1	GC
<i>codeine sulfate</i>	1	GC
<i>endocet</i>	1	GC
<i>fentanyl</i>	1	GC
<i>fentanyl citrate oral transmucosal</i>	1	GC; PA - Prior authorization required for coverage; QL - When authorized, quantity limited #96 lollipops per 30 days.
<i>fiorinal/codeine #3</i>	1	GC
<i>hydrocodone /acetaminophen</i>	1	GC
<i>hydrocodone /acetaminophen-hs</i>	1	GC
<i>hydrocodone bitartrate/acetaminophen</i>	1	GC
<i>hydromorphone hcl tablet</i>	1	GC
<b>KADIAN</b>	2	
<i>levorphanol tartrate</i>	1	GC
<i>margesic-h</i>	1	GC
<i>meperidine hcl solution, tablet</i>	1	GC
<i>meperitab</i>	1	GC
<i>methadone hcl concentrate, solution, tablet</i>	1	GC
<i>methadose</i>	1	GC
<i>morphine sulfate er</i>	1	GC
<i>morphine sulfate solution, suppository, tablet</i>	1	GC
<i>narvox</i>	1	GC
<i>oramorph sr</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>oxycodone /acetaminophen</i>	1	GC
<i>oxycodone /apap</i>	1	GC
<i>oxycodone /aspirin</i>	1	GC
<i>oxycodone /ibuprofen</i>	1	GC
<i>oxycodone hcl</i>	1	GC
<i>oxycodone hcl er</i>	1	GC; QL - Quantity limited up to 160mg per day. All strengths of generic oxycodone HCL ER and brand Oxycontin accumulate together.
<i>oxycodone-apap</i>	1	GC
<i>pentazocine /acetaminophen</i>	1	GC
<i>pentazocine/naloxone hcl</i>	1	GC
<i>perloxx</i>	1	GC
<i>phrenilin w/caffeine/codeine</i>	1	GC
<i>propoxyphene /acetaminophen</i>	1	GC
<i>propoxyphene hcl</i>	1	GC
<i>propoxyphene-n /acetaminophen</i>	1	GC
<i>roxicet</i>	1	GC
<i>stagesic</i>	1	GC
<i>tramadol hcl</i>	1	GC
<i>tramadol hydrochloride/acetaminophen</i>	1	GC
<i>trezix</i>	1	GC
<i>vanacet</i>	1	GC
<i>zerlor</i>	1	GC

## **Anesthetics**

### **Local Anesthetics**

<i>lidocaine</i>	1	GC
<i>lidocaine hcl jelly</i>	1	GC
<i>lidocaine hcl gel, solution</i>	1	GC
<i>lidocaine/prilocaine</i>	1	GC
LIDODERM	3	Potential preferred options: amitriptyline, gabapentin, nortriptyline
<i>lidomar viscous</i>	1	GC

## **Anti-Inflammatory Agents**

### **Glucocorticoids**

<i>prednisolone</i>	1	GC
<i>prednisone</i>	1	GC
ULTRAVATE	2	

### **Nonsteroidal Anti-inflammatory Drugs**

CELEBREX	3	PA - Prior authorization required for coverage. Potential preferred options: choline magnesium trisalicylate, diclofenac, etodolac, naproxen, salsalate
<i>choline magnesium trisalicylate</i>	1	GC
<i>diclofenac sodium dr</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>diclofenac sodium ec</i>	1	GC
<i>diclofenac sodium er</i>	1	GC
<i>diclofenac sodium xr</i>	1	GC
<i>etodolac</i>	1	FF GC
<i>etodolac er</i>	1	GC
<i>flurbiprofen</i>	1	GC
<i>hydrocodone /ibuprofen</i>	1	GC
<i>ibuprofen tablet</i>	1	FF GC
<i>ibuprofen suspension</i>	1	GC
<i>indomethacin</i>	1	GC
<i>indomethacin er</i>	1	GC
<i>ketoprofen</i>	1	GC
<i>ketoprofen er</i>	1	GC
<i>meclofenamate sodium</i>	1	GC
<i>meloxicam</i>	1	GC
<i>naproxen sodium</i>	1	FF GC
<i>naproxen tablet</i>	1	FF GC
<i>naproxen suspension</i>	1	GC
<i>piroxicam</i>	1	GC
<i>reprexain</i>	1	GC
<i>salsalate</i>	1	GC
<i>sulindac</i>	1	GC
<i>tolmetin sodium</i>	1	GC

## **Antibacterials**

### **Aminoglycosides**

<i>gentamicin sulfate cream, external ointment</i>	1	GC
<i>neomycin sulfate</i>	1	GC

### **Antibacterials, Other**

<i>ak-poly-bac</i>	1	GC
<i>bacitracin /neomycin /polymyxin</i>	1	GC
<i>bacitracin/polymyxin b</i>	1	GC
<i>bacitracin ointment</i>	1	GC
BACTROBAN NASAL	2	
<i>clindamycin hcl</i>	1	GC
<i>clindamycin phosphate cream, gel, lotion, solution, swab</i>	1	GC
FURADANTIN	2	
HELIDAC	2	
<i>methenamine hippurate</i>	1	GC
METROCREAM	2	
METROGEL	2	
METROLOTION	2	
<i>metronidazole</i>	1	GC
<i>metronidazole vaginal</i>	1	GC
<i>mupirocin</i>	1	GC
<i>neomycin /bacitracin /polymyxin</i>	1	GC
<i>neomycin /polymyxin /dexamethasone</i>	1	GC
<i>neomycin /polymyxin /gramicidin</i>	1	GC
<i>neomycin /polymyxin /hydrocortisone</i>	1	GC

Drug Name	Drug Tier	Notes
<i>neomycin/bacitracin zn/polymyx</i>	1	GC
<i>neomycin/polymyxin b sulfates</i>	1	GC
<i>nitrofurantoin macrocrystalline</i>	1	GC
<i>nitrofurantoin monohydrate</i>	1	GC
NORITATE	2	
<i>polycin b</i>	1	GC
<i>polymyxin b sulfate/trimethoprim sulfate</i>	1	GC
<i>silver sulfadiazine</i>	1	GC
<i>thermazene</i>	1	GC
<i>trimethoprim</i>	1	GC
<i>trimethoprim sulfate/polymyxin b sulfate</i>	1	GC
ZYVOX SUSPENSION RECONSTITUTED, TABLET	2	
<b>Beta-lactam, Cephalosporins</b>		
<i>cefaclor</i>	1	GC
<i>cefaclor er</i>	1	GC
<i>cefadroxil</i>	1	GC
<i>cefdinir</i>	1	GC
<i>cefepodoxime proxetil</i>	1	GC
<i>cefprozil</i>	1	GC
<i>cefuroxime axetil</i>	1	GC
<i>cephalexin</i>	1	GC
<b>Beta-lactam, Penicillins</b>		
<i>amoclan</i>	1	GC
<i>amoxicillin</i>	1	GC
<i>amoxicillin/clavulanate potassium</i>	1	GC
<i>amoxicillin/potassium clavulanate</i>	1	GC
<i>ampicillin</i>	1	GC
AUGMENTIN ES-600	2	
<i>dicloxacillin sodium</i>	1	GC
<i>penicillin v potassium</i>	1	GC
<i>veetids</i>	1	GC
<b>Macrolides</b>		
<i>azithromycin packet, suspension reconstituted, tablet</i>	1	GC
<i>clarithromycin</i>	1	GC
<i>clarithromycin er</i>	1	GC
<i>ery</i>	1	GC
<i>erythromycin</i>	1	GC
<i>erythromycin /sulfisoxazole</i>	1	GC
<i>erythromycin base</i>	1	GC
<i>erythromycin ethylsuccinate</i>	1	GC
<i>romycin</i>	1	GC
<b>Quinolones</b>		
AVELOX ABC PACK	2	
AVELOX TABLET	2	
<i>ciprofloxacin er</i>	1	GC
<i>ciprofloxacin extended-release</i>	1	GC
<i>ciprofloxacin hcl</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
LEVAQUIN LEVA-PAK	3	Potential preferred options: ciprofloxacin, ofloxacin, AVELOX
LEVAQUIN SOLUTION, TABLET	3	Potential preferred options: ciprofloxacin, ofloxacin, AVELOX
<i>ofloxacin</i>	1	GC
<b>Sulfonamides</b>		
<i>bleph-10</i>	1	GC
<i>ocusulf-10</i>	1	GC
<i>sodium sulfacetamide</i>	1	GC
<i>sulfacetamide sodium</i>	1	GC
<i>sulfadiazine</i>	1	GC
<i>sulfamethoxazole /trimethoprim suspension, tablet</i>	1	GC
<i>sulfamethoxazole/trimethoprim ds</i>	1	GC
<i>sulfatrim</i>	1	GC
<i>trimethoprim/sulfamethoxazole ds</i>	1	GC
<b>Tetracyclines</b>		
<i>demeclocycline hcl</i>	1	GC
<i>doxycycline hyclate capsule, capsule delayed release particles</i>	1	GC
<i>doxycycline monohydrate</i>	1	GC
<i>minocycline hcl</i>	1	GC
<i>tetracycline hcl</i>	1	GC
<b>Anticonvulsants</b>		
<b>Anticonvulsants, Other</b>		
<i>levetiracetam</i>	1	GC
<b>Calcium Channel Modifying Agents</b>		
CELONTIN	2	
<i>ethosuximide</i>	1	GC
LYRICA CAPSULE 300MG	3	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #60 capsules per 30 days.
LYRICA CAPSULE 100MG, 150MG, 200MG, 225MG, 25MG, 50MG, 75MG	3	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #90 capsules per 30 days.
<i>zonisamide</i>	1	GC
<b>Gamma-aminobutyric Acid (GABA) Augmenting Agents</b>		
<i>divalproex sodium</i>	1	GC
<i>gabapentin</i>	1	FF GC
GABITRIL	2	
<i>primidone</i>	1	GC
<i>valproic acid</i>	1	GC
<b>Glutamate Reducing Agents</b>		
FELBATOL	2	
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	2	
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	2	

