The Essence of Care

2012 FORMULARY

List of Covered Drugs

PLEASE READ:
This document contains information about the drugs we cover in this plan.

NOTE TO EXISTING MEMBERS:
This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

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

To receive this material in an alternate format or language, please call Member Services at 877-372-8085. (TTY only, call 888-844-5530). Hours are 8:00 a.m. to 8:00 p.m., seven days a week and calls to these numbers are free. TTY/TDD users should call 1.888.844.5530.

MCE 12_01 H2323, H5575, H5980
CMS File & Use 08/22/2011

Formulary ID 12311, Version 5
Last Updated: July 8, 2011

A Health Plan with a Medicare Contract

THIS PAGE HAS BEEN INTENTIONALLY LEFT BLANK.

What is the Fidelis SecureCare Formulary?

A formulary is a list of covered drugs selected by Fidelis SecureCare 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. Fidelis SecureCare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Fidelis SecureCare 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, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we 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 July 8, 2011. To get updated information about the drugs covered by Fidelis SecureCare, please visit our website at www.fidelissc.com or call Member Services at 877-372-8085. (TTY only, call 888-844-5530). Hours are 8:00 a.m. to 8:00 p.m., seven days a week and calls to these numbers are free. TTY/TDD users should call 1.888.844.5530.

In the event of mid-year non-maintenance formulary changes, Fidelis SecureCare will provide all members notice of those changes in a manner consistent with Medicare requirements. Examples of communications may include formulary errata sheets or formulary update letters mailed to beneficiaries.

How do I use the Formulary?

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

Medical Condition
The formulary begins on page seven (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 seven (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 50. 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?

Fidelis SecureCare 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:** Fidelis SecureCare requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Fidelis SecureCare before you fill your prescriptions. If you don't get approval, Fidelis SecureCare may not cover the drug.

- **Quantity Limits:** For certain drugs, Fidelis SecureCare limits the amount of the drug that Fidelis SecureCare will cover. For example, Fidelis SecureCare provides nine (9) tablets per 30 day prescription for ZOMIG ZMT. This may be in addition to a standard one month or three month supply.

- **Step Therapy:** In some cases, Fidelis SecureCare 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, Fidelis SecureCare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Fidelis SecureCare 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 seven (7). You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.fidelissc.com.

You can ask Fidelis SecureCare to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Fidelis SecureCare 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 Member Services and confirm that your drug is not covered. If you learn that Fidelis SecureCare does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Fidelis SecureCare. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Fidelis SecureCare.

- You can ask Fidelis SecureCare 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 Fidelis SecureCare Formulary?

You can ask Fidelis SecureCare 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, Fidelis SecureCare 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, Fidelis SecureCare 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 31-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 31-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 93-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.

If you are transitioning from one level of care to another as defined by one of the following situations: members moving from hospital to home, long term care facility, assisted living, or group home; members moving from a skilled nursing benefit and reverting to the Part D benefit; members terminating a hospice election and reverting to a Part D benefit, or members discharged from a chronic psychiatric hospital to home, long term care facility, assisted living, group home, a temporary, one time up to 31-day supply prescription fill for Part D eligible non-formulary drugs will be provided at a non-preferred tier copay or coinsurance. The authorization will be granted through an exception process at or prior to the transition pharmacy transaction.

For more information

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

If you have questions about Fidelis SecureCare, please call Member Services at 877-372-8085. (TTY only, call 888-844-5530). Hours are 8:00 a.m. to 8:00 p.m., seven days a week and calls to these numbers are free. TTY/TDD users should call 1.888.844.5530.
Or visit our website at www.fidelissc.com.

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.

Fidelis SecureCare's Formulary

The formulary that begins on page seven (7) provides coverage information about some of the drugs covered by Fidelis SecureCare. If you have trouble finding your drug in the list, turn to the index that begins on page 50.

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

All drugs on our "Drug List" are available from our mail order pharmacy except if designated as limited access. Limited access means that the prescription drug may be available only at certain pharmacies.

The second column of the chart indicates the drug tier level.

- Tier 1 : Preferred Generic
- Tier 2 : Preferred Brand
- Tier 3 : Non Preferred Drugs
- Tier 4 : Specialty

After you have paid your deductible, if applicable, and before your yearly prescription drug costs reach $2930, your copayments or coinsurances are designated by Fidelis SecureCare plan in the tables below.

Copayment or coinsurance information provided in the tables below is in the following format:

31 day retail/ 90 day retail or Mail Order

Plan	Deductible	Drug Tier 1	Drug Tier 2	Drug Tier 3	Drug Tier 4
Fidelis Secure Comfort (HMO SNP)	$320	25% / 25%	25% / 25%	25% / 25%	25% / 25%
Fidelis Secure Comfort Plus (HMO SNP)	$0	$5/$10	$30/$60	$65/$130	33% / 33%
Fidelis Secure Independence (HMO SNP)	$0	$5/$10	$30/$60	$65/$130	33% / 33%
Fidelis Secure Freedom (HMO SNP)	$320	25% / 25%	25% / 25%	25% / 25%	25% / 25%
Fidelis SecureHome (HMO SNP)	$320	25% / 25%	25% / 25%	25% / 25%	25% / 25%

The copays or co-insurances paid by a member that receives "Extra Help from Medicare" will be consistent with the subsidy level that the member is qualified. Medicare Part D "Extra Help" copays or coinsurances depend on a member's income and institutional status and are as follows: $0, $1.10, $2.60, or 15% for generic medications and $0, $3.30, $6.50 or 15% for all other medications.

Please refer to our *Evidence of Coverage* for more information about your plan coverage.

The third column, the Requirements/Limits column tells you if Fidelis SecureCare has any special requirements for coverage of your drug.

B/D — Indicates Authorization is required to identify if the use of the drug is for a Medicare Part B or Part D indication. This determines coverage status and impact on Part D drug benefit.

HI — This prescription drug is covered under our medical benefit. For more information, call Member Services at 877-372-8085. (TTY only, call 888-844-5530). Hours are 8:00 a.m. to 8:00 p.m., seven days a week and calls to these numbers are free. TTY/TDD users should call 1.888.844.5530.

LA — Indicates Limited Access. These prescriptions may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 877-372-8085. (TTY only, call 888-844-5530). Hours are 8:00 a.m. to 8:00 p.m., seven days a week and calls to these numbers are free. TTY/TDD users should call 1.888.844.5530.

PA — Indicates Prior Authorization is Required.

QL — Indicates Quantity Limits.

ST — Indicates Step Therapy.

Covered Medications by Therapeutic Category

Drug Name	Drug Tier	Requirements/ Limits
Analgesics		
SAVELLA	2	QL (62 per 31 days)
SAVELLA TITRATION PACK	2	QL (55 per 31 days)
Nonsteroidal Anti-inflammatory Drugs		
ARTHROTEC 50	3	
ARTHROTEC 75	3	
CELEBREX 200 MG, 400 MG, 50 MG	3	QL (62 per 31 days)
CELEBREX 100 MG	3	QL (93 per 31 days)
diclofenac	1	
diclofenac ec	1	
diclofenac xr	1	
diflunisal	1	
EQUAGESIC	3	
etodolac	1	
etodolac er	1	
fenoprofen	1	
flurbiprofen	1	
ibu	1	QL (124 per 31 days)
ibuprofen	1	
ketoprofen	1	
ketoprofen er	1	QL (31 per 31 days)
meclofenamate	1	
mefenamic acid	3	
meloxicam suspension	3	QL (310 per 31 days)
meloxicam 15 mg	1	QL (31 per 31 days)
meloxicam 7.5 mg	1	QL (62 per 31 days)
nabumetone	1	
NALFON	3	
naproxen dr	1	
naproxen	1	
sulindac	1	
tolmetin	1	
VOLTAREN GEL	2	
ZIPSOR	3	QL (124 per 31 days)
Opioid Analgesics		
ABSTRAL	4	QL (124 per 31 days), PA
acetaminophen/ caffeine/ dihydrocodeine	1	QL (155 per 31 days)
acetaminophen/ codeine #3	1	QL (372 per 31 days)
acetaminophen/ codeine #4	1	QL (186 per 31 days)
acetaminophen/ codeine	1	QL (403 per 31 days)
acetaminophen/ codeine solution	1	QL (4650 per 31 days)
ascomp/codeine	1	QL (186 per 31 days)
astramorph	1	
buprenorphine inj	3	
buprenorphine sublingual 2 mg	3	QL (16 per 31 days), PA
buprenorphine sublingual 8 mg	3	QL (8 per 31 days), PA
butalbital/APAP/ caffeine/ codeine	1	QL (186 per 31 days)
butorphanol inj	1	
butorphanol nasal solution	1	QL (5 per 1 days)

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
CAPITAL/CODEINE	2	QL (4650 per 31 days)
co-gesic	1	QL (248 per 31 days)
codeine	1	
DILAUDID-5	3	QL (4960 per 31 days)
duramorph	1	
endocet 10-650 mg	1	QL (186 per 31 days)
endocet 7.5-500 mg	1	QL (248 per 31 days)
endocet 10-325 mg; 5-325 mg; 7.5-325 mg	1	QL (372 per 31 days)
endodan	1	QL (372 per 31 days)
fentanyl	1	
fentanyl oral transmucosal	4	QL (124 per 31 days), PA
fentanyl patch 12, 25, & 50 mcg/hr	3	QL (15 per 31 days)
fentanyl patch 100 & 75 mcg/hr	3	QL (31 per 31 days)
FENTORA 300 MCG	4	
HYCET	3	QL (5735 per 31 days)
hydrocodone/APAP 10-300, 5-300 & 7.5-300 mg	3	QL (403 per 31 days)
hydrocodone/APAP 10-750 mg	1	QL (155 per 31 days)
hydrocodone/APAP solution 7.5-500 mg/15 ml	1	QL (3720 per 31 days)
hydrocodone/APAP solution 10-325 mg/15 ml	1	QL (5735 per 31 days)
hydrocodone/APAP 7.5-750 mg	1	QL (155 per 31 days)
hydrocodone/APAP 10-650 mg; 7.5-650 mg; 10-660 mg	1	QL (186 per 31 days)
hydrocodone/APAP 10-500 mg; 2.5-500 mg; 5-500 mg; 7.5 -500 mg	1	QL (248 per 31 days)
hydrocodone/APAP 10-325 mg; 5-325 mg; 7.5-325 mg	1	QL (372 per 31 days)
hydrocodone/ ibuprofen	1	QL (155 per 31 days)
hydromorphone dosette	3	
hydromorphone	1	QL (372 per 31 days)
hydromorphone inj	3	
INFUMORPH 200, 500	3	
levorphanol	3	QL (496 per 31 days)
margesic-h	1	QL (248 per 31 days)
METHADONE INJ	3	
methadone oral solution	1	QL (1860 per 31 days)
methadone	1	QL (372 per 31 days)
methadone concentrate	1	QL (744 per 31 days)
methadose	1	QL (372 per 31 days)

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
morphine add-vantage	1	
morphine dilute-a-jet	1	
morphine er 12 hour 15 mg, 30 mg, 60 mg	1	QL (124 per 31 days)
morphine er 12 hour 100 mg, 200 mg	1	QL (186 per 31 days)
morphine stick-gard	1	
morphine oral solution	1	
morphine	1	QL (372 per 31 days)
morphine inj	1	
nalbuphine	1	
OPANA ER	2	QL (124 per 31 days)
oxycodone concentrate	1	
oxycodone 10 mg, 20 mg	1	
oxycodone 15 mg, 30 mg, 5 mg	1	QL (496 per 31 days)
oxycodone/APAP	1	QL (248 per 31 days)
oxycodone/APAP 10-650 mg	1	QL (186 per 31 days)
oxycodone/APAP 7.5-500 mg	1	QL (248 per 31 days)
oxycodone/APAP 10-325 mg; 2.5-325 mg; 5-325 mg; 7.5-325 mg	1	QL (372 per 31 days)
oxycodone/ aspirin	1	QL (372 per 31 days)
oxycodone/ ibuprofen	1	QL (124 per 31 days)
OXYCONTIN ER 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	3	QL (124 per 31 days)
OXYCONTIN ER 80 MG	3	QL (186 per 31 days)
oxymorphone	3	QL (186 per 31 days)
ROXICET SOLUTION	3	QL (1922 per 31 days)
roxicet 5-500 mg	1	QL (248 per 31 days)
roxicet 5-325 mg	1	QL (372 per 31 days)
stagesic	1	QL (248 per 31 days)
SYNALGOS-DC	3	QL (372 per 31 days)
tramadol	1	QL (248 per 31 days)
tramadol er	1	QL (31 per 31 days)
tramadol/APAP	1	QL (248 per 31 days)
ULTRAM ER 300 MG	3	QL (31 per 31 days)
XODOL	3	QL (403 per 31 days)
zerlor	1	QL (155 per 31 days)
ZYDONE	3	QL (310 per 31 days)

Anesthetics

Local Anesthetics

Drug Name	Drug Tier	Requirements/ Limits
lidocaine jelly	1	
lidocaine gel, external solution	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
lidocaine inj	1	B/D
lidocaine viscous	1	
lidocaine/prilocaine	1	B/D
lidocaine ointment	1	B/D
LIDODERM	2	QL (93 per 31 days)

Antibacterials

Aminoglycosides

Drug Name	Drug Tier	Requirements/ Limits
ak-tob ophthalmic	1	
amikacin	1	HI
genoptic	1	
gentak ophthalmic	1	
gentamicin	1	
gentamicin injection	1	HI
gentasol ophthalmic	1	
gentamicin topical	1	
kanamycin injection	1	HI
neomycin	1	
paromomycin	1	
STREPTOMYCIN INJ	3	
TOBI	4	B/D
tobramycin injection	1	HI
tobrasol ophthalmic	1	
TOBREX OINTMENT	3	

Antibacterials, Other

Drug Name	Drug Tier	Requirements/ Limits
ak-poly-bac	1	
alcohol preps	1	
baciim	1	
bacitracin	1	
bacitracin/polymyxin b ophthalmic	1	
BACTROBAN NASAL	2	
BACTROBAN CREAM	2	
chloramphenicol inj	1	HI
CLEOCIN INJ	3	HI
CLEOCIN SUPPOSITORY	3	
CLEOCIN 75 MG	3	
CLINDAGEL	3	
clindamycin	1	
clindamycin palmitate	1	
clindamycin inj & add-vantage	1	HI
clindamycin foam	3	
clindamycin cream, gel, lotion,solution, swab	1	
CLINDESSE	3	
colistimethate inj	4	HI
CORTISPORIN CREAM	2	
CUBICIN	4	HI
FLAGYL ER	3	
methenamine hippurate	1	
METROGEL	3	
metronidazole	1	
metronidazole inj	1	HI
metronidazole vaginal & topical	1	
MONUROL	3	
mupirocin	1	
neomycin/bacitracin/ polymyxin ophthalmic	1	
neomycin/polymyxin b irrigation	1	
neomycin/polymyxin/ gramicidin ophthalmic	1	
nitrofurantoin macro	1	
nitrofurantoin mono	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
NORITATE	3	
polycin b	1	
polymyxin b inj	1	HI
PRIMSOL	3	
silver sulfadiazine cream	1	
ssd	1	
SULFAMYLON PACKET	3	
SULFAMYLON CREAM	2	
SYNERCID	4	HI
thermazene	1	
trimethoprim	1	
TYGACIL	3	HI
VANCOCIN	4	PA
vancomycin inj	1	HI
vandazole	1	
XIFAXAN 550 MG	4	
XIFAXAN 200 MG	3	
ZYVOX INJ	4	HI, PA
ZYVOX SUSPENSION	4	PA
Beta-lactam, Cephalosporins		
CEDAX	3	
cefaclor	1	
cefaclor er	1	
cefadroxil	1	
cefazolin	1	HI
cefazolin /dextrose	1	HI
cefdinir	1	
cefditoren	3	
CEFEPIME/ DEXTROSE INJ	3	HI
cefepime inj 1 gm, 2 gm	3	HI
CEFIZOX INJ	3	HI
CEFOTAXIME INJ 20 GM	2	HI
cefotaxime inj 10 gm, 1 gm, 2 gm, 500 mg	1	HI
CEFOTETAN / DEXTROSE	3	HI
cefoxitin inj 1 gm, 2 gm	3	HI
cefpodoxime proxetil	1	
cefprozil	1	
ceftazidime inj 500 mg	3	HI
ceftazidime inj 1 gm, 2 gm	1	HI
ceftriaxone in dextrose	3	HI
ceftriaxone inj 1 gm, 2 gm	3	HI
ceftriaxone inj 250 mg, 500 mg	1	HI
cefuroxime axetil	1	
cefuroxime inj 1.5 G & 750 mg	1	HI
cefuroxime/dextrose	1	HI
cephalexin	1	
CLAFORAN INJ	3	HI
FORTAZ INJ	3	HI
KEFLEX 750 MG	3	
MAXIPIME INJ 2 GM	2	HI
MAXIPIME INJ 1 GM	3	HI
SUPRAX	3	
tazicef inj 1 G, 2 G, 6 G	1	HI
ZINACEF INJ	3	HI

