



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.

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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 out-of-pocket drug costs reach \$4700, your copayments are designated by Fidelis SecureCare plan in the table below.

Plan	Deductible	Drug Tier 1	Drug Tier 2	Drug Tier 3	Drug Tier 4
Fidelis Secure Liberty (HMO SNP)	\$0	\$0, \$1.10, or \$2.60 for generic medication prescriptions and \$0, \$3.30, or \$6.50 for all other medication prescriptions depending on income and institutional status.			
Fidelis Secure Liberty Select (HMO SNP)	\$0	\$0, \$1.10, or \$2.60 for generic medication prescriptions and \$0, \$3.30, or \$6.50 for all other medication prescriptions depending on income and institutional status.			

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	Drug Name	Drug Tier	Requirements/ Limits
Analgesics			<i>sulindac</i>	1	
SAVELLA	2	QL (62 per 31 days)	<i>tolmetin</i>	1	
SAVELLA TITRATION PACK	2	QL (55 per 31 days)	VOLTAREN GEL	2	
Nonsteroidal Anti-inflammatory Drugs			ZIPSOR	3	QL (124 per 31 days)
ARTHROTEC 50	3		Opioid Analgesics		
ARTHROTEC 75	3		ABSTRAL	4	QL (124 per 31 days), PA
CELEBREX 200 MG, 400 MG, 50 MG	3	QL (62 per 31 days)	<i>acetaminophen/caffeine/dihydrocodeine</i>	1	QL (155 per 31 days)
CELEBREX 100 MG	3	QL (93 per 31 days)	<i>acetaminophen/codeine #3</i>	1	QL (372 per 31 days)
<i>diclofenac</i>	1		<i>acetaminophen/codeine #4</i>	1	QL (186 per 31 days)
<i>diclofenac ec</i>	1		<i>acetaminophen/codeine</i>	1	QL (403 per 31 days)
<i>diclofenac xr</i>	1		<i>acetaminophen/codeine solution</i>	1	QL (4650 per 31 days)
<i>diflunisal</i>	1		<i>ascomp/codeine</i>	1	QL (186 per 31 days)
EQUAGESIC	3		<i>astramorph</i>	1	
<i>etodolac</i>	1		<i>buprenorphine inj</i>	3	
<i>etodolac er</i>	1		<i>buprenorphine sublingual 2 mg</i>	3	QL (16 per 31 days), PA
<i>fenoprofen</i>	1		<i>buprenorphine sublingual 8 mg</i>	3	QL (8 per 31 days), PA
<i>flurbiprofen</i>	1		<i>butalbital/APAP/caffeine/codeine</i>	1	QL (186 per 31 days)
<i>ibu</i>	1	QL (124 per 31 days)	<i>butorphanol inj</i>	1	
<i>ibuprofen</i>	1		<i>butorphanol nasal solution</i>	1	QL (5 per 1 days)
<i>ketoprofen</i>	1		B/D – Authorization required to identify Medicare D coverage		
<i>ketoprofen er</i>	1	QL (31 per 31 days)	HI – Covered under our medical benefit		
<i>meclofenamate</i>	1		LA – Limited Access; drugs available only at certain pharmacies		
<i>mefenamic acid</i>	3		PA – Prior Authorization required		
<i>meloxicam suspension</i>	3	QL (310 per 31 days)	QL – Quantity Limit applies		
<i>meloxicam 15 mg</i>	1	QL (31 per 31 days)	ST – Step Therapy required		
<i>meloxicam 7.5 mg</i>	1	QL (62 per 31 days)			
<i>nabumetone</i>	1				
NALFON	3				
<i>naproxen dr</i>	1				
<i>naproxen</i>	1				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
CAPITAL/CODEINE	2	QL (4650 per 31 days)	<i>hydrocodone/APAP</i>	1	QL (186 per 31 days)
<i>co-gesic</i>	1	QL (248 per 31 days)	10-650 mg; 7.5-650 mg; 10-660 mg		
<i>codeine</i>	1		<i>hydrocodone/APAP</i>	1	QL (248 per 31 days)
DILAUDID-5	3	QL (4960 per 31 days)	10-500 mg; 2.5-500 mg; 5-500 mg; 7.5 -500 mg		
<i>duramorph</i>	1		<i>hydrocodone/APAP</i>	1	QL (372 per 31 days)
<i>endocet 10-650 mg</i>	1	QL (186 per 31 days)	10-325 mg; 5-325 mg; 7.5-325 mg		
<i>endocet 7.5-500 mg</i>	1	QL (248 per 31 days)	<i>hydrocodone/</i>	1	QL (155 per 31 days)
<i>endocet 10-325 mg;</i> <i>5-325 mg;</i> <i>7.5-325 mg</i>	1	QL (372 per 31 days)	<i>ibuprofen</i>	3	
<i>endodan</i>	1	QL (372 per 31 days)	<i>hydromorphone</i>	3	
<i>fentanyl</i>	1		<i>dosette</i>		
<i>fentanyl oral</i>	4	QL (124 per 31 days), PA	<i>hydromorphone</i>	1	QL (372 per 31 days)
<i>transmucosal</i>			<i>injection</i>	3	
<i>fentanyl patch 12, 25,</i> <i>& 50 mcg/hr</i>	3	QL (15 per 31 days)	INFUMORPH 200, 500	3	
<i>fentanyl patch 100 &</i> <i>75 mcg/hr</i>	3	QL (31 per 31 days)	<i>levorphanol</i>	3	QL (496 per 31 days)
FENTORA 300 MCG	4		<i>margesic-h</i>	1	QL (248 per 31 days)
HYCET	3	QL (5735 per 31 days)	METHADONE INJ	3	
<i>hydrocodone/APAP</i>	3	QL (403 per 31 days)	<i>methadone oral</i>	1	QL (1860 per 31 days)
10-300, 5-300 & 7.5-300 mg			<i>solution</i>		
<i>hydrocodone/APAP</i>	1	QL (155 per 31 days)	<i>methadone</i>	1	QL (372 per 31 days)
10-750 mg			<i>methadone</i>	1	QL (744 per 31 days)
<i>hydrocodone/APAP</i>	1	QL (3720 per 31 days)	<i>concentrate</i>		
solution 7.5-500 mg/15 ml			<i>methadose</i>	1	QL (372 per 31 days)
<i>hydrocodone/APAP</i>	1	QL (5735 per 31 days)			
solution 10-325 mg/15 ml			B/D		– Authorization required to identify Medicare D coverage
<i>hydrocodone/APAP</i>	1	QL (155 per 31 days)	HI		– Covered under our medical benefit
7.5-750 mg			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	Drug Name	Drug Tier	Requirements/ Limits
<i>morphine add-vantage</i>	1		OXYCONTIN ER 80 MG	3	QL (186 per 31 days)
<i>morphine dilute-a-jet</i>	1		<i>oxymorphone</i>	3	QL (186 per 31 days)
<i>morphine er 12 hour 15 mg, 30 mg, 60 mg</i>	1	QL (124 per 31 days)	ROXICET SOLUTION	3	QL (1922 per 31 days)
<i>morphine er 12 hour 100 mg, 200 mg</i>	1	QL (186 per 31 days)	<i>roxicet 5-500 mg</i>	1	QL (248 per 31 days)
<i>morphine stick-gard</i>	1		<i>roxicet 5-325 mg</i>	1	QL (372 per 31 days)
<i>morphine oral solution</i>	1		<i>stagesic</i>	1	QL (248 per 31 days)
<i>morphine</i>	1	QL (372 per 31 days)	SYNALGOS-DC	3	QL (372 per 31 days)
<i>morphine inj</i>	1		<i>tramadol</i>	1	QL (248 per 31 days)
<i>nalbuphine</i>	1		<i>tramadol er</i>	1	QL (31 per 31 days)
OPANA ER	2	QL (124 per 31 days)	<i>tramadol/APAP</i>	1	QL (248 per 31 days)
<i>oxycodone concentrate</i>	1		ULTRAM ER 300 MG	3	QL (31 per 31 days)
<i>oxycodone 10 mg, 20 mg</i>	1		XODOL	3	QL (403 per 31 days)
<i>oxycodone 15 mg, 30 mg, 5 mg</i>	1	QL (496 per 31 days)	<i>zerlor</i>	1	QL (155 per 31 days)
<i>oxycodone/APAP</i>	1	QL (248 per 31 days)	ZYDONE	3	QL (310 per 31 days)
<i>oxycodone/APAP 10-650 mg</i>	1	QL (186 per 31 days)			
<i>oxycodone/APAP 7.5-500 mg</i>	1	QL (248 per 31 days)	Anesthetics		
<i>oxycodone/APAP 10-325 mg; 2.5-325 mg; 5-325 mg; 7.5-325 mg</i>	1	QL (372 per 31 days)	Local Anesthetics		
<i>oxycodone/aspirin</i>	1	QL (372 per 31 days)	<i>lidocaine jelly</i>	1	
<i>oxycodone/ibuprofen</i>	1	QL (124 per 31 days)	<i>lidocaine gel, external solution</i>	1	
OXYCONTIN ER 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	3	QL (124 per 31 days)			