Drug Name	Drug Tier	Notes
LAMICTAL STARTER/TAKING VALPROATE	2	
<i>lamotrigine</i>	1	GC
<i>topiramate</i>	1	GC
<b>Sodium Channel Inhibitors</b>		
<i>carbamazepine</i>	1	GC
<i>carbamazepine er</i>	1	GC
DILANTIN	2	
DILANTIN INFATABS	2	
<i>oxcarbazepine</i>	1	GC
PHENYTEK	2	
<i>phenytoin</i>	1	GC
<i>phenytoin sodium extended</i>	1	GC
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100MG	2	
<b>Antidementia Agents</b>		
<b>Antidementia Agents, Other</b>		
<i>ergoloid mesylates</i>	1	GC
<b>Cholinesterase Inhibitors</b>		
ARICEPT	2	
ARICEPT ODT	2	
COGNEX	2	
EXELON	2	
<i>galantamine hydrobromide</i>	1	GC
RAZADYNE SOLUTION	2	
<b>Glutamate Pathway Modifiers</b>		
NAMENDA	3	Potential preferred options: ARICEPT, EXELON, RAZADYNE
NAMENDA TITRATION PAK	3	Potential preferred options: ARICEPT, EXELON, RAZADYNE
<b>Antidepressants</b>		
<b>Antidepressants, Other</b>		
<i>budeprion sr</i>	1	FF GC
<i>bupropion hcl</i>	1	GC
<i>bupropion hcl sr tablet extended release 12 hour 100mg, 200mg</i>	1	FF GC
<i>bupropion hcl sr tablet extended release 12 hour 150mg</i>	1	GC
<i>maprotiline hcl</i>	1	GC
<i>mirtazapine</i>	1	GC
<i>mirtazapine odt</i>	1	GC
<i>nefazodone hcl</i>	1	GC
<i>trazodone hcl</i>	1	GC
<b>Monoamine Oxidase Inhibitors</b>		
NARDIL	2	
<i>tranylcypromine sulfate</i>	1	GC
<b>Serotonin/ Norepinephrine Reuptake Inhibitors</b>		
<i>citalopram hydrobromide tablet</i>	1	FF GC
<i>citalopram hydrobromide solution</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
CYMBALTA	3	PA - Prior authorization required for coverage. Potential preferred options: bupropion SR, citalopram, fluoxetine, paroxetine, sertraline
EFFEXOR XR	2	PA - Prior authorization required for coverage.
<i>fluoxetine hcl capsule, tablet</i>	1	FF GC
<i>fluoxetine hcl solution</i>	1	GC
<i>fluvoxamine maleate</i>	1	GC
<i>paroxetine hcl</i>	1	FF GC
<i>paroxetine hcl er</i>	1	GC
<i>selfemra</i>	1	GC
<i>sertraline hcl</i>	1	FF GC
<i>sertraline hydrochloride</i>	1	GC
<i>venlafaxine hcl</i>	1	GC
<i>venlafaxine hcl er</i>	1	GC
<b>Tricyclics</b>		
<i>amitriptyline hcl</i>	1	GC
<i>amoxapine</i>	1	GC
<i>chlordiazepoxide /amitriptyline</i>	1	GC
<i>clomipramine hcl</i>	1	GC
<i>desipramine hcl</i>	1	GC
<i>imipramine hcl</i>	1	GC
<i>imipramine pamoate</i>	1	GC
<i>nortriptyline hcl</i>	1	GC
<i>protriptyline hcl</i>	1	GC
<i>trimipramine maleate</i>	1	GC
<b>Antidotes, Deterrents, and Toxicologic Agents</b>		
<b>Antidotes</b>		
CHEMET	2	
<i>sodium polystyrene sulfonate</i>	1	GC
<i>sps</i>	1	GC
<b>Deterrents</b>		
ANTABUSE	2	
<i>budeprion xl</i>	1	GC
<i>buproban</i>	1	GC
CHANTIX	3	Potential preferred options: budeprion SR, bupropion SR
<b>Toxicologic Agents</b>		
<i>depade</i>	1	GC
<i>naltrexone hcl</i>	1	GC

Drug Name	Drug Tier	Notes
<b>Antiemetics</b>		
<i>Antiemetics</i>		
ANZEMET TABLET	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>compro</i>	1	GC
<i>dronabinol</i>	1	GC
<i>granisetron hcl tablet</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>granisol</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>meclizine hcl</i>	1	GC
<i>metoclopramide hcl solution, tablet</i>	1	GC
<i>ondansetron hcl solution, tablet</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>ondansetron odt</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>phenadoz</i>	1	GC
<i>prochlorperazine</i>	1	GC
<i>prochlorperazine maleate</i>	1	GC
<i>promethazine hcl plain</i>	1	GC
<i>promethazine hcl suppository</i>	1	GC
<i>promethegan</i>	1	GC
<i>trimethobenzamide hcl capsule</i>	1	GC
<b>Antifungals</b>		
<i>Antifungals</i>		
ANCOBON	2	
<i>ciclopirox</i>	1	GC
<i>ciclopirox nail lacquer</i>	1	GC
<i>ciclopirox olamine</i>	1	GC
<i>clotrimazole</i>	1	GC
<i>clotrimazole/betamethasone dipropionate</i>	1	GC
<i>econazole nitrate</i>	1	GC
<i>fluconazole</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>grifulvin v tablet</i>	1	GC
<i>griseofulvin microsize</i>	1	GC
<i>itraconazole</i>	1	GC
<i>ketoconazole</i>	1	GC
<i>kuric</i>	1	GC
<i>miconazole 3</i>	1	GC
NATACYN	2	
<i>nyamyc</i>	1	GC
<i>nystatin</i>	1	GC
<i>nystatin/triamcinolone</i>	1	GC
<i>nystop</i>	1	GC
SPORANOX SOLUTION	2	
<i>terbinafine hcl</i>	1	GC
<i>terconazole</i>	1	GC
VFEND	2	
<i>zazole</i>	1	GC
<b>Antigout Agents</b>		
<b>Antigout Agents</b>		
<i>allopurinol</i>	1	GC
<i>colchicine</i>	1	GC
<i>probenecid</i>	1	GC
<i>probenecid/colchicine</i>	1	GC
<b>Antimigraine Agents</b>		
<b>Abortive</b>		
ERGOMAR	2	
<i>ergotamine tartrate/caffeine</i>	1	GC
IMITREX STATDOSE SYSTEM	2	QL - Quantity limited to #6 injections per 30 days.
IMITREX SOLUTION	2	QL - Quantity limited to #6 canisters per 30 days.
MAXALT	2	QL - Quantity limited to #12 tablets per 30 days.
MAXALT-MLT	2	QL - Quantity limited to #12 tablets per 30 days.
<i>migergot</i>	1	GC
MIGRANAL	2	
RELPAK	2	QL - Quantity limited to #12 tablets per 30 days.
<i>sumatriptan succinate tablet</i>	1	GC; QL - Quantity limited to #12 tablets per 30 days.
<i>sumatriptan succinate injection</i>	1	GC; QL - Quantity limited to #3ml (6 injections) per 30 days.
ZOMIG ZMT	2	QL - Quantity limited to #12 tablets per 30 days.
ZOMIG TABLET	2	QL - Quantity limited to #12 tablets per 30 days.
ZOMIG SOLUTION	2	QL - Quantity limited to #6 canisters per 30 days.