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
Beta-lactam, Other		
AZACTAM INJ 1 GM	3	HI
aztreonam inj	3	HI
CAYSTON	4	B/D
INVANZ	2	HI
meropenem inj	3	HI
MERREM INJ	3	HI
PRIMAXIN	3	HI
Beta-lactam, Penicillins		
amoxicillin	1	
amoxicillin/ clavulanate	1	
amoxicillin/ clavulanate er	1	
amoxil	1	
ampicillin inj	1	HI
ampicillin oral capsule, solution	1	
ampicillin-sulbactam inj	1	HI
BACTOCILL 2 GM INJ	4	HI
BACTOCILL 1 GM INJ	3	HI
BICILLIN C-R	3	
BICILLIN L-A	3	
dicloxacillin	1	
nafcillin	3	HI
NALLPEN	3	HI
oxacillin inj	3	HI
penicillin g potassium inj	3	HI
penicillin g in dextrose	3	HI
penicillin g sodium inj	3	HI
penicillin vk	1	
PIPERACILLIN	3	HI
piperacillin / tazobactam 3.375	3	HI
TIMENTIN INJ 3.1 G	2	HI
trimox	1	
veetids	1	
ZOSYN INJ 4.5 G & 2.25 G	2	HI
Macrolides		
AKNE-MYCIN	3	
AZASITE	2	
azithromycin	1	
azithromycin inj	1	HI
clarithromycin & ER	1	
e.e.s. 400	1	
E.E.S. GRANULES	2	
ery	1	
ERY-TAB	2	
ERYPED 200; 400	2	
ERYTHROCIN INJ 1000 MG	3	HI
ERYTHROCIN INJ 500 MG	2	HI
ERYTHROCIN STEARATE	3	
erythromycin	1	
erythromycin base	1	
erythromycin/ sulfisoxazole	1	
KETEK	3	PA
PCE	3	
romycin ophthalmic	1	
ZMAX ORAL SUSPENSION	3	
Quinolones		
AVELOX ABC PACK	2	
AVELOX INJ	3	HI
AVELOX	2	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
BESIVANCE OPHTHALMIC	2	
CILOXAN OINTMENT	2	
CIPRO SUSPENSION	3	
ciprofloxacin ophthalmic	1	
ciprofloxacin extended-release	1	
ciprofloxacin	1	
ciprofloxacin iv	1	HI
levofloxacin	1	
NOROXIN	3	
ofloxacin ophthalmic & otic	1	
PROQUIN XR	3	
VIGAMOX OPHTHALMIC	2	
ZYMAR OPHTHALMIC	2	
ZYMAXID OPHTHALMIC	2	
Sulfonamides		
GANTRISIN PEDIATRIC	2	
ocusulf-10 ophthalmic	1	
sulfacetamide ophthalmic	1	
sulfadiazine	3	
sulfamethoxazole/ trimethoprim inj	1	HI
sulfamethoxazole/ trimethoprim oral	1	
sulfatrim	1	
trimethoprim / polymyxin b ophthalmic	1	
Tetracyclines		
demeclocycline	3	
DORYX DR 150 MG	3	
doxy-caps	1	
doxycycline hyclate inj	3	HI
doxycycline hyclate capsules	1	
doxycycline mono	3	
doxycycline mono, suspension	1	
minocycline er	3	
minocycline tablets	3	
minocycline capsules	1	
ORACEA	2	
tetracycline	1	
VIBRAMYCIN SYRUP	3	

Anticonvulsants

Drug Name	Drug Tier	Requirements/ Limits
Anticonvulsants, Other		
BANZEL	3	
levetiracetam oral solution	1	
levetiracetam inj	3	
levetiracetam	1	
VIMPAT	3	
Calcium Channel Modifying Agents		
CELONTIN	3	
ethosuximide	1	
LYRICA	3	PA – new starts only
zonisamide	1	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
divalproex	1	
divalproex er	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
gabapentin solution	3	
gabapentin	1	
GABITRIL	3	
NEURONTIN SOLUTION	3	
primidone	1	
SABRIL	4	PA – new starts only
STAVZOR	3	
valproate inj	3	
valproic acid	1	
Glutamate Reducing Agents		
FELBATOL SUSPENSION	4	
FELBATOL	3	
LAMICTAL STARTER KITS	2	
lamotrigine chewable	1	
lamotrigine	1	
topiramate	1	
Channel Inhibitors		
carbamazepine	1	
carbamazepine er	1	
CARBATROL	2	
DILANTIN INFATABS	2	
DILANTIN 30 MG	2	
epitol	1	
fosphenytoin inj	1	HI
oxcarbazepine suspension	3	
oxcarbazepine	1	
PEGANONE	3	
phenytoin inj	1	
phenytoin suspension	1	
phenytoin ER	1	
TEGRETOL-XR 100 MG	2	
Antidementia Agents		
Cholinesterase Inhibitors		
ARICEPT 23 MG	2	ST
donepezil	1	
EXELON PATCH & ORAL SOLUTION	3	
galantamine	1	
rivastigmine	3	
Glutamate Pathway Modifiers		
NAMENDA	2	
NAMENDA TITRATION PAK	2	
Antidepressants		
Antidepressants, Other		
budeprion sr 12 hour 100 mg	1	QL (124 per 31 days)
budeprion sr 12 hour 150 mg	1	QL (62 per 31 days)
budeprion xl 24 hour 300 mg	1	QL (31 per 31 days)
budeprion xl 24 hour 150 mg	1	QL (93 per 31 days)
bupropion sr 12 hour 100 mg	1	QL (124 per 31 days)
bupropion sr 12 hour 200 mg	1	QL (62 per 31 days)
bupropion 100 mg	1	QL (124 per 31 days)
bupropion 75 mg	1	QL (93 per 31 days)
maprotiline	1	
mirtazapine	1	QL (31 per 31 days)
mirtazapine odt	1	QL (31 per 31 days)
nefazodone	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
trazodone	1	
Monoamine Oxidase Inhibitors		
EMSAM	3	QL (31 per 31 days), ST – new starts only
MARPLAN	3	
NARDIL	3	
phenelzine	1	
tranylcypromine	1	
Serotonin/Norepinephrine Reuptake Inhibitors		
citalopram solution	1	QL (930 per 31 days)
citalopram 10 mg	1	QL (31 per 31 days)
citalopram 40 mg	1	QL (45 per 31 days)
citalopram 20 mg	1	QL (93 per 31 days)
CYMBALTA 60 MG	2	QL (31 per 31 days)
CYMBALTA 20 MG, 30 MG	2	QL (62 per 31 days)
fluoxetine 20 mg	1	QL (124 per 31 days)
fluoxetine 40 mg	1	QL (62 per 31 days)
fluoxetine 10 mg	1	QL (93 per 31 days)
fluoxetine solution	1	QL (620 per 31 days)
fluvoxamine	1	QL (93 per 31 days)
paroxetine er 37.5 mg	3	QL (62 per 31 days)
paroxetine er 12.5 mg	3	QL (186 per 31 days)
paroxetine er 25 mg	3	QL (93 per 31 days)
paroxetine suspension	3	QL (930 per 31 days)
paroxetine 10 mg	1	QL (31 per 31 days)
paroxetine 40 mg	1	QL (45 per 31 days)
paroxetine 30 mg	1	QL (62 per 31 days)
paroxetine 20 mg	1	QL (93 per 31 days)
PEXEVA 10 MG, 20 MG	3	QL (31 per 31 days), ST – new starts only
PEXEVA 40 MG	3	QL (45 per 30 days), ST – new starts only
PEXEVA 30 MG	3	QL (62 per 31 days), ST – new starts only
PRISTIQ	2	QL (31 per 31 days)
sertraline concentrate	1	QL (310 per 31 days)
sertraline 50 mg	1	QL (31 per 31 days)
sertraline 25 mg	1	QL (45 per 31 days)
sertraline 100 mg	1	QL (62 per 31 days)
venlafaxine ER 150 mg	1	QL (62 per 31 days)
venlafaxine ER 37.5 mg, 75 mg	1	QL (93 per 31 days)
venlafaxine ER 225 mg	3	QL (31 per 31 days)

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
venlafaxine ER 150 mg	3	QL (62 per 31 days)
venlafaxine 50 mg	1	QL (217 per 31 days)
venlafaxine 100 mg, 25 mg, 37.5 mg, 75 mg	1	QL (93 per 31 days)
Tricyclics		
amitriptyline 10 mg, 25 mg, 50 mg	1	
amoxapine	1	
clomipramine	1	
desipramine	1	
doxepin 10 mg, 150 mg, 25 mg	1	
doxepin concentrate	1	
imipramine	1	
imipramine pamoate	3	
nortriptyline solution	3	
nortriptyline	1	
protriptyline	3	
SURMONTIL	3	
trimipramine	3	

Antidotes, Deterrents, and Toxicologic Agents

Drug Name	Drug Tier	Requirements/ Limits
Antidotes		
CUPRIMINE	2	
DEPEN TITRATABS	3	
EXJADE 250 MG, 500 MG	4	
EXJADE 125 MG	3	
kionex	1	
leucovorin	1	
polystyrene sulfonate suspension	1	
polystyrene sulfonate powder	1	
SYPRINE	3	
Deterrents		
ANTABUSE	2	
buproban	1	QL (62 per 31 days)
CAMPRAL	3	
CHANTIX 0.5 MG; 1 MG PACK	3	QL (53 per 31 days), PA
CHANTIX 0.5 MG, 1 MG	3	QL (62 per 31 days), PA
NICOTROL INHALER	3	QL (3024 per 180 days)
NICOTROL NS	3	QL (720 per 180 days)
Toxicologic Agents		
depade	1	
naloxone	1	
naltrexone	1	
SUBOXONE	3	QL (93 per 31 days), PA

Antiemetics

Drug Name	Drug Tier	Requirements/ Limits
Antiemetics		
ALOXI INJ	3	HI
ANTIVERT 50 MG	3	
ANZEMET INJ	3	HI
ANZEMET 100 MG	4	QL (3 per 3 days), B/D
ANZEMET 50 MG	3	QL (6 per 3 days), B/D
compro	1	
dronabinol 10 mg	4	PA
dronabinol 2.5 mg, 5 mg	3	QL (186 per 31 days), PA
EMEND	2	PA
EMEND INJ 150 MG	2	QL (2 per 31 days), PA

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
granisetron inj	3	
granisetron	3	QL (6 per 3 days), B/D
granisol	3	QL (30 per 3 days), B/D
meclizine	1	
metoclopramide	1	
ondansetron inj	3	HI
ondansetron oral solution	3	B/D
ondansetron	1	B/D
ondansetron odt	1	B/D
prochlorperazine	1	
SANCUSO	4	QL (2 per 28 days)
TRANSDERM-SCOP	3	QL (10 per 30 days)
ZUPLENZ FILM 4 MG	3	QL (18 per 28 days), B/D
ZUPLENZ FILM 8 MG	3	QL (60 per 28 days), B/D

Antifungals

Antifungals

Drug Name	Drug Tier	Requirements/ Limits
ABELCET	4	HI
AMBISOME	4	HI
amphotericin b	3	HI
ANCOBON	4	
CANCIDAS	4	HI
ciclopirox nail lacquer	1	
ciclopirox	1	
ciclopirox topical solution kit	3	
ciclopirox gel, shampoo	3	
ciclopirox suspension	1	
clotrimazole	1	
clotrimazole/ betamethasone dipropionate	1	
econazole nitrate	1	
ERAXIS INJ	4	HI
ERTACZO	3	
EXELDERM	3	
fluconazole oral	1	
fluconazole inj in dextrose	3	HI
fluconazole inj	3	HI
GRIFULVIN V	2	
GRIS-PEG	3	
griseofulvin microsize	1	
GYNAZOLE-1	2	
itraconazole	3	QL (130 per 31 days), PA
ketoconazole	1	
kuric	1	
LAMISIL SOLUTION	3	
MENTAX	3	
miconazole 3 suppository	1	
NATACYN OPHTHALMIC	2	
NOXAFIL SUSPENSION	4	
nyamyc	1	
nystatin	1	
nystatin/triamcinolone	1	
nystop	1	
OXISTAT	3	
pedi-dri powder	1	
SPORANOX SOLUTION	3	QL (1240 per 31 days), PA
terbinafine	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
terconazole vaginal cream & suppository	1	
VFEND IV	3	HI
VFEND SUSPENSION	4	
voriconazole	4	
XOLEGEL TOPICAL GEL	3	
zazole vaginal cream	1	
Antigout Agents		
Antigout Agents		
allopurinol oral	1	
allopurinol inj	3	
COLCRYS	3	QL (62 per 31 days)
KRYSTEXXA	4	QL (4 per 28 days), PA
probenecid	1	
probenecid/colchicine	1	
ULORIC	2	ST
Antimigraine Agents		
Abortive		
AXERT	3	QL (12 per 30 days), ST
ergotamine/caffeine	1	QL (40 per 28 days)
FROVA	3	QL (18 per 30 days), ST
IMITREX STATDOSE	2	
IMITREX SOLUTION	2	QL (6 per 30 days)
MAXALT	2	QL (12 per 30 days)
MAXALT-MLT	2	QL (12 per 30 days)
migergot	3	QL (20 per 28 days)
naratriptan	1	QL (9 per 30 days)
PANLOR DC	3	QL (372 per 31 days)
RELPAX	3	QL (6 per 30 days), ST
sumatriptan	1	QL (9 per 30 days)
sumatriptan inj 6 mg/0.5ml	3	QL (4 per 30 days)
sumatriptan inj 4 mg/0.5ml	3	QL (4 per 31 days)
trezix	1	QL (372 per 31 days)
ZOMIG ZMT & ZOMIG	3	QL (9 per 30 days)
ZOMIG SOLUTION	3	QL (6 per 30 days)
Antimyasthenic Agents		
Parasympathomimetics		
GUANIDINE	3	
MESTINON TIMESPAN	2	
MESTINON SYRUP	2	
MYTELASE	3	
pyridostigmine	1	
regonol inj	1	
Antimycobacterials		
Antimycobacterials, Other		
DAPSONE	2	
MYCOBUTIN	3	
Antituberculars		
CAPASTAT	3	HI
cycloserine	3	
ethambutol	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
isonarif	3	
isoniazid inj	3	
isoniazid syrup	1	
PASER	3	
PRIFTIN	3	
pyrazinamide	1	
rifampin inj	4	HI
rifampin	1	
RIFATER	3	
TRECATOR	3	
Antineoplastics		
Alkylating Agents		
BICNU INJ	3	
BUSULFEX INJ	4	
CEENU	2	
cyclophosphamide	3	B/D
cyclophosphamide inj	1	B/D
dacarbazine inj	1	
HEXALEN	4	PA- new starts only
ifosfamide/ mesna inj	4	
ifosfamide inj	3	
LEUKERAN	2	
MATULANE	4	
melphalan inj	4	
MUSTARGEN INJ	4	
THIOTEPA INJ	3	
TREANDA INJ	4	PA- new starts only
ZANOSAR INJ	4	
Antiangiogenic Agents		
REVLIMID	4	PA- new starts only, LA
THALOMID	4	PA- new starts only
VOTRIENT	4	PA- new starts only
Antiestrogens/Modifiers		
EMCYT	2	PA- new starts only

Drug Name	Drug Tier	Requirements/ Limits
FARESTON	3	
FASLODEX	4	
tamoxifen	1	
Antimetabolites		
cladribine inj	4	B/D
clolar inj	4	
cytarabine inj 20 mg/ml	1	B/D
CYTARABINE AQ INJ 100 MG/ML	3	B/D
DROXIA	2	
ELITEK INJ	4	
fluorouracil inj	1	B/D
FOLOTYN INJ	4	PA - new starts only
gemcitabine inj	4	
GEMZAR INJ	4	
hydroxyurea	1	
mercaptopurine	1	
pentostatin inj	4	
TABLOID	3	PA - new starts only
Antineoplastics, Other		
ABRAXANE	4	
adriamycin	3	B/D
ALIMTA	4	PA - new starts only
AMIFOSTINE	4	
ARRANON	4	
bleomycin inj	3	B/D
CARBOPLATIN INJ	3	
carboplatin inj 50 mg/5ml	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
cisplatin inj	1	
DACOGEN	4	
dactinomycin	3	
daunorubicin inj	3	
DAUNOXOME	3	
dexrazoxane inj	4	
DOXIL	4	B/D
doxorubicin	3	B/D
ELSPAR	3	
epirubicin	3	
ETOPOPHOS	4	
etoposide	1	
FIRMAGON INJ 120 MG	4	QL (2 per 365 days), PA - new starts only
FIRMAGON INJ 80 MG	3	QL (4 per 28 days), PA - new starts only
fludarabine	4	
HALAVEN	4	PA - new starts only
idarubicin	4	
irinotecan	3	
ISTODAX	4	PA - new starts only
IXEMPRA KIT INJ	4	
JEVTANA	4	PA - new starts only
mesna	3	
MESNEX	3	
mitomycin inj	3	
mitoxantrone	3	
NOVANTRONE	4	ST
ONCASPAR	4	
ONTAK	4	PA - new starts only
onxol	4	
oxaliplatin	4	
paclitaxel	3	
PHOTOFRIN	4	
PROLEUKIN	4	PA - new starts only
TAXOTERE	4	
toposar	1	
topotecan inj 4 mg	4	
TORISEL	4	
TRISENOX	3	PA - new starts only
VELCADE	4	PA - new starts only
VIDAZA	4	PA - new starts only
vinblastine	1	B/D
vincasar pfs	1	B/D
vincristine	1	B/D
vinorelbine	3	
ZOLINZA	4	PA - new starts only
Aromatase Inhibitors, 3rd Generation		
anastrozole	1	
AROMASIN	3	
FEMARA	2	
Molecular Target Inhibitors		
AFINITOR	4	PA - new starts only
GLEEVEC	4	PA - new starts only
NEXAVAR	4	PA - new starts only
SPRYCEL	4	PA - new starts only
SUTENT	4	PA - new starts only