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- 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	Drug Name	Drug Tier	Requirements/ Limits
<i>lidocaine inj</i>	1	B/D	<i>clindamycin</i>	1	
<i>lidocaine viscous</i>	1		<i>clindamycin palmitate</i>	1	
<i>lidocaine/prilocaine</i>	1	B/D	<i>clindamycin inj & add-vantage</i>	1	HI
<i>lidocaine ointment</i>	1	B/D	<i>clindamycin foam</i>	3	
LIDODERM	2	QL (93 per 31 days)	<i>clindamycin cream, gel, lotion, solution, swab</i>	1	
Antibacterials			CLINDESSE	3	
Aminoglycosides			<i>colistimethate inj</i>	4	HI
<i>ak-tob ophthalmic</i>	1		CORTISPORIN CREAM	2	
<i>amikacin</i>	1	HI	CUBICIN	4	HI
<i>genoptic</i>	1		FLAGYL ER	3	
<i>gentak ophthalmic</i>	1		<i>methenamine hippurate</i>	1	
<i>gentamicin</i>	1		METROGEL	3	
<i>gentamicin injection</i>	1	HI	<i>metronidazole</i>	1	
<i>gentasol ophthalmic</i>	1		<i>metronidazole inj</i>	1	HI
<i>gentamicin topical</i>	1		<i>metronidazole vaginal & topical</i>	1	
<i>kanamycin injection</i>	1	HI	MONUROL	3	
<i>neomycin</i>	1		<i>mupirocin</i>	1	
<i>paromomycin</i>	1		<i>neomycin/bacitracin/polymyxin ophthalmic</i>	1	
STREPTOMYCIN INJ	3		<i>neomycin/polymyxin b irrigation</i>	1	
TOBI	4	B/D	<i>neomycin/polymyxin/gramicidin ophthalmic</i>	1	
<i>tobramycin injection</i>	1	HI	<i>nitrofurantoin macro</i>	1	
<i>tobrasol ophthalmic</i>	1		<i>nitrofurantoin mono</i>	1	
TOBREX OINTMENT	3		<hr/>		
Antibacterials, Other			B/D	– Authorization required to identify Medicare D coverage	
<i>ak-poly-bac</i>	1		HI	– Covered under our medical benefit	
<i>alcohol preps</i>	1		LA	– Limited Access; drugs available only at certain pharmacies	
<i>baciim</i>	1		PA	– Prior Authorization required	
<i>bacitracin</i>	1		QL	– Quantity Limit applies	
<i>bacitracin/polymyxin b ophthalmic</i>	1		ST	– Step Therapy required	
BACTROBAN NASAL	2				
BACTROBAN CREAM	2				
<i>chloramphenicol inj</i>	1	HI			
CLEOCIN INJ	3	HI			
CLEOCIN SUPPOSITORY	3				
CLEOCIN 75 MG	3				
CLINDAGEL	3				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
NORITATE	3		<i>cefotaxime inj</i>	1	HI
<i>polycin b</i>	1		10 gm, 1 gm,		
<i>polymyxin b inj</i>	1	HI	2 gm, 500 mg		
PRIMSOL	3		CEFOTETAN /	3	HI
<i>silver sulfadiazine</i>	1		DEXTROSE		
cream			<i>cefoxitin inj</i>	3	HI
ssd	1		1 gm, 2 gm		
SULFAMYLON	3		<i>cefpodoxime proxetil</i>	1	
PACKET			<i>cefprozil</i>	1	
SULFAMYLON	2		<i>ceftazidime inj</i>	3	HI
CREAM			500 mg		
SYNERCID	4	HI	<i>ceftazidime inj</i>	1	HI
<i>thermazene</i>	1		1 gm, 2 gm		
<i>trimethoprim</i>	1		<i>ceftriaxone in</i>	3	HI
TYGACIL	3	HI	dextrose		
VANCOCIN	4	PA	<i>ceftriaxone inj</i>	3	HI
<i>vancomycin inj</i>	1	HI	1 gm, 2 gm		
<i>vandazole</i>	1		<i>ceftriaxone inj 250</i>	1	HI
XIFAXAN 550 MG	4		mg, 500 mg		
XIFAXAN 200 MG	3		<i>cefuroxime axetil</i>	1	
ZYVOX INJ	4	HI, PA	<i>cefuroxime inj 1.5 G</i>	1	HI
ZYVOX	4	PA	& 750 mg		
SUSPENSION			<i>cefuroxime/dextrose</i>	1	HI
Beta-lactam, Cephalosporins			<i>cephalexin</i>	1	
CEDAX	3		CLAFORAN INJ	3	HI
<i>cefaclor</i>	1		FORTAZ INJ	3	HI
<i>cefaclor er</i>	1		KEFLEX 750 MG	3	
<i>cefadroxil</i>	1		MAXIPIME INJ 2 GM	2	HI
<i>cefazolin</i>	1	HI	MAXIPIME INJ 1 GM	3	HI
<i>cefazolin /dextrose</i>	1	HI	SUPRAX	3	
<i>cefdinir</i>	1		<i>tazicef inj 1 G,</i>	1	HI
<i>cefditoren</i>	3		2 G, 6 G		
CEFEPIME/ DEXTROSE INJ	3	HI	ZINACEF INJ	3	HI
<i>cefepime inj</i>	3	HI			
1 gm, 2 gm			B/D – Authorization required to identify Medicare D coverage		
CEFIZOX INJ	3	HI	HI – Covered under our medical benefit		
CEFOTAXIME INJ 20 GM	2	HI	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	Drug Name	Drug Tier	Requirements/ Limits
Beta-lactam, Other			<i>veetids</i>	1	
AZACTAM INJ 1 GM	3	HI	ZOSYN INJ 4.5 G & 2.25 G	2	HI
<i>aztreonam inj</i>	3	HI	Macrolides		
CAYSTON	4	B/D	AKNE-MYCIN	3	
INVANZ	2	HI	AZASITE	2	
<i>meropenem inj</i>	3	HI	<i>azithromycin</i>	1	
MERREM INJ	3	HI	<i>azithromycin inj</i>	1	HI
PRIMAXIN	3	HI	<i>clarithromycin & ER</i> <i>e.e.s. 400</i>	1	
Beta-lactam, Penicillins			E.E.S. GRANULES	2	
<i>amoxicillin</i>	1		<i>ery</i>	1	
<i>amoxicillin/ clavulanate</i>	1		ERY-TAB	2	
<i>amoxicillin/ clavulanate er</i>	1		ERYPED 200; 400	2	
<i>amoxil</i>	1		ERYTHROCIN INJ 1000 MG	3	HI
<i>ampicillin inj</i>	1	HI	ERYTHROCIN INJ 500 MG	2	HI
<i>ampicillin oral capsule, solution</i>	1		ERYTHROCIN STEARATE	3	
<i>ampicillin-sulbactam inj</i>	1	HI	<i>erythromycin</i>	1	
BACTOCILL 2 GM INJ	4	HI	<i>erythromycin base</i>	1	
BACTOCILL 1 GM INJ	3	HI	<i>erythromycin/ sulfisoxazole</i>	1	
BICILLIN C-R	3		KETEK	3	PA
BICILLIN L-A	3		PCE	3	
<i>dicloxacillin</i>	1		<i>romycin ophthalmic</i>	1	
<i>nafcillin</i>	3	HI	ZMAX ORAL SUSPENSION	3	
NALLPEN	3	HI	Quinolones		
<i>oxacillin inj</i>	3	HI	AVELOX ABC PACK	2	
<i>penicillin g potassium inj</i>	3	HI	AVELOX INJ	3	HI
<i>penicillin g in dextrose</i>	3	HI	AVELOX	2	
<i>penicillin g sodium inj</i>	3	HI	B/D – Authorization required to identify Medicare D coverage		
<i>penicillin vk</i>	1		HI – Covered under our medical benefit		
PIPERACILLIN	3	HI	LA – Limited Access; drugs available only at certain pharmacies		
<i>piperacillin / tazobactam 3.375</i>	3	HI	PA – Prior Authorization required		
TIMENTIN INJ 3.1 G	2	HI	QL – Quantity Limit applies		
<i>trimox</i>	1		ST – Step Therapy required		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
BESIVANCE OPHTHALMIC	2		<i>doxycycline hyclate inj</i>	3	HI
CILOXAN OINTMENT	2		<i>doxycycline hyclate capsules</i>	1	
CIPRO SUSPENSION	3		<i>doxycycline mono</i>	3	
<i>ciprofloxacin ophthalmic</i>	1		<i>doxycycline mono, suspension</i>	1	
<i>ciprofloxacin extended-release</i>	1		<i>minocycline er</i>	3	
<i>ciprofloxacin</i>	1		<i>minocycline tablets</i>	3	
<i>ciprofloxacin iv</i>	1	HI	<i>minocycline capsules</i>	1	
<i>levofloxacin</i>	1		ORACEA	2	
NOROXIN	3		<i>tetracycline</i>	1	
<i>ofloxacin ophthalmic & otic</i>	1		VIBRAMYCIN SYRUP	3	
PROQUIN XR	3		Anticonvulsants		
VIGAMOX OPHTHALMIC	2		Anticonvulsants, Other		
ZYMAR OPHTHALMIC	2		BANZEL	3	
ZYMAXID OPHTHALMIC	2		<i>levetiracetam oral solution</i>	1	
Sulfonamides			<i>levetiracetam inj</i>	3	
GANTRISIN PEDIATRIC	2		<i>levetiracetam</i>	1	
<i>ocusulf-10 ophthalmic</i>	1		VIMPAT	3	
<i>sulfacetamide ophthalmic</i>	1		Calcium Channel Modifying Agents		
<i>sulfadiazine</i>	3		CELONTIN	3	
<i>sulfamethoxazole/ trimethoprim inj</i>	1	HI	<i>ethosuximide</i>	1	
<i>sulfamethoxazole/ trimethoprim oral</i>	1		LYRICA	3	PA – new starts only
<i>sulfatrim</i>	1		<i>zonisamide</i>	1	
<i>trimethoprim / polymyxin b ophthalmic</i>	1		Gamma-aminobutyric Acid (GABA) Augmenting Agents		
Tetracyclines			<i>divalproex</i>	1	
<i>demeclocycline</i>	3		<i>divalproex er</i>	1	
DORYX DR 150 MG	3		<hr/>		
<i>doxy-caps</i>	1		B/D	– Authorization required to identify Medicare D coverage	
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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>gabapentin solution</i>	3		<i>donepezil</i>	1	
<i>gabapentin</i>	1		EXELON PATCH & ORAL SOLUTION	3	
GABITRIL	3		<i>galantamine</i>	1	
NEURONTIN SOLUTION	3		<i>rivastigmine</i>	3	
<i>primidone</i>	1		Glutamate Pathway Modifiers		
SABRIL	4	PA – new starts only	NAMENDA	2	
STAVZOR	3		NAMENDA TITRATION PAK	2	
<i>valproate inj</i>	3		Antidepressants		
<i>valproic acid</i>	1		Antidepressants, Other		
Glutamate Reducing Agents			<i>budeprion sr</i> 12 hour 100 mg	1	QL (124 per 31 days)
FELBATOL SUSPENSION	4		<i>budeprion sr</i> 12 hour 150 mg	1	QL (62 per 31 days)
FELBATOL	3		<i>budeprion xl</i> 24 hour 300 mg	1	QL (31 per 31 days)
LAMICTAL STARTER KITS	2		<i>budeprion xl</i> 24 hour 150 mg	1	QL (93 per 31 days)
<i>lamotrigine chewable</i>	1		<i>bupropion sr</i> 12 hour 100 mg	1	QL (124 per 31 days)
<i>lamotrigine</i>	1		<i>bupropion sr</i> 12 hour 200 mg	1	QL (62 per 31 days)
<i>topiramate</i>	1		<i>bupropion 100 mg</i>	1	QL (124 per 31 days)
Channel Inhibitors			<i>bupropion 75 mg</i>	1	QL (93 per 31 days)
<i>carbamazepine</i>	1		<i>maprotiline</i>	1	
<i>carbamazepine er</i>	1		<i>mirtazapine</i>	1	QL (31 per 31 days)
CARBATROL	2		<i>mirtazapine odt</i>	1	QL (31 per 31 days)
DILANTIN INFATABS	2		<i>nefazodone</i>	1	
DILANTIN 30 MG	2				
<i>epitol</i>	1				
<i>fosphenytoin inj</i>	1	HI			
<i>oxcarbazepine suspension</i>	3				
<i>oxcarbazepine</i>	1				
PEGANONE	3				
<i>phenytoin inj</i>	1				
<i>phenytoin suspension</i>	1				
<i>phenytoin ER</i>	1				
TEGRETOL-XR 100 MG	2				
Antidementia Agents					
Cholinesterase Inhibitors					
ARICEPT 23 MG	2	ST			

