

# **C&O Employees Hospital Association Medicare Prescription Drug Plan (Employer PDP) 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.

This document includes C&O Employees Hospital Association Medicare Prescription Drug Plan's partial formulary as of January 1, 2012. For a complete, updated formulary, please visit our Web site at <http://www.coeha.com> or call 1-800-679-9135, 1-800-679-9135, 8:30am to 5:00pm (EST) Monday through Friday. TTY/TDD users should call 711.

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, 2012.

Please call 1-800-679-9135 to receive material in alternate format or language.

*HPMS Approved Formulary File Submission ID 12491, Version 5*

## **What is the C&O Employees Hospital Association Medicare Prescription Drug Plan Formulary?**

A formulary is a list of covered drugs selected by C&O Employees Hospital Association Medicare Prescription Drug Plan 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. C&O Employees Hospital Association Medicare Prescription Drug Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a C&O Employees Hospital Association Medicare Prescription Drug Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by C&O Employees Hospital Association Medicare Prescription Drug Plan. For a complete listing of all prescription drugs covered by C&O Employees Hospital Association Medicare Prescription Drug Plan, please visit our Web site at <http://www.coeha.com> or call 1-800-679-9135, 1-800-679-9135, 8:30am to 5:00pm (EST) Monday through Friday. TTY/TDD users should call 711.

### **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 January 1, 2012. To get updated information about the drugs covered by C&O Employees Hospital Association Medicare Prescription Drug Plan, please visit our Web site at <http://www.coeha.com> or call Member Services at 1-800-679-9135, 1-800-679-9135, 8:30am to 5:00pm (EST) Monday through Friday. TTY/TDD users should call 711.

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

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

## **Medical Condition**

The formulary begins on page 8. 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 below. 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 47. 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?**

C&O Employees Hospital Association Medicare Prescription Drug Plan 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:** C&O Employees Hospital Association Medicare Prescription Drug Plan requires your physician to get prior authorization for certain drugs. This means that you will need to get approval from C&O Employees Hospital Association Medicare Prescription Drug Plan before you fill your prescriptions. If you don't get approval, C&O Employees Hospital Association Medicare Prescription Drug Plan may not cover the drug.
- **Quantity Limits:** For certain drugs, C&O Employees Hospital Association Medicare Prescription Drug Plan limits the amount of the drug that C&O Employees Hospital Association Medicare Prescription Drug Plan will cover. For example, C&O Employees Hospital Association Medicare Prescription Drug Plan provides 18 per prescription for Imitrex. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, C&O Employees Hospital Association Medicare Prescription Drug Plan 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, C&O Employees Hospital Association Medicare Prescription Drug Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, C&O Employees Hospital Association Medicare Prescription Drug Plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at <http://www.coeha.com>.

You can ask C&O Employees Hospital Association Medicare Prescription Drug Plan to make an exception to these restrictions or limits. See the section, “How do I request an exception to the C&O Employees Hospital Association Medicare Prescription Drug Plan’s formulary?” on page 4 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 list of covered drugs, you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so C&O Employees Hospital Association Medicare Prescription Drug Plan may cover your drug. You can contact Member Services at 1-800-679-9135, 1-800-679-9135, 8:30am to 5:00pm (EST) Monday through Friday. TTY/TDD users should call 711.

If you learn that C&O Employees Hospital Association Medicare Prescription Drug Plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by C&O Employees Hospital Association Medicare Prescription Drug Plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by C&O Employees Hospital Association Medicare Prescription Drug Plan.
- You can ask C&O Employees Hospital Association Medicare Prescription Drug Plan 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 C&O Employees Hospital Association Medicare Prescription Drug Plan’s Formulary?**

You can ask C&O Employees Hospital Association Medicare Prescription Drug Plan 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, C&O Employees Hospital Association Medicare Prescription Drug Plan 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 our 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.

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

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

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

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

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with 91-day transition supply, consistent with 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 a current enrollee with a level of care change and you need a drug that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days), while you seek to obtain a formulary exception from C&O Employees Hospital Association Medicare Prescription Drug Plan. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.

## **For more information**

For more detailed information about your C&O Employees Hospital Association Medicare Prescription Drug Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about C&O Employees Hospital Association Medicare Prescription Drug Plan, please call Member Services at 1-800-679-9135, 1-800-679-9135, 8:30am to 5:00pm (EST) Monday through Friday. TTY/TDD users should call 711. Or visit <http://www.coeha.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](http://www.medicare.gov).

## **C&O Employees Hospital Association Medicare Prescription Drug Plan's Formulary**

The abridged formulary below provides coverage information about some of the drugs covered by C&O Employees Hospital Association Medicare Prescription Drug Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 47. Remember: This is only a partial list of drugs covered by C&O Employees Hospital Association Medicare Prescription Drug Plan. If your prescription is not in this partial formulary, please visit our Web site at <http://www.coeha.com> or call Member Services at 1-800-679-9135, 1-800-679-9135, 8:30am to 5:00pm (EST) Monday through Friday. TTY/TDD users should call 711 for additional help.

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

The information in the Notes column tells you if C&O Employees Hospital Association Medicare Prescription Drug Plan has any special requirements for coverage of your drug.

- **QL:** Quantity Limit. For certain drugs, C&O Employees Hospital Association Medicare Prescription Drug Plan limits the amount of the drug that C&O Employees Hospital Association Medicare Prescription Drug Plan will cover. For example, C&O Employees Hospital Association Medicare Prescription Drug Plan provides 9 tablets per prescription for Imitrex. This may be in addition to a standard one month or three month supply.
- **PA:** Prior Authorization. C&O Employees Hospital Association Medicare Prescription Drug Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from C&O Employees Hospital Association Medicare Prescription Drug Plan before you fill your prescriptions. If you don't get approval, C&O Employees Hospital Association Medicare Prescription Drug Plan may not cover the drug.
- **ST:** Step Therapy. In some cases, C&O Employees Hospital Association Medicare Prescription Drug Plan 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, C&O Employees Hospital Association Medicare Prescription Drug Plan may not cover drug B unless you try Drug A first. If Drug A does not work for you, C&O Employees Hospital Association Medicare Prescription Drug Plan will then cover Drug B.
- **LA:** Limited Availability. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-800-679-9135, Monday through Friday, 8:30am to 5:00pm (EST). TTY/TDD users should call 771.
- **B/D:** This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name	Drug Tier	Requirements/Limits
<b>Analgesics</b>		
<b>Analgesics</b>		
<i>acetaminophen/codeine</i>	1	
SAVELLA	2	QL (60 per 30 days) PA
SAVELLA TITRATION PACK	2	QL (55 per 365 days) PA
<b>Nonsteroidal Anti-inflammatory Drugs</b>		
<i>Endodan</i>	1	
FLECTOR	3	QL (28 per 14 days) PA
<i>Ibuprofen</i>	1	
<i>mefenamic acid</i>	1	
NALFON	3	
NAPRELAN	3	
<i>Naproxen</i>	1	
<i>naproxen sodium</i>	1	
PENNSAID	3	
<i>Piroxicam</i>	1	
TREXIMET	3	QL (9 per 30 days)
VIMOVO	2	
VOLTAREN	2	
ZIPSOR	3	
<b>Opioid Analgesics</b>		
ABSTRAL	3	
<i>acetaminophen/caffeine/dihydrocodeine bitartrate</i>	1	
<i>acetaminophen/codeine</i>	1	
<i>acetaminophen/codeine #3</i>	1	
<i>acetaminophen/codeine #4</i>	1	
<i>ascomp/codeine</i>	1	
<i>Astramorph</i>	1	
AVINZA	3	QL (30 per 30 days)
<i>buprenorphine hcl</i>	1	
<i>butalbital/acetaminophen/caffeine/codeine</i>	1	
<i>butorphanol tartrate inj</i>	1	
<i>butorphanol tartrate nasal soln</i>	1	QL (10 per 30 days)
BUTRANS	3	QL (4 per 28 days) PA
CAPITAL/CODEINE	3	
<i>co-gesic</i>	1	
<i>codeine sulfate</i>	1	
DEMEROL INJ 75MG/ML	3	
DILAUDID-5	2	
<i>Duramorph</i>	1	
EMBEDA CPCR 100MG; 4MG, 60MG; 2.4MG, 80MG; 3.2MG	3	
EMBEDA CPCR 20MG; 0.8MG, 30MG; 1.2MG, 50MG; 2MG	3	QL (60 per 30 days)
<i>Endocet</i>	1	
EXALGO	3	
<i>Fentanyl</i>	1	QL (10 per 30 days)
<i>fentanyl citrate</i>	1	
<i>fentanyl citrate oral transmucosal</i>	1	QL (120 per 30 days) PA
FENTORA	3	QL (112 per 28 days) PA