Drug Name	Drug Tier	Notes
<b>Prophylactic</b>		
<i>divalproex sodium</i>	1	GC
<i>propranolol hcl er</i>	1	GC
<i>propranolol hcl tablet</i>	1	GC
<i>timolol maleate</i>	1	GC
<b>Antimyasthenic Agents</b>		
<b>Parasympathomimetics</b>		
<i>guanidine hcl</i>	1	GC
<i>pyridostigmine bromide</i>	1	GC
<b>Antimycobacterials</b>		
<b>Antimycobacterials, Other</b>		
DAPSONE	2	
MYCOBUTIN	2	
<b>Antituberculars</b>		
<i>ethambutol hcl</i>	1	GC
<i>isonarif</i>	1	GC
<i>isoniazid syrup, tablet</i>	1	GC
<i>pyrazinamide</i>	1	GC
<i>rifampin capsule</i>	1	GC
SEROMYCIN	2	
<b>Antineoplastics</b>		
<b>Alkylating Agents</b>		
CEENU	2	
<i>cyclophosphamide tablet</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
HEXALEN	2	
LEUKERAN	2	
<b>Antiangiogenic Agents</b>		
REVLIMID	5	LA; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #30 capsules per 30 days.
THALOMID	5	
<b>Antiestrogens/Modifiers</b>		
FARESTON	2	
<i>tamoxifen citrate</i>	1	GC
<b>Antimetabolites</b>		
<i>allopurinol</i>	1	GC
DROXIA	2	
<i>mercaptopurine</i>	1	GC
TABLOID	2	
<b>Antineoplastics, Other</b>		
<i>hydroxyurea</i>	1	GC
<i>leucovorin calcium</i>	1	GC
MATULANE	2	
MESNEX TABLET	2	

Drug Name	Drug Tier	Notes
<b>Aromatase Inhibitors, 3rd Generation</b>		
ARIMIDEX	2	
AROMASIN	2	
FEMARA	2	
<b>Molecular Target Inhibitors</b>		
GLEEVEC	5	PA - Prior authorization required for coverage.
NEXAVAR	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #120 tablets per 30 days.
SPRYCEL	5	PA - Prior authorization required for coverage.
TARCEVA	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited up to 150mg per day.
<b>Retinoids</b>		
TARGRETIN CAPSULE	3	
<i>tretinoin</i>	1	GC
<b>Antiparasitics</b>		
<b>Anthelmintics</b>		
ALBENZA	2	
BILTRICIDE	2	
<i>mebendazole</i>	1	GC
STROMECTOL	2	
<b>Antiprotozoals</b>		
ALINIA	2	
<i>chloroquine phosphate</i>	1	GC
DARAPRIM	2	
FANSIDAR	2	
<i>hydroxychloroquine sulfate</i>	1	GC
<i>mefloquine hcl</i>	1	GC
MEPRON	2	
PRIMAQUINE PHOSPHATE	2	
<b>Pediculicides/ Scabicides</b>		
<i>acticin</i>	1	GC
EURAX	2	
<i>lindane</i>	1	GC
OVIDE	2	
<i>permethrin</i>	1	GC
<b>Antiparkinson Agents</b>		
<b>Antiparkinson Agents</b>		
<i>amantadine hcl</i>	1	GC
APOKYN	5	
<i>atamet</i>	1	GC
<i>benztropine mesylate tablet</i>	1	GC
<i>bromocriptine mesylate</i>	1	GC

Drug Name	Drug Tier	Notes
<i>carbidopa/levodopa</i>	1	GC
<i>carbidopa/levodopa cr</i>	1	GC
<i>carbidopa/levodopa er</i>	1	GC
<i>carbidopa/levodopa odt</i>	1	GC
<i>carbidopa/levodopa sr</i>	1	GC
COMTAN	2	
KEMADRIN	2	
MIRAPEX	2	
<i>ropinirole hcl</i>	1	GC
<i>selegiline hcl</i>	1	GC
STALEVO 100	2	
STALEVO 125	2	
STALEVO 150	2	
STALEVO 200	2	
STALEVO 50	2	
STALEVO 75	2	
<i>trihexyphenidyl hcl</i>	1	GC
<b>Antipsychotics</b>		
<b>Atypicals</b>		
ABILIFY TABLET	2	
<i>clozapine</i>	1	GC
RISPERDAL M-TAB	2	
<i>risperidone</i>	1	GC
<i>risperidone odt</i>	1	GC
SEROQUEL	2	
SEROQUEL XR	2	
ZYPREXA ZYDIS	2	
ZYPREXA TABLET	2	
<b>Conventional</b>		
<i>chlorpromazine hcl tablet</i>	1	GC
<i>clozapine</i>	1	GC
<i>fluphenazine hcl concentrate, elixir, tablet</i>	1	GC
<i>haloperidol</i>	1	GC
<i>loxapine succinate</i>	1	GC
MOBAN	2	
ORAP	2	
<i>perphenazine</i>	1	GC
<i>perphenazine /amitriptyline</i>	1	GC
<i>thioridazine hcl</i>	1	GC
<i>thiothixene</i>	1	GC
<i>trifluoperazine hcl</i>	1	GC
<b>Antispasticity Agents</b>		
<b>Antispasticity Agents</b>		
<i>orphenadrine citrate er</i>	1	GC
<i>tizanidine hcl</i>	1	GC

Drug Name	Drug Tier	Notes
<b>Antivirals</b>		
<b>Anti-cytomegalovirus (CMV) Agents</b>		
<i>ganciclovir</i>	1	GC
VALCYTE	3	
<b>Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors</b>		
INTELENCE	5	
RESCRIPTOR	2	
SUSTIVA	2	
VIRAMUNE	2	
<b>Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors</b>		
ATRIPLA	2	
COMBIVIR	2	
<i>didanosine</i>	1	GC
EMTRIVA	2	
EPIVIR	2	
EPIVIR HBV	2	
EPZICOM	2	
<i>stavudine</i>	1	GC
TRIZIVIR	2	
TRUVADA	2	
VIDEX PEDIATRIC	2	
VIREAD	2	
ZIAGEN	2	
<i>zidovudine</i>	1	GC
<b>Anti-HIV Agents, Other</b>		
FUZEON	5	
ISENTRESS	5	
SELZENTRY	5	
<b>Anti-HIV Agents, Protease Inhibitors</b>		
CRIXIVAN	2	
INVIRASE	2	
KALETRA	2	
LEXIVA	2	
NORVIR	2	
PREZISTA TABLET 300MG, 75MG	2	
REYATAZ	2	
VIRACEPT	2	
<b>Anti-influenza Agents</b>		
<i>amantadine hcl</i>	1	GC
<i>rimantadine hcl</i>	1	GC
TAMIFLU	2	
<b>Antihepatitis Agents</b>		
BARACLUDE	2	
HEPSERA	2	
<i>ribapak</i>	1	GC
<i>ribasphere</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>ribavirin</i>	1	GC
<b>Antiherpetic Agents</b>		
<i>acyclovir capsule, tablet</i>	1	FF GC
<i>acyclovir suspension</i>	1	GC
<i>famciclovir</i>	1	GC
<i>trifluridine</i>	1	GC
VALTREX	2	
<b>Anxiolytics</b>		
<b>Antidepressants</b>		
<i>doxepin hcl</i>	1	GC
LEXAPRO	3	PA - Prior authorization required for coverage. Potential preferred options: citalopram, fluoxetine, paroxetine, sertraline
<i>paroxetine hcl tablet</i>	1	FF GC
<i>paroxetine hcl suspension</i>	1	GC
<i>sertraline hcl</i>	1	GC
<b>Anxiolytics, Other</b>		
<i>buspirone hcl</i>	1	GC
<i>meprobamate</i>	1	GC
<b>Bipolar Agents</b>		
<b>Bipolar Agents</b>		
ABILIFY DISCMELT	2	
ABILIFY SOLUTION, TABLET	2	
<i>carbamazepine</i>	1	GC
CARBATROL	2	
GEODON	2	
<i>lithium carbonate</i>	1	GC
<i>lithium carbonate er</i>	1	GC
<i>lithium citrate</i>	1	GC
RISPERDAL M-TAB	2	
<i>risperidone odt</i>	1	GC
<b>Blood Glucose Regulators</b>		
<b>Antidiabetic Agents</b>		
<i>acarbose</i>	1	GC
ACTOPLUS MET	2	PA - Prior authorization required for coverage.
ACTOS	2	PA - Prior authorization required for coverage.
AVANDIA	2	PA - Prior authorization required for coverage.
<i>chlorpropamide</i>	1	GC
DUETACT	2	PA - Prior authorization required for coverage.
<i>glimepiride</i>	1	GC
<i>glipizide</i>	1	FF GC
<i>glipizide er</i>	1	FF GC
<i>glipizide xl</i>	1	FF GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>glipizide/metformin hcl</i>	1	GC
<i>glyburide</i>	1	FF GC
<i>glyburide micronized</i>	1	GC
<i>glyburide/metformin hcl</i>	1	GC
<i>glycron</i>	1	GC
<i>metformin hcl</i>	1	FF GC
<i>metformin hcl er</i>	1	FF GC
PRANDIN	2	
PRECOSE	2	
<i>tolazamide</i>	1	GC
<i>tolbutamide</i>	1	GC
<b>Glycemic Agents</b>		
GLUCAGEN HYPOKIT	2	
GLUCAGON EMERGENCY KIT	2	
PROGLYCEM	2	
<b>Insulins</b>		
HUMALOG	2	
HUMALOG KWIKPEN	2	
HUMALOG MIX 50/50	2	
HUMALOG MIX 50/50 KWIKPEN	2	
HUMALOG MIX 50/50 PEN	2	
HUMALOG MIX 75/25	2	
HUMALOG MIX 75/25 KWIKPEN	2	
HUMALOG MIX 75/25 PEN	2	
HUMALOG PEN	2	
HUMULIN 50/50	2	
HUMULIN 70/30	2	
HUMULIN 70/30 PEN	2	
HUMULIN N	2	
HUMULIN N U-100 PEN	2	
HUMULIN R	2	
HUMULIN R U-500 (CONCENTRATED)	2	
LANTUS	2	
LANTUS FOR OPTICLIK	2	
LANTUS SOLOSTAR	2	
NOVOLIN 70/30	2	
NOVOLIN 70/30 INNOLET	2	
NOVOLIN 70/30 PENFILL	2	
NOVOLIN N	2	
NOVOLIN N INNOLET	2	
NOVOLIN N U-100 PENFILL	2	
NOVOLIN R	2	
NOVOLIN R INNOLET	2	
NOVOLIN R U-100 PENFILL	2	
NOVOLOG	2	
NOVOLOG FLEXPEN	2	
NOVOLOG MIX 70/30	2	
NOVOLOG MIX 70/30 PENFILL	2	