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

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>venlafaxine ER</i> 150 mg	3	QL (62 per 31 days)	<i>buproban</i>	1	QL (62 per 31 days)
<i>venlafaxine 50 mg</i>	1	QL (217 per 31 days)	CAMPRAL	3	
<i>venlafaxine 100 mg, 25 mg, 37.5 mg, 75 mg</i>	1	QL (93 per 31 days)	CHANTIX 0.5 MG; 1 MG PACK	3	QL (53 per 31 days), PA
Tricyclics			CHANTIX 0.5 MG, 1 MG	3	QL (62 per 31 days), PA
<i>amitriptyline 10 mg, 25 mg, 50 mg</i>	1		NICOTROL INHALER	3	QL (3024 per 180 days)
<i>amoxapine</i>	1		NICOTROL NS	3	QL (720 per 180 days)
<i>clomipramine</i>	1		Toxicologic Agents		
<i>desipramine</i>	1		<i>depade</i>	1	
<i>doxepin 10 mg, 150 mg, 25 mg</i>	1		<i>naloxone</i>	1	
<i>doxepin concentrate</i>	1		<i>naltrexone</i>	1	
<i>imipramine</i>	1		SUBOXONE	3	QL (93 per 31 days), PA
<i>imipramine pamoate</i>	3		Antiemetics		
<i>nortriptyline solution</i>	3		Antiemetics		
<i>nortriptyline</i>	1		ALOXI INJ	3	HI
<i>protriptyline</i>	3		ANTIVERT 50 MG	3	
SURMONTIL	3		ANZEMET INJ	3	HI
<i>trimipramine</i>	3		ANZEMET 100 MG	4	QL (3 per 3 days), B/D
Antidotes, Deterrents, and Toxicologic Agents			ANZEMET 50 MG	3	QL (6 per 3 days), B/D
Antidotes			<i>compro</i>	1	
CUPRIMINE	2		<i>dronabinol 10 mg</i>	4	PA
DEPEN TITRATABS	3		<i>dronabinol 2.5 mg, 5 mg</i>	3	QL (186 per 31 days), PA
EXJADE 250 MG, 500 MG	4		EMEND	2	PA
EXJADE 125 MG	3		EMEND INJ 150 MG	2	QL (2 per 31 days), PA
<i>kionex</i>	1				
<i>leucovorin</i>	1				
<i>polystyrene sulfonate suspension</i>	1				
<i>polystyrene sulfonate powder</i>	1				
SYPRINE	3				
Deterrents					
ANTABUSE	2				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>granisetron inj</i>	3		ERTACZO	3	
<i>granisetron</i>	3	QL (6 per 3 days), B/D	EXELDERM	3	
<i>granisol</i>	3	QL (30 per 3 days), B/D	<i>fluconazole oral</i>	1	
<i>meclizine</i>	1		<i>fluconazole inj in dextrose</i>	3	HI
<i>metoclopramide</i>	1		<i>fluconazole inj</i>	3	HI
<i>ondansetron inj</i>	3	HI	GRIFULVIN V	2	
<i>ondansetron oral solution</i>	3	B/D	GRIS-PEG	3	
<i>ondansetron</i>	1	B/D	<i>griseofulvin microsize</i>	1	
<i>ondansetron odt</i>	1	B/D	GNAZOLE-1	2	
<i>prochlorperazine</i>	1		<i>itraconazole</i>	3	QL (130 per 31 days), PA
SANCUSO	4	QL (2 per 28 days)	<i>ketoconazole</i>	1	
TRANSDERM-SCOP	3	QL (10 per 30 days)	<i>kuric</i>	1	
ZUPLENZ FILM 4 MG	3	QL (18 per 28 days), B/D	LAMISIL SOLUTION	3	
ZUPLENZ FILM 8 MG	3	QL (60 per 28 days), B/D	MENTAX	3	
Antifungals			<i>miconazole 3 suppository</i>	1	
Antifungals			NATACYN	2	
ABELCET	4	HI	OPHTHALMIC		
AMBISOME	4	HI	NOXAFIL	4	
<i>amphotericin b</i>	3	HI	SUSPENSION		
ANCOBON	4		<i>nyamyc</i>	1	
CANCIDAS	4	HI	<i>nystatin</i>	1	
<i>ciclopirox nail lacquer</i>	1		<i>nystatin/triamcinolone</i>	1	
<i>ciclopirox</i>	1		<i>nystop</i>	1	
<i>ciclopirox topical solution kit</i>	3		OXISTAT	3	
<i>ciclopirox gel, shampoo</i>	3		<i>pedi-dri powder</i>	1	
<i>ciclopirox suspension</i>	1		SPORANOX	3	QL (1240 per 31 days), PA
<i>clotrimazole</i>	1		SOLUTION		
<i>clotrimazole/ betamethasone dipropionate</i>	1		<i>terbinafine</i>	1	
<i>econazole nitrate</i>	1				
ERAXIS INJ	4	HI			

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

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>isonarif</i>	3		FARESTON	3	
<i>isoniazid inj</i>	3		FASLODEX	4	
<i>isoniazid syrup</i>	1		<i>tamoxifen</i>	1	
PASER	3		Antimetabolites		
PRIFTIN	3		<i>cladribine inj</i>	4	B/D
<i>pyrazinamide</i>	1		<i>clolar inj</i>	4	
<i>rifampin inj</i>	4	HI	<i>cytarabine inj</i>	1	B/D
<i>rifampin</i>	1		20 mg/ml		
RIFATER	3		CYTARABINE AQ	3	B/D
TRECTOR	3		INJ 100 MG/ML		
Antineoplastics			DROXIA	2	
Alkylating Agents			ELITEK INJ	4	
BICNU INJ	3		<i>fluorouracil inj</i>	1	B/D
BUSULFEX INJ	4		FOLOTYN INJ	4	PA - new starts only
CEENU	2		<i>gemcitabine inj</i>	4	
<i>cyclophosphamide</i>	3	B/D	GEMZAR INJ	4	
<i>cyclophosphamide inj</i>	1	B/D	<i>hydroxyurea</i>	1	
<i>dacarbazine inj</i>	1		<i>mercaptopurine</i>	1	
HEXALEN	4	PA- new starts only	<i>pentostatin inj</i>	4	
<i>ifosfamide/</i>	4		TABLOID	3	PA - new starts only
<i>mesna inj</i>			Antineoplastics, Other		
<i>ifosfamide inj</i>	3		ABRAXANE	4	
LEUKERAN	2		<i>adriamycin</i>	3	B/D
MATULANE	4		ALIMTA	4	PA - new starts only
<i>melphalan inj</i>	4		AMIFOSTINE	4	
MUSTARGEN INJ	4		ARRANON	4	
THIOTEPA INJ	3		<i>bleomycin inj</i>	3	B/D
TREANDA INJ	4	PA- new starts only	CARBOPLATIN INJ	3	
ZANOSAR INJ	4		<i>carboplatin inj</i>	1	
Antiangiogenic Agents			50 mg/5ml		
REVLIMID	4	PA- new starts only, LA			
THALOMID	4	PA- new starts only	B/D	– Authorization required to identify Medicare D coverage	
VOTRIENT	4	PA- new starts only	HI	– Covered under our medical benefit	
Antiestrogens/Modifiers			LA	– Limited Access; drugs available only at certain pharmacies	
EMCYT	2	PA- new starts only	PA	– Prior Authorization required	
			QL	– Quantity Limit applies	
			ST	– Step Therapy required	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>cisplatin inj</i>	1		PROLEUKIN	4	PA - new starts only
DACOGEN	4		TAXOTERE	4	
<i>dactinomycin</i>	3		<i>toposar</i>	1	
<i>daunorubicin inj</i>	3		<i>topotecan inj 4 mg</i>	4	
DAUNOXOME	3		TORISEL	4	
<i>dexrazoxane inj</i>	4		TRISENOX	3	PA - new starts only
DOXIL	4	B/D	VELCADE	4	PA - new starts only
<i>doxorubicin</i>	3	B/D	VIDAZA	4	PA - new starts only
ELSPAR	3		<i>vinblastine</i>	1	B/D
<i>epirubicin</i>	3		<i>vincasar pfs</i>	1	B/D
ETOPOPHOS	4		<i>vincristine</i>	1	B/D
<i>etoposide</i>	1		<i>vinorelbine</i>	3	
FIRMAGON INJ 120 MG	4	QL (2 per 365 days), PA - new starts only	ZOLINZA	4	PA - new starts only
FIRMAGON INJ 80 MG	3	QL (4 per 28 days), PA - new starts only	Aromatase Inhibitors, 3rd Generation		
<i>fludarabine</i>	4		anastrozole	1	
HALAVEN	4	PA - new starts only	AROMASIN	3	
<i>idarubicin</i>	4		FEMARA	2	
<i>irinotecan</i>	3		Molecular Target Inhibitors		
ISTODAX	4	PA - new starts only	AFINITOR	4	PA - new starts only
IXEMPRA KIT INJ	4		GLEEVEC	4	PA - new starts only
JEVTANA	4	PA - new starts only	NEXAVAR	4	PA - new starts only
<i>mesna</i>	3		SPRYCEL	4	PA - new starts only
MESNEX	3		SUTENT	4	PA - new starts only
<i>mitomycin inj</i>	3		<hr/>		
<i>mitoxantrone</i>	3		B/D	- Authorization required to identify Medicare D coverage	
NOVANTRONE	4	ST	HI	- Covered under our medical benefit	
ONCASPARG	4		LA	- Limited Access; drugs available only at certain pharmacies	
ONTAK	4	PA - new starts only	PA	- Prior Authorization required	
<i>onxol</i>	4		QL	- Quantity Limit applies	
<i>oxaliplatin</i>	4		ST	- Step Therapy required	
<i>paclitaxel</i>	3				
PHOTOFRIN	4				

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

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Antipsychotics			<i>risperidone odt</i> 3		
Atypicals			<i>risperidone solution</i> 1		
ABILIFY DISCMELT	3	QL (62 per 31 days)	<i>risperidone</i>	1	
ABILIFY INJ	3		ZYPREXA	4	QL (1 per 28 days)
ABILIFY	3	QL (31 per 31 days)	RELPREVV INJ 405 MG		
ABILIFY ORAL SOLUTION	3	QL (775 per 31 days)	ZYPREXA	4	QL (2 per 28 days)
<i>clozapine</i>	1		RELPREVV INJ 210 MG, 300 MG		
FANAPT	3	QL (62 per 31 days), ST – new starts only	ZYPREXA ZYDIS	3	QL (31 per 31 days)
FANAPT TITRATION PACK	3	QL (8 per 31 days), ST – new starts only	ZYPREXA INJ	3	
FAZACLO	3		ZYPREXA	3	QL (31 per 31 days)
GEODON	3		Conventional		
INVEGA	3		<i>chlorpromazine</i>	1	
INVEGA SUSTENNA INJ 117 MG /0.75ML	4	QL (0.75 per 28 days)	<i>fluphenazine decanoate</i>	1	
INVEGA SUSTENNA INJ 156 MG/ML	4	QL (1 per 28 days)	<i>fluphenazine</i>	1	
INVEGA SUSTENNA INJ 234 MG/ 1.5ML	4	QL (1.5 per 28 days)	<i>haloperidol</i>	1	
INVEGA SUSTENNA INJ 39 MG /0.25ML	3	QL (0.25 per 28 days)	<i>haloperidol decanoate</i>	1	
INVEGA SUSTENNA INJ 78 MG/0.5ML	3	QL (0.5 per 28 days)	<i>haloperidol lactate</i>	1	
LATUDA	3	QL (31 per 31 days), PA – new starts only	<i>loxapine</i>	1	
RISPERDAL CONSTA INJ 37.5 MG, 50 MG	4	QL (4 per 28 days)	MOBAN	3	
RISPERDAL CONSTA INJ 12.5 MG, 25 MG	3	QL (4 per 28 days)	NAVANE 20 MG	3	
<i>risperidone m-tab</i>	3		ORAP	2	
			<i>perphenazine 16 mg, 2 mg, 8 mg</i>	1	
			<i>prochlorperazine edisylate</i>	1	
			<i>prochlorperazine</i>	1	
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<i>thioridazine</i>	1	PA – new starts only	VIDEX PEDIATRIC	3	
<i>thiothixene</i>	1		VIREAD	4	
<i>trifluoperazine</i>	1		ZIAGEN	2	
Antispasticity Agents			<i>zidovudine syrup</i>	3	
Antispasticity Agents			<i>zidovudine</i>	1	
<i>baclofen</i>	1		Anti-HIV Agents, Other		
<i>dantrolene</i>	1		FUZEON	4	
<i>tizanidine</i>	1		ISENTRESS	4	
ZANAFLEX	3		SELZENTRY	4	
Antivirals			Anti-HIV Agents, Protease Inhibitors		
Anticytomegalovirus (CMV) Agents			APTIVUS	4	
FOSCARNET	2	B/D	CRIXIVAN	2	
<i>ganciclovir 500 mg</i>	4		INVIRASE	4	
<i>ganciclovir 250 mg</i>	3		INVIRASE	3	
<i>ganciclovir inj</i>	3	B/D	KALETRA	4	
VALCYTE	4		SOLUTION		
ZIRGAN	2		KALETRA	4	
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors			200 MG; 50 MG		
ATRIPLA	4		KALETRA 100 MG; 25 MG	3	QL (62 per 31 days)
INTELENCE	4		LEXIVA	4	
RESCRIPTOR	3		LEXIVA	3	
SUSTIVA	3		SUSPENSION		
VIRAMUNE	3		NORVIR	3	
SUSPENSION			PREZISTA 400 MG, 600 MG	4	QL (62 per 31 days)
VIRAMUNE	2		PREZISTA 150 MG	3	QL (186 per 31 days)
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors			PREZISTA 75 MG	3	QL (62 per 31 days)
COMBIVIR	4		REYATAZ 150 MG, 300 MG	4	QL (31 per 31 days)
<i>didanosine</i>	3				
EMTRIVA	3				
EPIVIR	2				
EPIVIR HBV	2				
EPZICOM	4				
RETROVIR IV INFUSION	3				
<i>stavudine</i>	3				
TRIZIVIR	4				
TRUVADA	4				