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocodone bitartrate/acetaminophen</i>	1	
<i>hydrocodone/acetaminophen tabs</i>	1	
HYDROCODONE/ACETAMINOPHEN SOLN 325MG/15ML; 10MG/15ML	3	
<i>hydrocodone/acetaminophen soln 500mg/15ml; 7.5mg/15ml</i>	1	
<i>hydrocodone/ibuprofen</i>	1	
<i>hydromorphone hcl</i>	1	
INFUMORPH 200	2	
INFUMORPH 500	2	
KADIAN	2	QL (60 per 30 days)
<i>levorphanol tartrate</i>	1	
MAGNACET	3	
<i>margesic-h</i>	1	
<i>meperidine hcl</i>	1	
<i>methadone hcl</i>	1	
Methadose	1	
<i>morphine sulfate</i>	1	
<i>morphine sulfate er</i>	1	QL (90 per 30 days)
<i>nalbuphine hcl</i>	1	
NUCYNTA	3	QL (180 per 30 days)
ONSOLIS	2	QL (120 per 30 days) PA
OPANA ER	2	QL (60 per 30 days)
ORAMORPH SR	3	QL (90 per 30 days)
<i>oxycodone hcl</i>	1	
<i>oxycodone/acetaminophen</i>	1	
<i>oxycodone/aspirin</i>	1	
<i>oxycodone/ibuprofen</i>	1	QL (28 per 7 days)
OXYCONTIN	2	QL (120 per 30 days)
<i>oxymorphone hydrochloride</i>	1	
<i>pentazocine/acetaminophen</i>	1	
<i>pentazocine/naloxone hcl</i>	1	
REPRESXAIN TABS 2.5MG; 200MG	3	
<i>reprexain tabs 10mg; 200mg</i>	1	
ROXICET SOLN	2	
ROXICET TABS 500MG; 5MG	3	
<i>roxicet tabs 325mg; 5mg</i>	1	
RYZOLT	3	QL (30 per 30 days)
Stagesic	1	
SYNALGOS-DC	3	
TALWIN	3	
<i>tramadol hcl</i>	1	QL (240 per 30 days)
<i>tramadol hcl er</i>	1	QL (30 per 30 days)
<i>tramadol hydrochloride/acetaminophen</i>	1	QL (240 per 30 days)
ULTRAM ER TB24 300MG	3	QL (30 per 30 days)
<i>vicodin hp</i>	1	
Zerlor	1	
ZYDONE	3	

## Anesthetics

### Local Anesthetics

Drug Name	Drug Tier	Requirements/Limits
<i>Lidocaine</i>	1	
<i>lidocaine hcl jelly</i>	1	
<i>lidocaine hcl gel, soln</i>	1	
<i>lidocaine/prilocaine</i>	1	
LIDODERM	2	
SYNERA	3	
<b>ANTI – INFECTIVES</b>		
<b>MISCELLANEOUS ANTIINFECTIVES</b>		
NEUTREXIN	2	
<b>Anti-inflammatory Agents</b>		
<b>Nonsteroidal Anti-inflammatory Drugs</b>		
ARTHROTEC 50	3	
ARTHROTEC 75	3	
CELEBREX	2	QL (60 per 30 days)
<i>diclofenac potassium</i>	1	
<i>diclofenac sodium</i>	1	
<i>diclofenac sodium ec</i>	1	
<i>diclofenac sodium xr</i>	1	
<i>Etodolac</i>	1	
<i>etodolac er</i>	1	
<i>fenoprofen calcium</i>	1	
<i>Flurbiprofen</i>	1	
<i>Ibuprofen</i>	1	
INDOCIN	3	
<i>Indomethacin</i>	1	
<i>indomethacin er</i>	1	
<i>Ketoprofen</i>	1	
<i>ketoprofen er</i>	1	
<i>ketorolac tromethamine inj</i>	1	
<i>ketorolac tromethamine tabs</i>	1	QL (20 per 10 days)
<i>meclofenamate sodium</i>	1	
<i>Meloxicam</i>	1	
<i>Nabumetone</i>	1	
NALFON	3	
NAPRELAN	3	
<i>Naproxen</i>	1	
<i>naproxen dr</i>	1	
<i>Oxaprozin</i>	1	
<i>Piroxicam</i>	1	
<i>Sulindac</i>	1	
<i>tolmetin sodium</i>	1	
<b>Antibacterials</b>		
<b>Amino Derivative Penicillins</b>		
AUGMENTIN	3	
<b>Aminoglycosides</b>		
<i>ak-tob</i>	1	
<i>Gentak</i>	1	
<i>gentamicin sulfate crea, oint, soln</i>	1	
<i>Gentasol</i>	1	
<i>tobramycin sulfate soln</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>Tobrasol</i>	1	
TOBREX OINT	2	
<b>Antibacterials, Other</b>		
ALTABAX	2	
<i>Baciim</i>	1	
<i>bacitracin/polymyxin b</i>	1	
<i>bacitracin oint</i>	1	
BACTROBAN NASAL	2	
BACTROBAN CREA	2	
CHLORAMPHENICOL SODIUM SUCCINATE	3	
CLEOCIN GALAXY	2	
CLEOCIN CAPS 75MG	3	
CLINDAGEL	3	
<i>clindamycin hcl</i>	1	
<i>clindamycin phosphate add-vantage</i>	1	
<i>clindamycin phosphate foam, gel, lotn, soln, swab</i>	1	
<i>colistimethate sodium</i>	1	
CORTISPORIN CREA	3	
CUBICIN	2	B/D
FLAGYL ER	3	
LINCOCIN	3	
METROGEL	2	
<i>metronidazole</i>	1	
<i>metronidazole in nacl 0.79%</i>	1	
<i>Mupirocin</i>	1	
<i>neomycin/bacitracin/polymyxin</i>	1	
<i>neomycin/polymyxin b sulfates</i>	1	
<i>neomycin/polymyxin/gramicidin</i>	1	
NORITATE	3	
<i>polycin b</i>	1	
<i>polymyxin b sulfate</i>	1	
PREVPAC	3	
PRIMSOL	3	
<i>silver sulfadiazine</i>	1	
<i>Ssd</i>	1	
SULFAMYLON	2	
SYNERCID	3	
<i>Thermazene</i>	1	
<i>Trimethoprim</i>	1	
TYGACIL	2	
VANCOCIN HCL	2	
<i>vancomycin hcl</i>	1	B/D
VIBATIV	2	
XIFAXAN	2	
ZIANA	3	PA
ZYVOX INJ	2	
ZYVOX SUSR	2	QL (1800 per 30 days)
ZYVOX TABS	2	QL (56 per 30 days)
<b>Beta-lactam, Cephalosporins</b>		
CEDAX	3	

Drug Name	Drug Tier	Requirements/Limits
<i>Cefaclor</i>	1	
CEFACLOR ER	3	
<i>Cefadroxil</i>	1	
<i>cefazolin sodium</i>	1	
<i>Cefdinir</i>	1	
<i>Cefepime</i>	1	
<i>cefotaxime sodium</i>	1	
CEFOTETAN	3	
CEFOXITIN SODIUM INJ 1GM; 4%, 2GM; 2.2%	3	
<i>cefoxitin sodium inj 10gm, 1gm, 2gm</i>	1	
<i>cefpodoxime proxetil</i>	1	
<i>Cefprozil</i>	1	
<i>Ceftazidime</i>	1	
CEFTIN SUSR 250MG/5ML	3	
<i>ceftriaxone sodium</i>	1	
<i>cefuroxime axetil</i>	1	
<i>cefuroxime sodium</i>	1	
CEFUROXIME/DEXTROSE	2	
<i>Cephalexin</i>	1	
CLAFORAN INJ 1GM	3	
FORTAZ INJ 1GM/50ML; 5%, 2GM/50ML; 5%	2	
KEFLEX CAPS 750MG	3	
SUPRAX	3	
<i>Tazicef</i>	1	
TEFLARO	2	
ZINACEF IN ISO-OSMOTIC DEXTROSE	2	
ZINACEF IN ISO-OSMOTIC DILUENT	2	
ZINACEF INJ 750MG	2	
<i>zinacef inj 7.5gm</i>	1	
<b>Beta-lactam, Other</b>		
AZACTAM IN ISO-OSMOTIC DEXTROSE	2	
<i>Aztreonam</i>	1	
CAYSTON	2	
DORIBAX	3	
INVANZ	3	
<i>Meropenem</i>	1	
PRIMAXIN I.M.	2	
PRIMAXIN IV	2	
<b>Beta-lactam, Penicillins</b>		
<i>Amoxicillin</i>	1	
<i>amoxicillin/clavulanate potassium</i>	1	
<i>amoxicillin/clavulanate potassium er</i>	1	
<i>amoxicillin/potassium clavulanate</i>	1	
<i>Ampicillin</i>	1	
AMPICILLIN SODIUM INJ 125MG	2	
<i>ampicillin sodium inj 10gm, 1gm</i>	1	
<i>ampicillin-sulbactam</i>	1	
BACTOCILL IN DEXTROSE	3	
BICILLIN C-R	2	
BICILLIN L-A	2	