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
TARCEVA	4	PA - new starts only
TASIGNA	4	PA - new starts only
TYKERB	4	PA - new starts only
Monoclonal Antibodies		
ARZERRA	4	PA - new starts only
AVASTIN	4	PA - new starts only
CAMPATH	4	PA - new starts only
ERBITUX	4	PA - new starts only
HERCEPTIN	4	
RITUXAN	4	PA - new starts only
VECTIBIX	4	PA - new starts only
Retinoids		
PANRETIN	4	PA - new starts only
TARGRETIN	4	PA - new starts only
tretinoin	4	
Antiparasitics		
Anthelmintics		
ALBENZA	2	
BILTRICIDE	2	
mebendazole	1	
STROMECTOL	2	
Antiprotozoals		
ALINIA	3	
chloroquine	1	
DARAPRIM	2	
hydroxychloroquine	1	
MALARONE	3	
mefloquine	1	
MEPRON	4	
PRIMAQUINE	2	
QUALAQUIN	3	PA
Pediculicides/ Scabicides		
acticin	1	
EURAX	3	
lindane	3	
malathion	3	
permethrin	1	
Antiparkinson Agents		
Antiparkinson Agents		
APOKYN	4	QL (60 per 31 days)
atamet	1	
AZILECT	2	
benztropine inj	3	
benztropine	1	
bromocriptine	3	
bromocriptine	1	
carbidopa/levodopa	1	
carbidopa/levodopa cr	1	
carbidopa/ levodopa er	1	
carbidopa/ levodopa odt	1	
COMTAN	2	
LODOSYN	3	
pramipexole	1	
ropinirole	1	
selegiline	1	
STALEVO	3	ST
trihexyphenidyl	1	
ZELAPAR	3	ST

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
Antipsychotics		
Atypicals		
ABILIFY DISCMELT	3	QL (62 per 31 days)
ABILIFY INJ	3	
ABILIFY	3	QL (31 per 31 days)
ABILIFY ORAL SOLUTION	3	QL (775 per 31 days)
clozapine	1	
FANAPT	3	QL (62 per 31 days), ST – new starts only
FANAPT TITRATION PACK	3	QL (8 per 31 days), ST – new starts only
FAZACLO	3	
GEODON	3	
INVEGA	3	
INVEGA SUSTENNA INJ 117 MG /0.75ML	4	QL (0.75 per 28 days)
INVEGA SUSTENNA INJ 156 MG/ML	4	QL (1 per 28 days)
INVEGA SUSTENNA INJ 234 MG/ 1.5ML	4	QL (1.5 per 28 days)
INVEGA SUSTENNA INJ 39 MG /0.25ML	3	QL (0.25 per 28 days)
INVEGA SUSTENNA INJ 78 MG/0.5ML	3	QL (0.5 per 28 days)
LATUDA	3	QL (31 per 31 days), PA – new starts only
RISPERDAL CONSTA INJ 37.5 MG, 50 MG	4	QL (4 per 28 days)
RISPERDAL CONSTA INJ 12.5 MG, 25 MG	3	QL (4 per 28 days)
risperidone m-tab	3	
risperidone odt	3	
risperidone solution	1	
risperidone	1	
ZYPREXA RELPREVV INJ 405 MG	4	QL (1 per 28 days)
ZYPREXA RELPREVV INJ 210 MG, 300 MG	4	QL (2 per 28 days)
ZYPREXA ZYDIS	3	QL (31 per 31 days)
ZYPREXA INJ	3	
ZYPREXA	3	QL (31 per 31 days)
Conventional		
chlorpromazine	1	
fluphenazine decanoate	1	
fluphenazine	1	
haloperidol	1	
haloperidol decanoate	1	
haloperidol lactate	1	
loxapine	1	
MOBAN	3	
NAVANE 20 MG	3	
ORAP	2	
perphenazine 16 mg, 2 mg, 8 mg	1	
prochlorperazine edisylate	1	
prochlorperazine	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
thioridazine	1	PA – new starts only
thiothixene	1	
trifluoperazine	1	

Antispasticity Agents

Antispasticity Agents

Drug Name	Drug Tier	Requirements/ Limits
baclofen	1	
dantrolene	1	
tizanidine	1	
ZANAFLEX	3	

Antivirals

Anticytomegalovirus (CMV) Agents

Drug Name	Drug Tier	Requirements/ Limits
FOSCARNET	2	B/D
ganciclovir 500 mg	4	
ganciclovir 250 mg	3	
ganciclovir inj	3	B/D
VALCYTE	4	
ZIRGAN	2	

Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors

Drug Name	Drug Tier	Requirements/ Limits
ATRIPLA	4	
INTELENCE	4	
RESCRIPTOR	3	
SUSTIVA	3	
VIRAMUNE SUSPENSION	3	
VIRAMUNE	2	

Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors

Drug Name	Drug Tier	Requirements/ Limits
COMBIVIR	4	
didanosine	3	
EMTRIVA	3	
EPIVIR	2	
EPIVIR HBV	2	
EPZICOM	4	
RETROVIR IV INFUSION	3	
stavudine	3	
TRIZIVIR	4	
TRUVADA	4	
VIDEX PEDIATRIC	3	
VIREAD	4	
ZIAGEN	2	
zidovudine syrup	3	
zidovudine	1	

Anti-HIV Agents, Other

Drug Name	Drug Tier	Requirements/ Limits
FUZEON	4	
ISENTRESS	4	
SELZENTRY	4	

Anti-HIV Agents, Protease Inhibitors

Drug Name	Drug Tier	Requirements/ Limits
APTIVUS	4	
CRIXIVAN	2	
INVIRASE	4	
INVIRASE	3	
KALETRA SOLUTION	4	
KALETRA 200 MG; 50 MG	4	
KALETRA 100 MG; 25 MG	3	QL (62 per 31 days)
LEXIVA	4	
LEXIVA SUSPENSION	3	
NORVIR	3	
PREZISTA 400 MG, 600 MG	4	QL (62 per 31 days)
PREZISTA 150 MG	3	QL (186 per 31 days)
PREZISTA 75 MG	3	QL (62 per 31 days)
REYATAZ 150 MG, 300 MG	4	QL (31 per 31 days)

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
REYATAZ 200 MG	4	QL (62 per 31 days)
REYATAZ 100 MG	3	QL (31 per 31 days)
VIRACEPT	4	
VIRACEPT POWDER	3	
Anti-influenza Agents		
amantadine	1	
RELENZA DISKHALER	3	QL (62 per 31 days)
rimantadine	1	
TAMIFLU SUSPENSION	2	QL (194 per 31 days)
TAMIFLU 45 MG, 75 MG	2	QL (31 per 31 days)
TAMIFLU 30 MG	2	QL (62 per 31 days)
Antihepatitis Agents		
BARACLUDE	4	
BARACLUDE SOLUTION	3	
HEPSERA	4	
REBETOL SOLUTION	3	PA
ribasphere 200 mg capsule	1	QL (217 per 31 days), PA
ribasphere 400 mg, 600 mg	4	QL (56 per 28 days), PA
ribasphere 200 mg tablet	1	QL (93 per 31 days), PA
ribavirin 200 mg	1	QL (155 per 31 days), PA
ribavirin 400 mg, 600 mg	4	QL (56 per 28 days), PA
TYZEKA	4	
Antiherpetic Agents		
acyclovir	1	
acyclovir inj	3	HI
DENAVIR	2	
famciclovir	3	
trifluridine	3	
valacyclovir	3	
ZOVIRAX CREAM, OINTMENT	2	

Anxiolytics

Drug Name	Drug Tier	Requirements/ Limits
Anxiolytics, Other		
buspirone	1	
meprobamate	1	PA

Bipolar Agents

Drug Name	Drug Tier	Requirements/ Limits
Bipolar Agents		
EQUETRO	2	
lithium carbonate	1	
lithium carbonate er	1	
lithium citrate syrup	1	
LITHOBID	2	
SAPHRIS	2	
SEROQUEL	3	
SEROQUEL XR	2	

Blood Glucose Regulators

Drug Name	Drug Tier	Requirements/ Limits
Antidiabetic Agents		
acarbose 50 mg	1	QL (186 per 31 days), ST
acarbose 25 mg	1	QL (372 per 31 days), ST
acarbose 100 mg	1	QL (93 per 31 days), ST
ACTOPLUS MET	2	QL (93 per 31 days), ST
ACTOS 30 MG, 45 MG	2	QL (31 per 31 days), ST
ACTOS 15 MG	2	QL (93 per 31 days), ST
AVANDAMET 2- 500 MG	3	QL (124 per 31 days), PA

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
AVANDAMET 2- 1000 MG; 4-1000 MG; 4-500 MG	3	QL (62 per 31 days), PA
AVANDARYL	3	QL (31 per 31 days), PA
BYETTA INJ 5MCG/0.02ML	2	QL (1.2 per 30 days)
BYETTA INJ 10MCG/0.04ML	2	QL (2.4 per 30 days), ST
DUETACT	2	QL (31 per 31 days), ST
FORTAMET ER 500 MG	3	QL (155 per 31 days)
FORTAMET ER 1000 MG	3	QL (62 per 31 days)
glimepiride 2 mg	1	QL (124 per 31 days)
glimepiride 1 mg	1	QL (248 per 31 days)
glimepiride 4 mg	1	QL (62 per 31 days)
glipizide er 10 mg	1	QL (62 per 31 days)
glipizide er 5 mg	1	QL (124 per 31 days)
glipizide er 2.5 mg	1	QL (248 per 31 days)
glipizide xl	1	
glipizide/metformin 2.5-500 mg; 5- 500 mg	1	QL (124 per 31 days)
glipizide/metformin 2.5- 250 mg	1	QL (248 per 31 days)
glipizide 10 mg	1	QL (124 per 31 days)
glipizide 5 mg	1	QL (248 per 31 days)
GLUMETZA	3	QL (124 per 31 days)
glyburide micronized 3 mg	1	QL (124 per 31 days)
glyburide micronized 1.5 mg	1	QL (248 per 31 days)
glyburide micronized 6 mg	1	QL (62 per 31 days)
glyburide/metformin 2.5-500 mg; 5-500 mg	1	QL (124 per 31 days)
glyburide/metformin 1.25-250 mg	1	QL (248 per 31 days)
glyburide 5 mg	1	QL (124 per 31 days)
glyburide 2.5 mg	1	QL (248 per 31 days)
glyburide 1.25 mg	1	QL (496 per 31 days)
glycron 3 mg	1	QL (124 per 31 days)
glycron 1.5 mg	1	QL (248 per 31 days)
glycron 6 mg	1	QL (62 per 31 days)
GLYSET 50 MG	3	QL (186 per 31 days), ST
GLYSET 25 MG	3	QL (372 per 31 days), ST
GLYSET 100 MG	3	QL (93 per 31 days), ST
JANUMET	2	QL (62 per 31 days), ST
JANUVIA 25 MG	2	QL (124 per 31 days), ST
JANUVIA 100 MG	2	QL (31 per 31 days), ST

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
JANUVIA 50 MG	2	QL (62 per 31 days), ST
KOMBIGLYZE XR 5-1000 MG; 5-500 MG	2	QL (31 per 31 days), ST
KOMBIGLYZE XR 2.5- 1000 MG	2	QL (62 per 31 days), ST
metformin er 500 mg	1	QL (124 per 31 days)
metformin er 750 mg	1	QL (62 per 31 days)
metformin 500 mg	1	QL (155 per 31 days)
metformin 1000 mg	1	QL (62 per 31 days)
metformin 850 mg	1	QL (93 per 31 days)
nateglinide 60 mg	1	QL (186 per 31 days)
nateglinide 120 mg	1	QL (93 per 31 days)
ONGLYZA 5 MG	2	QL (31 per 31 days), ST
ONGLYZA 2.5 MG	2	QL (62 per 31 days), ST
PRANDIN 2 MG	3	QL (248 per 31 days), ST
PRANDIN 1 MG	3	QL (496 per 31 days), ST
PRANDIN 0.5 MG	3	QL (992 per 31 days), ST
RIOMET	3	QL (791 per 31 days)
SYMLIN	3	QL (20 per 31 days)
SYMLINPEN 120	3	QL (10.8 per 30 days)
SYMLINPEN 60	3	QL (6 per 31 days)
tolazamide 250 mg	1	QL (124 per 31 days)

Drug Name	Drug Tier	Requirements/ Limits
tolazamide 500 mg	1	QL (62 per 31 days)
tolbutamide	1	QL (186 per 31 days)
Glycemic Agents		
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	2	
PROGLYCEM	3	
Insulins		
HUMALOG	2	
HUMALOG KWIKPEN	2	
HUMALOG MIX 50/50	2	
HUMALOG MIX 50/50 KWIKPEN	2	
HUMALOG MIX 75/25	2	
HUMALOG MIX 75/25 KWIKPEN	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 (CONCENTRATE)	2	B/D
LANTUS	2	
LANTUS SOLOSTAR	2	
LEVEMIR	2	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
LEVEMIR FLEXPEN	2	
NOVOLIN 70/30	2	
NOVOLIN 70/30 INNOLET	2	
NOVOLIN N	2	
NOVOLIN R	2	
NOVOLOG	2	
NOVOLOG FLEXPEN	2	
NOVOLOG MIX 70/30	2	
NOVOLOG MIX 70/30 FLEXPEN	2	

Blood Products/Modifiers/ Volume Expanders

Anticoagulants

Drug Name	Drug Tier	Requirements/ Limits
ARIXTRA INJ 5 MG/0.4ML	4	QL (12.4 per 31 days)
ARIXTRA INJ 7.5 MG/0.6 ML	4	QL (18.6 per 31 days)
ARIXTRA INJ 10 MG/0.8 ML	4	QL (24.8 per 31 days)
ARIXTRA INJ 2.5 MG/0.5 ML	3	QL (15.5 per 31 days)
COUMADIN INJ	3	
enoxaparin inj 120 mg/0.8 ml	4	QL (49.6 per 31 days)
enoxaparin inj 100 mg/ml, 150 mg/ml	4	QL (62 per 31 days)
enoxaparin inj 30 mg/0.3ml	3	QL (18.6 per 31 days)
enoxaparin inj 40 mg/0.4ml	3	QL (24.8 per 31 days)
enoxaparin inj 60 mg/0.6ml	3	QL (37.2 per 31 days)
enoxaparin inj 80 mg/0.8ml	3	QL (49.6 per 31 days)
FRAGMIN INJ 10000 UNIT/ML	4	QL (31 per 31 days)
FRAGMIN INJ 7500 UNIT/0.3 ML	4	QL (9.3 per 31 days)
FRAGMIN INJ 2500 UNIT/0.2ML, 5000 UNIT/0.2ML	3	QL (12.4 per 31 days)
FRAGMIN INJ 25000 UNIT/ML	3	QL (31 per 31 days)
heparin	1	
heparin /D5W	1	HI
HEPARIN / NACL	1	HI
heparin / chloride 0.9% premix	1	HI
jantoven	1	
LOVENOX INJ 300 MG/3ML	3	QL (93 per 31 days)
PRADAXA	2	QL (62 per 31 days), PA
warfarin	1	

Blood Formation Products

Drug Name	Drug Tier	Requirements/ Limits
ARANESP 500 MCG/ML	4	QL (1 per 21 days), PA
ARANESP 150 MCG/0.3 ML	4	QL (1.2 per 28 days), PA
ARANESP 200 MCG/0.4 ML	4	QL (1.6 per 28 days), PA
ARANESP 300 MCG/0.6 ML	4	QL (2.4 per 28 days), PA
ARANESP 200 MCG/ML, 300 MCG/ML	4	QL (4 per 28 days), PA
ARANESP 60 MCG/0.3 ML	3	QL (1.2 per 28 days),PA
ARANESP 40 MCG/0.4 ML	3	QL (1.6 per 28 days), PA