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REYATAZ 200 MG	4	QL (62 per 31 days)	<i>valacyclovir</i>	3	
REYATAZ 100 MG	3	QL (31 per 31 days)	ZOVIRAX CREAM, OINTMENT	2	
VIRACEPT	4		Anxiolytics		
VIRACEPT POWDER	3		Anxiolytics, Other		
Anti-influenza Agents			<i>bupirone</i>	1	
<i>amantadine</i>	1		<i>meprobamate</i>	1	PA
RELENZA DISKHALER	3	QL (62 per 31 days)	Bipolar Agents		
<i>rimantadine</i>	1		Bipolar Agents		
TAMIFLU SUSPENSION	2	QL (194 per 31 days)	EQUETRO	2	
TAMIFLU 45 MG, 75 MG	2	QL (31 per 31 days)	<i>lithium carbonate</i>	1	
TAMIFLU 30 MG	2	QL (62 per 31 days)	<i>lithium carbonate er</i>	1	
			<i>lithium citrate syrup</i>	1	
Antih hepatitis Agents			LITHOBID	2	
BARACLUDE	4		SAPHRIS	2	
BARACLUDE SOLUTION	3		SEROQUEL	3	
HEPSERA	4		SEROQUEL XR	2	
REBETOL SOLUTION	3	PA	Blood Glucose Regulators		
<i>ribasphere 200 mg capsule</i>	1	QL (217 per 31 days), PA	Antidiabetic Agents		
<i>ribasphere 400 mg, 600 mg</i>	4	QL (56 per 28 days), PA	<i>acarbose 50 mg</i>	1	QL (186 per 31 days), ST
<i>ribasphere 200 mg tablet</i>	1	QL (93 per 31 days), PA	<i>acarbose 25 mg</i>	1	QL (372 per 31 days), ST
<i>ribavirin 200 mg</i>	1	QL (155 per 31 days), PA	<i>acarbose 100 mg</i>	1	QL (93 per 31 days), ST
<i>ribavirin 400 mg, 600 mg</i>	4	QL (56 per 28 days), PA	ACTOPLUS MET	2	QL (93 per 31 days), ST
TYZEKA	4		ACTOS 30 MG, 45 MG	2	QL (31 per 31 days), ST
Antitherpetic Agents			ACTOS 15 MG	2	QL (93 per 31 days), ST
<i>acyclovir</i>	1		AVANDAMET 2- 500 MG	3	QL (124 per 31 days), PA
<i>acyclovir inj</i>	3	HI			
DENAVIR	2				
<i>famciclovir</i>	3				
<i>trifluridine</i>	3				

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

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JANUVIA 50 MG	2	QL (62 per 31 days), ST	<i>tolazamide 500 mg</i>	1	QL (62 per 31 days)
KOMBIGLYZE XR 5-1000 MG; 5-500 MG	2	QL (31 per 31 days), ST	<i>tolbutamide</i>	1	QL (186 per 31 days)
KOMBIGLYZE XR 2.5- 1000 MG	2	QL (62 per 31 days), ST	Glycemic Agents		
<i>metformin er 500 mg</i>	1	QL (124 per 31 days)	GLUCAGEN	3	
<i>metformin er 750 mg</i>	1	QL (62 per 31 days)	HYPOKIT		
<i>metformin 500 mg</i>	1	QL (155 per 31 days)	GLUCAGON EMERGENCY KIT	2	
<i>metformin 1000 mg</i>	1	QL (62 per 31 days)	PROGLYCEM	3	
<i>metformin 850 mg</i>	1	QL (93 per 31 days)	Insulins		
<i>nateglinide 60 mg</i>	1	QL (186 per 31 days)	HUMALOG	2	
<i>nateglinide 120 mg</i>	1	QL (93 per 31 days)	HUMALOG KWIKPEN	2	
ONGLYZA 5 MG	2	QL (31 per 31 days), ST	HUMALOG MIX 50/50	2	
ONGLYZA 2.5 MG	2	QL (62 per 31 days), ST	HUMALOG MIX 50/50 KWIKPEN	2	
PRANDIN 2 MG	3	QL (248 per 31 days), ST	HUMALOG MIX 75/25	2	
PRANDIN 1 MG	3	QL (496 per 31 days), ST	HUMALOG MIX 75/25 KWIKPEN	2	
PRANDIN 0.5 MG	3	QL (992 per 31 days), ST	HUMULIN 70/30	2	
RIOMET	3	QL (791 per 31 days)	HUMULIN 70/30 PEN	2	
SYMLIN	3	QL (20 per 31 days)	HUMULIN N	2	
SYMLINPEN 120	3	QL (10.8 per 30 days)	HUMULIN N U-100 PEN	2	
SYMLINPEN 60	3	QL (6 per 31 days)	HUMULIN R	2	
<i>tolazamide 250 mg</i>	1	QL (124 per 31 days)	HUMULIN R U-500 (CONCENTRATE)	2	B/D
			LANTUS	2	
			LANTUS SOLOSTAR	2	
			LEVEMIR	2	

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LEVEMIR FLEXPEN	2		FRAGMIN INJ	4	QL (9.3 per 31 days)
NOVOLIN 70/30	2		7500 UNIT/0.3 ML		
NOVOLIN 70/30	2		FRAGMIN INJ	3	QL (12.4 per 31 days)
INNOLET			2500 UNIT/0.2ML,		
NOVOLIN N	2		5000 UNIT/0.2ML		
NOVOLIN R	2		FRAGMIN INJ	3	QL (31 per 31 days)
NOVOLOG	2		25000 UNIT/ML		
NOVOLOG	2		<i>heparin</i>	1	
FLEXPEN			<i>heparin /D5W</i>	1	HI
NOVOLOG MIX	2		HEPARIN / NACL	1	HI
70/30			<i>heparin / chloride</i>	1	HI
NOVOLOG MIX	2		0.9% premix		
70/30 FLEXPEN			<i>jantoven</i>	1	
Blood Products/Modifiers/ Volume Expanders			LOVENOX INJ 300	3	QL (93 per 31 days)
Anticoagulants			MG/3ML		
ARIXTRA INJ	4	QL (12.4 per 31 days)	PRADAXA	2	QL (62 per 31 days), PA
5 MG/0.4ML			<i>warfarin</i>	1	
ARIXTRA INJ	4	QL (18.6 per 31 days)	Blood Formation Products		
7.5 MG/0.6 ML			ARANESP	4	QL (1 per 21 days), PA
ARIXTRA INJ	4	QL (24.8 per 31 days)	500 MCG/ML		
10 MG/0.8 ML			ARANESP	4	QL (1.2 per 28 days), PA
ARIXTRA INJ	3	QL (15.5 per 31 days)	150 MCG/0.3 ML		
2.5 MG/0.5 ML			ARANESP	4	QL (1.6 per 28 days), PA
COUMADIN INJ	3		200 MCG/0.4 ML		
<i>enoxaparin inj</i>	4	QL (49.6 per 31 days)	ARANESP	4	QL (2.4 per 28 days), PA
120 mg/0.8 ml			300 MCG/0.6 ML		
<i>enoxaparin inj</i>	4	QL (62 per 31 days)	ARANESP	4	QL (4 per 28 days), PA
100 mg/ml,			200 MCG/ML,		
150 mg/ml			300 MCG/ML		
<i>enoxaparin inj</i>	3	QL (18.6 per 31 days)	ARANESP	3	QL (1.2 per 28 days),PA
30 mg/0.3ml			60 MCG/0.3 ML		
<i>enoxaparin inj</i>	3	QL (24.8 per 31 days)	ARANESP	3	QL (1.6 per 28 days), PA
40 mg/0.4ml			40 MCG/0.4 ML		
<i>enoxaparin inj 60</i>	3	QL (37.2 per 31 days)			
mg/0.6ml					
<i>enoxaparin inj 80</i>	3	QL (49.6 per 31 days)			
mg/0.8ml					
FRAGMIN INJ	4	QL (31 per 31 days)			
10000 UNIT/ML					