Drug Name	Drug Tier	Requirements/Limits
<i>dicloxacillin sodium</i>	1	
MOXATAG	3	
<i>nafcillin sodium</i>	1	
NALLPEN/DEXTROSE	2	
OXACILLIN SODIUM	3	
<i>penicillin g potassium</i>	1	
PENICILLIN G POTASSIUM IN ISO-OSMOTIC DEXTROSE	2	
PENICILLIN G PROCAINE	2	
PENICILLIN G SODIUM	2	
<i>penicillin v potassium</i>	1	
<i>pfizerpen-g</i>	1	
PIPERACILLIN SODIUM	3	
<i>piperacillin sodium/tazobactam sodium</i>	1	
TIMENTIN	3	
UNASYN BULK PACK	3	
ZOSYN INJ 5%; 2GM/50ML; 0.25GM/50ML, 5%; 3GM/50ML; 0.375GM/50ML	2	
<b>Cephalosporin Antibacterials, 3rd Generation</b>		
CLAFORAN/D5W	3	
<b>Macrolides</b>		
AKNE-MYCIN	3	
AZASITE	2	
<i>Azithromycin</i>	1	
<i>clarithromycin</i>	1	
<i>clarithromycin er</i>	1	QL (28 per 14 days)
<i>e.e.s. 400</i>	1	
E.E.S. GRANULES	2	
<i>Ery</i>	1	
ERY-TAB	2	
ERYPED 200	3	
ERYPED 400	3	
ERYTHROCIN LACTOBIONATE	2	
<i>erythrocine stearate</i>	1	
<i>Erythromycin</i>	1	
ERYTHROMYCIN BASE	2	
<i>erythromycin ethylsuccinate</i>	1	
<i>erythromycin/sulfisoxazole</i>	1	
KETEK	2	PA
PCE	3	
<i>Romycin</i>	1	
ZMAX	2	
<b>Natural Penicillins</b>		
<i>pfizerpen-g</i>	1	
<b>Quinolones</b>		
AVELOX	2	
AVELOX ABC PACK	2	
BESIVANCE	3	
CILOXAN OINT	2	
CIPRO SUSR	3	

Drug Name	Drug Tier	Requirements/Limits
<i>Ciprofloxacin</i>	1	
<i>ciprofloxacin er</i>	1	QL (14 per 14 days)
<i>ciprofloxacin extended-release</i>	1	QL (3 per 3 days)
<i>ciprofloxacin hcl</i>	1	
FACTIVE	3	
IQUIX	3	
<i>Levofloxacin</i>	1	
MOXEZA	3	
NOROXIN	3	
<i>ofloxacin soln, tabs</i>	1	
PROQUIN XR	3	QL (3 per 3 days)
VIGAMOX	2	
ZYMAR	2	
ZYMAXID	2	
<b>Sulfonamides</b>		
<i>sodium sulfacetamide</i>	1	
<i>sulfamethoxazole/trimethoprim</i>	1	
<i>sulfamethoxazole/trimethoprim ds</i>	1	
<i>trimethoprim sulfate/polymyxin b sulfate</i>	1	
<b>Tetracyclines</b>		
<i>demeclocycline hcl</i>	1	
DORYX TBEC 150MG	3	
DOXYCYCLINE HYCLATE CPEP	3	
<i>doxycycline hyclate caps, inj, tabs, tbec</i>	1	
<i>doxycycline monohydrate</i>	1	
<i>minocycline hcl</i>	1	
<i>minocycline hcl er</i>	1	
ORACEA	3	
SOLODYN TB24 105MG, 115MG, 55MG, 65MG, 80MG	3	
<i>tetracycline hcl</i>	1	
VIBRAMYCIN SYRP	2	
VIBRAMYCIN SUSR	3	
<b>Anticonvulsants</b>		
<b>Anticonvulsants, Other</b>		
BANZEL	2	
KEPPRA XR	3	
<i>Levetiracetam</i>	1	
VIMPAT	2	
<b>Calcium Channel Modifying Agents</b>		
CELONTIN	2	
<i>Ethosuximide</i>	1	
LYRICA	2	
<i>Zonisamide</i>	1	
<b>Gamma-aminobutyric Acid (GABA) Augmenting Agents</b>		
<i>Gabapentin</i>	1	
GABITRIL	2	
<i>Primidone</i>	1	
SABRIL	2	
STAVZOR	3	
<i>valproate sodium</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>valproic acid</i>	1	
<b>Glutamate Reducing Agents</b>		
<i>divalproex sodium</i>	1	
<i>divalproex sodium er</i>	1	
FELBATOL	2	
LAMICTAL ODT	2	
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	3	
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	3	
LAMICTAL STARTER/TAKING VALPROATE	3	
LAMICTAL XR	2	
<i>Lamotrigine</i>	1	
<i>Topiramate</i>	1	
<b>Sodium Channel Inhibitors</b>		
<i>carbamazepine</i>	1	
<i>carbamazepine er</i>	1	
CARBATROL	2	
DILANTIN INFATABS	2	
DILANTIN CAPS 30MG	2	
<i>Epitol</i>	1	
<i>fosphenytoin sodium</i>	1	
<i>oxcarbazepine</i>	1	
PEGANONE	2	
<i>Phenytoin</i>	1	
<i>phenytoin sodium</i>	1	
<i>phenytoin sodium extended</i>	1	
TEGRETOL-XR TB12 100MG	2	
<b>Antidementia Agents</b>		
<b>Antidementia Agents, Other</b>		
<i>ergoloid mesylates</i>	1	
<b>Cholinesterase Inhibitors</b>		
<i>donepezil hcl</i>	1	
EXELON PT24, SOLN	2	
<i>galantamine hydrobromide</i>	1	
<i>rivastigmine tartrate</i>	1	
<b>Glutamate Pathway Modifiers</b>		
NAMENDA	2	
NAMENDA TITRATION PAK	2	
<b>Antidepressants</b>		
<b>Antidepressants, Other</b>		
ALENZIN	3	
<i>budeprion sr</i>	1	
<i>budeprion xl</i>	1	
<i>Buproban</i>	1	
<i>bupropion hcl</i>	1	
<i>bupropion hcl sr</i>	1	
<i>maprotiline hcl</i>	1	
<i>Mirtazapine</i>	1	
<i>mirtazapine odt</i>	1	
<i>nefazodone hcl</i>	1	

Drug Name	Drug Tier	Requirements/Limits
OLEPTRO	2	
<i>trazodone hcl</i>	1	
<b>Monoamine Oxidase Inhibitors</b>		
EMSAM	3	QL (30 per 30 days) PA
MARPLAN	2	
NARDIL	3	
<i>phenelzine sulfate</i>	1	
<i>tranylcypromine sulfate</i>	1	
<b>Serotonin/ Norepinephrine Reuptake Inhibitors</b>		
<i>citalopram hydrobromide</i>	1	
CYMBALTA	2	
<i>fluoxetine dr</i>	1	QL (4 per 28 days)
<i>fluoxetine hcl</i>	1	
<i>fluvoxamine maleate</i>	1	
LEXAPRO	2	
LUVOX CR	3	
<i>paroxetine hcl</i>	1	
<i>paroxetine hcl er</i>	1	
PEXEVA	3	
PRISTIQ	2	
<i>Selfemra</i>	1	
<i>sertraline hcl</i>	1	
<i>venlafaxine hcl</i>	1	
<i>venlafaxine hcl er cp24</i>	1	
VENLAFAXINE HCL ER TB24 225MG	3	
<i>venlafaxine hcl er tb24 150mg, 37.5mg, 75mg</i>	1	
VIIBRYD	3	
<b>Tricyclics</b>		
<i>amitriptyline hcl</i>	1	
<i>Amoxapine</i>	1	
<i>clomipramine hcl</i>	1	
<i>desipramine hcl</i>	1	
<i>doxepin hcl</i>	1	
<i>imipramine hcl</i>	1	
<i>imipramine pamoate</i>	1	
<i>nortriptyline hcl</i>	1	
<i>protriptyline hcl</i>	1	
SILENOR	3	QL (30 per 30 days)
SURMONTIL	3	
<b>Antidotes, Deterrents, and Toxicologic Agents</b>		
<b>Antidotes</b>		
RELISTOR	2	QL (18 per 30 days)
<b>Deterrents</b>		
ANTABUSE	2	
CAMPRAL	2	
CHANTIX	2	
<b>Toxicologic Agents</b>		
SUBOXONE	2	
<b>Antiemetics</b>		
<b>Antiemetics</b>		

Drug Name	Drug Tier	Requirements/Limits
<i>Compro</i>	1	
<i>Dronabinol</i>	1	QL (60 per 30 days) B/D
EMEND CAPS 40MG	2	QL (1 per 30 days) B/D
EMEND CAPS 125MG, 80MG	2	QL (2 per 30 days) B/D
EMEND CAPS 0	2	QL (6 per 30 days) B/D
<i>granisetron hcl inj</i>	1	B/D
<i>granisetron hcl tabs</i>	1	QL (30 per 30 days) B/D
<i>hydroxyzine pamoate</i>	1	
<i>meclizine hcl</i>	1	
<i>metoclopramide hcl</i>	1	
<i>ondansetron hcl inj, oral soln</i>	1	QL (450 per 30 days) B/D
<i>ondansetron hcl tabs 24mg</i>	1	QL (21 per 30 days) B/D
<i>ondansetron hcl tabs 4mg, 8mg</i>	1	QL (45 per 30 days) B/D
<i>ondansetron odt</i>	1	QL (45 per 30 days) B/D
<i>Phenadoz</i>	1	
<i>promethazine hcl</i>	1	
<i>Promethegan</i>	1	
SANCUSO	2	QL (2 per 30 days) B/D
<i>trimethobenzamide hcl</i>	1	
ZUPLENZ	2	QL (45 per 30 days) B/D