Drug Name	Drug Tier	Notes
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	2	
NOVOLOG PENFILL	2	
RELION 70/30	2	
RELION 70/30 INNOLET	2	
RELION N	2	
RELION N INNOLET	2	
RELION R	2	
<b>Blood Products/Modifiers/ Volume Expanders</b>		
<b>Anticoagulants</b>		
FRAGMIN	2	
<i>heparin sodium</i>	4	HI
<i>heparin sodium dcu</i>	4	HI
<i>heparin sodium/nacl 0.45%</i>	4	HI
<i>heparin sodium/nacl 0.9%</i>	4	HI
<i>heparin sodium/sodium chloride 0.9% premix</i>	4	HI
INNOHEP	2	
<i>jantoven</i>	1	GC
LOVENOX INJECTION 30MG/0.3ML, 40MG/0.4ML	4	
LOVENOX INJECTION 100MG/ML, 120MG/0.8ML, 150MG/ML, 300MG/3ML, 60MG/0.6ML, 80MG/0.8ML	5	
<i>warfarin sodium</i>	1	GC
<b>Blood Formation Products</b>		
ARANESP ALBUMIN FREE SURECLICK	5	
ARANESP ALBUMIN FREE INJECTION 25MCG/0.42ML, 25MCG/ML	4	
ARANESP ALBUMIN FREE INJECTION 100MCG/ML, 150MCG/0.3ML, 150MCG/0.75ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/ML	5	
EPOGEN INJECTION 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	
EPOGEN INJECTION 10000UNIT/ML, 20000UNIT/ML, 40000UNIT/ML	5	
LEUKINE	5	HI
NEUPOGEN	5	
PROCRIT INJECTION 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	
PROCRIT INJECTION 10000UNIT/ML, 20000UNIT/ML, 40000UNIT/ML	5	
<b>Coagulants</b>		
<i>aminocaproic acid syrup, tablet</i>	1	GC
<i>aminocaproic acid injection</i>	4	
<b>Platelet Aggregation Inhibitors</b>		
AGGRENOX	3	Potential preferred options: cilostazol, dipyridamole + ticlopidine, PLAVIX
<i>anagrelide hydrochloride</i>	1	GC
<i>cilostazol</i>	1	GC