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
ARANESP 25 MCG/0.42 ML	3	QL (1.7 per 28 days), PA
ARANESP 100 MCG/0.5 ML	3	QL (2 per 28 days), PA
ARANESP 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	3	QL (4 per 28 days), PA
LEUKINE	4	PA
NEULASTA	4	PA
NEUMEGA	2	PA
NEUPOGEN	4	PA
PROCRIT INJ 40000 UNIT/ML	4	PA
PROCRIT INJ 20000 UNIT/ML	4	QL (12 per 28 days), PA
PROCRIT INJ 10000 UNIT/ML	3	QL (12 per 28 days), PA
PROCRIT INJ 2000 UNIT/ML	3	QL (15 per 31 days), PA
PROCRIT INJ 3000 UNIT/ML, 4000 UNIT/ML	3	QL (30 per 31 days), PA
Blood Products/Modifiers/ Volume Expanders		
BERINERT	4	PA
CINRYZE	4	PA
MOZOBIL	4	PA
pentopak	1	
pentoxifylline er	1	
PROMACTA	4	PA
Coagulants		
aminocaproic acid	1	
CYKLOKAPRON	2	
Platelet Aggregation Inhibitors		
AGGRENOX	2	QL (62 per 31 days)
cilostazol	1	
EFFIENT	2	QL (31 per 31 days)
pentoxil	1	
PLAVIX 300 MG	2	QL (3 per 31 days)
PLAVIX 75 MG	2	QL (31 per 31 days)

Cardiovascular Agents

Drug Name	Drug Tier	Requirements/ Limits
Alpha-adrenergic Agonists		
clonidine	1	
clonidine patch weekly 0.2 mg/24hr, 0.3 mg/24hr	1	QL (10 per 31 days)
clonidine patch weekly 0.1 mg/24hr	1	QL (5 per 31 days)
guanabenz	1	
guanfacine	1	
midodrine	1	
Alpha-adrenergic Blocking Agents		
DIBENZYLINE	3	
prazosin	1	
Antiarrhythmics		
amiodarone	1	
flecainide	1	
mexiletine	1	
MULTAQ	3	
PACERONE 300 MG	3	
procainamide	1	
propafenone	1	
propafenone er	3	
QUINIDINE GLUCONATE	3	
quinidine gluconate cr	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
quinidine	1	
quinidine er	1	
sorine	1	
sotalol	1	
sotalol (af)	1	
sotalol inj	3	
TIKOSYN	3	
Beta-adrenergic Blocking Agents		
acebutolol	1	
atenolol	1	
atenolol/ chlorthalidone	1	
betaxolol	1	
bisoprolol	1	
bisoprolol /HCTZ	1	
BYSTOLIC 2.5 MG	2	QL (31 per 31 days)
BYSTOLIC 20 MG	2	QL (62 per 31 days)
BYSTOLIC 10 MG, 5 MG	2	QL (93 per 31 days)
carvedilol	1	
INNOPRAN XL	3	
labetalol	1	
LEVATOL	3	
metoprolol er	1	
metoprolol	1	
metoprolol/HCTZ	1	
nadolol/bendrof- lumethiazide	1	
nadolol 20 mg, 40 mg, 80 mg	1	
pindolol	1	
propranolol	1	
propranolol er	1	
propranolol/HCTZ	1	
timolol	1	
Calcium Channel Blocking Agents		
afeditab cr	1	
amlodipine	1	
amlodipine / benazepril	1	
AZOR	2	QL (31 per 31 days), ST
CARDIZEM CD ER 24 HOUR 360 MG	3	
cartia xt	1	
COVERA-HS ER 24 HOUR 240 MG	3	QL (62 per 31 days)
COVERA-HS ER 24 HOUR 180 MG	3	QL (93 per 31 days)
dilt-cd	1	
dilt-xr	1	
diltiazem cd	1	
diltiazem er	1	
diltiazem ER 24 hour	1	
diltiazem inj	1	
diltzac	1	
DYNACIRC CR 10 MG	3	QL (62 per 31 days)
DYNACIRC CR 5 MG	3	QL (93 per 31 days)
felodipine er	1	
isradipine	1	
matzim la	1	
nicardipine	1	
nifediac cc	1	
nifedical xl	1	
nifedipine er 24 hour 60 mg	1	
nifedipine er 24 hour 30 mg	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
nifedipine er 24 hour 90 mg	1	
nimodipine	4	
nisoldipine 20 mg, 30 mg, 40 mg	1	
nisoldipine ER 17 mg, 25.5 mg, 34 mg, 8.5 mg	1	QL (31 per 31 days)
taztia xt	1	
TRIBENZOR	2	QL (31 per 31 days), ST
TWYNSTA	3	QL (31 per 31 days), ST
verapamil	1	
verapamil er	1	
verapamil sr	1	QL (31 per 31 days)
Cardiovascular Agents, Other		
DEMSER	4	
digoxin	1	
LANOXIN 0.125 MG	2	
RANEXA	2	ST
Cardiovascular Agents		
Diuretics		
acetazolamide	1	
ALDACTAZIDE 50 MG; 50 MG	3	
amiloride	1	
amiloride/HCTZ	1	
bumetanide	1	injection- HI
chlorothiazide	1	
chlorothiazide inj	3	HI
chlorthalidone	1	
DEMADEX INJ	3	HI
DIURIL	2	
DYRENIUM	3	
EDECRIN	3	
eplerenone	3	
furosemide	1	injection- HI
hydrochlorothiazide	1	
indapamide	1	
methyclothiazide	1	
metolazone	1	
SAMSCA 15 MG	4	QL (31 per 31 days), PA
SAMSCA 30 MG	4	QL (62 per 31 days), PA
spironolactone	1	
spironolactone/HCTZ	1	
THALITONE	3	
torsemide	1	injection- HI
triamterene/HCTZ	1	
Dyslipidemics		
ADVICOR ER 40-1000 MG	3	QL (31 per 31 days)
ADVICOR ER 20-1000 MG; 20- 500 MG; 20-750 MG	3	QL (62 per 31 days)
ALTOPREV	3	QL (31 per 31 days), ST
ANTARA	2	
cholestyramine	1	
cholestyramine light	1	
colestipol	1	
colestipol for oral suspension	1	
CRESTOR	2	QL (31 per 31 days)
fenofibrate	1	
fenofibrate micronized	1	
gemfibrozil	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
LESCOL XL	3	QL (31 per 31 days), ST
LESCOL 20 MG	3	QL (31 per 31 days), ST
LESCOL 40 MG	3	QL (62 per 31 days), ST
LIPITOR	2	QL (31 per 31 days)
lovastatin	1	
LOVAZA	3	
niacor	1	
NIASPAN	2	
pravastatin	1	
prevalite	1	
SIMCOR ER 40-1000 MG; 40- 500 MG	2	QL (31 per 31 days)
SIMCOR ER 20-1000 MG; 20-500 MG; 20-750 MG	2	QL (62 per 31 days)
simvastatin	1	
TRICOR	2	
TRILIPIX	2	
VYTORIN	3	QL (31 per 31 days), ST
WELCHOL	2	
ZETIA	2	QL (31 per 31 days), ST
Renin-angiotensin-aldosterone System Inhibitors		
benazepril	1	
benazepril /HCTZ	1	
BENICAR	2	QL (31 per 31 days)
BENICAR HCT	2	QL (31 per 31 days)
captopril	1	
captopril/HCTZ	1	
DIOVAN HCT 320-12.5 MG; 320 -25 MG	2	QL (31 per 31 days)
DIOVAN HCT 160-12.5 MG; 80 -12.5 MG; 160- 25 MG	2	QL (62 per 31 days)
DIOVAN 320 MG	2	QL (31 per 31 days)
DIOVAN 160 MG, 40 MG, 80 MG	2	QL (62 per 31 days)
enalapril	1	
enalapril/HCTZ	1	
fosinopril	1	
fosinopril/HCTZ	1	
lisinopril	1	
lisinopril/HCTZ	1	
losartan/HCTZ 100-12.5 mg; 25-100 mg	1	QL (31 per 31 days)
losartan/HCTZ 50-12.5 mg	1	QL (62 per 31 days)
losartan 100 mg	1	QL (31 per 31 days)
losartan 25 mg, 50 mg	1	QL (62 per 31 days)
MICARDIS	3	QL (31 per 31 days)
MICARDIS HCT	3	QL (31 per 31 days)
moexipril	1	
moexipril/HCTZ	1	
perindopril	1	
quinapril	1	
quinapril/HCTZ	1	
quinaretic	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
ramipril	1	
TEKTURNA	2	QL (31 per 31 days), ST
TEKTURNA HCT	2	QL (31 per 31 days), ST
trandolapril	1	
trandolapril/verapamil	1	
VALTURNA	2	QL (31 per 31 days), ST
Vasodilators		
BIDIL	2	
DILATRATE SR	3	
hydralazine inj	3	
hydralazine	1	
isochron	1	
ISORDIL TITRADOSE 40 MG	3	
isosorbide dinitrate	1	
isosorbide dinitrate er	1	
isosorbide mononitrate	1	
isosorbide mononitrate er	1	
minitran	1	
minoxidil	1	
NITRO-DUR PATCH 0.3 MG/HR, 0.8 MG/HR	3	
nitroglycerin transdermal	1	
nitroglycerin sublingual	1	
nitroglycerin inj, patch 24 hour	1	
NITROLINGUAL PUMPSPRAY	3	
NITROMIST	3	
NITROSTAT	2	

Central Nervous System Agents

Drug Name	Drug Tier	Requirements/ Limits
Amphetamines, ADHD		
amphetamine/ dextroamph- etamine er	3	QL (62 per 31 days)
amphetamine/ dextroamph- etamine	1	QL (62 per 31 days)
dextroamphetamine 10 mg	1	QL (186 per 31 days)
dextroamphetamine 5 mg	1	QL (62 per 31 days)
Central Nervous System Agents		
Non-amphetamines, ADHD		
FOCALIN XR 30 MG, 40 MG	3	QL (31 per 31 days)
FOCALIN XR 10 MG, 15 MG, 5 MG	3	QL (31 per 31 days)
FOCALIN XR 20 MG	3	QL (62 per 31 days)
methylin	1	QL (93 per 31 days)
methylphenidate 5 mg	1	
methylphenidate	3	
STRATTERA 100 MG, 60 MG, 80 MG	3	QL (31 per 31 days), ST
STRATTERA 10 MG, 18 MG, 25 MG, 40 MG	3	QL (62 per 31 days), ST
Non-amphetamines, Other		
AMPYRA	4	QL (62 per 31 days), PA

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
PROVIGIL 100 MG	3	QL (31 per 31 days), PA
PROVIGIL 200 MG	3	QL (62 per 31 days), PA
RILUTEK	4	
XYREM	2	QL (540 per 30 days), PA, LA

Dental and Oral Agents

Dental and Oral Agents

Drug Name	Drug Tier	Requirements/ Limits
APHTHASOL	2	
chlorhexidine gluconate oral	1	
EVOXAC	3	ST
KEPIVANCE	4	
periogard	1	
pilocarpine	3	
triamcinolone in orabase	1	

Dermatological Agents

Dermatological Agents

Drug Name	Drug Tier	Requirements/ Limits
adapalene cream	3	
adapalene gel	1	
ammonium lactate	1	
amnesteem	3	
avita	1	PA
AZELEX	3	
BENZACLIN CARE KIT	2	
calcipotriene	3	
CARAC	2	
claravis	3	
clindamycin/benzoyl peroxide	3	
CONDYLOX	3	
DIFFERIN LOTION	3	
DOVONEX	2	
ELIDEL	3	ST
EPIDUO	3	
erythromycin/benzoyl peroxide	1	
FINACEA	2	
FLUOROPLEX	2	
fluorouracil cream	3	
fluorouracil external solution	1	
imiquimod	3	
laclotion	1	
OXSORALEN	3	PA
OXSORALEN ULTRA	4	PA
podofilox	1	
PROTOPIC	3	ST
REGRANEX	4	PA
RETIN-A MICRO	2	PA
SANTYL	3	
selenium sulfide lotion	1	
sulfacetamide	1	
SOLARAZE	3	
SORIATANE	4	
sotret	3	
TAZORAC GEL	3	PA
tretinoin	1	PA
ZYCLARA	2	

Enzyme Replacements/ Modifiers

Enzyme Replacements/ Modifiers

Drug Name	Drug Tier	Requirements/ Limits
ADAGEN	4	
ALDURAZYME	4	
BUPHENYL	4	
CEREZYME INJ	4	
CREON	2	
CYSTADANE	4	
CYSTAGON	3	
ELAPRASE	4	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
FABRAZYME INJ	4	
KUVAN	4	
MYOZYME	4	
NAGLAZYME	4	
ORFADIN	4	
ULTRASE	2	
ULTRASE MT 12, MT 18, MT 20	2	
VPRIV	4	PA
ZAVESCA	4	
ZENPEP	2	
Gastrointestinal Agents		
Antispasmodics, Gastrointestinal		
atropine inj	1	
CUVPOSA	3	
dicyclomine	1	PA
glycopyrrolate	1	
HELIDAC	3	QL (56 per 180 days)
methscopolamine	1	
propantheline	1	
Gastrointestinal Agents, Other		
AMITIZA	2	QL (62 per 31 days), ST
constulose	1	
enulose	1	
GASTROCROM	3	
gavilyte-g	1	QL (4000 per 31 days)
gavilyte-n/flavor pack	1	QL (4000 per 31 days)
generlac	1	
HALFLYTELY BOWEL PREP	2	QL (1 per 31 days)
KRISTALOSE	2	
lactulose	1	
lonox	1	
loperamide	1	
MOVIPREP	2	
NULYTELY/FLAVOR PACKS	2	QL (4000 per 31 days)

Drug Name	Drug Tier	Requirements/ Limits
OSMOPREP	2	
peg 3350/electrolytes	1	QL (4000 per 31 days)
peg-3350/nacl/na bicarbonate/kcl	1	QL (4000 per 31 days)
polyethylene glycol 3350	1	
RELISTOR	3	PA
ursodiol	3	
VISICOL	2	
Histamine2 (H2) Blocking Agents		
cimetidine inj	1	HI
cimetidine 300 mg, 400 mg, 800 mg	1	
famotidine premixed	1	HI
famotidine suspension	3	
famotidine inj	1	HI
nizatidine solution	3	
nizatidine	1	
ranitidine syrup	3	
ranitidine inj	1	HI
ZANTAC PACKET, EFFERVESCENT	3	
ZANTAC INJ	3	HI
Irritable Bowel Syndrome Agents		
LOTRONEX	4	QL (62 per 31 days), PA
Protectants		
CARAFATE SUSPENSION	3	
misoprostol	1	
sucralfate	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
Proton Pump Inhibitors		
DEXILANT	3	QL (62 per 31 days)
lansoprazole	1	QL (62 per 31 days)
lansoprazole odt	3	QL (62 per 31 days), ST
NEXIUM	2	QL (62 per 31 days)
NEXIUM I.V.	3	HI
omeprazole	1	QL (62 per 31 days)
omeprazole/ bicarbonate	3	QL (62 per 31 days)
pantoprazole	1	QL (62 per 31 days)
PREVPAC	3	QL (112 per 180 days)
PROTONIX INJ	3	HI

Genitourinary Agents

Drug Name	Drug Tier	Requirements/ Limits
Antispasmodics, Urinary		
ENABLEX	2	QL (31 per 31 days)
flavoxate	1	
SANCTURA XR	3	QL (31 per 31 days)
trospium	3	QL (62 per 31 days)
VESICARE	2	QL (31 per 31 days)
Benign Prostatic Hypertrophy Agents		
AVODART	2	QL (31 per 31 days)
CARDURA XL	3	QL (31 per 31 days)
doxazosin	1	
finasteride	1	QL (31 per 31 days)
RAPAFLO	2	QL (31 per 31 days)
tamsulosin	1	QL (62 per 31 days)
terazosin	1	
Genitourinary Agents, Other		
bethanechol chloride	1	
ELMIRON	3	
Binders		
calcium acetate	3	
eliphos	1	
FOSRENOL CHEW 250 MG	3	
FOSRENOL CHEW 1000 MG, 500 MG, 750 MG	2	
RENAGEL	2	ST
RENVELA	2	

Hormonal Agents, Stimulant/ Replacement/Modifying (Adrenal)