## Antifungals

### Antifungals

<i>Ciclopirox</i>	1	
<i>ciclopirox nail lacquer</i>	1	
<i>ciclopirox olamine</i>	1	
<i>clotrimazole/betamethasone dipropionate</i>	1	
<i>clotrimazole crea, soln</i>	1	
<i>econazole nitrate</i>	1	
ERTACZO	3	
EXELDERM	3	
EXTINA	3	
GRIFULVIN V	3	
<i>ketoconazole crea, sham</i>	1	
LAMISIL SOLN	3	
MENTAX	3	
NAFTIN	2	
NATACYN	2	
<i>Nyamyc</i>	1	
<i>nystatin/triamcinolone</i>	1	
<i>nystatin crea, oint, powd</i>	1	
<i>Nystop</i>	1	
OXISTAT	3	
<i>pedi-dri</i>	1	

## Antigout Agents

### Antigout Agents

<i>Allopurinol</i>	1	
<i>allopurinol sodium</i>	1	
COLCRYS	2	
<i>Probenecid</i>	1	
<i>probenecid/colchicine</i>	1	

Drug Name	Drug Tier	Requirements/Limits
ULORIC	2	
<b>Antimigraine Agents</b>		
<b>Prophylactic</b>		
INNOPRAN XL	3	
<i>propranolol hcl</i>	1	
<i>timolol maleate</i>	1	
<b>Antimycobacterials</b>		
<b>Antimycobacterials, Other</b>		
DAPSONE	2	
<b>ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS</b>		
<b>ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS</b>		
<i>cyclophosphamide</i>	1	
<b>Antineoplastics</b>		
<b>Alkylating Agents</b>		
BUSULFEX	2	B/D
CEENU	2	
<i>cyclophosphamide</i>	1	B/D
<i>Dacarbazine</i>	1	B/D
HEXALEN	2	
<i>Ifosfamide</i>	1	B/D
<i>ifosfamide/mesna</i>	1	B/D
LEUKERAN	2	
MATULANE	2	
<i>melphalan hydrochloride</i>	1	B/D
<i>Thiotepa</i>	1	B/D
TREANDA	2	B/D
<b>Antiangiogenic Agents</b>		
VANDETANIB	2	
VOTRIENT	2	QL (120 per 30 days) PA
<b>Antiestrogens/Modifiers</b>		
EMCYT	2	
FASLODEX	2	B/D
<i>tamoxifen citrate</i>	1	
<b>Antimetabolites</b>		
<i>Cladribine</i>	1	B/D
<i>Cytarabine</i>	1	B/D
<i>cytarabine aqueous</i>	1	B/D
DROXIA	2	
ELITEK	2	B/D
<i>fludarabine phosphate</i>	1	B/D
<i>Fluorouracil</i>	1	B/D
GEMCITABINE HCL	2	B/D
<i>Hydroxyurea</i>	1	
<i>mercaptopurine</i>	1	
<i>Pentostatin</i>	1	B/D
TABLOID	2	
<b>Antineoplastics, Other</b>		
<i>Adriamycin</i>	1	B/D
<i>Amifostine</i>	1	B/D
<i>bleomycin sulfate</i>	1	B/D

Drug Name	Drug Tier	Requirements/Limits
<i>Carboplatin</i>	1	B/D
<i>Cisplatin</i>	1	B/D
DACOGEN	2	
<i>daunorubicin hcl</i>	1	B/D
<i>Dexrazoxane</i>	1	B/D
<i>Docetaxel</i>	1	B/D
DOXIL	2	B/D
<i>doxorubicin hcl</i>	1	B/D
<i>epirubicin hcl</i>	1	B/D
<i>Etoposide</i>	1	B/D
FIRMAGON INJ 80MG	2	QL (1 per 28 days) B/D
FIRMAGON INJ 120MG	2	QL (2 per 365 days) B/D
HALAVEN	2	
<i>idarubicin hcl</i>	1	B/D
<i>Irinotecan</i>	1	B/D
ISTODAX	2	B/D
IXEMPRA KIT	2	B/D
JEVTANA	2	
<i>Mesna</i>	1	B/D
MESNEX TABS	2	
<i>Mitomycin</i>	1	B/D
<i>mitoxantrone hcl</i>	1	B/D
<i>Oxaliplatin</i>	1	B/D
<i>Paclitaxel</i>	1	B/D
PROLEUKIN	2	B/D
TAXOTERE	2	B/D
<i>Toposar</i>	1	B/D
<i>topotecan hcl</i>	1	B/D
TORISEL	2	
TRISENOX	2	B/D
VIDAZA	2	B/D
<i>vinblastine sulfate</i>	1	B/D
<i>vincasar pfs</i>	1	B/D
<i>vincristine sulfate</i>	1	B/D
<i>vinorelbine tartrate</i>	1	B/D
ZOLINZA	2	
ZYTIGA	2	QL (120 per 30 days) PA
<b>Aromatase Inhibitors, 3rd Generation</b>		
<i>Anastrozole</i>	1	
<i>Exemestane</i>	1	
<i>Letrozole</i>	1	
<b>Molecular Target Inhibitors</b>		
AFINITOR TABS 5MG	2	QL (120 per 30 days) PA
AFINITOR TABS 10MG, 2.5MG	2	QL (60 per 30 days) PA
GLEEVEC TABS 100MG	2	QL (240 per 30 days) PA
GLEEVEC TABS 400MG	2	QL (60 per 30 days) PA
NEXAVAR	2	QL (120 per 30 days) PA LA
SPRYCEL TABS 50MG	2	QL (120 per 30 days) PA
SPRYCEL TABS 20MG	2	QL (270 per 30 days) PA
SPRYCEL TABS 140MG	2	QL (30 per 30 days) PA

Drug Name	Drug Tier	Requirements/Limits
SPRYCEL TABS 100MG, 70MG, 80MG	2	QL (60 per 30 days) PA
SUTENT CAPS 12.5MG	2	QL (210 per 30 days) PA
SUTENT CAPS 25MG, 50MG	2	QL (30 per 30 days) PA
TARCEVA TABS 100MG, 150MG	2	QL (30 per 30 days) PA
TARCEVA TABS 25MG	2	QL (90 per 30 days) PA
TASIGNA	2	QL (120 per 30 days) PA
TYKERB	2	QL (180 per 30 days) PA LA
<b>Monoclonal Antibodies</b>		
ARZERRA	2	B/D
RITUXAN	2	
VECTIBIX	2	
<b>Retinoids</b>		
PANRETIN	2	
TARGRETIN	2	
<i>Tretinoin</i>	1	
<b>Antiparasitics</b>		
<b>Antiprotozoals</b>		
ALINIA	2	
MEPRON	2	
NEBUPENT	2	B/D
PENTAM 300	3	B/D
<b>Pediculicides/ Scabicides</b>		
<i>Acticin</i>	1	
EURAX	2	
LINDANE SHAM	2	
<i>lindane lotn</i>	1	
<i>Malathion</i>	1	
<i>Permethrin</i>	1	
ULESFIA	3	
<b>Antiparkinson Agents</b>		
<b>Antiparkinson Agents</b>		
APOKYN	2	LA
AZILECT	2	
<i>benztropine mesylate</i>	1	
<i>bromocriptine mesylate</i>	1	
<i>carbidopa/levodopa</i>	1	
<i>carbidopa/levodopa cr</i>	1	
<i>carbidopa/levodopa odt</i>	1	
<i>carbidopa/levodopa sr</i>	1	
COMTAN	2	
LODOSYN	2	
MIRAPEX ER	2	
<i>pramipexole dihydrochloride</i>	1	
REQUIP XL	2	
<i>ropinirole hcl</i>	1	
<i>selegiline hcl</i>	1	
STALEVO 100	2	
STALEVO 125	2	
STALEVO 150	2	
STALEVO 200	2	