Drug Name	Drug Tier	Notes
<i>dipyridamole</i>	1	GC
<i>pentoxifylline er</i>	1	GC
<i>pentoxil</i>	1	GC
PLAVIX TABLET 75MG	2	
<i>ticlopidine hcl</i>	1	GC
<b>Cardiovascular Agents</b>		
<b>Alpha-adrenergic Agonists</b>		
CATAPRES-TTS-1	2	
CATAPRES-TTS-2	2	
CATAPRES-TTS-3	2	
<i>clonidine hcl</i>	1	GC
<i>guanabenz acetate</i>	1	GC
<i>guanfacine hcl</i>	1	GC
<i>methyldopa</i>	1	GC
<i>midodrine hcl</i>	1	GC
<b>Alpha-adrenergic Blocking Agents</b>		
<i>prazosin hcl</i>	1	GC
<i>terazosin hcl</i>	1	GC
<b>Antiarrhythmics</b>		
<i>acebutolol hcl</i>	1	GC
<i>amiodarone hcl tablet</i>	1	GC
<i>diltiazem hcl er</i>	1	GC
<i>diltiazem hcl capsule extended release 24 hour, tablet</i>	1	GC
<i>diltiazem hcl injection 100mg</i>	1	GC HI
<i>disopyramide phosphate</i>	1	GC
<i>disopyramide phosphate er</i>	1	GC
<i>flecainide acetate</i>	1	GC
<i>mexiletine hcl</i>	1	GC
<i>pacerone</i>	1	GC
PROCANBID	2	
<i>propafenone hcl</i>	1	GC
<i>quinidine gluconate cr</i>	1	GC
<i>quinidine gluconate er</i>	1	GC
<i>quinidine gluconate sa</i>	1	GC
<i>quinidine sulfate</i>	1	GC
<i>quinidine sulfate er</i>	1	GC
<i>sorine</i>	1	GC
<i>sotalol hcl</i>	1	GC
<i>sotalol hcl (af)</i>	1	GC
<i>verapamil hcl er</i>	1	GC
<i>verapamil hcl tablet</i>	1	GC
<i>verapamil hcl injection</i>	1	GC HI
<b>Beta-adrenergic Blocking Agents</b>		
<i>acebutolol hcl</i>	1	GC
<i>atenolol</i>	1	GC
<i>atenolol/chlorthalidone</i>	1	GC
<i>betaxolol hcl</i>	1	GC
<i>bisoprolol fumarate</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>bisoprolol fumarate/hydrochlorothiazide</i>	1	GC
<i>carvedilol</i>	1	GC
INNOPRAN XL	2	
<i>labetalol hcl tablet</i>	1	GC
<i>metoprolol /hydrochlorothiazide</i>	1	GC
<i>metoprolol succinate er</i>	1	GC
<i>metoprolol tartrate tablet</i>	1	FF GC
<i>nadolol</i>	1	GC
<i>nadolol /bendroflumethiazide</i>	1	GC
<i>pindolol</i>	1	GC
<i>propranolol /hydrochlorothiazide</i>	1	GC
<i>propranolol hcl er</i>	1	GC
<i>propranolol hcl solution, tablet</i>	1	GC
<i>timolol maleate</i>	1	GC
<b>Calcium Channel Blocking Agents</b>		
<i>afeditab cr</i>	1	GC
<i>amlodipine besylate</i>	1	GC
CADUET	3	Potential preferred options: diltiazem SR, verapamil SR, nifedipine SA, felodipine + lovastatin, pravastatin sodium, simvastatin, CRESTOR, VYTORIN
<i>cartia xt</i>	1	GC
<i>dilt-cd</i>	1	GC
<i>dilt-xr</i>	1	GC
<i>diltiazem cd</i>	1	GC
<i>diltiazem hcl er</i>	1	GC
<i>diltiazem hcl tablet</i>	1	GC
<i>diltzac</i>	1	GC
<i>felodipine er</i>	1	FF GC
<i>isradipine</i>	1	GC
LOTREL	3	Potential preferred option: amlodipine besylate/benazepril
<i>nicardipine hcl</i>	1	GC
<i>nifediac cc</i>	1	GC
<i>nifedical xl</i>	1	GC
<i>nifedipine</i>	1	GC
<i>nifedipine er</i>	1	GC
<i>nimodipine</i>	1	GC
<i>nisoldipine</i>	1	GC
SULAR	2	
<i>taztia xt</i>	1	GC
<b>Cardiovascular Agents, Other</b>		
<i>digoxin solution, tablet</i>	1	GC
<i>reserpine</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<b>Diuretics</b>		
<i>acetazolamide</i>	1	GC
<i>amiloride /hydrochlorothiazide</i>	1	GC
<i>amiloride hcl</i>	1	GC
<i>bumetanide tablet</i>	1	GC
<i>chlorothiazide</i>	1	GC
<i>chlorthalidone</i>	1	GC
<i>furosemide solution, tablet</i>	1	GC
<i>hydrochlorothiazide</i>	1	GC
<i>indapamide</i>	1	GC
<i>methazolamide</i>	1	GC
<i>methyclothiazide</i>	1	GC
<i>methyldopa /hydrochlorothiazide</i>	1	GC
<i>metolazone</i>	1	GC
<i>quinapril /hydrochlorothiazide</i>	1	GC
<i>spironolactone</i>	1	GC
<i>spironolactone /hydrochlorothiazide</i>	1	GC
<i>toremide</i>	1	GC
<i>triamterene /hydrochlorothiazide</i>	1	GC
<b>Dyslipidemics</b>		
<i>cholestyramine</i>	1	GC
<i>cholestyramine light</i>	1	GC
<i>colestipol hcl</i>	1	GC
<i>colestipol hcl for oral suspension</i>	1	GC
CRESTOR	2	PA - Prior authorization required for coverage.
<i>fenofibrate</i>	1	FF GC
<i>fenofibrate micronized</i>	1	FF GC
<i>gemfibrozil</i>	1	FF GC
LESCOL XL	3	Potential preferred options: lovastatin, pravastatin sodium, simvastatin, CRESTOR, VYTORIN
LIPITOR	3	PA - Prior authorization required for coverage. Potential preferred options: lovastatin, pravastatin sodium, simvastatin, CRESTOR, VYTORIN
<i>lofibra</i>	1	FF GC
<i>lovastatin</i>	1	FF GC
NIASPAN	2	
<i>pravastatin sodium</i>	1	GC
<i>prevalite</i>	1	GC
<i>simvastatin</i>	1	FF GC
TRICOR	3	Potential preferred options: fenofibrate, gemfibrozil
VYTORIN	2	PA - Prior authorization required for coverage.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
ZETIA	3	Potential preferred options: lovastatin, pravastatin sodium, simvastatin, CRESTOR, VYTORIN
<b>Renin-angiotensin-aldosterone System Inhibitors</b>		
<i>amlodipine besylate/benazepril hydrochloride</i>	1	GC
ATACAND	3	Potential preferred options: benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, quinapril, trandolapril, BENICAR, MICARDIS
AVALIDE	3	Potential preferred options: benazepril/HCTZ, captopril/HCTZ, enalapril/HCTZ, fosinopril/HCTZ, lisinopril/HCTZ, moexipril/HCTZ, quinapril/HCT, MICARDIS HCT
AVAPRO	3	Potential preferred options: benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, quinapril, trandolapril, BENICAR, MICARDIS
<i>benazepril hcl</i>	1	FF GC
<i>benazepril hcl/hydrochlorothiazide</i>	1	GC
BENICAR	2	
BENICAR HCT	2	
<i>captopril</i>	1	GC
<i>captopril /hydrochlorothiazide</i>	1	GC
COZAAR	3	Potential preferred options: BENICAR, MICARDIS
DIOVAN	3	Potential preferred options: BENICAR, MICARDIS
DIOVAN HCT	3	Potential preferred options: BENICAR HCT, MICARDIS HCT
<i>enalapril maleate</i>	1	FF GC
<i>enalapril maleate/hydrochlorothiazide</i>	1	GC
<i>epplerenone</i>	1	GC
<i>fosinopril sodium</i>	1	GC
<i>fosinopril sodium/hydrochlorothiazide</i>	1	GC
HYZAAR	3	Potential preferred options: BENICAR HCT, MICARDIS HCT
<i>lisinopril</i>	1	FF GC
<i>lisinopril /hydrochlorothiazide</i>	1	FF GC
LOTREL	3	Potential preferred option: amlodipine besylate/benazepril
MICARDIS	2	
MICARDIS HCT	2	
<i>moexipril /hydrochlorothiazide</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>moexipril hcl</i>	1	GC
<i>quinapril hcl</i>	1	GC
<i>quinaretic</i>	1	GC
<i>ramipril</i>	1	GC
<i>trandolapril</i>	1	GC
<b>Vasodilators</b>		
<i>hydralazine hcl tablet</i>	1	GC
<i>isosorbide dinitrate</i>	1	GC
<i>isosorbide dinitrate er</i>	1	GC
<i>isosorbide mononitrate</i>	1	GC
<i>isosorbide mononitrate er</i>	1	GC
<i>minitran</i>	1	GC
<i>minoxidil</i>	1	GC
<i>nitroglycerin transdermal</i>	1	GC
<i>nitroglycerin patch 24 hour, tablet sublingual</i>	1	GC
<b>Central Nervous System Agents</b>		
<b>Amphetamines, ADHD</b>		
ADDERALL XR	2	
<i>amphetamine salt combo</i>	1	GC
<i>dextroamphetamine sulfate</i>	1	GC
<i>dextroamphetamine sulfate cr</i>	1	GC
<i>dextrostat</i>	1	GC
VYVANSE	2	
<b>Non-amphetamines, ADHD</b>		
<i>dexmethylphenidate hcl</i>	1	GC
METADATE CD	2	
<i>methylin</i>	1	GC
<i>methylin er</i>	1	GC
<i>methylphenidate hcl</i>	1	GC
<i>methylphenidate hcl er</i>	1	GC
<b>Non-amphetamines, Other</b>		
RILUTEK	2	
<b>Dental and Oral Agents</b>		
<b>Dental and Oral Agents</b>		
<i>chlorhexidine gluconate</i>	1	GC
<i>chlorhexidine gluconate oral rinse</i>	1	GC
<i>doxycycline hyclate</i>	1	GC
EVOXAC	2	
<i>minocycline hcl</i>	1	GC
<i>periogard</i>	1	GC
<i>pilocarpine hcl</i>	1	GC
<i>pilocarpine hydrochloride</i>	1	GC
<i>triamcinolone in orabase</i>	1	GC
<b>Dermatological Agents</b>		
<b>Dermatological Agents</b>		
8-MOP	2	
<i>alclometasone dipropionate</i>	1	GC
<i>amcinonide</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>ammonium lactate</i>	1	GC
<i>amnesteem</i>	1	GC
<i>augmented betamethasone dipropionate</i>	1	GC
AZELEX	2	
<i>benzoyl peroxide</i>	1	GC
<i>benzoyl peroxide wash</i>	1	GC
<i>beta-val</i>	1	GC
<i>betamethasone dipropionate</i>	1	GC
<i>betamethasone valerate</i>	1	GC
<i>calcipotriene</i>	1	GC
CAPEX	2	
CARAC	2	
<i>claravis</i>	1	GC
<i>clobetasol propionate</i>	1	GC
<i>clobetasol propionate e</i>	1	GC
<i>clobetasol propionate emollient</i>	1	GC
CLODERM	2	
<i>clotrimazole/betamethasone dipropionate</i>	1	GC
CORDRAN	2	
CORDRAN SP	2	
CORDRAN TAPE	2	
<i>del-beta</i>	1	GC
DERMA-SMOOTH/FS BODY OIL	2	
DERMA-SMOOTH/FS SCALP OIL	2	
<i>desonide</i>	1	GC
<i>desoximetasone</i>	1	GC
DIFFERIN	2	
<i>diflorasone diacetate</i>	1	GC
DOVONEX CREAM	2	
<i>doxepin hcl</i>	1	GC
<i>doxycycline monohydrate</i>	1	GC
<i>erythromycin/benzoyl peroxide</i>	1	GC
<i>fluocinolone acetonide</i>	1	GC
<i>fluocinonide</i>	1	GC
<i>fluocinonide emollient base</i>	1	GC
<i>fluocinonide-e</i>	1	GC
FLUOROPLEX	2	
<i>fluorouracil</i>	1	GC
<i>fluticasone propionate</i>	1	GC
<i>halobetasol propionate</i>	1	GC
<i>hydrocortisone</i>	1	GC
<i>hydrocortisone butyrate</i>	1	GC
<i>hydrocortisone in absorbbase</i>	1	GC
<i>hydrocortisone valerate</i>	1	GC
LUXIQ	2	
<i>mometasone furoate</i>	1	GC
<i>nystatin/triamcinolone</i>	1	GC
OXSORALEN	2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
OXSORALEN ULTRA	2	
<i>podofilox</i>	1	GC
<i>prednicarbate</i>	1	GC
RETIN-A MICRO	2	PA - Prior authorization required for coverage.
<i>selenium sulfide</i>	1	GC
SORIATANE CK	5	
<i>sotret</i>	1	GC
TAZORAC	2	
<i>tretinoin</i>	1	GC; PA - Prior authorization required for coverage.
<i>triamcinolone acetonide</i>	1	GC
<i>triamcinolone acetonide in absorbbase</i>	1	GC
<i>triderm</i>	1	GC
<i>urea</i>	1	GC
<i>urea nail</i>	1	GC
<i>urea nailstik</i>	1	GC
<i>urealac</i>	1	GC