Drug Name	Drug Tier	Requirements/ Limits
Glucocorticoids/Mineralocorticoids		
a-hydrocort	1	
a-methapred inj	1	HI
ala cort	1	
ala-cort	1	
alclometasone dipropionate	1	
amcinonide	1	
augmented betamethasone dipropionate	1	
beta-val	1	
betamethasone dipropionate	1	
betamethasone valerate	1	
CAPEX	3	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
CELESTONE	3	
clobetasol e	1	
clobetasol foam	3	
clobetasol gel, ointment, solution	1	
CLOBEX	3	
CLODERM	3	
CORDRAN	3	
CORDRAN SP	3	
CORDRAN TAPE	3	
cormax	1	
cortisone	1	
CUTIVATE LOTION	3	
del-beta	1	
DEPO-MEDROL 20 MG/ML INJ	2	
DERMA-SMOOTHE/ FS BODY OIL	3	
desonide	1	
desoximetasone	1	
dexamethasone intensol	1	
dexamethasone	1	
dexamethasone solution	1	
dexamethasone elixir	1	
DEXPAK 13 DAY	3	
diflorasone	1	
fludrocortisone	1	
fluocinolone	1	
fluocinonide	1	
fluocinonide emollient base	1	
fluticasone	1	
halobetasol	1	
HALOG	3	
HALONATE PAC	3	
hydrocortisone butyrate	1	
hydrocortisone in absorbase	1	
hydrocortisone valerate	1	
hydrocortisone enema	3	
hydrocortisone cream, lotion, ointment	1	
isovate	1	
KENALOG	2	
LOCOID	3	
LOKARA	1	
LUXIQ	3	
methylprednisolone inj	1	HI
methylprednisolone	1	
methylprednisolone	1	
mometasone	1	
OLUX-E	3	
PANDEL	3	
prednicarbate	1	
prednisolone	1	
prednisone	1	
prednisone intensol	1	
procto-pak	1	
proctocream-hc	1	
proctosol hc	1	
proctozone-hc	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
scalacort	1	
SOLU-CORTEF INJ 1 G, 500 MG	2	
SOLU-CORTEF INJ 250 MG	2	HI
SOLU-MEDROL 2000 MG	2	HI
TEXACORT	3	
triamcinolone acetonide	1	
triamcinolone acetonide in absorbase	1	
triderm	1	
u-cort	1	
VANOS	3	

Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)

Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)

Drug Name	Drug Tier	Requirements/ Limits
chorionic gonadotropin	3	PA
desmopressin inj	3	
desmopressin	1	
desmopressin nasal solution	3	
EGRIFTA	4	QL (60 per 30 days), PA
GENOTROPIN	4	PA
GENOTROPIN MINIQUICK 0.4 MG, 0.6 MG, 0.8 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 1 MG, 2 MG	4	QL (28 per 28 days), PA
GENOTROPIN MINIQUICK 0.2 MG	3	QL (28 per 28 days), PA
HUMATROPE	4	PA
HUMATROPE COMBO PACK	4	PA
INCRELEX	4	PA
NORDITROPIN NORDIFLEX PEN	4	PA
novarel	3	PA
NUTROPIN	4	PA
NUTROPIN AQ	4	PA
NUTROPIN AQ PEN	4	PA
OMNITROPE INJ 5.8 MG, 5 MG/1.5ML	4	PA
OMNITROPE INJ 10 MG/1.5ML	3	PA
pregnyl	3	PA
SAIZEN	4	PA
SAIZEN CLICK EASY	4	PA
STIMATE	3	
TEV-TROPIN	3	PA

Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)

Anabolic Steroids

Drug Name	Drug Tier	Requirements/ Limits
ANADROL-50	4	PA
oxandrolone 10 mg	4	QL (62 per 31 days), PA
oxandrolone 2.5 mg	1	QL (124 per 31 days), PA

Androgens

Drug Name	Drug Tier	Requirements/ Limits
ANDRODERM	2	QL (30 per 30 days), PA
ANDROGEL	2	QL (300 per 30 days), PA
androxy	3	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
danazol	3	
STRIANT	3	QL (60 per 30 days), PA
testosterone cypionate inj	1	PA
testosterone enanthate	1	PA
Estrogens		
ALORA PATCH BIWEEKLY	2	
apri	1	
aviane	1	
cesia	1	
CLIMARA PRO	3	
COMBIPATCH	3	
cryselle-28	1	
cyclafem 1/35	1	
cyclafem 7/7/7	1	
DEPO-ESTRADIOL	3	
DIVIGEL	3	QL (60 per 31 days)
enpresse-28	1	
ESTRACE CREAM	3	
ESTRADERM	2	
estradiol valerate	1	
estradiol patch weekly	1	
ESTRING	2	QL (1 per 90 days)
FEMRING	3	QL (1 per 90 days)
gianvi	1	
gynodiol	1	
jinteli	1	
junel 1.5/30	1	
junel 1/20	1	
junel fe 1.5/30	1	
junel fe 1/20	1	
kariva	1	
kelnor 1/35	1	
lessina-28	1	
levora 0.15/30-28	1	
low-ogestrel	1	
lutera	1	
MENOSTAR	3	
microgestin 1.5/30	1	
microgestin 1/20	1	
microgestin fe	1	
microgestin fe 1.5/30	1	
mononessa	1	
necon 10/11-28	1	
necon 7/7/7	1	
nortrel 7/7/7	1	
NUVARING	2	
ogestrel	1	
ORTHO EVRA	2	
portia-28	1	
PREMARIN VAGINAL	2	
PREMARIN	2	
PREMPRO	2	
previfem	1	
reclipsen	1	
solia	1	
sprintec 28	1	
sronyx	1	
tri-previfem	1	
tri-sprintec	1	
trinessa	1	
trivora-28	1	
velivet	1	
VIVELLE-DOT	2	
zovia 1/35e	1	
zovia 1/50e	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
Progestins		
camila	1	
CRINONE	3	
DEPO-PROVERA	3	
ELLA	3	
errin	1	
jolivette	1	
MAKENA	4	
medroxyprogesterone	1	
MEGACE ES	3	
megestrol	1	
necon 1/50-28	1	
next choice	1	
nora-be	1	
norethindrone	1	
PLAN B	3	
PLAN B ONE-STEP	3	QL (1 per 1 day)
PROCHIEVE	3	
progesterone	1	
PROMETRIUM	2	
Selective Estrogen Receptor Modifying Agents		
EVISTA	2	QL (31 per 31 days)

Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)

Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
LEVOTHROID	2	
levothyroxine	1	
levoxyl	1	
liothyronine inj	3	
liothyronine	1	
SYNTHROID	2	
THYROLAR	2	
unithroid	1	

Hormonal Agents, Suppressant (Adrenal)

Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	2	

Hormonal Agents, Suppressant (Parathyroid)

Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents, Suppressant (Parathyroid)		
SENSIPAR 90 MG	4	QL (124 per 31 days)
SENSIPAR 60 MG	4	QL (62 per 31 days)
SENSIPAR 30 MG	2	QL (62 per 31 days)

Hormonal Agents, Suppressant (Pituitary)

Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents, Suppressant (Pituitary)		
cabergoline	3	
ELIGARD 45 MG	4	QL (1 per 168 days)
ELIGARD 30 MG	3	QL (1 per 112 days)
ELIGARD 7.5 MG	3	QL (1 per 28 days)
ELIGARD 22.5 MG	3	QL (1 per 84 days)
leuprolide	3	
LUPRON DEPOT-PED INJ 7.5 MG	4	
LUPRON DEPOT-PED INJ 11.25 MG, 15 MG	4	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
LUPRON DEPOT INJ 30 MG	4	QL (1 per 112 days)
LUPRON DEPOT INJ 11.25 MG, 22.5 MG	4	QL (1 per 84 days)
LUPRON DEPOT INJ 3.75 MG, 7.5 MG	2	QL (1 per 28 days)
octreotide inj 1000 mcg/ml	4	PA
octreotide inj 200 mcg/ml	4	QL (120 per 30 days), PA
octreotide inj 500 mcg/ml	4	QL (93 per 31 days), PA
octreotide inj 100mcg/ml, 50mcg/ml	3	QL (124 per 31 days), PA
SANDOSTATIN LAR DEPOT	4	PA
SOMATULINE DEPOT	4	PA
SOMAVERT	4	PA
SYNAREL	4	PA
TRELSTAR DEPOT	4	
TRELSTAR LA	4	
TRELSTAR	4	

Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)

Antiandrogens

Drug Name	Drug Tier	Requirements/ Limits
bicalutamide	1	
flutamide	3	
NILANDRON	3	

Hormonal Agents, Suppressant (Thyroid)

Antithyroid Agents

Drug Name	Drug Tier	Requirements/ Limits
methimazole	1	
propylthiouracil	1	

Immunological Agents

Immune Suppressants

Drug Name	Drug Tier	Requirements/ Limits
AZASAN	2	
azathioprine	1	
azathioprine	3	
CELLCEPT INTRAVENOUS	3	PA - new starts only
CELLCEPT SUSPENSION	4	PA - new starts only
CIMZIA	4	PA
CIMZIA STARTER KIT	4	PA
cyclosporine modified	3	B/D
cyclosporine oral solution	3	B/D
cyclosporine, inj	3	B/D
ENBREL SURECLICK	4	QL (7.84 per 28 days) PA
ENBREL INJ 25 MG	4	QL (4 per 28 days) PA
ENBREL INJ 25 MG/0.5ML, 50 MG/ML	4	QL (7.84 per 28 days) PA
gengraf	3	B/D
HUMIRA PEN-CROHNS	4	QL (1 per 28 days) PA
HUMIRA INJ 20 MG/0.4 ML	4	QL (1 per 28 days) PA
HUMIRA INJ 40 MG/0.8 ML	4	QL (2 per 28 days) PA
methotrexate	1	
methotrexate	1	
mycophenolate mofetil	3	PA - new starts only
MYFORTIC	3	B/D
ORENCIA	4	QL (4 per 28 days), PA

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
PROGRAF INJ	3	PA - new starts only
RAPAMUNE SOLUTION	4	B/D
RAPAMUNE 1 MG	4	QL (31 per 31 days) B/D
RAPAMUNE 2 MG	4	QL (620 per 31 days) B/D
RAPAMUNE 0.5 MG	3	QL (31 per 31 days) B/D
STELARA	4	
tacrolimus 5 mg	4	PA- new starts only
tacrolimus 1 mg	3	QL (248 per 31 days), PA - new starts starts only
tacrolimus 0.5 mg	3	QL (62 per 31 days), PA - new starts only)
TREXALL	3	
ZORTRESS 0.75 MG	4	PA - new starts only
ZORTRESS 0.5 MG	4	QL (62 per 31 days), PA - new starts only
ZORTRESS 0.25 MG	3	QL (62 per 31 days), PA - new starts only
Immunizing Agents, Passive		
CARIMUNE	4	PA
GAMASTAN S/D	2	PA
GAMMAGARD	4	PA
GAMMAGARD S/D	4	PA
GAMMAPLEX	4	PA
GAMUNEX	4	PA
GAMUNEX-C	4	PA
HIZENTRA	4	QL (20 per 28 days), PA
POLYGAM S/D	3	PA
PRIVIGEN	4	PA

Drug Name	Drug Tier	Requirements/ Limits
Immunological Agents		
Immunomodulators		
ACTIMMUNE	4	
ARCALYST	4	PA
AVONEX INJ 30 MCG/0.5 ML	4	QL (2 per 28 days)
AVONEX INJ 30 MCG/VIAL	4	QL (4 per 28 days)
BETASERON	4	QL (14 per 28 days)
COPAXONE	4	QL (30 per 30 days)
GILENYA	4	QL (28 per 28 days) PA
INFERGEN	4	PA
INTRON-A W/ DILUENT 18 MU, 50 MU	3	PA - new starts only
INTRON-A W/ DILUENT 10 MU	4	PA - new starts only
INTRON-A INJ 10 MU/ML	4	PA - new starts only
INTRON-A INJ 10 MU/0.2 ML, 5 MU/0.2 ML	4	PA - new starts only
INTRON-A INJ 3 MU/0.2 ML	4	QL (6 per 28 days), PA - new starts only
INTRON-A INJ 6000000 UNIT/ML	3	PA - new starts only
KINERET	4	QL (20.77 per 31 days), PA
LEFLUNOMIDE	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
PEG-INTRON	4	PA
PEG-INTRON REDIPEN	4	PA
PEGASYS	4	PA
REBIF	4	QL (6 per 28 days)
REBIF TITRATION PACK	4	QL (4.2 per 28 days)
REMICADE	4	PA
RIDAURA	3	
SYNAGIS	4	
TYSABRI	4	PA , LA
Vaccines		
ACTHIB	2	
ADACEL	2	
ATTENUVAX	2	
BOOSTRIX	2	
CERVARIX	2	
COMVAX	2	
DAPTACEL	2	
DECAVAC	2	
DIPHTHERIA/ TETANUS TOXOID PEDIATRIC	2	
ENGERIX-B	2	B/D
GARDASIL	2	
HAVRIX	2	
HEPAGAM B	2	
HIBERIX	2	
IMOVAX RABIES (H.D.C.V.)	2	B/D
INFANRIX	2	
IPOL INACTIVATED	2	
IXIARO	2	
JE-VAX	2	
KINRIX	2	
M-M-R II	2	
MENACTRA	2	
MENOMUNE-A/C/ Y/W-135	2	
MENVEO	2	
MERUVAX II	2	
PEDIARIX	2	
PEDVAX HIB	2	
PROQUAD	2	
RABAVERT	2	
RECOMBIVAX HB	2	B/D
ROTARIX	2	
ROTATEQ	2	
TETANUS TOXOID ADSORBED	2	
TETANUS/ DIPHTHERIA TOXOIDS-ADSORBED ADULT	2	
TRIHIBIT	2	
TRIPEDIA	2	
TWINRIX	2	
TYPHIM VI	2	
VAQTA INJ	2	
VARIVAX	2	
YF-VAX	2	
ZOSTAVAX	2	

Inflammatory Bowel Disease Agents

Drug Name	Drug Tier	Requirements/ Limits
Glucocorticoids		
colocort	3	
CORTIFOAM	3	
ENTOCORT EC	3	
methylprednisolone	1	
MILLIPRED	3	
Salicylates		
APRISO	2	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
ASACOL	2	
ASACOL HD	2	
balsalazide	3	
CANASA	2	
DIPENTUM	3	
mesalamine	3	
PENTASA	3	
Sulfonamides		
sulfasalazine	1	
sulfazine	1	
sulfazine ec	1	

Metabolic Bone Disease Agents

Drug Name	Drug Tier	Requirements/ Limits
Metabolic Bone Disease Agents		
ACTONEL WITH CALCIUM	2	QL (31 per 31 days)
ACTONEL 150 MG	2	QL (1 per 28 days)
ACTONEL 75 MG	2	QL (2 per 31 days)
ACTONEL 30 MG, 5 MG	2	QL (31 per 31 days)
ACTONEL 35 MG	2	QL (4 per 28 days)
alendronate	1	
BONIVA 2.5 MG	2	QL (31 per 31 days)
calcitonin-salmon	1	QL (3.8 per 31 days)
calcitriol oral solution	3	B/D
calcitriol	1	B/D
calcitriol inj	3	B/D
etidronate	1	
FORTEO	4	PA
FOSAMAX PLUS D	3	QL (4 per 28 days)
FOSAMAX SOLUTION	3	QL (375 per 31 days)
HECTOROL	2	B/D
MIACALCIN INJ	3	PA
pamidronate inj 30 mg, 90 mg	3	
pamidronate inj 30 mg/10ml, 6 mg/ml, 90 mg/10ml	1	
PROLIA	3	QL (1 per 180 days), PA
XGEVA	4	QL (1.7 per 28 days), PA
ZEMPLAR	2	B/D
ZOMETA	4	

Miscellaneous Therapeutic Agents

Drug Name	Drug Tier	Requirements/ Limits
Miscellaneous Therapeutic Agents		
anagrelide	1	
BD INSULIN SYRINGE SAFETYGLIDE	2	
BD INSULIN SYRINGE ULTRAFINE	2	
BD PEN NEEDLE/ ULTRAFINE	2	
BOTOX	3	PA
GAUZE PADS 2"X2"	2	
dextrose 10% flex container	1	
intralipid inj	3	HI
KALBITOR	4	PA
leucovorin	1	
levocarnitine inj, oral solution	3	B/D
levocarnitine	1	B/D
METHERGINE	2	
MONOJECT INSULIN SYRINGE/PERM NEEDLE	2	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
MONOJECT INSULIN SYRINGE/ SAFETY/PERM	2	
MONOJECT ULTRA COMFORT INSULIN SYRINGE	2	
sterile water irrigation	1	
XENAZINE	4	PA

Ophthalmic Agents

Ophthalmic Agents, Other

Drug Name	Drug Tier	Requirements/ Limits
ak-con	1	
LACRISERT	2	
mydral	1	
naphazoline	1	
parcaine	1	
proparacaine	1	
RESTASIS	2	QL (24 per 30 days)
tropicacyl	1	
tropicamide	1	

Ophthalmic Anti-allergy Agents

Drug Name	Drug Tier	Requirements/ Limits
ALAMAST	3	
ALOCRIL	3	
ALOMIDE	3	
azelastine	1	
cromolyn	1	
ELESTAT	3	ST
EMADINE	3	ST
PATADAY	2	
PATANOL	2	