Drug Name	Drug Tier	Requirements/Limits
STALEVO 50	2	
STALEVO 75	2	
<i>trihexyphenidyl hcl</i>	1	
ZELAPAR	2	
<b>Antipsychotics</b>		
<b>Atypicals</b>		
<i>clozapine</i>	1	
GEODON	2	
INVEGA	2	
INVEGA SUSTENNA	2	
LATUDA	2	
RISPERDAL CONSTA	2	
<i>risperidone</i>	1	
<i>risperidone odt</i>	1	
SEROQUEL	2	
SEROQUEL XR	2	
ZYPREXA	2	
ZYPREXA ZYDIS	2	
<b>Conventional</b>		
<i>chlorpromazine hcl</i>	1	
<i>fluphenazine decanoate</i>	1	
<i>fluphenazine hcl</i>	1	
<i>haloperidol</i>	1	
<i>haloperidol decanoate</i>	1	
<i>haloperidol lactate</i>	1	
<i>loxapine succinate</i>	1	
NAVANE CAPS 20MG	2	
ORAP	2	
<i>perphenazine</i>	1	
<i>prochlorperazine</i>	1	
<i>prochlorperazine edisylate</i>	1	
<i>prochlorperazine maleate</i>	1	
<i>thioridazine hcl</i>	1	
<i>thiothixene</i>	1	
<i>trifluoperazine hcl</i>	1	
<b>Antispasticity Agents</b>		
<b>Antispasticity Agents</b>		
<i>baclofen</i>	1	
<i>dantrolene sodium</i>	1	
<i>tizanidine hcl</i>	1	
ZANAFLEX CAPS	3	
<b>Antivirals</b>		
<b>Anti-cytomegalovirus (CMV) Agents</b>		
<i>foscarnet sodium</i>	1	
<i>ganciclovir</i>	1	
VALCYTE	2	
ZIRGAN	3	
<b>Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors</b>		
ATRIPLA	2	

Drug Name	Drug Tier	Requirements/Limits
EDURANT	2	
INTELENCE	2	
SUSTIVA	2	
VIRAMUNE	2	
VIRAMUNE XR	2	
<b>Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors</b>		
COMBIVIR	2	
<i>didanosine</i>	1	
EMTRIVA	2	
EPIVIR	2	
EPIVIR HBV	2	
EPZICOM	2	
RETROVIR	3	
RETROVIR IV INFUSION	2	
<i>stavudine</i>	1	
TRIZIVIR	2	
TRUVADA	2	
TYZEKA	2	
VIDEX PEDIATRIC	2	
VIREAD	2	
ZIAGEN	2	
<i>zidovudine</i>	1	
<b>Anti-HIV Agents, Other</b>		
FUZEON	2	QL (60 per 30 days)
ISENTRESS	2	
SELZENTRY	2	
<b>Anti-HIV Agents, Protease Inhibitors</b>		
APTIVUS	2	
CRIXIVAN	2	
INVIRASE	2	
KALETRA	2	
LEXIVA	2	
NORVIR	2	
PREZISTA	2	
REYATAZ	2	
VIRACEPT	2	
<b>Anti-influenza Agents</b>		
<i>amantadine hcl</i>	1	
RELENZA DISKHALER	2	
<i>rimantadine hcl</i>	1	
TAMIFLU SUSR	2	QL (300 per 365 days)
TAMIFLU CAPS 30MG	2	QL (112 per 365 days)
TAMIFLU CAPS 45MG, 75MG	2	QL (56 per 365 days)
<b>Antih hepatitis Agents</b>		
BARACLUDE	2	
HEPSERA	2	
REBETOL SOLN	2	
<i>ribapak</i>	1	
<i>ribasphere</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>ribavirin</i>	1	
<b>Antitherpetic Agents</b>		
<i>acyclovir</i>	1	
<i>acyclovir sodium</i>	1	
DENAVIR	2	
<i>famciclovir tabs 500mg</i>	1	QL (21 per 30 days)
<i>famciclovir tabs 125mg</i>	1	QL (30 per 30 days)
<i>famciclovir tabs 250mg</i>	1	QL (60 per 30 days)
<i>trifluridine</i>	1	
<i>valacyclovir hcl tabs 1000mg</i>	1	QL (30 per 30 days)
<i>valacyclovir hcl tabs 500mg</i>	1	QL (60 per 30 days)
ZOVIRAX CREA, OINT	3	
<b>Anxiolytics</b>		
<b>Anxiolytics, Other</b>		
<i>bupirone hcl</i>	1	
<i>chlordiazepoxide/amitriptyline</i>	1	
<i>meprobamate</i>	1	
<b>Bipolar Agents</b>		
<b>Bipolar Agents</b>		
EQUETRO	2	
<i>lithium carbonate</i>	1	
<i>lithium carbonate er</i>	1	
<i>lithium citrate</i>	1	
SAPHRIS	2	
SEROQUEL XR	2	
<b>Blood Glucose Regulators</b>		
<b>Antidiabetic Agents</b>		
<i>acarbose</i>	1	
ACTOPLUS MET	2	
ACTOPLUS MET XR	2	
ACTOS	2	
AVANDAMET	2	
AVANDARYL	2	
AVANDIA	2	
BYETTA	3	
<i>chlorpropamide</i>	1	
CYCLOSET	3	
DUETACT	2	
FORTAMET	3	
<i>glimepiride</i>	1	
<i>glipizide</i>	1	
<i>glipizide er</i>	1	
<i>glipizide/metformin hcl</i>	1	
GLUMETZA	3	
<i>glyburide</i>	1	
<i>glyburide micronized</i>	1	
<i>glyburide/metformin hcl</i>	1	
GLYCRON TABS 4.5MG	2	
<i>glycron tabs 1.5mg, 3mg, 6mg</i>	1	
GLYSET	3	