### **Enzyme Replacements/ Modifiers**

#### ***Enzyme Replacements/ Modifiers***

BUPHENYL	2	
CREON	2	
CREON 5	2	
CREON 10	2	
CREON 20	2	
CYSTADANE	2	
<i>dygase</i>	1	GC
ENZYMAX	2	
KU-ZYME	2	
KU-ZYME HP	2	
KUTRASE	2	
<i>lapase</i>	1	GC
<i>lipram 4500</i>	1	GC
<i>lipram-pn10</i>	1	GC
<i>lipram-pn16</i>	1	GC
<i>lipram-pn20</i>	1	GC
<i>lipram-ul12</i>	1	GC
<i>lipram-ul18</i>	1	GC
<i>lipram-ul20</i>	1	GC
<i>palcaps 10</i>	1	GC
<i>palcaps 20</i>	1	GC
PANCREASE MT 10	2	
PANCREASE MT 16	2	
PANCREASE MT 20	2	
PANCREASE MT 4	2	
PANCRECARB MS-16	2	
PANCRECARB MS-4	2	
PANCRECARB MS-8	2	

Drug Name	Drug Tier	Notes
<i>pancrelipase</i>	1	GC
<i>pancrelipase mst-16</i>	1	GC
<i>pancron 10</i>	1	GC
<i>pancron 20</i>	1	GC
<i>pangestyme cn 10</i>	1	GC
<i>pangestyme cn 20</i>	1	GC
<i>pangestyme ec</i>	1	GC
<i>pangestyme mt 16</i>	1	GC
<i>pangestyme ul 12</i>	1	GC
<i>pangestyme ul 18</i>	1	GC
<i>pangestyme ul 20</i>	1	GC
<i>panocaps</i>	1	GC
<i>panocaps mt 16</i>	1	GC
<i>panocaps mt 20</i>	1	GC
<i>panokase</i>	1	GC
<i>panokase-16</i>	1	GC
<i>plaretase 8000</i>	1	GC
<i>ultracaps mt 20</i>	1	GC
ULTRASE	2	
ULTRASE MT 12	2	
ULTRASE MT 18	2	
ULTRASE MT 20	2	
VIOKASE	2	
VIOKASE 16	2	
VIOKASE 8	2	

**Gastrointestinal Agents**

**Antispasmodics, Gastrointestinal**

<i>dicyclomine hcl capsule, solution, tablet</i>	1	GC
<i>glycopyrrolate tablet</i>	1	GC
<i>hyomax-ft</i>	1	GC
<i>hyomax-sl</i>	1	GC
<i>hyoscyamine sulfate</i>	1	GC
<i>methscopolamine bromide</i>	1	GC
<i>propantheline bromide</i>	1	GC
<i>symax fastabs</i>	1	GC
<i>symax-sl</i>	1	GC

**Gastrointestinal Agents, Other**

<i>diphenoxylate/atropine</i>	1	GC
<i>gavilyte-g</i>	1	GC
<i>generlac</i>	1	GC
KRISTALOSE	2	
<i>lactulose</i>	1	GC
<i>lofene</i>	1	GC
<i>lonox</i>	1	GC
<i>loperamide hcl</i>	1	GC
<i>peg 3350/electrolytes</i>	1	GC
<i>polyethylene glycol 3350</i>	1	GC
<i>trilyte</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>ursodiol</i>	1	GC
<b>Histamine2 (H2) Blocking Agents</b>		
<i>cimetidine</i>	1	GC
<i>cimetidine hcl solution</i>	1	GC
<i>famotidine tablet</i>	1	GC
<i>nizatidine</i>	1	GC
<i>ranitidine hcl capsule, syrup, tablet</i>	1	GC
<b>Irritable Bowel Syndrome Agents</b>		
LOTRONEX	3	
<b>Protectants</b>		
<i>misoprostol</i>	1	GC
<i>sucralfate</i>	1	GC
<b>Proton Pump Inhibitors</b>		
ACIPHEX	3	PA - Prior authorization required for coverage. Potential preferred options: cimetidine, famotidine, omeprazole, pantoprazole, ranitidine, PREVACID
KAPIDEX	2	PA - Prior authorization required for coverage. Potential preferred options: cimetidine, famotidine, omeprazole, pantoprazole, ranitidine, PREVACID
NEXIUM CAPSULE DELAYED RELEASE	3	PA - Prior authorization required for coverage. Potential preferred options: cimetidine, famotidine, omeprazole, pantoprazole, ranitidine, PREVACID
NEXIUM PACKET 20MG, 40MG	3	PA - Prior authorization required for coverage. Potential preferred options: cimetidine, famotidine, omeprazole, pantoprazole, ranitidine, PREVACID
<i>omeprazole capsule delayed release 10mg, 20mg</i>	1	FF GC
<i>omeprazole capsule delayed release 40mg</i>	1	GC
<i>pantoprazole sodium</i>	1	GC
PREVACID	2	PA - Prior authorization required for coverage.
PREVACID SOLUTAB	2	PA - Prior authorization required for coverage.
PREVPAC	2	
<b>Genitourinary Agents</b>		
<b>Antispasmodics, Urinary</b>		
DETROL LA	2	
<i>flavoxate hcl</i>	1	GC
<i>oxybutynin chloride er</i>	1	GC
<i>oxybutynin chloride tablet</i>	1	FF GC
<i>oxybutynin chloride syrup</i>	1	GC

Drug Name	Drug Tier	Notes
VESICARE	3	Potential preferred options: oxybutynin, oxybutynin chloride ER tablet, DETROL LA
<b>Benign Prostatic Hypertrophy Agents</b>		
AVODART	3	Potential preferred options: doxazosin, prazosin, terazosin, UROXATRAL
<i>doxazosin mesylate</i>	1	FF GC
<i>finasteride</i>	1	GC
FLOMAX	3	Potential preferred options: doxazosin, prazosin, terazosin, UROXATRAL
<i>prazosin hcl</i>	1	GC
UROXATRAL	2	
<b>Genitourinary Agents, Other</b>		
<i>bethanechol chloride</i>	1	GC
ELMIRON	2	
<b>Phosphate Binders</b>		
<i>calcium acetate</i>	1	GC
ELIPHOS	2	
PHOSLO	2	
RENAGEL	3	
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)</b>		
<b>Glucocorticoids/ Mineralocorticoids</b>		
<i>alclometasone dipropionate</i>	1	GC
<i>augmented betamethasone dipropionate</i>	1	GC
<i>betamethasone valerate</i>	1	GC
<i>clobetasol propionate</i>	1	GC
<i>cortisone acetate</i>	1	GC
<i>desonide</i>	1	GC
<i>dexamethasone</i>	1	GC
DEXAMETHASONE INTENSOL	2	
<i>fludrocortisone acetate</i>	1	GC
<i>hydrocortisone</i>	1	GC
<i>hydrocortisone butyrate</i>	1	GC
<i>methylprednisolone</i>	1	GC
PEDIAPRED	2	
<i>prednisolone</i>	1	GC
<i>prednisolone sodium phosphate</i>	1	GC
<i>prednisone</i>	1	GC
PREDNISONE INTENSOL	2	
<i>sterapred</i>	1	GC
<i>sterapred 12 day</i>	1	GC
<i>sterapred ds</i>	1	GC
<i>sterapred ds 12 day</i>	1	GC
<i>triamcinolone acetonide</i>	1	GC

Drug Name	Drug Tier	Notes
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</b>		
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</i>		
<i>desmopressin acetate solution, tablet</i>	1	GC
NUTROPIN	5	PA - Prior authorization required for coverage.
NUTROPIN AQ	5	PA - Prior authorization required for coverage.
NUTROPIN AQ PEN	5	PA - Prior authorization required for coverage.
SAIZEN	5	PA - Prior authorization required for coverage.
SAIZEN CLICK.EASY	5	PA - Prior authorization required for coverage.
STIMATE	2	
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)</b>		
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)</i>		
<i>misoprostol</i>	1	GC
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)</b>		
<i>Anabolic Steroids</i>		
ANADROL-50	3	
<i>oxandrolone</i>	1	GC
<i>Androgens</i>		
<i>danazol</i>	1	GC
METHITEST	2	
TESTRED	2	
<i>Estrogens</i>		
<i>alora</i>	1	GC
<i>apri</i>	1	GC
<i>aranelle</i>	1	GC
<i>aviane</i>	1	GC
<i>brevicon-28</i>	1	GC
CENESTIN	2	
<i>cryselle-28</i>	1	GC
<i>enpresse-28</i>	1	GC
ESTRADERM	2	
<i>estradiol/norethindrone acetate</i>	1	GC
<i>estradiol tablet</i>	1	FF GC
<i>estradiol patch weekly</i>	1	GC
<i>estropipate</i>	1	GC
<i>junel 1.5/30</i>	1	GC
<i>junel 1/20</i>	1	GC
<i>junel fe 1.5/30</i>	1	GC
<i>junel fe 1/20</i>	1	GC