Ophthalmic Anti-inflammatories

Drug Name	Drug Tier	Requirements/ Limits
ALREX	3	
BLEPHAMIDE	2	
BLEPHAMIDE S.O.P.	2	
BROMDAY	3	
CORTISPORIN	3	
dexamethasone	1	
dexasporin	1	
diclofenac	1	
DUREZOL	3	
FLAREX	2	
fluor-op	1	
fluorometholone	1	
flurbiprofen	1	
FML	2	
FML FORTE	2	ST
ketorolac	1	
LOTEMAX	3	
MAXIDEX	2	
neomycin/polymyxin/ bacitracin/ hydrocortisone	1	
neomycin/polymyxin/ dexamethasone	1	
NEVANAC	3	
poly-dex	1	
POLY-PRED	2	
PRED MILD	2	
PRED-G	3	
PRED-G S.O.P.	2	
prednisolone acetate	1	
prednisolone	1	
sulfacetamide / prednisolone	1	
TOBRADEX OINTMENT	2	
tobramycin/ dexamethasone	1	
VEXOL	2	ST
XIBROM	3	
ZYLET	2	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
Ophthalmic Antiglaucoma Agents		
acetazolamide ER	3	
acetazolamide	1	
ALPHAGAN P 0.1%	2	
apraclonidine	1	
AZOPT	2	
betaxolol	1	
BETIMOL	3	
brimonidine	1	
carteolol	1	
COMBIGAN	2	
dipivefrin	1	
dorzolamide	1	
dorzolamide /timolol	1	
IOPIDINE 1%	3	
ISTALOL	3	
levobunolol	1	
methazolamide	1	
metipranolol	1	
PHOSPHOLINE	2	
PILOPINE HS	2	
timolol	1	
Ophthalmic Prostaglandin and Prostamide Analogs		
latanoprost	1	
LUMIGAN	2	
TRAVATAN Z	2	

Otic Agents

Drug Name	Drug Tier	Requirements/ Limits
Otic Agents		
acetic acid	1	
acetic acid/aluminum acetate	1	
acetic acid/ hydrocortisone	3	
borofair	1	
CIPRO HC	2	
COLY-MYCIN S	3	
CORTISPORIN-TC	3	
cortomycin	1	
DERMOTIC	2	
neomycin/ polymyxin/hc	1	
neomycin/polymyxin/ hydrocortisone	1	

Respiratory Tract Agents

Drug Name	Drug Tier	Requirements/ Limits
Anti-inflammatories, Inhaled Corticosteroids		
ADVAIR DISKUS	2	QL (60 per 30 days) ST
ADVAIR HFA	2	QL (1 per 30 days) ST
AEROBID	3	
AEROBID-M	3	
ALVESCO	3	QL (2 per 30 days) ST
ASMANEX 14; 30; 60; 120 (220MCG)	3	QL (1 per 30 days) ST
ASMANEX 30 (110MCG)	3	QL (1 per 30 days) ST
BECONASE AQ	3	QL (1 per 31 days)
budesonide nebulization	3	B/D
FLOVENT HFA 44 MCG/ACT	2	QL (1 per 30 days)
FLOVENT HFA 110 MCG/ACT, 220 MCG/ACT	2	QL (1 per 30 days)
flunisolide nasal	1	
fluticasone nasal	1	
NASONEX	2	QL (1 per 30 days)

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
PULMICORT FLEXHALER	2	QL (1 per 30 days)
PULMICORT SUSPENSION 1 MG/2ML	3	B/D
QVAR 40 MCG	2	QL (1 per 30 days)
QVAR 80 MCG	2	QL (1 per 30 days)
SYMBICORT	2	QL (1 per 30 days) ST
Antihistamines		
ALLEGRA SUSPENSION	3	QL (310 per 31 days) ST
ASTEPRO	2	QL (60 per 31 days)
azelastine	1	QL (60 per 31 days)
cetirizine	1	
CLARINEX-D 12H	3	QL (62 per 31 days) ST
CLARINEX-D 24H	3	QL (31 per 31 days) ST
clemastine	1	
dytuss	1	
fexofenadine	1	
fexofenadine pseudoephedrine	3	QL (31 per 31 days)
levocetirizine	1	QL (31 per 31 days)
PATANASE	2	QL (30.5 per 31 days)
promethazine	1	
promethegan	1	
SEMPREX-D	3	
Antileukotrienes		
SINGULAIR	2	QL (31 per 31 days)
zafirlukast	1	QL (62 per 31 days)
ZYFLO CR	3	QL (124 per 31 days) ST
Bronchodilators, Anticholinergic		
ATROVENT HFA	2	QL (2 per 31 days)
COMBIVENT	2	QL (2 per 31 days)
ipratropium/ albuterol	1	B/D
ipratropium nasal	1	
ipratropium inhalation	1	B/D
SPIRIVA	2	QL (30 per 30 days)
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)		
aminophylline	1	
ELIXOPHYLLIN	2	
THEO-24	2	
theochron	1	
theophylline cr	1	
theophylline er	1	
Bronchodilators, Sympathomimetic		
ADRENACLICK	3	
albuterol syrup	1	
albuterol nebulization	1	B/D
EPINEPHRINE	1	
epinephrine	1	
EPIPEN	2	
EPIPEN-JR	2	
FORADIL	2	QL (60 per 30 days) ST
levalbuterol	3	ST, B/D
MAXAIR	3	QL (1 per 31 days)
metaproterenol	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
PROAIR HFA	2	QL (3 per 31 days)
PROVENTIL HFA	2	QL (3 per 31 days)
SEREVENT DISKUS	2	QL (60 per 30 days), ST
terbutaline inj	4	
terbutaline	1	
TWINJECT	3	
VENTOLIN HFA	2	QL (3 per 31 days)
XOPENEX	3	ST, B/D
XOPENEX HFA	3	QL (2 per 31 days)
Mast Cell Stabilizers		
cromolyn	1	B/D
Pulmonary Antihypertensives		
ADCIRCA	4	QL (62 per 31 days)
LETAIRIS	4	QL (31 per 31 days)
REMODULIN	4	PA
REVATIO Inj	4	
REVATIO	4	QL (93 per 31 days)
TRACLEER	4	QL (62 per 31 days), LA
VENTAVIS	4	PA
Respiratory Tract Agents, Other		
acetylcysteine	1	B/D
ARALAST NP Inj	4	PA
GLASSIA	4	PA
PROLASTIN-C	4	PA
PROLASTIN Inj	4	PA
PULMOZYME	4	B/D
TYZINE NASAL	2	
XOLAIR	4	PA
ZEMAIRA	4	PA

Sedatives/Hypnotics

Drug Name	Drug Tier	Requirements/ Limits
Sedatives/Hypnotics		
LUNESTA	2	QL (31 per 31 days), ST
ROZEREM	3	QL (31 per 31 days)
zaleplon 5 mg	1	QL (31 per 31 days)
zaleplon 10 mg	1	QL (62 per 31 days)
zolpidem	1	QL (31 per 31 days)
zolpidem er	3	QL (31 per 31 days)

Skeletal Muscle Relaxants

Drug Name	Drug Tier	Requirements/ Limits
Skeletal Muscle Relaxants		
carisoprodol 250 mg	1	
chlorzoxazone 250 mg	1	
cyclobenzaprine	1	QL (93 per 31 days)
metaxalone	3	QL (124 per 31 days)

Therapeutic Nutrients/Minerals/ Electrolytes

Drug Name	Drug Tier	Requirements/ Limits
Electrolytes/Minerals		
AMINOSYN	3	HI
AMINOSYN /LYTES	3	HI
AMINOSYN II	3	HI
AMINOSYN II / DEXTROSE	3	HI
AMINOSYN II M / DEXTROSE	3	HI

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
AMINOSYN M	3	HI
AMINOSYN-HBC	3	HI
aminosyn-hf	3	HI
AMINOSYN-PF	3	HI
CLINIMIX / DEXTROSE	3	HI
CLINIMIX E / DEXTROSE	3	HI
clinisol sf	3	HI
dextrose 10% / NaCl	1	HI
DEXTROSE 5% / ELECTROLYTE	3	HI
dextrose 2.5% / NaCl	1	HI
dextrose 5% / lactated ringers	1	HI
dextrose 5% / NaCl	1	HI
ed k+10	1	
FREAMINE III & HBC	3	HI
HEPATASOL	3	HI
hepatamine	3	HI
IONOSOL-B, MB, T IN DEXTROSE	3	HI
ISOLYTE-H, M, P, S IN DEXTROSE	3	HI
isolyte-m/dextrose 5%	1	HI
ISOLYTE-S	3	HI
kaon-cl-10	1	
kcl in NaCl/D5W	1	HI
kcl in D5W/LR	1	HI
klor-con 8 , 10	1	
KLOR-CON M15	2	
klor-con m20	1	
lactated ringers IV	1	HI
lactated ringers irrigation	1	
magnesium inj in D5W	1	HI
NEPHRAMINE	3	HI
normosol-m & r in D5W	1	HI
NORMOSOL-R	3	HI
novamine	3	HI
PHYSIOSOL IRRIGATION	3	
physiolyte	3	HI
PLASMA-LYTE 56, 148, A, R	3	HI
PLASMA-LYTE-IN D5W	3	HI
potassium chloride in D5W	1	HI
potassium chloride in D5W/NaCl	1	HI
potassium chloride in NaCl	1	HI
potassium chloride er tablet	1	
potassium chloride sr	1	
potassium citrate ER	1	
PREMASOL	3	HI
PROCALAMINE	3	HI
PROSOL	3	HI
RENAMIN	3	HI
ringers inj	1	HI
ringers irrigation	1	
sodium bicarbonate inj	1	HI
sodium chloride inj (0.9%, 0.45%)	1	HI

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Drug Name	Drug Tier	Requirements/ Limits
sodium irrigation	1	
sodium fluoride	1	
sodium lactate inj	1	HI
tis-u-sol irrigation	1	
tpn electrolytes ftv	1	HI
TRAVASOL	3	HI
TRAVASOL/ DEXTROSE	3	HI
travasol / electrolytes	3	HI
TROPHAMINE 10%	3	HI
Therapeutic Nutrients/Minerals/Electrolytes, Other		
dextrose 25% inj	1	
dextrose 30% , 40%, 50%, 70%	1	HI
dextrose 5% viaflex	1	HI

Vitamins

Drug Name	Drug Tier	Requirements/ Limits
prenatabs obn	1	
prenatal low iron	1	
rovin-nv dha	1	
vinacal	1	

B/D – Authorization required to identify Medicare D coverage
HI – Covered under our medical benefit
LA – Limited Access; drugs available only at certain pharmacies
PA – Prior Authorization required
QL – Quantity Limit applies
ST – Step Therapy required

Index of Drugs

A

ABELCET 17
ABILIFY 22
ABILIFY DISCMELT . . . 22
ABILIFY INJ 22
ABRAXANE 19
ABSTRAL 7
acarbose 24
acebutolol 29
acetaminophen/caffeine/ dihydrocodeine 7
acetaminophen/codeine . . 7
acetazolamide 30
acetazolamide 45
acetazolamide er 45
acetic acid 45
acetic acid/ aluminum acetate. . . 45
acetic acid/hydrocortisone 45
acetylcysteine 47
ACTHIB 42
acticin 21
ACTIMMUNE. 41
ACTONEL 43
ACTOPLUS MET. 24
ACTOS 24
acyclovir 24
ADACEL 42
ADAGEN 33
adapalene 33
ADCIRCA. 47
ADRENACLICK 46
adriamycin 19
ADVAIR DISKUS. 45
ADVAIR HFA 45
ADVICOR ER 30
AEROBID 45
AEROBID-M 45
afeditab cr 29
AFINITOR 20
AGGRENOX 28
a-hydrocort 35
AK-CON 44
AKNE-MYCIN 12
ak-poly-bac. 10
ak-tob ophthalmic 10
ala cort 35
ALAMAST 44
ALBENZA 21
albuterol syrup 46
albuterol nebulization. . . 46
alclometasone 35
alcohol preps 10
ALDACTAZIDE 30
ALDURAZYME. 33
alendronate 43
ALIMTA. 19
ALINIA 21
ALLEGRA SUSPENSION 46
allopurinol 18
ALOCRIL 44
ALOMIDE 44
ALORA PATCH 38
ALOXI INJ 16
ALPHAGAN P 0.1% . . . 45
ALREX 44
ALTOPREV. 30
ALVESCO 45
amantadine 24
AMBISOME 17
amcinonide 35
a-methapred inj. 35
AMIFOSTINE. 19
amikacin 10
amiloride 30
amiloride/HCTZ 30
aminocaproic acid 28
amiodarone 28
aminophylline. 46
AMINOSYN 47
AMINOSYN II 47
AMINOSYN M 48
AMINOSYN-HBC. 48
aminosyn-hf 48
AMINOSYN-PF. 48
AMITIZA 34
amitriptyline 16
amlodipine 29
amlodipine /benazepril . . 29
ammonium lactate 33
amnesteem. 33
amoxapine 16
amoxicillin 12
amoxicillin/clavulanate . . 12
amoxicillin/clavulanate er 12
amoxil 12
amphetamine/ dextroamphetamine . 32
amphetamine/ dextroamphetamine er 32
amphotericin b 17
ampicillin 12
ampicillinsulbactam . . . 12
AMPYRA 32
ANADROL-50 37

anagrelide *43*
anastrozole *20*
ANCOBON 17
ANDRODERM 37
ANDROGEL 37
ANDROXY 37
ANTABUSE 16
ANTARA 30
ANTIVERT 16
ANZEMET 16
APHTHASOL. 33
APOKYN 21
apraclonidine *45*
apri *38*
APRISO 42
APTIVUS 23
ARALAST NP INJ 47
ARANESP 27, 28
ARCALYST. 41
ARICEPT 23 MG 14
ARIXTRA. 27
AROMASIN 20
ARRANON 19
ARTHROTEC 7
ARZERRA 21
ASACOL 43
ASACOL HD 43
ascomp/codeine . . . . . . *.7*
ASMANEX 45, 47
ASTEPRO 46
ASTRAMORPH 7
ATAMET 21
atenolol. *29*
atenolol/chlorthalidone . . *29*
ATRIPLA 23
atropine inj *34*
ATROVENT HFA 46
ATTENUVAX 42
augmented betamethasone dipropionate *35*
AVANDAMET. 24, 25
AVANDARYL 25
AVASTIN 21
AVELOX 12
AVIANE. 38
avita *33*
AVODART 35
AVONEX INJ 41
AXERT 18
AZACTAM 12
AZASAN 40
AZASITE 12
azathioprine 40
azelastine *44, 46*
AZELEX 33
AZILECT 21
azithromycin *12*
AZOPT 45
AZOR. 29
aztreonam inj. *12*

B

baciim *10*
bacitracin. *10*
bacitracin/polymyxin b ophthalmic *10*
baclofen *23*
BACTOCILL 12
BACTROBAN 10
balsalazide *43*
BANZEL 13
BARACLUDE 24
BD INSULIN SYRINGE . 43
BD PEN NEEDLE/ ULTRAFINE 43
BECONASE AQ 45
benazepril *31*
benazepril /HCTZ *31*
BENICAR. 31
BENICAR HCT 31
BENZACLIN CARE KIT . 33
benztropine *21*
BERINERT 28
BESIVANCE 13
betamethasone dipropionate *35*
betamethasone valerate . *35*
BETASERON. 41
beta-val. *35*
betaxolol opthth . . . 29, 45
bethanechol chloride . . . *35*
BETIMOL. 45
bicalutamide *40*
BICILLIN C-R. 12
BICILLIN L-A 12
BICNU INJ 19
BIDIL 32
BILTRICIDE 21
bisoprolol *29*
bisoprolol /HCTZ *29*
BLEOMYCIN INJ 19
BLEPHAMIDE 44
BLEPHAMIDE S.O.P. . . 44
BONIVA 43
BOOSTRIX. 42
BOROFAIR. 45
BOTOX. 43
brimonidine *45*
BROMDAY 44
bromocriptine *21*

budeprion sr 12 hour . . . 14
budeprion xl 14
budesonide nebulization 45
bumetanide 30
BUPHENYL 33
buprenorphine 7
bupropion 14
buspirone 24
BUSULFEX INJ 19
butalbital/APAP/caffeine/codeine 7
butorphanol 7
butorphanol nasal solution 7
BYETTA 25
BYSTOLIC 29

C

cabergoline 39
calcipotriene 33
calcitonin-salmon 43
calcitriol 43
calcium acetate 35
CAMILA 39
CAMPATH 21
CAMPRAL 16
CANASA 43
CANCIDAS 17
CAPASTAT 18
CAPEX 35
CAPITAL/CODEINE 8
captopril 31
captopril/HCTZ 31
CARAC 33
CARAFATE SUSPENSION 34
carbamazepine 14
carbamazepine er 14
CARBATROL 14
carbidopa/levodopa . . . 21
carbidopa/levodopa cr . . 21
carbidopa/levodopa er 21
carbidopa/levodopa odt 21
CARBOPLATIN INJ . . . 19
CARDIZEM CD 29
CARDURA XL 35
CARIMUNE 41
carisoprodol 47
carteolol 45
cartia xt 29
carvedilol 29
CAYSTON 12
CEDAX 11
CEENU 19
cefaclor 11
cefaclor er 11
cefadroxil 11
cefazolin 11
cefdinir 11
cefditoren 11
cefepime inj 11
CEFIZOX INJ 11
CEFOTAXIME INJ . . . 11
CEFOTETAN / DEXTROSE 11
cefoxitin inj 11
cefpodoxime proxetil . . . 11
cefprozil 11
ceftazidime inj 11
ceftriaxone inj 11
cefuroxime axetil 11
cefuroxime/dextrose . . . 11
CELEBREX 7
CELESTONE 36
CELLCEPT 40
CELONTIN 13
cephalexin 11
CEREZYME 33
CERVARIX 42
CESIA 38
cetirizine 46
CHANTIX 16
chloramphenicol inj . . . 10
chlorhexidine gluconate oral 33
chloroquine 21
chlorothiazide 30
chlorzoxazone 47
chlorpromazine 22
chlorthalidone 30
cholestyramine 30
cholestyramine light 30
CHORIONIC GONADOTROPIN . . 37
ciclopirox 17
cilostazol 28
CILOXAN OINTMENT . . 13
cimetidine 34
CIMZIA 40
CINRYZE 28
ciprofloxacin 13
ciprofloxacin er 13
ciprofloxacin ophthalmic . 13
CIPRO HC 45
CIPRO SUSPENSION . . 13
cisplatin inj 20
citalopram 15
cladribine inj 19