Drug Name	Drug Tier	Requirements/Limits
JANUMET	2	
JANUVIA	2	
KOMBIGLYZE XR	2	
<i>metformin hcl</i>	1	
<i>metformin hcl er</i>	1	
<i>nateglinide</i>	1	
ONGLYZA	2	
PRANDIMET	3	
PRANDIN	2	
RIOMET	3	
SYMLIN	3	
SYMLINPEN 120	3	
SYMLINPEN 60	3	
<i>tolazamide</i>	1	
<i>tolbutamide</i>	1	
TRADJENTA	3	
VICTOZA	3	
<b>Glycemic Agents</b>		
GLUCAGEN HYPOKIT	2	
GLUCAGON EMERGENCY KIT	2	
PROGLYCEM	2	
<b>Insulins</b>		
APIDRA	3	
APIDRA SOLOSTAR	3	
HUMALOG	2	
HUMALOG KWIKPEN	2	
HUMALOG MIX 50/50	2	
HUMALOG MIX 50/50 KWIKPEN	2	
HUMALOG MIX 75/25	2	
HUMALOG MIX 75/25 KWIKPEN	2	
HUMULIN 70/30	2	
HUMULIN 70/30 PEN	2	
HUMULIN N	2	
HUMULIN N U-100 PEN	2	
HUMULIN R	2	
HUMULIN R U-500 (CONCENTRATED)	2	
LANTUS	2	
LANTUS SOLOSTAR	2	
LEVEMIR	3	
LEVEMIR FLEXPEN	3	
NOVOLIN 70/30	2	
NOVOLIN N	2	
NOVOLIN R	2	
NOVOLOG	2	
NOVOLOG FLEXPEN	2	
NOVOLOG MIX 70/30	2	
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	2	
<b>Blood Products/Modifiers/ Volume Expanders</b>		
<b>Anticoagulants</b>		
ARIXTRA INJ 5MG/0.4ML	2	QL (12 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ARIXTRA INJ 2.5MG/0.5ML	2	QL (15 per 30 days)
ARIXTRA INJ 7.5MG/0.6ML	2	QL (18 per 30 days)
ARIXTRA INJ 10MG/0.8ML	2	QL (24 per 30 days)
COUMADIN INJ	3	
<i>enoxaparin sodium inj 40mg/0.4ml</i>	1	QL (12 per 30 days)
<i>enoxaparin sodium inj 60mg/0.6ml</i>	1	QL (18 per 30 days)
<i>enoxaparin sodium inj 120mg/0.8ml, 80mg/0.8ml</i>	1	QL (24 per 30 days)
<i>enoxaparin sodium inj 100mg/ml, 150mg/ml</i>	1	QL (30 per 30 days)
<i>enoxaparin sodium inj 30mg/0.3ml</i>	1	QL (9 per 30 days)
FRAGMIN INJ 12500UNIT/0.5ML	2	QL (15 per 30 days)
FRAGMIN INJ 15000UNIT/0.6ML	2	QL (18 per 30 days)
FRAGMIN INJ 25000UNIT/ML	2	QL (2 per 30 days)
FRAGMIN INJ 18000UNT/0.72ML	2	QL (21.6 per 30 days)
FRAGMIN INJ 10000UNIT/ML	2	QL (30 per 30 days)
FRAGMIN INJ 2500UNIT/0.2ML, 5000UNIT/0.2ML	2	QL (6 per 30 days)
FRAGMIN INJ 7500UNIT/0.3ML	2	QL (9 per 30 days)
<i>heparin sodium/d5w</i>	1	
HEPARIN SODIUM/NACL 0.45%	2	
<i>heparin sodium/sodium chloride 0.9% premix</i>	1	
HEPARIN SODIUM INJ 2000UNIT/ML, 2500UNIT/ML	2	
<i>heparin sodium inj 10000unit/ml, 1000unit/ml, 20000unit/ml, 5000unit/ml</i>	1	
INNOHEP	3	QL (30 per 30 days)
<i>jantoven</i>	1	
LOVENOX INJ 300MG/3ML	2	QL (90 per 30 days)
PRADAXA	2	
<i>warfarin sodium</i>	1	
<b>Blood Formation Products</b>		
ARANESP ALBUMIN FREE	2	PA
LEUKINE	2	PA
NEUMEGA	2	
NEUPOGEN	2	PA
PROCRIT	2	PA
<b>Blood Products/Modifiers/ Volume Expanders</b>		
MOZOBIL	2	QL (16 per 30 days)
PROMACTA TABS 50MG, 75MG	2	QL (30 per 30 days) PA LA
PROMACTA TABS 25MG	2	QL (90 per 30 days) PA LA
<b>Platelet Aggregation Inhibitors</b>		
AGGRENOX	2	
<i>cilostazol</i>	1	
<i>dipyridamole</i>	1	
EFFIENT	2	
PLAVIX	2	
<i>ticlopidine hcl</i>	1	
<b>Cardiovascular Agents</b>		
<b>Alpha-adrenergic Agonists</b>		
<i>clonidine hcl</i>	1	
CLORPRES	3	
GUANABENZ ACETATE	3	
<i>guanfacine hcl</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>methyldopa</i>	1	
METHYLDOPA/HYDROCHLOROTHIAZIDE	3	
METHYLDOPATE HCL	3	
<b>Alpha-adrenergic Blocking Agents</b>		
CARDURA XL	3	
DIBENZYLINE	3	
<i>prazosin hcl</i>	1	
<i>reserpine</i>	1	
<b>Antiarrhythmics</b>		
<i>amiodarone hcl</i>	1	
<i>dilt-cd</i>	1	
<i>disopyramide phosphate</i>	1	
<i>flecainide acetate</i>	1	
<i>mexiletine hcl</i>	1	
MULTAQ	2	
NORPACE CR	2	
PACERONE TABS 100MG	2	
<i>pacerone tabs 200mg</i>	1	
<i>procainamide hcl</i>	1	
<i>propafenone hcl</i>	1	
<i>propafenone hcl er</i>	1	
<i>quinidine gluconate er</i>	1	
<i>quinidine sulfate</i>	1	
<i>quinidine sulfate er</i>	1	
<i>sorine</i>	1	
<i>sotalol hcl</i>	1	
<i>sotalol hydrochloride</i>	1	
<i>verapamil hcl er</i>	1	
<b>Beta-adrenergic Blocking Agents</b>		
<i>acebutolol hcl</i>	1	
<i>atenolol</i>	1	
<i>atenolol/chlorthalidone</i>	1	
<i>betaxolol hcl</i>	1	
<i>bisoprolol fumarate</i>	1	
<i>bisoprolol fumarate/hydrochlorothiazide</i>	1	
BYSTOLIC	2	
<i>carvedilol</i>	1	
COREG CR	2	
<i>labetalol hcl</i>	1	
LEVATOL	3	
<i>metoprolol succinate er</i>	1	
<i>metoprolol tartrate</i>	1	
<i>metoprolol/hydrochlorothiazide</i>	1	
<i>nadolol</i>	1	
<i>nadolol/bendroflumethiazide</i>	1	
<i>pindolol</i>	1	
<i>propranolol hcl</i>	1	
<i>propranolol hcl er</i>	1	
<i>propranolol/hydrochlorothiazide</i>	1	
<i>timolol maleate</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<b>Calcium Channel Blocking Agents</b>		
<i>afeditab cr</i>	1	
<i>amlodipine besylate</i>	1	
<i>amlodipine besylate/benazepril hcl</i>	1	
<i>amlodipine besylate/benazepril hydrochloride</i>	1	
AZOR	3	
CADUET	2	
CARDIZEM CD CP24 360MG	3	
CARDIZEM LA TB24 120MG	3	
<i>cartia xt</i>	1	
COVERA-HS	3	
<i>dilt-cd</i>	1	
<i>dilt-xr</i>	1	
<i>diltiazem cd</i>	1	
<i>diltiazem hcl er</i>	1	
<i>diltiazem hcl tabs</i>	1	
DILTIAZEM HCL INJ 100MG	2	
<i>diltiazem hcl inj 25mg/5ml</i>	1	
<i>diltzac</i>	1	
DYNACIRC CR	3	
EXFORGE	2	
EXFORGE HCT	2	
<i>felodipine er</i>	1	
<i>isradipine</i>	1	
<i>matzim la</i>	1	
<i>nicardipine hcl</i>	1	
<i>nifediac cc</i>	1	
<i>nifedical xl</i>	1	
<i>nifedipine</i>	1	
<i>nifedipine er</i>	1	
<i>nimodipine</i>	1	
<i>nisoldipine</i>	1	
<i>nisoldipine er</i>	1	
<i>taztia xt</i>	1	
TRIBENZOR	3	
TWYNSTA	2	
<i>verapamil hcl</i>	1	
<i>verapamil hcl er</i>	1	
<b>Cardiovascular Agents, Other</b>		
DEMSER	2	
<i>digoxin</i>	1	
LANOXIN	2	
RANEXA	2	
<b>Diuretics</b>		
<i>acetazolamide sodium</i>	1	
ALDACTAZIDE TABS 50MG; 50MG	3	
<i>amiloride hcl</i>	1	
<i>amiloride/hydrochlorothiazide</i>	1	
<i>bumetanide</i>	1	
<i>chlorothiazide</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>chlorothiazide sodium</i>	1	
<i>chlorthalidone</i>	1	
DIURIL	3	
DYRENIUM	3	
EDECIN	2	
<i>furosemide inj, tabs</i>	1	
FUROSEMIDE ORAL SOLN 8MG/ML	2	
<i>furosemide oral soln 10mg/ml</i>	1	
<i>hydrochlorothiazide</i>	1	
<i>indapamide</i>	1	
<i>methyclothiazide</i>	1	
<i>metolazone</i>	1	
SAMSCA	2	
SODIUM EDECIN	2	
<i>spironolactone/hydrochlorothiazide</i>	1	
THALITONE	3	
<i>toremide</i>	1	
<i>triamterene/hydrochlorothiazide</i>	1	
<b>Dyslipidemics</b>		
ADVICOR	3	
ALTOPREV	3	
ANTARA	3	
<i>cholestyramine light</i>	1	
<i>colestipol hcl</i>	1	
CRESTOR	2	
<i>fenofibrate</i>	1	
<i>fenofibrate micronized</i>	1	
FENOGLIDE	3	
<i>gemfibrozil</i>	1	
LESCOL	3	
LESCOL XL	3	
LIPITOR	2	
LIPOFEN	3	
LIVALO	2	
<i>lovastatin</i>	1	
LOVAZA	2	
NIASPAN	2	
<i>pravastatin sodium</i>	1	
<i>prevalite</i>	1	
SIMCOR	3	
<i>simvastatin</i>	1	
TRICOR	2	
TRIGLIDE	3	
TRILIPIX	2	
VYTORIN	3	
WELCHOL PACK	2	
WELCHOL TABS	3	
ZETIA	2	
<b>Renin-angiotensin-aldosterone System Inhibitors</b>		
AMTURNIDE	3	