Drug Name	Drug Tier	Notes
<i>kariva</i>	1	GC
<i>kelnor 1/35</i>	1	GC
<i>leena</i>	1	GC
<i>lessina-28</i>	1	GC
<i>levora 0.15/30-28</i>	1	GC
LOESTRIN FE 1.5/30	2	
LOESTRIN FE 1/20	2	
<i>low-ogestrel</i>	1	GC
<i>lutera</i>	1	GC
<i>menest</i>	1	GC
<i>microgestin 1.5/30</i>	1	GC
<i>microgestin 1/20</i>	1	GC
<i>microgestin fe</i>	1	GC
<i>microgestin fe 1.5/30</i>	1	GC
<i>mononessa</i>	1	GC
<i>necon 0.5/35-28</i>	1	GC
<i>necon 1/35-28</i>	1	GC
<i>necon 1/50-28</i>	1	GC
<i>necon 10/11-28</i>	1	GC
<i>necon 7/7/7</i>	1	GC
NORDETTE-28	2	
NORINYL 1+35	2	
<i>nortrel 0.5/35 (28)</i>	1	GC
<i>nortrel 1/35 (21)</i>	1	GC
<i>nortrel 1/35 (28)</i>	1	GC
<i>nortrel 7/7/7</i>	1	GC
ORTHO EVRA	2	
ORTHO TRI-CYCLEN LO	2	
<i>portia-28</i>	1	GC
PREMARIN W/APPLICATOR	2	
PREMARIN TABLET	2	
PREMPHASE	2	
PREMPRO	2	
<i>previfem</i>	1	GC
<i>quasense</i>	1	GC
<i>reclipsen</i>	1	GC
<i>sprintec 28</i>	1	GC
<i>sronyx</i>	1	GC
<i>tri-legest fe</i>	1	GC
<i>tri-lo-sprintec</i>	1	GC
TRI-NORINYL 28	2	
<i>tri-previfem</i>	1	GC
<i>tri-sprintec</i>	1	GC
<i>trinessa</i>	1	GC
<i>trivora-28</i>	1	GC
VAGIFEM	2	
<i>velivet</i>	1	GC
VIVELLE-DOT	2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>zovia 1/35e</i>	1	GC
<i>zovia 1/50e</i>	1	GC
<b>Progestins</b>		
<i>camila</i>	1	GC
<i>cesia</i>	1	GC
DESOGEN	2	
<i>errin</i>	1	GC
FEMHRT 1/5	2	
FEMHRT LOW DOSE	2	
<i>jolivette</i>	1	GC
LO/OVRAL-28	2	
LOESTRIN 1.5/30-21	2	
LOESTRIN 1/20-21	2	
LOESTRIN 24 FE	2	
<i>medroxyprogesterone acetate tablet</i>	1	GC
<i>megestrol acetate</i>	1	GC
MODICON-28	2	
<i>next choice</i>	1	GC
NOR-QD	2	
<i>nora-be</i>	1	GC
<i>norethindrone acetate</i>	1	GC
<i>ocella</i>	1	GC
<i>ogestrel</i>	1	GC
ORTHO MICRONOR	2	
ORTHO-CEPT-28	2	
ORTHO-CYCLEN-28	2	
ORTHO-NOVUM 1/50-28	2	
ORTHO-NOVUM 7/7/7-28	2	
<i>solia</i>	1	GC
<b>Selective Estrogen Receptor Modifying Agents</b>		
EVISTA	2	
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)</b>		
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)</b>		
ARMOUR THYROID	2	
LEVOTHROID	2	
<i>levothyroxine sodium</i>	1	FF GC
LEVOXYL	2	
<i>liothyronine sodium tablet</i>	1	GC
SYNTHROID	2	
THYROLAR-1	2	
THYROLAR-1/2	2	
THYROLAR-1/4	2	
THYROLAR-2	2	
THYROLAR-3	2	
<i>unithroid</i>	1	GC

Drug Name	Drug Tier	Notes
<b>Hormonal Agents, Suppressant (Adrenal)</b>		
<i>Hormonal Agents, Suppressant (Adrenal)</i>		
LYSODREN	2	
<b>Hormonal Agents, Suppressant (Parathyroid)</b>		
<i>Hormonal Agents, Suppressant (Parathyroid)</i>		
SENSIPAR	2	
<b>Hormonal Agents, Suppressant (Pituitary)</b>		
<i>Hormonal Agents, Suppressant (Pituitary)</i>		
<i>bromocriptine mesylate</i>	1	GC
<i>cabergoline</i>	1	GC
<i>leuprolide acetate</i>	4	
OCTREOTIDE ACETATE	5	
<b>Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)</b>		
<i>Antiandrogens</i>		
<i>bicalutamide</i>	1	GC
CASODEX	2	
EMCYT	2	
<i>flutamide</i>	1	GC
NILANDRON	2	
<b>Hormonal Agents, Suppressant (Thyroid)</b>		
<i>Antithyroid Agents</i>		
<i>methimazole</i>	1	GC
<i>propylthiouracil</i>	1	GC
<b>Immunological Agents</b>		
<i>Immune Suppressants</i>		
<i>azathioprine</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CELLCEPT SUSPENSION RECONSTITUTED	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CUPRIMINE	2	
<i>cyclosporine</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
<i>cyclosporine modified</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
DEPEN TITRATABS	2	
ENBREL SURECLICK	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #4 injections per 30 days.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
ENBREL INJECTION 50MG/ML	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #4 injections per 30 days.
ENBREL INJECTION 25MG	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #8 injections per 30 days.
<i>gengraf</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
HUMIRA	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #2 - 40mg injections per 30 days.
HUMIRA PEN	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #2 - 40mg injections per 30 days.
HUMIRA PEN-CROHNS DISEASESTARTER	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #2 - 40mg injections per 30 days.
<i>methotrexate</i>	1	GC
<i>mycophenolate mofetil</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
MYFORTIC	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PROGRAF CAPSULE	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
RAPAMUNE	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
REMICADE	5	HI; PA - Prior authorization required for coverage.
SYPRINE	2	
<i>tacrolimus</i>	1	GC; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

### ***Immunomodulators***

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
AVONEX	5	
COPAXONE	5	
INTRON-A W/DILUENT	5	
INTRON-A INJECTION 3MU/0.2ML	4	
INTRON-A INJECTION 10MU/0.2ML, 10MU/ML, 5MU/0.2ML, 6000000UNIT/ML	5	
<i>leflunomide</i>	1	GC
PEG-INTRON	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #4 injections per 30 days.
PEG-INTRON REDIPEN	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #4 injections per 30 days.
PEG-INTRON REDIPEN PAK 4	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #4 injections per 30 days.
PEGASYS	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #4 injections per 30 days.
REBIF	5	
REBIF TITRATION PACK	5	
RIDAURA	2	
<b>Vaccines</b>		
HAVRIX	4	
RECOMBIVAX HB	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
<b>Inflammatory Bowel Disease Agents</b>		
<b>Glucocorticoids</b>		
<i>colocort</i>	1	GC
CORTIFOAM	2	
<i>hydrocortisone</i>	1	GC
<i>procto-pak</i>	1	GC
<i>proctosol hc</i>	1	GC
<i>proctozone-hc</i>	1	GC
<b>Salicylates</b>		
ASACOL	2	
ASACOL HD	2	
<i>balsalazide disodium</i>	1	GC
CANASA	2	
DIPENTUM	2	
<i>mesalamine</i>	1	GC
PENTASA	2	