CLAFORAN INJ 11
CLARINEX-D. 46
claravis 33
clarithromycin & ER . . . 12
clemastine 46
CLEOCIN. 10
CLIMARA PRO. 38
CLINDAGEL 10
clindamycin 10
clindamycin/benzoyl peroxide 33
clindamycin topical 10
CLINDESSE 10
CLINIMIX/DEXTROSE . . 48
clinisol sf 48
clobetasol 36
CLOBEX 36
CLODERM 36
CLOLAR INJ 19
clomipramine 16
clonidine patch. 28
clotrimazole 17
clotrimazole/betamethasone dipropionate 17
clozapine 22
codeine 8
co-gesic 8
COLCRYS 18
colestipol 30
colistimethate inj 10
colocort. 42
COLY-MYCIN S 45
COMBIGAN 45
COMBIPATCH 38
COMBIVENT. 46
COMBIVIR 23
compro 16
COMTAN 21
COMVAX 42
CONDYLOX 33
constulose 34
COPAXONE 41
CORDRAN 36
cormax 36
cortisone 36
CORTISPORIN. 44
CORTISPORIN CREAM . 10
CORTISPORIN-TC. . . . 45
cortomycin 45
COUMADIN INJ 27
COVERA-HS 29
CREON. 33
CRESTOR 30
CRINONE 39
CRIXIVAN 23
CROMOLYN 44, 47
cryselle-28 38
CUBICIN 10
CUPRIMINE 16
CUTIVATE LOTION . . . 36
CUVPOSA 34
cyclafem 1/35 38
cyclafem 7/7/7 38
cyclobenzaprine 47
cyclophosphamide 19
cycloserine 18
cyclosporine 40
CYKLOKAPRON 28
CYMBALTA. 15
CYSTADANE. 33
CYSTAGON 33
CYTARABINE 19

D

dacarbazine inj 19
DACOGEN 20
dactinomycin 20
DANAZOL 38
dantrolene 23
DAPSONE 18
DAPTACEL. 42
DARAPRIM. 21
daunorubicin 20
DAUNOXOME 20
DECAVAC 42
del-beta. 36
DEMADEX 30
demeclocycline 13
DEMSER. 30
DENAVIR. 24
depade 16
DEPEN TITRATABS . . . 16
DEPO-ESTRADIOL . . . 38
DEPO-MEDROL 36
DEPO-PROVERA 39
DERMA-SMOOTHE . . . 36
DERMOTIC 45
desipramine 16
desmopressin 37
desonide 36
desoximetasone 36
dexamethasone 36
DEXASPORIN 44
DEXILANT 35
DEXPAK 13 DAY 36
dexrazoxane inj 20
dextroamphetamine . . . 32
dextrose 49
dextrose 10%. 43, 48

dextrose 10%/NaCl . . . *48*
DEXTROSE 5%/ ELECTROLYTE . . . 48
dextrose 2.5%/NaCl . . . *48*
dextrose 5%/ lactated ringers *48*
dextrose 5%/NaCl *48*
DIBENZYLINE 28
diclofenac *7, 44*
dicloxacillin *12*
dicyclomine *34*
didanosine *23*
DIFFERIN LOTION. . . . 33
diflorasone *36*
diflunisal *7*
digoxin *30*
DILANTIN 14
DILATRATE SR 32
DILAUDID-5 8
dilt-cd *29*
diltiazem cd. *29*
diltiazem ER *29*
diltiazem inj. *29*
dilt-xr *29*
diltzac *29*
DIOVAN 31
DIOVAN HCT 31
DIPENTUM. 43
DIPHTHERIA/TETANUS TOXOID PEDIATRIC 42
dipivefrin *45*
DIURIL 30
divalproex *13*
divalproex er *13*
DIVIGEL 38
donepezil *14*
DORYX. 13
dorzolamide *45*
dorzolamide /timolol . . . *45*
DOVONEX 33
doxazosin *35*
doxepin. *16*
DOXIL 20
doxorubicin *20*
DOXY-CAPS 13
doxycycline hyclate. . . . *13*
doxycycline mono *13*
dronabinol *16*
DROXIA 19
DUETACT 25
duramorph *8*
DUREZOL 44
DYNACIRC CR. 29
DYRENIUM 30
dytuss *46*

E

econazole nitrate *17*
ed k+10. . . . . *48*
EDECRIN 30
e.e.s. 400. . . . . *12*
E.E.S. GRANULES. . . . 12
EFFIENT 28
EGRIFTA 37
ELAPRASE. 33
ELESTAT 44
ELIDEL 33
ELIGARD. 39
ELIPHOS. 35
ELITEK INJ. 19
ELIXOPHYLLIN 46
ELLA 39
ELMIRON 35
ELSPAR 20
EMADINE 44
EMCYT. 19
EMEND 16
EMSAM 15
EMTRIVA. 23
ENABLEX 35
enalapril *31*
enalapril/HCTZ *31*
ENBREL 40
endocet. *8*
endodan *8*
ENGERIX-B 42
enoxaparin *27*
enpresse-28 . . . . *38*
ENTOCORT EC 42
enulose. *34*
EPIDUO 33
EPINPHRINE. 46
epinephrine. *46*
EPIPEN 46
epirubicin *20*
epitol *14*
EPIVIR 23
eplerenone *30*
EPZICOM 23
EQUAGESIC. 7
EQUETRO 24
ERAXIS INJ 17
ERBITUX. 21
ergotamine/caffeine . . . *18*
errin *39*
ERTACZO 17
ery *12*
ERYPED 12
ERY-TAB 12
erythromycin *12*

erythromycin/benzoyl peroxide *33*
erythromycin/sulfisoxazole *12*
ESTRACE CREAM. . . . 38
ESTRADERM 38
estradiol patch weekly . . *38*
estradiol valerate *38*
ESTRING. 38
ethambutol *18*
ethosuximide *13*
ETIDRONATE 43
etodolac *7*
etodolac er *7*
ETOPOPHOS 20
ETOPOSIDE 20
EURAX 21
EVISTA 39
EVOXAC 33
EXELDERM 17
EXELON 14
EXJADE 16

F

FABRAZYME. 34
famciclovir *24*
famotidine inj *34*
famotidine *34*
FANAPT 22
FARESTON 19
FASLODEX. 19
FAZACLO 22
FELBATOL 14
felodipine er *29*
FEMARA 20
FEMRING 38
fenofibrate *30*
fenofibrate micronized . . *30*
fenoprofen *7*
fentanyl *8*
FENTORA 8
fexofenadine *46*
fexofenadine pseudoephedrine . . . *46*
FINACEA. 33
finasteride *35*
FIRMAGON 20
FLAGYL ER 10
FLAREX 44
flavoxate *35*
flecainide *28*
FLOVENT HFA 45
fluconazole inj *17*
fluconazole oral *17*
fludarabine *20*
fludrocortisone *36*
flunisolide nasal *45*
fluocinolone *36*
fluorometholone *44*
fluor-op *44*
FLUOROPLEX 33
fluorouracil cream *33*
fluorouracil external solution *33*
fluorouracil inj *19*
fluoxetine *15*
fluphenazine *22*
fluphenazine decanoate . *22*
flurbiprofen *7*
flurbiprofen ophth *44*
flutamide *40*
fluticasone *36, 45*
fluvoxamine *15*
FML 44
FML FORTE 44
FOCALIN XR. 32
FOLOTYN INJ 19
FORADIL. 46
FORTAMET 25
FORTAZ INJ 11
FORTEO 43
FOSAMAX PLUS D . . . 43
FOSAMAX SOLUTION. . 43
FOSCARNET 23
fosinopril *31*
fosinopril/HCTZ. *31*
fosphenytoin inj. *14*
FOSRENOL 35
FRAGMIN INJ 27
FREAMINE III & HBC . . 48
FROVA 18
furosemide *30*
FUZEON 23

G

gabapentin *14*
GABITRIL 14
galantamine *14*
GAMASTAN S/D 41
GAMMAGARD 41
GAMMAGARD S/D. . . . 41
GAMMAPLEX 41
GAMUNEX 41
GAMUNEX-C. 41
ganciclovir *23*
GANTRISIN PEDIATRIC 13
GARDASIL 42
GASTROCROM 34
GAUZE PADS 2"X2" . . . 43
gavilyte-g *34*

gavilyte-n/flavor pack . . . 34
gemcitabine 19
gemfibrozil 30
GEMZAR 19
generlac 34
gengraf 40
genoptic 10
GENOTROPIN 37
gentak ophthalmic 10
gentamicin 10
gentasol ophthalmic . . . 10
GEODON. 22
gianvi 38
GILENYA 41
GLASSIA 47
GLEEVEC 20
glimepiride 25
glipizide. 25
glipizide er 25
glipizide/metformin 25
glipizide xl 25
GLUCAGON 26
GLUMETZA 25
glyburide 25
glyburide/metformin . . . 25
glyburide micronized . . . 25
GLYCOL 3350 34
glycopyrrolate 34
glycron 25
GLYSET 25
granisetron 17
granisol 17
GRIFULVIN V 17
griseofulvin microsize . . 17
GRIS-PEG 17
guanabenz 28
guanfacine 28
guanidine 18
GYNAZOLE-1 17
gynodiol 38

H

HALAVEN 20
HALFLYTELY. 34
halobetasol 36
HALOG 36
HALONATE PAC 36
haloperidol 22
HAVRIX 42
HECTOROL 43
HELIDAC. 34
HEPAGAM B 42
heparin 27
HEPATASOL 48
hepatamine. 48
HEPSERA 24
HERCEPTIN 21
HEXALEN 19
HIBERIX 42
HIZENTRA 41
HUMALOG 26
HUMALOG MIX 50/50 . . 26
HUMALOG MIX 75/25 . . 26
HUMATROPE 37
HUMIRA 40
HUMULIN 70/30 26
HUMULIN N 26
HUMULIN R 26
HUMULIN R U-500. . . . 26
HYCET 8
hydralazine 32
hydrochlorothiazide . . . 30
hydrocodone/APAP. 8
hydrocodone/ibuprofen . . . 8
hydrocortisone butyrate . 36
hydrocortisone cream, lotion, ointment 36
hydrocortisone enema . . 36
hydrocortisone in absorbase 36
hydrocortisone valerate . 36
hydromorphone 8
hydroxychloroquine . . . 21
hydroxyurea 19

I

ibuprofen 7
idarubicin 20
ifosfamide inj 19
ifosfamide/mesna inj . . . 19
imipramine 16
imiquimod 33
IMITREX SOLUTION. . . 18
IMITREX STATDOSE . . 18
IMOVAX RABIES. 42
INCRELEX 37
indapamide 30
INFANRIX 42
INFERGEN. 41
INFUMORPH. 8
INNOPRAN XL 29
INTELENCE 23
intralipid inj 43
INTRON-A 41
INVANZ. 12
INVEGA 22
INVEGA SUSTENNA. . . 22
INVIRASE 23
IONOSOL-B, MB, T IN DEXTROSE 48

IOPIDINE 1%. 45
IPOL 42
ipratropium *46*
irinotecan *20*
ISENTRESS 23
isochron *32*
ISOLYTE-H, M, P, S, IN DEXTROSE 48
isolyte-m/dextrose 5% . . *48*
ISOLYTE-S 48
isonarif *19*
isoniazid *19*
isordil titradose *32*
isosorbide dinitrate *32*
isosorbide dinitrate er . . *32*
isosorbide mononitrate . . *32*
isosorbide mononitrate er *32*
ISOVATE 36
isradipine *29*
ISTALOL 45
ISTODAX. 20
itraconazole *17*
IXEMPRA KIT INJ 20
IXIARO 42

J

jantoven *27*
JANUMET 25
JANUVIA 25, 26
JE-VAX 42
JEVTANA. 20
jinteli *38*
jolivette *39*
junel *38*
junel fe *38*

K

KALBITOR 43
KALETRA 23
kanamycin *10*
kaon-cl-10 . . . . *48*
KARIVA. 38
kcl *48*
KEFLEX 11
KELNOR 1/35 38
KENALOG 36
KEPIVANCE 33
KETEK 12
ketoconazole *17*
ketoprofen *7*
ketoprofen er *7*
ketorolac *44*
KINERET. 41
KINRIX 42
KIONEX 16
klor-con 8, 10. . . . . . . *48*
KLOR-CON M15 48
klor-con m20 . . . . *48*
KOMBIGLYZE XR 26
KRISTALOSE 34
KRYSTEXXA. 18
kuric *17*
KUVAN 34

L

labetalol *29*
laclotion *33*
LACRISERT 44
lactated ringers IV *48*
lactated ringers irrigation *48*
lactulose *34*
LAMICTAL STARTER . . 14
LAMISIL SOLUTION . . . 17
lamotrigine *14*
lamotrigine chewable . . *14*
LANOXIN. 30
lansoprazole *35*
lansoprazole odt *35*
LANTUS 26
LANTUS SOLOSTAR . . 26
latanoprost *45*
LATUDA 22
leflunomide. *41*
LESCOL 31
LESCOL XL 31
lessina-28 . . . . *38*
LETAIRIS. 47
leucovorin *43*
LEUKERAN 19
LEUKINE. 28
leuprolide *39*
levalbuterol *46*
LEVATOL. 29
LEVEMIR. 26
levetiracetam *13*
levobunolol *45*
levocetirizine *46*
levocarnitine *43*
levofloxacin. *13*
LEVORA 38
levorphanol *8*
LEVOTHROID 39
levothyroxine *39*
levoxyl *39*
LEXIVA 23
lidocaine topical *9*
lidocaine inj. *10*
lidocaine/prilocaine. . . . *10*
lidocaine viscous *10*

LIDODERM. 10
lindane *21*
liothyronine *39*
LIPITOR 31
lisinopril. *31*
lisinopril/HCTZ *31*
lithium carbonate *24*
lithium carbonate er . . . *24*
lithium citrate syrup. . . . *24*
LITHOBID 24
LOCOID 36
LODOSYN 21
LOKARA 36
lonox *34*
loperamide *34*
losartan. *31*
losartan/HCTZ *31*
LOTEMAX 44
LOTRONEX 34
lovastatin *31*
LOVAZA 31
LOVENOX 27
low-ogestrel *38*
loxapine *22*
LUMIGAN 45
LUNESTA 47
LUPRON DEPOT . . 39, 40
lutera *38*
LUXIQ 36
LYRICA. 13
LYSODREN 39

M

magnesium inj in D5W . . *48*
MAKENA 39
MALARONE 21
malathion *21*
MAPROTILINE 14
margesic-h *8*
MARPLAN 15
MATULANE 19
matzim la *29*
MAXAIR 46
MAXALT 18
MAXALT-MLT. 18
MAXIDEX 44
MAXIPIME 11
mebendazole *21*
meclizine *17*
meclofenamate *7*
medroxyprogesterone . . *39*
mefenamic acid *7*
mefloquine *21*
MEGACE ES 39
megestrol *39*
meloxicam *7*
melphalan inj *19*
MENACTRA 42
MENOMUNE 42
MENOSTAR 38
MENTAX 17
MENVEO. 42
meprobamate *24*
MEPRON. 21
mercaptopurine. *19*
meropenem inj *12*
MERREM INJ 12
MERUVAX II 42
mesalamine *43*
mesna *20*
MESNEX 20
MESTINON. 18
metaproterenol *46*
metaxalone *47*
metformin. *26*
metformin er *26*
methadone *8*
methazolamide *45*
methenamine hippurate . *10*
METHERGINE 43
methimazole *40*
methotrexate *40*
methscopolamine *34*
methyclothiazide *30*
METHYLIN 32
methylphenidate . 32, 36,42
methylprednisolone . . . *36*
metipranolol *45*
metoclopramide 17
metolazone. *30*
metoprolol *29*
metoprolol er. *29*
metoprolol/HCTZ *29*
METROGEL 10
metronidazole *10*
metronidazole vaginal & topical. *10*
mexiletine *28*
MIACALCIN Inj 43
MICARDIS 31
MICARDIS HCT 31
miconazole 3 suppository *17*
microgestin *38*
microgestin fe *38*
MIDODRINE 28
migergot *18*
MILLIPRED 42
MINITRAN 32
minocycline *13*
minocycline er *13*

minoxidil *32*
mirtazapine *14*
mirtazapine odt *14*
misoprostol *34*
mitomycin inj *20*
mitoxantrone *20*
M-M-R II 42
MOBAN 22
moexipril 31
moexipril/HCTZ. *31*
mometasone *36*
MONOJECT INSULIN SYRINGE. 43
mononessa *38*
MONUROL 10
morphine *9*
morphine er *9*
morphine inj *9*
MOVIPREP. 34
MOZOBIL 28
MULTAQ 28
mupirocin *10*
MUSTARGEN INJ 19
MYCOBUTIN 18
mycophenolate mofetil . . *40*
mydral *44*
MYFORTIC. 40
MYOZYME 34
MYTELASE 18