Drug Name	Drug Tier	Requirements/Limits
ATACAND	3	
ATACAND HCT	3	
AVALIDE	3	
AVAPRO	3	
<i>benazepril hcl</i>	1	
<i>benazepril hcl/hydrochlorothiazide</i>	1	
BENICAR	3	
BENICAR HCT	3	
<i>captopril</i>	1	
<i>captopril/hydrochlorothiazide</i>	1	
DIOVAN	2	
DIOVAN HCT	2	
EDARBI	3	
<i>enalapril maleate</i>	1	
<i>enalapril maleate/hydrochlorothiazide</i>	1	
<i>epplerenone</i>	1	
<i>fosinopril sodium</i>	1	
<i>fosinopril sodium/hydrochlorothiazide</i>	1	
<i>lisinopril</i>	1	
<i>lisinopril/hydrochlorothiazide</i>	1	
<i>losartan potassium</i>	1	
<i>losartan potassium/hydrochlorothiazide</i>	1	
MICARDIS	2	
MICARDIS HCT	2	
<i>moexipril hcl</i>	1	
<i>moexipril/hydrochlorothiazide</i>	1	
<i>perindopril erbumine</i>	1	
<i>quinapril hcl</i>	1	
<i>quinapril/hydrochlorothiazide</i>	1	
<i>ramipril</i>	1	
<i>spironolactone</i>	1	
TARKA	3	
TEKAMLO	2	
TEKTURNA	2	
TEKTURNA HCT	2	
TEVETEN	3	
TEVETEN HCT	3	
<i>trandolapril</i>	1	
VALTURNA	2	
<b>Vasodilators</b>		
BIDIL	2	
DILATRATE SR	3	
<i>hydralazine hcl</i>	1	
<i>isochron</i>	1	
ISORDIL TITRADOSE TABS 40MG	3	
<i>isosorbide dinitrate</i>	1	
<i>isosorbide dinitrate er</i>	1	
<i>isosorbide mononitrate</i>	1	
<i>isosorbide mononitrate er</i>	1	
<i>minitran</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>minoxidil</i>	1	
<i>nitro-bid</i>	1	
NITRO-DUR PT24 0.3MG/HR, 0.8MG/HR	2	
<i>nitroglycerin</i>	1	
<i>nitroglycerin transdermal</i>	1	
NITROLINGUAL PUMPSPRAY	2	
NITROMIST	3	
NITROSTAT	2	
<b>CARDIOVASCULAR, HYPERTENSION / LIPIDS</b>		
<b>ANTIHYPERTENSIVE THERAPY</b>		
<i>dilt-cd</i>	1	
<b>COAGULATION THERAPY</b>		
<i>heparin sodium/d5w</i>	1	
<i>heparin sodium/nacl 0.9%</i>	1	
<b>LIPID/CHOLESTEROL LOWERING AGENTS</b>		
<i>cholestyramine</i>	1	
<i>cholestyramine light</i>	1	
<i>prevalite</i>	1	
<b>Central Nervous System Agents</b>		
<b>Non-amphetamines, ADHD</b>		
FOCALIN XR	2	
<b>Non-amphetamines, Other</b>		
NUEDEXTA	2	
XYREM	2	QL (540 per 30 days) PA
<b>Dermatological Agents</b>		
<b>Dermatological Agents</b>		
8-MOP	2	
ACANYA	3	
ACZONE	3	
<i>adapalene</i>	1	PA
AMEVIVE	3	QL (4 per 30 days) PA
<i>ammonium lactate</i>	1	
<i>amnesteem</i>	1	
ATRALIN	3	PA
<i>avita</i>	1	PA
AZELEX	2	
<i>calcipotriene</i>	1	
CARAC	2	
<i>claravis</i>	1	
CLINDACIN PAC	3	
<i>clindamycin/benzoyl peroxide</i>	1	
CONDYLOX	2	
DIFFERIN LOTN	2	PA
DIFFERIN GEL 0.3%	3	PA
DOVONEX	3	
ELIDEL	3	
EPIDUO	3	PA
<i>erythromycin/benzoyl peroxide</i>	1	
FINACEA	2	
FLUOROPLEX	2	

Drug Name	Drug Tier	Requirements/Limits
<i>fluorouracil</i>	1	
<i>imiquimod</i>	1	
<i>laclotion</i>	1	
OXSORALEN	3	
OXSORALEN ULTRA	2	
<i>podofilox</i>	1	
PROTOPIC	3	
REGRANEX	2	PA
RETIN-A MICRO	3	PA
SANTYL	2	
<i>selenium sulfide</i>	1	
<i>sodium sulfacetamide</i>	1	
SOLARAZE	2	
SORIATANE	2	
<i>sotret</i>	1	
STELARA	3	PA
TACLONEX	3	QL (400 per 30 days)
TACLONEX SCALP	3	QL (120 per 30 days)
TAZORAC	3	QL (100 per 30 days) PA
TRETIN-X	3	PA
<i>tretinoin</i>	1	PA
VECTICAL	3	
VEREGEN	3	
ZONALON	2	
ZYCLARA	3	
<b>DIAGNOSTICS / MISCELLANEOUS AGENTS</b>		
<b>MISCELLANEOUS AGENTS</b>		
<i>dextrose 5%/lactated ringers</i>	1	
<b>Enzyme Replacements/ Modifiers</b>		
<b>Enzyme Replacements/ Modifiers</b>		
ALDURAZYME	2	LA
BUPHENYL	2	
CEREZYME	2	LA
CYSTADANE	2	
CYSTAGON	2	LA
ELAPRASE	3	
FABRAZYME	2	LA
KUVAN	2	PA LA
MYOZYME	3	
NAGLAZYME	2	LA
ORFADIN	2	LA
ZAVESCA	2	LA
<b>GASTROENTEROLOGY</b>		
<b>MISCELLANEOUS GASTROINTESTINAL AGENTS</b>		
<i>peg 3350/electrolytes</i>	1	
<i>sulfazine</i>	1	
<b>Gastrointestinal Agents</b>		
<b>Antispasmodics, Gastrointestinal</b>		
ATROPINE SULFATE INJ 0.05MG/ML	2	
<i>atropine sulfate inj 0.1mg/ml</i>	1	

Drug Name	Drug Tier	Requirements/Limits
BENTYL INJ	3	
CANTIL	3	
<i>dicyclomine hcl</i>	1	
<i>glycopyrrolate</i>	1	
HELIDAC	3	
<i>methscopolamine bromide</i>	1	
<i>propantheline bromide</i>	1	
<b>Gastrointestinal Agents, Other</b>		
AMITIZA	2	
<i>constulose</i>	1	
<i>enulose</i>	1	
GASTROCROM	2	
<i>gavilyte-c</i>	1	
<i>gavilyte-g</i>	1	
<i>gavilyte-n/ flavor pack</i>	1	
<i>generlac</i>	1	
<i>lactulose</i>	1	
<i>polyethylene glycol 3350</i>	1	
PYLERA	2	
<i>trilyte</i>	1	
<i>ursodiol</i>	1	
<b>Histamine2 (H2) Blocking Agents</b>		
<i>cimetidine</i>	1	
<i>cimetidine hcl</i>	1	
<i>famotidine</i>	1	
<i>famotidine premixed</i>	1	
<i>nizatidine</i>	1	
<i>ranitidine hcl</i>	1	
ZANTAC TBEF	3	
ZANTAC INJ 50MG/50ML; 0.45%	2	
<b>Irritable Bowel Syndrome Agents</b>		
LOTRONEX	2	
<b>Protectants</b>		
CARAFATE SUSP	2	
<i>misoprostol</i>	1	
<i>sucralfate</i>	1	
<b>Proton Pump Inhibitors</b>		
ACIPHEX	3	
DEXILANT	3	
<i>lansoprazole</i>	1	
<i>lansoprazole odt</i>	1	
NEXIUM	2	
NEXIUM I.V.	2	
<i>omeprazole</i>	1	
<i>omeprazole/sodium bicarbonate</i>	1	
<i>pantoprazole sodium</i>	1	
PROTONIX INJ, PACK	3	
ZEGERID PACK	3	

**Genitourinary Agents**  
**Antispasmodics, Urinary**

Drug Name	Drug Tier	Requirements/Limits
DETROL	2	
DETROL LA	2	
ENABLEX	2	
<i>flavoxate hcl</i>	1	
GELNIQUE	2	
<i>oxybutynin chloride</i>	1	
<i>oxybutynin chloride er</i>	1	
OXYTROL	2	QL (8 per 28 days)
TOVIAZ	2	
<i>tropium chloride</i>	1	
VESICARE	2	
<b>Benign Prostatic Hypertrophy Agents</b>		
AVODART	2	
<i>doxazosin mesylate</i>	1	
<i>finasteride</i>	1	
JALYN	2	
RAPAFLO	2	
<i>tamsulosin hcl</i>	1	
<i>terazosin hcl</i>	1	
UROXATRAL	2	
<b>Genitourinary Agents, Other</b>		
<i>bethanechol chloride</i>	1	
ELMIRON	2	
<b>Phosphate Binders</b>		
<i>calcium acetate</i>	1	
FOSRENOL	2	
RENAGEL	2	
RENVELA	2	
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)</b>		
<b>Glucocorticoids-Systemic</b>		
MEDROL	3	
<b>Glucocorticoids-Topical-Low Potency</b>		
<i>hydrocortisone in absorbbase</i>	1	
TEXACORT	3	
<b>Glucocorticoids/ Mineralocorticoids</b>		
<i>a-hydrocort</i>	1	
<i>a-methapred</i>	1	
<i>ala cort</i>	1	
<i>ala-cort</i>	1	
<i>alclometasone dipropionate</i>	1	
<i>amcinonide</i>	1	
<i>augmented betamethasone dipropionate</i>	1	
<i>betamethasone dipropionate</i>	1	
<i>betamethasone valerate</i>	1	
CAPEX	2	
CELESTONE	3	
<i>clobetasol propionate</i>	1	
<i>clobetasol propionate e</i>	1	
CLOBEX LOTN, SHAM	2	