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ARANESP 25 MCG/0.42 ML	3	QL (1.7 per 28 days), PA	<i>pentoxil</i>	1	
ARANESP 100 MCG/0.5 ML	3	QL (2 per 28 days), PA	PLAVIX 300 MG	2	QL (3 per 31 days)
ARANESP 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	3	QL (4 per 28 days), PA	PLAVIX 75 MG	2	QL (31 per 31 days)
LEUKINE	4	PA	Cardiovascular Agents		
NEULASTA	4	PA	Alpha-adrenergic Agonists		
NEUMEGA	2	PA	<i>clonidine</i>	1	
NEUPOGEN	4	PA	<i>clonidine patch weekly</i>	1	QL (10 per 31 days)
PROCRIT INJ 40000 UNIT/ML	4	PA	<i>0.2 mg/24hr, 0.3 mg/24hr</i>		
PROCRIT INJ 20000 UNIT/ML	4	QL (12 per 28 days), PA	<i>clonidine patch weekly 0.1 mg/24hr</i>	1	QL (5 per 31 days)
PROCRIT INJ 10000 UNIT/ML	3	QL (12 per 28 days), PA	<i>guanabenz</i>	1	
PROCRIT INJ 2000 UNIT/ML	3	QL (15 per 31 days), PA	<i>guanfacine</i>	1	
PROCRIT INJ 3000 UNIT/ML, 4000 UNIT/ML	3	QL (30 per 31 days), PA	<i>midodrine</i>	1	
Blood Products/Modifiers/ Volume Expanders			Alpha-adrenergic Blocking Agents		
BERINERT	4	PA	DIBENZYLINE	3	
CINRYZE	4	PA	<i>prazosin</i>	1	
MOZOBIL	4	PA	Antiarrhythmics		
<i>pentopak</i>	1		<i>amiodarone</i>	1	
<i>pentoxifylline er</i>	1		<i>flecainide</i>	1	
PROMACTA	4	PA	<i>mexiletine</i>	1	
Coagulants			MULTAQ	3	
<i>aminocaproic acid</i>	1		PACERONE 300 MG	3	
CYKLOKAPRON	2		<i>procainamide</i>	1	
Platelet Aggregation Inhibitors			<i>propafenone</i>	1	
AGGRENOX	2	QL (62 per 31 days)	<i>propafenone er</i>	3	
<i>cilostazol</i>	1		QUINIDINE GLUCONATE	3	
EFFIENT	2	QL (31 per 31 days)	<i>quinidine gluconate cr</i>	1	
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<i>quinidine</i>	1		<i>amlodipine / benazepril</i>	1	
<i>quinidine er</i>	1		AZOR	2	QL (31 per 31 days), ST
<i>sorine</i>	1		CARDIZEM CD ER 24 HOUR 360 MG	3	
<i>sotalol</i>	1		<i>cartia xt</i>	1	
<i>sotalol (af)</i>	1		COVERA-HS ER 24 HOUR 240 MG	3	QL (62 per 31 days)
<i>sotalol inj</i>	3		COVERA-HS ER 24 HOUR 180 MG	3	QL (93 per 31 days)
TIKOSYN	3		<i>dilt-cd</i>	1	
Beta-adrenergic Blocking Agents			<i>dilt-xr</i>	1	
<i>acebutolol</i>	1		<i>diltiazem cd</i>	1	
<i>atenolol</i>	1		<i>diltiazem er</i>	1	
<i>atenolol/ chlorthalidone</i>	1		<i>diltiazem ER 24 hour</i>	1	
<i>betaxolol</i>	1		<i>diltiazem inj</i>	1	
<i>bisoprolol</i>	1		<i>diltzac</i>	1	
<i>bisoprolol /HCTZ</i>	1		DYNACIRC CR 10 MG	3	QL (62 per 31 days)
BYSTOLIC 2.5 MG	2	QL (31 per 31 days)	DYNACIRC CR 5 MG	3	QL (93 per 31 days)
BYSTOLIC 20 MG	2	QL (62 per 31 days)	<i>felodipine er</i>	1	
BYSTOLIC 10 MG, 5 MG	2	QL (93 per 31 days)	<i>isradipine</i>	1	
<i>carvedilol</i>	1		<i>matzim la</i>	1	
INNOPRAN XL	3		<i>nicardipine</i>	1	
<i>labetalol</i>	1		<i>nifediac cc</i>	1	
LEVATOL	3		<i>nifedical xl</i>	1	
<i>metoprolol er</i>	1		<i>nifedipine er 24 hour 60 mg</i>	1	
<i>metoprolol</i>	1		<i>nifedipine er 24 hour 30 mg</i>	1	
<i>metoprolol/HCTZ</i>	1				
<i>nadolol/bendroflumethiazide</i>	1				
<i>nadolol 20 mg, 40 mg, 80 mg</i>	1				
<i>pindolol</i>	1				
<i>propranolol</i>	1				
<i>propranolol er</i>	1				
<i>propranolol/HCTZ</i>	1				
<i>timolol</i>	1				
Calcium Channel Blocking Agents					
<i>afeditab cr</i>	1				
<i>amlodipine</i>	1				

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

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

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<i>ramipril</i>	1		Central Nervous System Agents		
TEKTURNA	2	QL (31 per 31 days), ST	Amphetamines, ADHD		
TEKTURNA HCT	2	QL (31 per 31 days), ST	<i>amphetamine/dextroamphetamine er</i>	3	QL (62 per 31 days)
<i>trandolapril</i>	1		<i>amphetamine/dextroamphetamine</i>	1	QL (62 per 31 days)
<i>trandolapril/verapamil</i>	1		<i>dextroamphetamine 10 mg</i>	1	QL (186 per 31 days)
VALTURNA	2	QL (31 per 31 days), ST	<i>dextroamphetamine 5 mg</i>	1	QL (62 per 31 days)
Vasodilators			Central Nervous System Agents		
BIDIL	2		Non-amphetamines, ADHD		
DILATRATE SR	3		FOCALIN XR 30 MG, 40 MG	3	QL (31 per 31 days)
<i>hydralazine inj</i>	3		FOCALIN XR 10 MG, 15 MG, 5 MG	3	QL (31 per 31 days)
<i>hydralazine</i>	1		FOCALIN XR 20 MG	3	QL (62 per 31 days)
<i>isochron</i>	1		<i>methylin</i>	1	QL (93 per 31 days)
ISORDIL	3		<i>methylphenidate 5 mg</i>	1	
TITRADOSE 40 MG			<i>methylphenidate</i>	3	
<i>isosorbide dinitrate</i>	1		STRATTERA 100 MG, 60 MG, 80 MG	3	QL (31 per 31 days), ST
<i>isosorbide dinitrate er</i>	1		STRATTERA 10 MG, 18 MG, 25 MG, 40 MG	3	QL (62 per 31 days), ST
<i>isosorbide mononitrate</i>	1		Non-amphetamines, Other		
<i>isosorbide mononitrate er</i>	1		AMPYRA	4	QL (62 per 31 days), PA
<i>minitran</i>	1		B/D – Authorization required to identify Medicare D coverage		
<i>minoxidil</i>	1		HI – Covered under our medical benefit		
NITRO-DUR PATCH 0.3 MG/HR, 0.8 MG/HR	3		LA – Limited Access; drugs available only at certain pharmacies		
<i>nitroglycerin transdermal</i>	1		PA – Prior Authorization required		
<i>nitroglycerin sublingual</i>	1		QL – Quantity Limit applies		
<i>nitroglycerin inj, patch 24 hour</i>	1		ST – Step Therapy required		
NITROLINGUAL PUMPSPRAY	3				
NITROMIST	3				
NITROSTAT	2				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
PROVIGIL 100 MG	3	QL (31 per 31 days), PA	FINACEA	2	
PROVIGIL 200 MG	3	QL (62 per 31 days), PA	FLUOROPLEX	2	
RILUTEK	4		<i>fluorouracil cream</i>	3	
XYREM	2	QL (540 per 30 days), PA, LA	<i>fluorouracil external solution</i>	1	
Dental and Oral Agents			<i>imiquimod</i>	3	
Dental and Oral Agents			<i>lacloction</i>	1	
APHTHASOL	2		OXSORALEN	3	PA
<i>chlorhexidine gluconate oral</i>	1		OXSORALEN ULTRA	4	PA
EVOXAC	3	ST	<i>podofilox</i>	1	
KEPIVANCE	4		PROTOPIC	3	ST
<i>periogard</i>	1		REGRANEX	4	PA
<i>pilocarpine</i>	3		RETIN-A MICRO	2	PA
<i>triamcinolone in orabase</i>	1		SANTYL	3	
Dermatological Agents			<i>selenium sulfide lotion</i>	1	
Dermatological Agents			<i>sulfacetamide</i>	1	
<i>adapalene cream</i>	3		SOLARAZE	3	
<i>adapalene gel</i>	1		SORIATANE	4	
<i>ammonium lactate</i>	1		<i>sotret</i>	3	
<i>amnesteam</i>	3		TAZORAC GEL	3	PA
<i>avita</i>	1	PA	<i>tretinoin</i>	1	PA
AZELEX	3		ZYCLARA	2	
BENZACLIN CARE KIT	2		Enzyme Replacements/ Modifiers		
<i>calcipotriene</i>	3		Enzyme Replacements/ Modifiers		
CARAC	2		ADAGEN	4	
<i>claravis</i>	3		ALDURAZYME	4	
<i>clindamycin/benzoyl peroxide</i>	3		BUPHENYL	4	
CONDYLOX	3		CEREZYME INJ	4	
DIFFERIN LOTION	3		CREON	2	
DOVONEX	2		CYSTADANE	4	
ELIDEL	3	ST	CYSTAGON	3	
EPIDUO	3		ELAPRASE	4	
<i>erythromycin/benzoyl peroxide</i>	1		<hr/> 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	Drug Name	Drug Tier	Requirements/ Limits
FABRAZYME INJ	4		OSMOPREP	2	
KUVAN	4		<i>peg 3350/electrolytes</i>	1	QL (4000 per 31 days)
MYOZYME	4		<i>peg-3350/nacl/na bicarbonate/kcl polyethylene glycol 3350</i>	1	QL (4000 per 31 days)
NAGLAZYME	4		RELISTOR	3	PA
ORFADIN	4		<i>ursodiol</i>	3	
ULTRASE	2		VISICOL	2	
ULTRASE MT 12, MT 18, MT 20	2		Histamine2 (H2) Blocking Agents		
VPRIV	4	PA	<i>cimetidine inj</i>	1	HI
ZAVESCA	4		<i>cimetidine 300 mg, 400 mg, 800 mg</i>	1	
ZENPEP	2		<i>famotidine premixed</i>	1	HI
Gastrointestinal Agents			<i>famotidine suspension</i>	3	
Antispasmodics, Gastrointestinal			<i>famotidine inj</i>	1	HI
<i>atropine inj</i>	1		<i>nizatidine solution</i>	3	
CUVPOSA	3		<i>nizatidine</i>	1	
<i>dicyclomine</i>	1	PA	<i>ranitidine syrup</i>	3	
<i>glycopyrrolate</i>	1		<i>ranitidine inj</i>	1	HI
HELIDAC	3	QL (56 per 180 days)	ZANTAC PACKET, EFFERVESCENT	3	
<i>methscopolamine</i>	1		ZANTAC INJ	3	HI
<i>propantheline</i>	1		Irritable Bowel Syndrome Agents		
Gastrointestinal Agents, Other			LOTRONEX	4	QL (62 per 31 days), PA
AMITIZA	2	QL (62 per 31 days), ST	Protectants		
<i>constulose</i>	1		CARAFATE SUSPENSION	3	
<i>enulose</i>	1		<i>misoprostol</i>	1	
GASTROCROM	3		<i>sucralfate</i>	1	
<i>gavilyte-g</i>	1	QL (4000 per 31 days)			
<i>gavilyte-n/ flavor pack</i>	1	QL (4000 per 31 days)			
<i>generlac</i>	1				
HALFLYTELY BOWEL PREP	2	QL (1 per 31 days)			
KRISTALOSE	2				
<i>lactulose</i>	1				
<i>lonox</i>	1				
<i>loperamide</i>	1				
MOVIPREP	2				
NULYTELY/FLAVOR PACKS	2	QL (4000 per 31 days)			

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Proton Pump Inhibitors			<i>terazosin</i>	1	
DEXILANT	3	QL (62 per 31 days)	Genitourinary Agents, Other		
<i>lansoprazole</i>	1	QL (62 per 31 days)	<i>bethanechol chloride</i>	1	
<i>lansoprazole odt</i>	3	QL (62 per 31 days), ST	ELMIRON	3	
NEXIUM	2	QL (62 per 31 days)	Binders		
NEXIUM I.V.	3	HI	<i>calcium acetate</i>	3	
<i>omeprazole</i>	1	QL (62 per 31 days)	<i>eliphos</i>	1	
<i>omeprazole/bicarbonate</i>	3	QL (62 per 31 days)	FOSRENOL CHEW 250 MG	3	
<i>pantoprazole</i>	1	QL (62 per 31 days)	FOSRENOL CHEW 1000 MG, 500 MG, 750 MG	2	
PREVPAC	3	QL (112 per 180 days)	RENAGEL	2	ST
PROTONIX INJ	3	HI	REVELA	2	
Genitourinary Agents			Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
Antispasmodics, Urinary			Glucocorticoids/Mineralocorticoids		
ENABLEX	2	QL (31 per 31 days)	<i>a-hydrocort</i>	1	
<i>flavoxate</i>	1		<i>a-methapred inj</i>	1	HI
SANCTURA XR	3	QL (31 per 31 days)	<i>ala cort</i>	1	
<i>trospium</i>	3	QL (62 per 31 days)	<i>ala-cort</i>	1	
VESICARE	2	QL (31 per 31 days)	<i>alclometasone dipropionate</i>	1	
Benign Prostatic Hypertrophy Agents			<i>amcinonide</i>	1	
AVODART	2	QL (31 per 31 days)	<i>augmented betamethasone dipropionate</i>	1	
CARDURA XL	3	QL (31 per 31 days)	<i>beta-val</i>	1	
<i>doxazosin</i>	1		<i>betamethasone dipropionate</i>	1	
<i>finasteride</i>	1	QL (31 per 31 days)	<i>betamethasone valerate</i>	1	
RAPAFLO	2	QL (31 per 31 days)	CAPEX	3	
<i>tamsulosin</i>	1	QL (62 per 31 days)	<hr/> 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		