N

nabumetone *7*
nadolol *29*
nadolol/bendroflumethiazide *29*
nafcillin *12*
NAGLAZYME 34
nalbuphine *9*
NALFON 7
NALLPEN 12
naloxone *16*
naltrexone *16*
NAMENDA 14
naphazoline *44*
naproxen *7*
naratriptan *18*
NARDIL 15
NASONEX 45
NATACYN OPHTHALMIC 17
natealinide *26*
NAVANE 22
necon. *39*
nefazodone *14*
neomycin *10*
neomycin/bacitracin/polymyxin ophthalmic *10*
neomycin/polymyxin/bacitracin/hydrocortisone *44*
neomycin/polymyxin/dexamethasone. . . . *44*
neomycin/polymyxin/gramicidin ophthalmic *10*
neomycin/polymyxin/hc *45*
NEPHRAMINE 48
NEULASTA. 28
NEUMEGA 28
NEUPOGEN 28
NEURONTIN SOLUTION 14
NEVANAC 44
NEXAVAR 20
NEXIUM 35
next choice *39*
niacor. *31*
NIASPAN. 31
nicardipine *29*
NICOTROL INHALER . . 16
NICOTROL NS. 16
nifediac cc *29*
nifedical xl *29*
nifedipine er *30*
NILANDRON 40
nimodipine *30*
nisoldipine *30*
NITRO-DUR PATCH . . . 32
nitrofurantoin macro . . . *10*
nitroglycerin products . . *32*
NITROLINGUAL PUMPSPRAY. 32
NITROMIST 32
nizatidine *34*
nora-be *39*
NORDITROPIN PEN. . . 37
norethindrone *39*
NORITATE 11
normosol-m & r in D5W . *48*
NORMOSOL-R. 48
NOROXIN 13
NORTREL 7/7/7 38
nortriptyline *16*
nortriptyline solution . . . *16*
NORVIR 23
novamine. *48*
NOVANTRONE 20
NOVAREL 37
NOVOLIN 70/30 27
NOVOLIN N 27
NOVOLIN R 27

NOVOLOG 27
NOVOLOG MIX 70/30 . . 27
NOXAFIL SUSPENSION 17
NULYTELY/
FLAVOR PACKS . . . 34
NUTROPIN. 37
NUTROPIN AQ. 37
NUVARING. 38
NYAMYC 17
nystatin *17*
nystatin/triamcinolone . . *17*
nystop *17*

O

octreotide *40*
ocusulf-10 ophthalmic . . *13*
ofloxacin ophthalmic & otic *13*
ogestrel. *38*
OLUX-E 36
omeprazole. *35*
omeprazole/ bicarbonate *35*
OMNITROPE. 37
ONCASPAR 20
ondansetron *17*
ondansetron odt *17*
ONGLYZA 26
ONTAK 20
onxol *20*
OPANA ER 9
ORACEA *13*
ORAP 22
ORENCIA 40
ORFADIN. 34
ORTHO EVRA 38
OSMOPREP 34
oxacillin inj. *12*
OXALIPLATIN 20
oxandrolone *37*
oxcarbazepine *14*
OXISTAT 17
OXSORALEN 33
OXSORALEN ULTRA . . 33
oxycodone *9*
oxycodone/APAP *9*
oxycodone/aspirin *9*
oxycodone/ibuprofen . . . *9*
OXYCONTIN 9
oxymorphone *9*

P

PACERONE 28
paclitaxel *20*
pamidronate inj *43*
PANDEL 36
PANLOR DC 18
PANRETIN 21
pantoprazole *35*
PARCAINE 44
paromomycin *10*
paroxetine *15*
paroxetine er *15*
paroxetine suspension . . *15*
PASER 19
PATADAY. 44
PATANASE 46
PATANOL. 44
PCE 12
PEDIARIX 42
PEDI-DRI POWDER . . . 17
PEDVAX HIB 42
peg-3350/lytes *34*
PEGANONE 14
PEGASYS 42
PEG-INTRON 42
penicillin g *12*
penicillin g potassium *12*
penicillin vk. *12*
PENTASA 43
pentopak *28*
pentostatin inj *19*
pentoxifylline er. *28*
pentoxil *28*
perindopril *31*
PERIOGARD. 33
permethrin *21*
perphenazine. *22*
PEXEVA 15
phenelzine *15*
phenytoin ER. *14*
phenytoin inj *14*
phenytoin suspension . . *14*
PHOSPHOLINE 45
PHOTOFRIN 20
PHYSIOSOL IRRIGATION 48
physiolyte. *48*
pilocarpine *33*
PILOPINE HS 45
PINDOLOL 29
piperacillin *12*
piperacillin /tazobactam . *12*
PLAN B. 39
PLAVIX 28
PLASMA-LYTE 56, 148, A, R 48
PLASMA-LYTE-IN D5W . 48
PODOFILOX 33
polycin b *11*
poly-dex *44*

polyethylene *34*
POLYGAM S/D 41
polymyxin b inj *11*
poly-pred *44*
polystyrene sulfonate. . . . *16*
portia-28 . . . . *38*
potassium chloride *48*
PRADAXA 27
pramipexole *21*
PRANDIN 26
pravastatin *31*
prazosin *28*
PRED-G 44
PRED-G S.O.P. 44
PRED MILD 44
prednicarbate. *36*
prednisolone ophth *36*
prednisone *36*
PREGNYL 37
PREMARIN 38
PREMARIN VAGINAL . . 38
PREMASOL 48
PREMPRO 38
prenatabs obn *49*
prenatal low iron *49*
prevalite *31*
previfem *38*
PREVPAC 35
PREZISTA 23
PRIFTIN 19
PRIMAQUINE 21
PRIMAXIN 12
primidone. *14*
PRIMSOL 11
PRISTIQ 15
PRIVIGEN 41
PROAIR HFA. 47
probenecid *18*
probenecid/colchicine . . *18*
procainamide *28*
PROCALAMINE 48
PROCHIEVE 39
prochlorperazine *22*
PROCRIT 28
PROCTOCREAM-HC . . 36
PROCTO-PAK 36
PROCTOSOL HC 36
PROCTOZONE-HC . . . 36
progesterone *39*
PROGLYCEM 26
PROGRAF INJ 41
PROLEUKIN 20
PROLASTIN 47
PROLIA. 43
PROMACTA 28
PROMETRIUM. 39
promethazine. *46*
promethegan *46*
propafenone *28*
propafenone er *28*
propantheline. *34*
proparacaine *44*
propranolol *29*
propranolol er *29*
propranolol/HCTZ *29*
propylthiouracil *40*
PROQUAD 42
PROQUIN XR 13
PROSOL 48
PROTONIX INJ 35
PROTOPIC. 33
protriptyline *16*
PROVENTIL HFA 47
PROVIGIL 33
PULMICORT 46
PULMICORT SUSPENSION 46
PULMOZYME 47
pyrazinamide *19*
pyridostigmine *18*

Q

QUALAQUIN 21
quinapril *31*
quinapril/HCTZ *31*
quinaretic. *31*
quinidine *29*
quinidine er. *29*
quinidine gluconate. *28*
quinidine gluconate cr . . *28*
QVAR. 46

R

RABAVERT. 42
ramipril *32*
RANEXA 30
ranitidine *34*
RAPAFLO 35
RAPAMUNE 41
REBETOL SOLUTION . . 24
REBIF 42
RECLIPSEN 38
RECOMBIVAX HB 42
regonol inj *18*
REGRANEX 33
RELENZA DISKHALER . 24
RELISTOR 34
RELPAX 18
REMICADE. 42
REMODULIN. 47
RENAGEL 35

RENAMIN 48
RENVELA 35
RESCRIPTOR 23
RESTASIS 44
RETIN-A MICRO 33
RETROVIR IV 23
REVATIO 47
REVLIMID 19
REYATAZ. 23, 24
ribasphere 24
ribavirin. 24
RIDAURA. 42
rifampin 19
RIFATER 19
RILUTEK 33
rimantadine 24
ringers 48
RIOMET 26
RISPERDAL CONSTA . . 22
risperidone 22
risperidone m-tab. 22
risperidone odt 22
RITUXAN. 21
rivastigmine 14
romycin ophthalmic. . . . 12
ropinirole 21
ROTARIX. 42
ROTATEQ 42
rovin-nv dha 49
roxicet 9
ROZEREM 47

S

SABRIL. 14
SAIZEN. 37
SAMSCA 30
SANCTURA XR 35
SANCUSO 17
SANDOSTATIN LAR . . . 40
SANTYL 33
SAPHRIS. 24
SAVELLA. 7
scalacort 37
selegiline 21
selenium sulfide lotion . . 33
SELZENTRY 23
SEMPREX-D 46
SENSIPAR 39
SEREVENT DISKUS. . . 47
SEROQUEL 24
SEROQUEL XR 24
sertraline 15
silver sulfadiazine cream . 11
SIMCOR ER 31
simvastatin 31
SINGULAIR 46
sodium bicarbonate inj . . 48
sodium chloride inj 48
sodium irrigation 49
sodium fluoride 49
sodium lactate inj. 49
SOLARAZE 33
solia 38
SOLU-CORTEF INJ . . . 37
SOLU-MEDROL 37
SOMATULINE DEPOT . . 40
SOMAVERT 40
SORIATANE 33
sorine. 29
sotalol 29
sotalol inj. 29
sotret 33
SPIRIVA 46
spironolactone 30
spironolactone/HCTZ. . . 30
SPORANOX SOLUTION 17
SPRINTEC 28 38
SPRYCEL 20
sronyx 38
ssd 11
stagesic 9
STALEVO 21
stavudine 23
STAVZOR 14
STELARA 41
sterile water irrigation . . 44
STIMATE 37
STRATTERA 32
STREPTOMYCIN INJ . . 10
STRIANT 38
STROMECTOL. 21
SUBOXONE 16
sucralfate 34
sulfacetamide 33
sulfacetamide ophthalmic 13
sulfacetamide/ prednisolone 44
sulfadiazine. 13
sulfamethoxazole/ trimethoprim 13
SULFAMYLON 11
sulfasalazine 43
sulfatrim 13
sulfazine 43
sulfazine ec. 43
sulindac 7
sumatriptan 18
SUPRAX 11
SURMONTIL 16
SUSTIVA 23

SUTENT 20
SYMBICORT 46
SYMLIN 26
SYNAGIS. 42
SYNALGOS-DC 9
SYNAREL 40
SYNERCID. 11
SYNTHROID 39
SYPRINE. 16

T

TABLOID 19
tacrolimus 41
TAMIFLU 24
tamoxifen 19
tamsulosin 35
TARCEVA 21
TARGRETIN 21
TASIGNA 21
TAXOTERE 20
TAZICEF 11
TAZORAC GEL. 33
TAZTIA XT 30
TEGRETOL-XR 14
TEKTURNA 32
TEKTURNA HCT 32
terazosin 35
terbinafine 17
terbutaline inj 47
terbutaline 47
terconazole vaginal cream & suppository 18
testosterone cypionate inj 38
testosterone enanthate. . 38
tetanus/diphtheria toxoids-adsorbed adult 42
tetracycline 13
TEV-TROPIN. 37
TEXACORT 37
THALITONE 30
THALOMID. 19
THEO-24 46
theochron. 46
theophylline 46
thermazene. 11
thioridazine 23
THIOTEPA INJ 19
thiothixene 23
THYROLAR 39
TIKOSYN. 29
TIMENTIN INJ 12
timolol 29
timolol ophth 45
tis-u-sol irrigation 49
tizanidine 23
TOBI 10
TOBRADEX OINTMENT 44
tobramycin/ dexamethasone. . . . 44
tobramycin injection . . . 10
tobrasol ophthalmic . . . 10
TOBREX OINTMENT . . 10
tolazamide 26
tolbutamide. 26
TOLMETIN 7
topiramate 14
toposar 20
topotecan. 20
TORISEL 20
torsemide. 30
tpn electrolytes ftv 49
TRACLEER 47
tramadol 9
tramadol/APAP 9
tramadol er 9
trandolapril 32
trandolapril/verapamil . . 32
TRANSDERM-SCOP . . 17
tranylcypromine 15
TRAVASOL. 49
travasol/electrolytes . . . 49
TRAVATAN Z 45
trazodone 15
TREANDA INJ 19
TRECATOR 19
TRELSTAR. 40
TRELSTAR DEPOT . . . 40
TRELSTAR LA 40
tretinoin 21
TRETINOIN TOPICAL . . 33
TREXALL. 41
TREZIX. 18
triamcinolone acetonide . 37
triamcinolone in orabase 33
triamterene/HCTZ 30
TRIBENZOR 30
TRICOR 31
TRIDERM 37
trifluoperazine 23
trifluridine. 24
trihexyphenidyl 21
TRIHIBIT 42
TRILIPIX 31
trimethoprim 11
trimethoprim /polymyxin b ophthalmic 13
trimipramine 16
trimox. 12
trinessa. 38
TRIPEDIA 42
tri-previfem 38

TRISENOX 20
tri-sprintec 38
TRIVORA-28 38
TRIZIVIR 23
TROPHAMINE 10% . . . 49
TROPICACYL 44
tropicamide 44
trospium 35
TRUVADA 23
TWINJECT 47
TWINRIX 42
TWYNSTA 30
TYGACIL 11
TYKERB 21
TYPHIM VI 42
TYSABRI 42
TYZEKA 24
TYZINE NASAL 47

U

U-CORT 37
ULORIC 18
ULTRAM ER 300 MG . . . 9
ULTRASE 34
unithroid 39
ursodiol 34

V

valacyclovir 24
VALCYTE 23
valproate inj 14
valproic acid 14
VALTURNA 32
VANCOCIN 11
vancomycin inj 11
vandazole 11
VANOS 37
VAQTA INJ 42
VARIVAX 42
VECTIBIX 21
veetids 12
VELCADE 20
VELIVET 38
venlafaxine 15, 16
venlafaxine ER 15, 16
VENTAVIS 47
VENTOLIN HFA 47
verapamil 30
verapamil er 30
verapamil sr 30
VESICARE 35
VEXOL 44
VFEND 18
VIBRAMYCIN SYRUP . . 13
VIDAZA. 20
VIDEX PEDIATRIC. . . . 23
VIGAMOX 13
VIMPAT. 13
vinacal 49
vinblastine 20
vincasar pfs 20
vincristine 20
vinorelbine 20
VIRACEPT 24
VIRAMUNE 23
VIREAD 23
VISICOL 34
VIVELLE-DOT 38
VOLTAREN GEL 7
voriconazole 18
VOTRIENT 19
VPRIV 34
VYTORIN. 31

W

warfarin 27
WELCHOL 31

X

XENAZINE 44
XGEVA 43
XIBROM 44
XIFAXAN 11
XODOL 9
XOLAIR 47
XOLEGEL TOPICAL . . . 18
XOPENEX 47
XYREM. 33

Y

YF-VAX. 42

Z

zafirlukast 46
zaleplon 47
ZANAFLEX 23
ZANOSAR INJ 19
ZANTAC INJ 34
ZANTAC EFFERVESCENT . . 34

ZAVESCA 34
ZAZOLE VAGINAL 18
ZELAPAR 21
ZEMAIRA. 47
ZEMPLAR 43
ZENPEP 34
ZERLOR 9
ZETIA. 31
ZIAGEN 23
zidovudine 23
ZINACEF INJ. 11
ZIPSOR 7
ZIRGAN 23
ZOLINZA 20
zolpidem 47
zolpidem er 47
ZOMETA 43
ZOMIG ZMT & ZOMIG . 18
zonisamide 13
ZORTRESS 41
ZOSTAVAX 42
ZOSYN 12
zovia 38
ZOVIRAX TOPICAL . . . 24
ZUPLENZ FILM 17
ZYCLARA 33
ZYDONE 9
ZYFLO CR 46
ZYLET 44
ZYMAR OPHTHALMIC . 13
ZYMAXID OPHTHALMIC 13
ZYPREXA 22
ZYPREXA INJ 22
ZYPREXA RELPREVV . 22
ZYPREXA ZYDIS 22
ZYVOX INJ 11
ZYVOX SUSPENSION. . 11