Drug Name	Drug Tier	Notes
<b>Sulfonamides</b>		
<i>sulfasalazine</i>	1	GC
<i>sulfazine</i>	1	GC
<i>sulfazine ec</i>	1	GC
<b>Metabolic Bone Disease Agents</b>		
<b>Metabolic Bone Disease Agents</b>		
ACTONEL	2	PA - Prior authorization required for coverage.
ACTONEL WITH CALCIUM	2	PA - Prior authorization required for coverage.
<i>alendronate sodium</i>	1	GC
BONIVA TABLET	3	PA - Prior authorization required for coverage.
<i>calcitonin-salmon</i>	1	GC
<i>calcitriol capsule, solution</i>	1	GC
<i>etidronate disodium</i>	1	GC
FORTICAL	2	
MIACALCIN INJECTION	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
<b>Miscellaneous Therapeutic Agents</b>		
<b>Miscellaneous Therapeutic Agents</b>		
ALCOHOL PREPS	2	
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	2	
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	2	
BD ULTRA-FINE ORIGINAL PEN NEEDLES/29G X 12.7MM	2	
CURITY GAUZE PADS 2"X2"	2	
<b>Ophthalmic Agents</b>		
<b>Ophthalmic Agents, Other</b>		
<i>ak-con</i>	1	GC
<i>ak-tob</i>	1	GC
CILOXAN	2	
<i>ciprofloxacin hcl</i>	1	GC
<i>erythromycin</i>	1	GC
<i>gentamicin sulfate</i>	1	GC
<i>gentasol</i>	1	GC
<i>mydral</i>	1	GC
<i>naphazoline hcl</i>	1	GC
<i>ofloxacin</i>	1	GC
<i>proparacaine hcl</i>	1	GC
<i>tobramycin sulfate</i>	1	GC
<i>tobrasol</i>	1	GC
<i>tropicamide</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
VIGAMOX	3	Potential preferred options: ciprofloxacin, ofloxacin
ZYMAR	3	Potential preferred options: CILOXAN, OCUFLOX
<b>Ophthalmic Anti-allergy Agents</b>		
ALOCRIAL	2	
<i>cromolyn sodium</i>	1	GC
PATANOL	2	
<b>Ophthalmic Anti-inflammatories</b>		
ACULAR	2	
ACULAR LS	2	
ACULAR PF	2	
ALREX	2	
<i>bac /poly /neomy /hc</i>	1	GC
BLEPHAMIDE S.O.P.	2	
<i>dexamethasone sodium phosphate</i>	1	GC
<i>diclofenac sodium</i>	1	GC
<i>fluor-op</i>	1	GC
<i>fluorometholone</i>	1	GC
<i>flurbiprofen sodium</i>	1	GC
FML	2	
LOTEMAX	2	
<i>neo /poly /bac /hc</i>	1	GC
<i>neomycin /polymyxin /dexamethasone</i>	1	GC
<i>poly-dex</i>	1	GC
PRED MILD	2	
<i>prednisolone acetate</i>	1	GC
<i>prednisolone sodium phosphate</i>	1	GC
TOBRADEX	2	
<i>tobramycin /dexamethasone</i>	1	GC
<b>Ophthalmic Antiglaucoma Agents</b>		
<i>acetazolamide</i>	1	GC
ALPHAGAN P	2	
<i>apraclonidine</i>	1	GC
AZOPT	2	
<i>betaxolol hcl</i>	1	GC
BETIMOL	2	
BETOPTIC-S	2	
<i>brimonidine tartrate</i>	1	GC
<i>carteolol hcl</i>	1	GC
<i>dipivefrin hcl</i>	1	GC
<i>dorzolamide hcl/timolol maleate</i>	1	GC
<i>levobunolol hcl</i>	1	GC
<i>metipranolol</i>	1	GC
<i>pilocarpine hcl</i>	1	GC
PILOPINE HS	2	
PROPINE	2	
<i>timolol maleate</i>	1	GC

Drug Name	Drug Tier	Notes
<i>timolol maleate ophthalmic gel forming</i>	1	GC
<b>Ophthalmic Prostaglandin and Prostanamide Analogs</b>		
<i>dorzolamide hcl</i>	1	GC
LUMIGAN	2	
TRAVATAN	2	
TRAVATAN Z	2	
XALATAN	3	Potential preferred options: LUMIGAN, TRAVATAN
<b>Otic Agents</b>		
<b>Otic Agents</b>		
<i>acetazol hc</i>	1	GC
<i>acetic acid</i>	1	GC
<i>borofair</i>	1	GC
CIPRO HC	2	
CIPRODEX	2	
<i>cortomycin</i>	1	GC
<i>neomycin /polymyxin /hc</i>	1	GC
<i>neomycin /polymyxin /hydrocortisone</i>	1	GC
<i>ofloxacin</i>	1	GC
<i>oticin hc</i>	1	GC
<b>Respiratory Tract Agents</b>		
<b>Anti-inflammatories, Inhaled Corticosteroids</b>		
ADVAIR DISKUS	2	
ASMANEX 120 METERED DOSES	2	
ASMANEX 14 METERED DOSES	2	
ASMANEX 30 METERED DOSES	2	
ASMANEX 60 METERED DOSES	2	
AZMACORT	2	
FLOVENT DISKUS	2	
FLOVENT HFA	2	
<i>flunisolide</i>	1	GC
<i>fluticasone propionate</i>	1	GC
NASACORT AQ	2	PA - Prior authorization required for coverage.
NASONEX	2	PA - Prior authorization required for coverage.
PULMICORT	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PULMICORT FLEXHALER	2	
QVAR	2	
RHINOCORT AQUA	2	PA - Prior authorization required for coverage.
<b>Antihistamines</b>		
ASTELIN	2	
ASTEPRO	2	
<i>carbinoxamine maleate</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>cetirizine hcl</i>	1	GC
<i>clemastine fumarate</i>	1	GC
<i>cyproheptadine hcl</i>	1	GC
<i>dexchlorpheniramine maleate</i>	1	GC
<i>diphenhydramine hcl</i>	1	GC
<i>fexofenadine hcl</i>	1	GC
<i>hydroxyzine hcl syrup, tablet</i>	1	GC
<i>hydroxyzine pamoate</i>	1	GC
<i>promethazine hcl syrup, tablet</i>	1	GC
<b>Antileukotrienes</b>		
ACCOLATE	2	
SINGULAIR	2	
<b>Bronchodilators, Anticholinergic</b>		
ATROVENT HFA	2	
<i>ipratropium bromide solution</i>	1	GC
SPIRIVA HANDIHALER	2	
<b>Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)</b>		
<i>aminophylline tablet</i>	1	GC
<i>elixophyllin</i>	1	GC
<i>theochron</i>	1	GC
<i>theophylline cr</i>	1	GC
<i>theophylline er</i>	1	GC
<i>theophylline td</i>	1	GC
<b>Bronchodilators, Sympathomimetic</b>		
ADVAIR HFA	2	
<i>albuterol sulfate er</i>	1	GC
<i>albuterol sulfate syrup, tablet</i>	1	GC
COMBIVENT	2	
EPIPEN 2-PAK	2	
EPIPEN-JR 2-PAK	2	
FORADIL AEROLIZER	2	
<i>metaproterenol sulfate syrup, tablet</i>	1	GC
PROAIR HFA	2	
PROVENTIL HFA	2	
SEREVENT DISKUS	2	
<i>terbutaline sulfate tablet</i>	1	GC
VENTOLIN HFA	2	
<b>Mast Cell Stabilizers</b>		
<i>cromolyn sodium</i>	1	GC
INTAL	2	
INTAL INHALER	2	
<b>Pulmonary Antihypertensives</b>		
LETAIRIS	5	LA
REVATIO	5	PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #90 tablets per 30 days.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
TRACLEER	5	LA
<b>Sedatives/Hypnotics</b>		
<i>Sedatives/Hypnotics</i>		
AMBIEN CR TABLET EXTENDED RELEASE 12.5MG	3	QL - Quantity limited to #30 tablets per 30 days. All strengths of Ambien, Ambien CR, Lunesta, Rozerem, Sonata, zaleplon, zolpidem tartrate accumulate together.
LUNESTA	3	QL - Quantity limited to #30 tablets per 30 days. All strengths of Ambien, Ambien CR, Lunesta, Rozerem, Sonata, zaleplon, zolpidem tartrate accumulate together.
<i>zaleplon</i>	1	GC; QL - Quantity limited to #30 capsules per 30 days. All strengths of Ambien, Ambien CR, Lunesta, Rozerem, Sonata, zaleplon, zolpidem tartrate accumulate together.
<i>zolpidem tartrate</i>	1	GC; QL - Quantity limited to #30 tablets per 30 days All strengths of Ambien, Ambien CR, Lunesta, Rozerem, Sonata, zaleplon, zolpidem tartrate accumulate together.
<b>Skeletal Muscle Relaxants</b>		
<i>Skeletal Muscle Relaxants</i>		
<i>baclofen</i>	1	GC
<i>carisoprodol</i>	1	GC
<i>carisoprodol /aspirin /codeine</i>	1	GC
<i>carisoprodol/aspirin</i>	1	GC
<i>chlorzoxazone</i>	1	GC
<i>cyclobenzaprine hcl</i>	1	GC
<i>dantrolene sodium</i>	1	GC
<i>methocarbamol</i>	1	GC
<i>orphenadrine /asa /caffeine</i>	1	GC
<i>orphenadrine compound ds</i>	1	GC
<i>tizanidine hcl</i>	1	GC
<b>Therapeutic Nutrients/Minerals/ Electrolytes</b>		
<i>Electrolytes/Minerals</i>		
<i>ed k+10</i>	1	GC
<i>klor-con 10</i>	1	GC
<i>klor-con 8</i>	1	GC
<i>klor-con m10</i>	1	GC
<i>klor-con m15</i>	1	GC
<i>klor-con m20</i>	1	GC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Notes</b>
<i>klotrix</i>	1	GC
<i>lactated ringer's irrigation</i>	1	GC
<i>levocarnitine oral solution, tablet</i>	1	GC
<i>levocarnitine injection</i>	4	HI
MICRO-K CAPSULE EXTENDED RELEASE 10MEQ	2	
<i>phospha 250 neutral</i>	1	GC
<i>physiolyte</i>	1	GC
<i>potassium chloride cr</i>	1	GC
<i>potassium chloride er</i>	1	GC
<i>potassium chloride sr</i>	1	GC
<i>potassium citrate extended-release</i>	1	GC
<i>ringer's irrigation</i>	1	GC
<i>sodium chloride 0.9%</i>	1	GC
<i>sodium chloride 0.9%</i>	1	GC
<b>Vitamins</b>		
<i>prenatal rx 1</i>	1	GC
<i>sodium fluoride</i>	1	GC

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