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

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<i>scalacort</i>	1		HUMATROPE	4	PA
SOLU-CORTEF INJ 1 G, 500 MG	2		COMBO PACK		
SOLU-CORTEF INJ 250 MG	2	HI	INCRELEX	4	PA
SOLU-MEDROL 2000 MG	2	HI	NORDITROPIN	4	PA
TEXACORT	3		NORDIFLEX PEN		
<i>triamcinolone acetoneide</i>	1		<i>novarel</i>	3	PA
<i>triamcinolone acetoneide in absorbase</i>	1		NUTROPIN	4	PA
<i>triderm</i>	1		NUTROPIN AQ	4	PA
<i>u-cort</i>	1		NUTROPIN AQ PEN	4	PA
VANOS	3		OMNITROPE INJ 5.8 MG, 5 MG/1.5ML	4	PA
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)			OMNITROPE INJ 10 MG/1.5ML	3	PA
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)			<i>pregnyl</i>	3	PA
<i>chorionic gonadotropin</i>	3	PA	SAIZEN	4	PA
<i>desmopressin inj</i>	3		SAIZEN CLICK EASY	4	PA
<i>desmopressin</i>	1		STIMATE	3	
<i>desmopressin nasal solution</i>	3		TEV-TROPIN	3	PA
EGRIFTA	4	QL (60 per 30 days), PA	Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
GENOTROPIN	4	PA	Anabolic Steroids		
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	ANADROL-50	4	PA
GENOTROPIN MINIQUICK 0.2 MG	3	QL (28 per 28 days), PA	<i>oxandrolone 10 mg</i>	4	QL (62 per 31 days), PA
HUMATROPE	4	PA	<i>oxandrolone 2.5 mg</i>	1	QL (124 per 31 days), PA
			Androgens		
			ANDRODERM	2	QL (30 per 30 days), PA
			ANDROGEL	2	QL (300 per 30 days), PA
			<i>androxy</i>	3	
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<i>danazol</i>	3		<i>levora 0.15/30-28</i>	1	
STRIANT	3	QL (60 per 30 days), PA	<i>low-ogestrel</i>	1	
<i>testosterone cypionate inj</i>	1	PA	<i>lutera</i>	1	
<i>testosterone enanthate</i>	1	PA	MENOSTAR	3	
Estrogens			<i>microgestin 1.5/30</i>	1	
ALORA PATCH BIWEEKLY	2		<i>microgestin 1/20</i>	1	
<i>apri</i>	1		<i>microgestin fe</i>	1	
<i>aviane</i>	1		<i>microgestin fe 1.5/30</i>	1	
<i>cesia</i>	1		<i>mononessa</i>	1	
CLIMARA PRO	3		<i>necon 10/11-28</i>	1	
COMBIPATCH	3		<i>necon 7/7/7</i>	1	
<i>cryselle-28</i>	1		<i>nortrel 7/7/7</i>	1	
<i>cyclafem 1/35</i>	1		NUVARING	2	
<i>cyclafem 7/7/7</i>	1		<i>ogestrel</i>	1	
DEPO-ESTRADIOL	3		ORTHO EVRA	2	
DIVIGEL	3	QL (60 per 31 days)	<i>portia-28</i>	1	
<i>enpresse-28</i>	1		PREMARIN VAGINAL	2	
ESTRACE CREAM	3		PREMARIN	2	
ESTRADERM	2		PREMPRO	2	
<i>estradiol valerate</i>	1		<i>previfem</i>	1	
<i>estradiol patch weekly</i>	1		<i>reclipsen</i>	1	
ESTRING	2	QL (1 per 90 days)	<i>solia</i>	1	
FEMRING	3	QL (1 per 90 days)	<i>sprintec 28</i>	1	
<i>gianvi</i>	1		<i>sronyx</i>	1	
<i>gynodiol</i>	1		<i>tri-previfem</i>	1	
<i>jinteli</i>	1		<i>tri-sprintec</i>	1	
<i>junel 1.5/30</i>	1		<i>trinessa</i>	1	
<i>junel 1/20</i>	1		<i>trivora-28</i>	1	
<i>junel fe 1.5/30</i>	1		<i>velivet</i>	1	
<i>junel fe 1/20</i>	1		VIVELLE-DOT	2	
<i>kariva</i>	1		<i>zovia 1/35e</i>	1	
<i>kelnor 1/35</i>	1		<i>zovia 1/50e</i>	1	
<i>lessina-28</i>	1				

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Progestins			Hormonal Agents, Suppressant (Adrenal)		
<i>camila</i>	1		Hormonal Agents, Suppressant (Adrenal)		
CRINONE	3		LYSODREN	2	
DEPO-PROVERA	3		Hormonal Agents, Suppressant (Parathyroid)		
ELLA	3		Hormonal Agents, Suppressant (Parathyroid)		
<i>errin</i>	1		SENSIPAR 90 MG	4	QL (124 per 31 days)
<i>jolivette</i>	1		SENSIPAR 60 MG	4	QL (62 per 31 days)
MAKENA	4		SENSIPAR 30 MG	2	QL (62 per 31 days)
<i>medroxyprogesterone</i>	1		Hormonal Agents, Suppressant (Pituitary)		
MEGACE ES	3		Hormonal Agents, Suppressant (Pituitary)		
<i>megestrol</i>	1		<i>cabergoline</i>	3	
<i>necon 1/50-28</i>	1		ELIGARD 45 MG	4	QL (1 per 168 days)
<i>next choice</i>	1		ELIGARD 30 MG	3	QL (1 per 112 days)
<i>nora-be</i>	1		ELIGARD 7.5 MG	3	QL (1 per 28 days)
<i>norethindrone</i>	1		ELIGARD 22.5 MG	3	QL (1 per 84 days)
PLAN B	3		<i>leuprolide</i>	3	
PLAN B ONE-STEP	3	QL (1 per 1 day)	LUPRON DEPOT- PED INJ 7.5 MG	4	
PROCHIEVE	3		LUPRON DEPOT- PED INJ 11.25 MG, 15 MG	4	
<i>progesterone</i>	1		<hr/>		
PROMETRIUM	2		B/D	– Authorization required to identify Medicare D coverage	
Selective Estrogen Receptor Modifying Agents			HI	– Covered under our medical benefit	
EVISTA	2	QL (31 per 31 days)	LA	– Limited Access; drugs available only at certain pharmacies	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)			PA	– Prior Authorization required	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)			QL	– Quantity Limit applies	
LEVOTHROID	2		ST	– Step Therapy required	
<i>levothyroxine</i>	1				
<i>levoxyl</i>	1				
<i>liothyronine inj</i>	3				
<i>liothyronine</i>	1				
SYNTHROID	2				
THYROLAR	2				
<i>unithroid</i>	1				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
LUPRON DEPOT INJ 30 MG	4	QL (1 per 112 days)	<i>azathioprine</i>	3	
LUPRON DEPOT INJ 11.25 MG, 22.5 MG	4	QL (1 per 84 days)	CELLCEPT INTRAVENOUS	3	PA - new starts only
LUPRON DEPOT INJ 3.75 MG, 7.5 MG	2	QL (1 per 28 days)	CELLCEPT SUSPENSION	4	PA - new starts only
<i>octreotide inj 1000 mcg/ml</i>	4	PA	CIMZIA	4	PA
<i>octreotide inj 200 mcg/ml</i>	4	QL (120 per 30 days), PA	CIMZIA STARTER KIT	4	PA
<i>octreotide inj 500 mcg/ml</i>	4	QL (93 per 31 days), PA	<i>cyclosporine modified</i>	3	B/D
<i>octreotide inj 100mcg/ml, 50mcg/ml</i>	3	QL (124 per 31 days), PA	<i>cyclosporine oral solution</i>	3	B/D
SANDOSTATIN LAR DEPOT	4	PA	<i>cyclosporine, inj</i>	3	B/D
SOMATULINE DEPOT	4	PA	ENBREL	4	QL (7.84 per 28 days) PA
SOMAVERT	4	PA	SURECLICK	4	QL (4 per 28 days) PA
SYNAREL	4	PA	ENBREL INJ 25 MG	4	QL (4 per 28 days) PA
TRELSTAR DEPOT	4		ENBREL INJ 25 MG/0.5ML, 50 MG/ML	4	QL (7.84 per 28 days) PA
TRELSTAR LA	4		<i>gengraf</i>	3	B/D
TRELSTAR	4		HUMIRA PEN-CROHNS	4	QL (1 per 28 days) PA
Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)			HUMIRA INJ 20 MG/0.4 ML	4	QL (1 per 28 days) PA
Antiandrogens			HUMIRA INJ 40 MG/0.8 ML	4	QL (2 per 28 days) PA
<i>bicalutamide</i>	1		<i>methotrexate</i>	1	
<i>flutamide</i>	3		<i>methotrexate</i>	1	
NILANDRON	3		<i>mycophenolate mofetil</i>	3	PA - new starts only
Hormonal Agents, Suppressant (Thyroid)			MYFORTIC	3	B/D
Antithyroid Agents			ORENCIA	4	QL (4 per 28 days), PA
<i>methimazole</i>	1		<hr/>		
<i>propylthiouracil</i>	1		B/D	– Authorization required to identify Medicare D coverage	
Immunological Agents			HI	– Covered under our medical benefit	
Immune Suppressants			LA	– Limited Access; drugs available only at certain pharmacies	
AZASAN	2		PA	– Prior Authorization required	
<i>azathioprine</i>	1		QL	– Quantity Limit applies	
			ST	– Step Therapy required	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
PROGRAF INJ	3	PA - new starts only	Immunological Agents		
RAPAMUNE SOLUTION	4	B/D	Immunomodulators		
RAPAMUNE 1 MG	4	QL (31 per 31 days) B/D	ACTIMMUNE	4	
RAPAMUNE 2 MG	4	QL (620 per 31 days) B/D	ARCALYST	4	PA
RAPAMUNE 0.5 MG	3	QL (31 per 31 days) B/D	AVONEX INJ 30 MCG/0.5 ML	4	QL (2 per 28 days)
STELARA	4		AVONEX INJ 30 MCG/VIAL	4	QL (4 per 28 days)
<i>tacrolimus 5 mg</i>	4	PA- new starts only	BETASERON	4	QL (14 per 28 days)
<i>tacrolimus 1 mg</i>	3	QL (248 per 31 days), PA - new starts only	COPAXONE	4	QL (30 per 30 days)
<i>tacrolimus 0.5 mg</i>	3	QL (62 per 31 days), PA - new starts only	GILENYA	4	QL (28 per 28 days) PA
TREXALL	3		INFERGEN	4	PA
ZORTRESS 0.75 MG	4	PA - new starts only	INTRON-A W/ DILUENT 18 MU, 50 MU	3	PA - new starts only
ZORTRESS 0.5 MG	4	QL (62 per 31 days), PA - new starts only	INTRON-A W/ DILUENT 10 MU	4	PA - new starts only
ZORTRESS 0.25 MG	3	QL (62 per 31 days), PA - new starts only	INTRON-A INJ 10 MU/ML	4	PA - new starts only
Immunizing Agents, Passive			INTRON-A INJ 10 MU/0.2 ML, 5 MU/0.2 ML	4	PA - new starts only
CARIMUNE	4	PA	INTRON-A INJ 3 MU/0.2 ML	4	QL (6 per 28 days), PA - new starts only
GAMASTAN S/D	2	PA	INTRON-A INJ 6000000 UNIT/ML	3	PA - new starts only
GAMMAGARD	4	PA	KINERET	4	QL (20.77 per 31 days), PA
GAMMAGARD S/D	4	PA	LEFLUNOMIDE	1	
GAMMAPLEX	4	PA	<hr/>		
GAMUNEX	4	PA	B/D	- Authorization required to identify Medicare D coverage	
GAMUNEX-C	4	PA	HI	- Covered under our medical benefit	
HIZENTRA	4	QL (20 per 28 days), PA	LA	- Limited Access; drugs available only at certain pharmacies	
POLYGAM S/D	3	PA	PA	- Prior Authorization required	
PRIVIGEN	4	PA	QL	- Quantity Limit applies	
			ST	- Step Therapy required	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
PEG-INTRON	4	PA	MENVEO	2	
PEG-INTRON REDIPEN	4	PA	MERUVAX II	2	
PEGASYS	4	PA	PEDIARIX	2	
REBIF	4	QL (6 per 28 days)	PEDVAX HIB	2	
REBIF TITRATION PACK	4	QL (4.2 per 28 days)	PROQUAD	2	
REMICADE	4	PA	RABAVERT	2	
RIDAURA	3		RECOMBIVAX HB	2	B/D
SYNAGIS	4		ROTARIX	2	
TYSABRI	4	PA , LA	ROTATEQ	2	
Vaccines			TETANUS TOXOID ADSORBED	2	
ACTHIB	2		TETANUS/ DIPHThERIA TOXOIDS- ADSORBED ADULT	2	
ADACEL	2		TRIHIBIT	2	
ATTENUVAX	2		TRIPEDIA	2	
BOOSTRIX	2		TWINRIX	2	
CERVARIX	2		TYPHIM VI	2	
COMVAX	2		VAQTA INJ	2	
DAPTACEL	2		VARIVAX	2	
DECAVAC	2		YF-VAX	2	
DIPHThERIA/ TETANUS TOXOID PEDIATRIC	2		ZOSTAVAX	2	
ENGERIX-B	2	B/D	Inflammatory Bowel Disease Agents		
GARDASIL	2		Glucocorticoids		
HAVRIX	2		<i>colocort</i>	3	
HEPAGAM B	2		CORTIFOAM	3	
HIBERIX	2		ENTOCORT EC	3	
IMOVAX RABIES (H.D.C.V.)	2	B/D	<i>methylprednisolone</i>	1	
INFANRIX	2		MILLIPRED	3	
IPOL INACTIVATED	2		Salicylates		
IXIARO	2		APRISO	2	
JE-VAX	2				
KINRIX	2				
M-M-R II	2				
MENACTRA	2				
MENOMUNE-A/C/ Y/W-135	2				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ASACOL	2		<i>pamidronate inj</i>	1	
ASACOL HD	2		30 mg/10ml, 6 mg/ ml, 90 mg/10ml		
<i>balsalazide</i>	3		PROLIA	3	QL (1 per 180 days), PA
CANASA	2		XGEVA	4	QL (1.7 per 28 days), PA
DIPENTUM	3		ZEMPLAR	2	B/D
<i>mesalamine</i>	3		ZOMETA	4	
PENTASA	3		Miscellaneous Therapeutic Agents		
Sulfonamides			Miscellaneous Therapeutic Agents		
<i>sulfasalazine</i>	1		<i>anagrelide</i>	1	
<i>sulfazine</i>	1		BD INSULIN	2	
<i>sulfazine ec</i>	1		SYRINGE		
Metabolic Bone Disease Agents			SAFETYGLIDE		
Metabolic Bone Disease Agents			BD INSULIN	2	
ACTONEL WITH	2	QL (31 per 31 days)	SYRINGE		
CALCIUM			ULTRAFINE		
ACTONEL 150 MG	2	QL (1 per 28 days)	BD PEN NEEDLE/ ULTRAFINE	2	
ACTONEL 75 MG	2	QL (2 per 31 days)	BOTOX	3	PA
ACTONEL	2	QL (31 per 31 days)	GAUZE PADS 2"X2"	2	
30 MG, 5 MG			<i>dextrose 10% flex</i>	1	
ACTONEL 35 MG	2	QL (4 per 28 days)	<i>container</i>		
<i>alendronate</i>	1		<i>intralipid inj</i>	3	HI
BONIVA 2.5 MG	2	QL (31 per 31 days)	KALBITOR	4	PA
<i>calcitonin-salmon</i>	1	QL (3.8 per 31 days)	<i>leucovorin</i>	1	
<i>calcitriol oral solution</i>	3	B/D	<i>levocarnitine inj, oral</i>	3	B/D
<i>calcitriol</i>	1	B/D	<i>solution</i>		
<i>calcitriol inj</i>	3	B/D	<i>levocarnitine</i>	1	B/D
<i>etidronate</i>	1		METHERGINE	2	
FORTEO	4	PA	MONOJECT INSULIN	2	
FOSAMAX PLUS D	3	QL (4 per 28 days)	SYRINGE/PERM NEEDLE		
FOSAMAX	3	QL (375 per 31 days)	B/D – Authorization required to identify Medicare D coverage		
SOLUTION			HI – Covered under our medical benefit		
HECTOROL	2	B/D	LA – Limited Access; drugs available only at certain pharmacies		
MIACALCIN INJ	3	PA	PA – Prior Authorization required		
<i>pamidronate inj</i>	3		QL – Quantity Limit applies		
30 mg, 90 mg			ST – Step Therapy required		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
MONOJECT INSULIN SYRINGE/ SAFETY/PERM	2		DUREZOL	3	
MONOJECT ULTRA COMFORT INSULIN SYRINGE	2		FLAREX	2	
<i>sterile water irrigation</i>	1		<i>fluor-op</i>	1	
XENAZINE	4	PA	<i>fluorometholone</i>	1	
Ophthalmic Agents			<i>flurbiprofen</i>	1	
Ophthalmic Agents, Other			FML	2	
<i>ak-con</i>	1		FML FORTE	2	ST
LACRISERT	2		<i>ketorolac</i>	1	
<i>mydral</i>	1		LOTEMAX	3	
<i>naphazoline</i>	1		MAXIDEX	2	
<i>parcaine</i>	1		<i>neomycin/polymyxin/ bacitracin/ hydrocortisone</i>	1	
<i>proparacaine</i>	1		<i>neomycin/polymyxin/ dexamethasone</i>	1	
RESTASIS	2	QL (24 per 30 days)	NEVANAC	3	
<i>tropicacyl</i>	1		<i>poly-dex</i>	1	
<i>tropicamide</i>	1		POLY-PRED	2	
Ophthalmic Anti-allergy Agents			PRED MILD	2	
ALAMAST	3		PRED-G	3	
ALOCRIL	3		PRED-G S.O.P.	2	
ALOMIDE	3		<i>prednisolone acetate</i>	1	
<i>azelastine</i>	1		<i>prednisolone</i>	1	
<i>cromolyn</i>	1		<i>sulfacetamide / prednisolone</i>	1	
ELESTAT	3	ST	TOBRADEX OINTMENT	2	
EMADINE	3	ST	<i>tobramycin/ dexamethasone</i>	1	
PATADAY	2		VEXOL	2	ST
PATANOL	2		XIBROM	3	
Ophthalmic Anti-inflammatories			ZYLET	2	
ALREX	3				
BLEPHAMIDE	2				
BLEPHAMIDE S.O.P.	2				
BROMDAY	3				
CORTISPORIN	3				
<i>dexamethasone</i>	1				
<i>dexasporin</i>	1				
<i>diclofenac</i>	1				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Ophthalmic Antiglaucoma Agents			<i>neomycin/ polymyxin/hc</i>	1	
<i>acetazolamide ER</i>	3		<i>neomycin/polymyxin/ hydrocortisone</i>	1	
<i>acetazolamide</i>	1		Respiratory Tract Agents		
ALPHAGAN P 0.1%	2		Anti-inflammatories, Inhaled		
<i>apraclonidine</i>	1		Corticosteroids		
AZOPT	2		ADVAIR DISKUS	2	QL (60 per 30 days) ST
<i>betaxolol</i>	1		ADVAIR HFA	2	QL (1 per 30 days) ST
BETIMOL	3		AEROBID	3	
<i>brimonidine</i>	1		AEROBID-M	3	
<i>carteolol</i>	1		ALVESCO	3	QL (2 per 30 days) ST
COMBIGAN	2		ASMANEX 14; 30; 60; 120 (220MCG)	3	QL (1 per 30 days) ST
<i>dipivefrin</i>	1		ASMANEX 30 (110MCG)	3	QL (1 per 30 days) ST
<i>dorzolamide</i>	1		BECONASE AQ	3	QL (1 per 31 days)
<i>dorzolamide /timolol</i>	1		<i>budesonide nebulization</i>	3	B/D
IOPIDINE 1%	3		FLOVENT HFA 44 MCG/ACT	2	QL (1 per 30 days)
ISTALOL	3		FLOVENT HFA 110 MCG/ACT, 220 MCG/ACT	2	QL (1 per 30 days)
<i>levobunolol</i>	1		<i>flunisolide nasal</i>	1	
<i>methazolamide</i>	1		<i>fluticasone nasal</i>	1	
<i>metipranolol</i>	1		NASONEX	2	QL (1 per 30 days)
PHOSPHOLINE	2		<hr/>		
PILOPINE HS	2		B/D	– Authorization required to identify Medicare D coverage	
<i>timolol</i>	1		HI	– Covered under our medical benefit	
Ophthalmic Prostaglandin and Prostanamide Analogs			LA	– Limited Access; drugs available only at certain pharmacies	
<i>latanoprost</i>	1		PA	– Prior Authorization required	
LUMIGAN	2		QL	– Quantity Limit applies	
TRAVATAN Z	2		ST	– Step Therapy required	
Otic Agents					
<i>acetic acid</i>	1				
<i>acetic acid/aluminum acetate</i>	1				
<i>acetic acid/ hydrocortisone</i>	3				
<i>borofair</i>	1				
CIPRO HC	2				
COLY-MYCIN S	3				
CORTISPORIN-TC	3				
<i>cortomycin</i>	1				
DERMOTIC	2				

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

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
PROAIR HFA	2	QL (3 per 31 days)	Sedatives/Hypnotics		
PROVENTIL HFA	2	QL (3 per 31 days)	Sedatives/Hypnotics		
SEREVENT DISKUS	2	QL (60 per 30 days), ST	LUNESTA	2	QL (31 per 31 days), ST
<i>terbutaline inj</i>	4		ROZEREM	3	QL (31 per 31 days)
<i>terbutaline</i>	1		<i>zaleplon 5 mg</i>	1	QL (31 per 31 days)
TWINJECT	3		<i>zaleplon 10 mg</i>	1	QL (62 per 31 days)
VENTOLIN HFA	2	QL (3 per 31 days)	<i>zolpidem</i>	1	QL (31 per 31 days)
XOPENEX	3	ST, B/D	<i>zolpidem er</i>	3	QL (31 per 31 days)
XOPENEX HFA	3	QL (2 per 31 days)	Skeletal Muscle Relaxants		
Mast Cell Stabilizers			Skeletal Muscle Relaxants		
<i>cromolyn</i>	1	B/D	<i>carisoprodol 250 mg</i>	1	
Pulmonary Antihypertensives			<i>chlorzoxazone 250 mg</i>	1	
ADCIRCA	4	QL (62 per 31 days)	<i>cyclobenzaprine</i>	1	QL (93 per 31 days)
LETAIRIS	4	QL (31 per 31 days)	<i>metaxalone</i>	3	QL (124 per 31 days)
REMODULIN	4	PA	Therapeutic Nutrients/Minerals/ Electrolytes		
REVATIO Inj	4		Electrolytes/Minerals		
REVATIO	4	QL (93 per 31 days)	AMINOSYN	3	HI
TRACLEER	4	QL (62 per 31 days), LA	AMINOSYN /LYTES	3	HI
VENTAVIS	4	PA	AMINOSYN II	3	HI
Respiratory Tract Agents, Other			AMINOSYN II / DEXTROSE	3	HI
<i>acetylcysteine</i>	1	B/D	AMINOSYN II M / DEXTROSE	3	HI
ARALAST NP Inj	4	PA	<hr/>		
GLASSIA	4	PA	B/D	– Authorization required to identify Medicare D coverage	
PROLASTIN-C	4	PA	HI	– Covered under our medical benefit	
PROLASTIN Inj	4	PA	LA	– Limited Access; drugs available only at certain pharmacies	
PULMOZYME	4	B/D	PA	– Prior Authorization required	
TYZINE NASAL	2		QL	– Quantity Limit applies	
XOLAIR	4	PA	ST	– Step Therapy required	
ZEMAIRA	4	PA			

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

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<i>sodium irrigation</i>	1		Therapeutic Nutrients/Minerals/Electrolytes, Other		
<i>sodium fluoride</i>	1		<i>dextrose 25% inj</i>	1	
<i>sodium lactate inj</i>	1	HI	<i>dextrose 30% , 40%, 50%, 70%</i>	1	HI
<i>tis-u-sol irrigation</i>	1		<i>dextrose 5% viaflex</i>	1	HI
<i>tpn electrolytes ftv</i>	1	HI	Vitamins		
TRAVASOL	3	HI	<i>prenatabs obn</i>	1	
TRAVASOL/ DEXTROSE	3	HI	<i>prenatal low iron</i>	1	
<i>travasol / electrolytes</i>	3	HI	<i>rovin-nv dha</i>	1	
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- 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

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MYFORTIC	40	<i>gramicidin ophthalmic</i>	10	NORTREL 7/7/7	38
MYOZYME	34	<i>neomycin/</i>		<i>nortriptyline</i>	16
MYTELASE	18	<i>polymyxin/hc</i>	45	<i>nortriptyline solution</i>	16
		NEPHRAMINE	48	NORVIR	23
N		NEULASTA	28	<i>novamine</i>	48
<hr/>		NEUMEGA	28	NOVANTRONE	20
<i>nabumetone</i>	7	NEUPOGEN	28	NOVAREL	37
<i>nadolol</i>	29	NEURONTIN SOLUTION	14	NOVOLIN 70/30	27
<i>nadolol/bendrof-</i>		NEVANAC	44	NOVOLIN N	27
<i>lumethiazide</i>	29	NEXAVAR	20	NOVOLIN R	27
<i>nafcillin</i>	12	NEXIUM	35		

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

O

<i>octreotide</i>	40
<i>ocusulf-10 ophthalmic</i>	13
<i>ofloxacin ophthalmic & otic</i>	13
<i>ogestrel</i>	38
OLUX-E	36
<i>omeprazole</i>	35
<i>omeprazole/ bicarbonate</i>	35
OMNITROPE	37
ONCASPAR	20
<i>ondansetron</i>	17
<i>ondansetron odt</i>	17
ONGLYZA	26
ONTAK	20
<i>onxol</i>	20
OPANA ER	9
ORACEA	13
ORAP	22
ORENCIA	40
ORFADIN	34
ORTHO EVRA	38
OSMOPREP	34
<i>oxacillin inj</i>	12
OXALIPLATIN	20

<i>oxandrolone</i>	37
<i>oxcarbazepine</i>	14
OXISTAT	17
OXSORALEN	33
OXSORALEN ULTRA	33
<i>oxycodone</i>	9
<i>oxycodone/APAP</i>	9
<i>oxycodone/aspirin</i>	9
<i>oxycodone/ibuprofen</i>	9
OXYCONTIN	9
<i>oxymorphone</i>	9

P

PACERONE	28
<i>paclitaxel</i>	20
<i>pamidronate inj</i>	43
PANDEL	36
PANLOR DC	18
PANRETIN	21
<i>pantoprazole</i>	35
PARCAINE	44
<i>paromomycin</i>	10
<i>paroxetine</i>	15
<i>paroxetine er</i>	15
<i>paroxetine suspension</i>	15
PASER	19
PATADAY	44
PATANASE	46
PATANOL	44
PCE	12
PEDIARIX	42
PEDI-DRI POWDER	17
PEDVAX HIB	42
<i>peg-3350/lytes</i>	34
PEGANONE	14
PEGASYS	42

PEG-INTRON	42
<i>penicillin g</i>	12
<i>penicillin g potassium</i>	12
<i>penicillin vk</i>	12
PENTASA	43
<i>pentopak</i>	28
<i>pentostatin inj</i>	19
<i>pentoxifylline er</i>	28
<i>pentoxil</i>	28
<i>perindopril</i>	31
PERIOGARD	33
<i>permethrin</i>	21
<i>perphenazine</i>	22
PEXEVA	15
<i>phenelzine</i>	15
<i>phenytoin ER</i>	14
<i>phenytoin inj</i>	14
<i>phenytoin suspension</i>	14
PHOSPHOLINE	45
PHOTOFRIN	20
PHYSIOSOL IRRIGATION	48
<i>physiolyte</i>	48
<i>pilocarpine</i>	33
PILOPINE HS	45
PINDOLOL	29
<i>piperacillin</i>	12
<i>piperacillin /tazobactam</i>	12
PLAN B	39
PLAVIX	28
PLASMA-LYTE 56, 148, A, R	48
PLASMA-LYTE-IN D5W	48
PODOFILOX	33
<i>polycin b</i>	11
<i>poly-dex</i>	44

<i>polyethylene</i>	34	<i>probenecid</i>	18	PULMICORT	46
POLYGAM S/D	41	<i>probenecid/colchicine</i>	18	PULMICORT SUSPENSION	46
<i>polymyxin b inj</i>	11	<i>procainamide</i>	28	PULMOZYME	47
<i>poly-pred</i>	44	PROCALAMINE	48	<i>pyrazinamide</i>	19
<i>polystyrene sulfonate</i>	16	PROCHIEVE	39	<i>pyridostigmine</i>	18
<i>portia-28</i>	38	<i>prochlorperazine</i>	22		
<i>potassium chloride</i>	48	PROCRIT	28	Q	
PRADAXA	27	PROCTOCREAM-HC	36	QUALAQUIN	21
<i>pramipexole</i>	21	PROCTO-PAK	36	<i>quinapril</i>	31
PRANDIN	26	PROCTOSOL HC	36	<i>quinapril/HCTZ</i>	31
<i>pravastatin</i>	31	PROCTOZONE-HC	36	<i>quinaretic</i>	31
<i>prazosin</i>	28	<i>progesterone</i>	39	<i>quinidine</i>	29
PRED-G	44	PROGLYCEM	26	<i>quinidine er.</i>	29
PRED-G S.O.P.	44	PROGRAF INJ	41	<i>quinidine gluconate</i>	28
PRED MILD	44	PROLEUKIN	20	<i>quinidine gluconate cr</i>	28
<i>prednicarbate</i>	36	PROLASTIN	47	QVAR	46
<i>prednisolone ophth.</i>	36	PROLIA	43		
<i>prednisone</i>	36	PROMACTA	28	R	
PREGNYL	37	PROMETRIUM	39	RABAVERT	42
PREMARIN	38	<i>promethazine</i>	46	<i>ramipril</i>	32
PREMARIN VAGINAL	38	<i>promethegan</i>	46	RANEXA	30
PREMASOL	48	<i>propafenone</i>	28	<i>ranitidine</i>	34
PREMPRO	38	<i>propafenone er.</i>	28	RAPAFLO	35
<i>prenatabs obn</i>	49	<i>propantheline</i>	34	RAPAMUNE	41
<i>prenatal low iron</i>	49	<i>proparacaine</i>	44	REBETOL SOLUTION	24
<i>prevalite</i>	31	<i>propranolol</i>	29	REBIF	42
<i>previfem</i>	38	<i>propranolol er</i>	29	RECLIPSEN	38
PREVPAC	35	<i>propranolol/HCTZ</i>	29	RECOMBIVAX HB	42
PREZISTA	23	<i>propylthiouracil</i>	40	<i>regonol inj</i>	18
PRIFTIN	19	PROQUAD	42	REGRANEX	33
PRIMAQUINE	21	PROQUIN XR	13	RELENZA DISKHALER	24
PRIMAXIN	12	PROSOL	48	RELISTOR	34
<i>primidone</i>	14	PROTONIX INJ	35	RELPAK	18
PRIMSOL	11	PROTOPIC	33	REMICADE	42
PRISTIQ	15	<i>protriptyline</i>	16	REMODULIN	47
PRIVIGEN	41	PROVENTIL HFA	47	RENAGEL	35
PROAIR HFA	47	PROVIGIL	33		

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

TRISENOX	20	VANCOCIN	11	VIVELLE-DOT	38
<i>tri-sprintec</i>	38	<i>vancomycin inj</i>	11	VOLTAREN GEL	7
TRIVORA-28	38	<i>vandazole</i>	11	<i>voriconazole</i>	18
TRIZIVIR	23	VANOS	37	VOTRIENT	19
TROPHAMINE 10%	49	VAQTA INJ	42	VPRIV	34
TROPICACYL	44	VARIVAX	42	VYTORIN	31
<i>tropicamide</i>	44	VECTIBIX	21		
<i>trospium</i>	35	<i>veetids</i>	12	<u>W</u>	
TRUVADA	23	VELCADE	20	<i>warfarin</i>	27
TWINJECT	47	VELIVET	38	WELCHOL	31
TWINRIX	42	<i>venlafaxine</i>	15, 16		
TWYNSTA	30	<i>venlafaxine ER</i>	15, 16	<u>X</u>	
TYGACIL	11	VENTAVIS	47	XENAZINE	44
TYKERB	21	VENTOLIN HFA	47	XGEVA	43
TYPHIM VI	42	<i>verapamil</i>	30	XIBROM	44
TYSABRI	42	<i>verapamil er</i>	30	XIFAXAN	11
TYZEKA	24	<i>verapamil sr</i>	30	XODOL	9
TYZINE NASAL	47	VESICARE	35	XOLAIR	47
		VEXOL	44	XOLEGEL TOPICAL	18
<u>U</u>		VFEND	18	XOPENEX	47
U-CORT	37	VIBRAMYCIN SYRUP	13	XYREM	33
ULORIC	18	VIDAZA	20		
ULTRAM ER 300 MG	9	VIDEX PEDIATRIC	23	<u>Y</u>	
ULTRASE	34	VIGAMOX	13	YF-VAX	42
<i>unithroid</i>	39	VIMPAT	13		
<i>ursodiol</i>	34	<i>vinacal</i>	49	<u>Z</u>	
		<i>vinblastine</i>	20	<i>zafirlukast</i>	46
<u>V</u>		<i>vincasar pfs</i>	20	<i>zaleplon</i>	47
<i>valacyclovir</i>	24	<i>vincristine</i>	20	ZANAFLEX	23
VALCYTE	23	<i>vinorelbine</i>	20	ZANOSAR INJ	19
<i>valproate inj</i>	14	VIRACEPT	24	ZANTAC INJ	34
<i>valproic acid</i>	14	VIRAMUNE	23	ZANTAC	
VALTURNA	32	VIREAD	23	EFFERVESCENT	34
		VISICOL	34		

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