Drug Name	Drug Tier	Requirements/Limits
CLOBEX LIQD	3	
CLODERM	3	
CORDRAN	3	
CORDRAN SP	3	
CORDRAN TAPE	2	
<i>cortisone acetate</i>	1	
CUTIVATE LOTN	3	
DEPO-MEDROL INJ 20MG/ML	2	
DERMA-SMOOTHIE/FS BODY OIL	2	
DESONATE	3	
<i>desonide</i>	1	
DESOWEN LOTION/CETAPHIL CREAM	3	
DESOWEN OINTMENT/CETAPHIL LOTION	3	
<i>desoximetasone</i>	1	
DEXAMETHASONE INTENSOL	2	
<i>dexamethasone sodium phosphate</i>	1	
<i>dexamethasone elix</i>	1	
DEXAMETHASONE TABS 1MG, 2MG	2	
<i>dexamethasone tabs 0.5mg, 0.75mg, 1.5mg, 4mg, 6mg</i>	1	
DEXPAK 13 DAY	3	
<i>diflorasone diacetate</i>	1	
<i>fludrocortisone acetate</i>	1	
<i>fluocinolone acetonide</i>	1	
<i>fluocinonide</i>	1	
<i>fluocinonide emollient base</i>	1	
<i>fluticasone propionate</i>	1	
<i>halobetasol propionate</i>	1	
HALOG	3	
<i>hydrocortisone</i>	1	
<i>hydrocortisone butyrate</i>	1	
<i>hydrocortisone valerate</i>	1	
KENALOG	3	
LOCOID LIPOCREAM	3	
LOCOID LOTN	2	
<i>lokara</i>	1	
LUXIQ	2	
<i>methylprednisolone</i>	1	
<i>methylprednisolone acetate</i>	1	
<i>methylprednisolone sodiumsuccinate</i>	1	
MILLIPRED	3	
<i>mometasone furoate</i>	1	
OLUX-E	3	
ORAPRED ODT	3	
PANDEL	2	
<i>prednicarbate</i>	1	
<i>prednisolone sodium phosphate</i>	1	
<i>prednisone</i>	1	
PREDNISONO INTENSOL	2	
SOLU-CORTEF INJ 250MG	2	
SOLU-MEDROL INJ 2GM	2	

Drug Name	Drug Tier	Requirements/Limits
<i>triamcinolone acetonide</i>	1	
<i>triderm</i>	1	
<i>u-cort</i>	1	
VANOS	3	
VERDESO	3	
VERIPRED 20	3	

**Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)**

***Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)***

<i>chorionic gonadotropin</i>	1	
<i>desmopressin acetate</i>	1	
EGRIFTA	3	
GENOTROPIN	3	PA
GENOTROPIN MINIQUICK	3	PA
HUMATROPE	3	PA
HUMATROPE COMBO PACK	3	PA
INCRELEX	2	PA LA
NORDITROPIN FLEXPPO	2	PA
NORDITROPIN NORDIFLEX PEN	2	PA
<i>novarel</i>	1	
NUTROPIN	3	PA
NUTROPIN AQ	3	PA
NUTROPIN AQ NUSPIN 5	2	PA
NUTROPIN AQ PEN	3	PA
OMNITROPE	2	PA
<i>pregnyl w/diluent benzyl alcohol/nacl</i>	1	
SAIZEN	3	PA
SAIZEN CLICK.EASY	3	PA
SEROSTIM	3	PA
STIMATE	2	
TEV-TROPIN	2	PA
ZORBTIVE	3	PA

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

***Estrogens***

ALORA	2	
CLIMARA PRO	2	
COMBIPATCH	2	
DIVIGEL	2	
ELESTRIN	3	
ESTRADERM	2	
<i>estradiol</i>	1	
<i>estradiol valerate</i>	1	
<i>estradiol/norethindrone acetate</i>	1	
<i>estropipate</i>	1	
<i>jinteli</i>	1	
<i>ortho-est</i>	1	
PREMARIN TABS	2	
PREMPHASE	2	

Drug Name	Drug Tier	Requirements/Limits
PREMPRO	2	
VIVELLE-DOT	2	
<b>Progestins</b>		
DEPO-PROVERA	2	
<i>megestrol acetate</i>	1	
<b>Selective Estrogen Receptor Modifying Agents</b>		
EVISTA	2	
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)</b>		
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)</b>		
<i>levothroid</i>	1	
<i>levothyroxine sodium</i>	1	
<i>levoxyl</i>	1	
<i>liothyronine sodium</i>	1	
SYNTHROID	2	
THYROLAR-1	3	
THYROLAR-1/2	3	
THYROLAR-1/4	3	
THYROLAR-2	3	
THYROLAR-3	3	
TIROSINT	3	
<i>unithroid</i>	1	
<b>Hormonal Agents, Suppressant (Adrenal)</b>		
<b>Hormonal Agents, Suppressant (Adrenal)</b>		
LYSODREN	2	
<b>Hormonal Agents, Suppressant (Parathyroid)</b>		
<b>Hormonal Agents, Suppressant (Parathyroid)</b>		
SENSIPAR	2	
<b>Hormonal Agents, Suppressant (Pituitary)</b>		
<b>Hormonal Agents, Suppressant (Pituitary)</b>		
<i>cabergoline</i>	1	
<i>leuprolide acetate</i>	1	PA
LUPRON DEPOT	2	PA
LUPRON DEPOT-PED	2	PA
<i>octreotide acetate</i>	1	
SANDOSTATIN LAR DEPOT	3	
SOMATULINE DEPOT	2	
SOMAVERT	2	PA
SYNAREL	3	
<b>Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)</b>		
<b>Antiandrogens</b>		
<i>bicalutamide</i>	1	
<i>flutamide</i>	1	
<b>Hormonal Agents, Suppressant (Thyroid)</b>		
<b>Antithyroid Agents</b>		
<i>methimazole</i>	1	
<i>propylthiouracil</i>	1	
<b>Immunological Agents</b>		
<b>Immune Suppressants</b>		

Drug Name	Drug Tier	Requirements/Limits
ACTEMRA	3	PA
CIMZIA	2	QL (6 per 28 days) PA
ENBREL INJ 25MG/0.5ML, 50MG/ML	2	QL (7.84 per 28 days) PA
ENBREL INJ 25MG	2	QL (8 per 30 days) PA
HUMIRA	2	QL (6 per 30 days) PA
HUMIRA PEN-CROHNS DISEASESTARTER	2	QL (1 per 30 days) PA
<i>methotrexate</i>	1	B/D
<i>methotrexate sodium</i>	1	
MYFORTIC	2	B/D
NEORAL	3	B/D
ORENCIA	3	QL (4 per 30 days)
REMICADE	2	PA
RHEUMATREX	3	
SANDIMMUNE	3	B/D
SIMPONI	2	QL (1 per 30 days) PA
<b>Immunomodulators</b>		
ACTIMMUNE	2	LA
ARCALYST	2	PA LA
AVONEX	2	QL (2 per 28 days)
BETASERON	2	QL (14 per 28 days)
COPAXONE	2	QL (30 per 30 days)
GILENYA	2	
INTRON-A	2	
INTRON-A W/DILUENT	2	
KINERET	3	PA
<i>leflunomide</i>	1	
PEG-INTRON	2	PA
PEG-INTRON REDIPEN	2	PA
PEGASYS	2	PA
REBIF	2	QL (12 per 30 days)
REBIF TITRATION PACK	2	QL (5 per 30 days)
RIDAURA	3	
<b>Vaccines</b>		
ACTHIB	2	
CERVARIX	2	
COMVAX	2	
ENGERIX-B	2	B/D
GARDASIL	2	
HAVRIX	2	
IMOVAX RABIES (H.D.C.V.)	2	B/D
IPOL INACTIVATED IPV	2	
IXIARO	2	
JE-VAX	2	
M-M-R II W/DILUENT 10 DOSE	2	
MENACTRA	2	
MENOMUNE-A/C/Y/W-135	2	
MENVEO	2	
PEDVAX HIB	2	
PROQUAD	2	
RABAVERT	2	B/D

Drug Name	Drug Tier	Requirements/Limits
RECOMBIVAX HB	2	B/D
ROTATEQ	2	
TWINRIX	2	B/D
TYPHIM VI	2	
VAQTA	2	
VARIVAX	2	
YF-VAX	2	
ZOSTAVAX	2	
<b>IMMUNOLOGY, VACCINES / BIOTECHNOLOGY</b>		
<b>BIOTECHNOLOGY DRUGS</b>		
PEG-INTRON REDIPEN PAK 4	2	PA
<b>Inflammatory Bowel Disease Agents</b>		
<b>Glucocorticoids</b>		
ENTOCORT EC	2	
<i>methylprednisolone</i>	1	
MILLIPRED	3	
<b>Salicylates</b>		
ASACOL	2	
ASACOL HD	2	
<i>balsalazide disodium</i>	1	
CANASA	2	
<i>mesalamine</i>	1	
PENTASA	2	
<b>Sulfonamides</b>		
<i>sulfasalazine</i>	1	
<i>sulfazine ec</i>	1	
<b>Metabolic Bone Disease Agents</b>		
<b>Metabolic Bone Disease Agents</b>		
ACTONEL TABS 30MG, 5MG	3	
ACTONEL TABS 150MG	3	QL (1 per 30 days)
ACTONEL TABS 35MG	3	QL (4 per 30 days)
<i>alendronate sodium tabs 10mg, 5mg</i>	1	
<i>alendronate sodium tabs 40mg</i>	1	QL (30 per 30 days)
<i>alendronate sodium tabs 70mg</i>	1	QL (4 per 28 days)
<i>alendronate sodium tabs 35mg</i>	1	QL (4 per 30 days)
ATELVIA	3	QL (4 per 30 days)
BONIVA TABS	2	QL (1 per 30 days)
BONIVA INJ	3	QL (3 per 90 days) PA
<i>calcitonin-salmon</i>	1	QL (4 per 30 days)
<i>calcitriol</i>	1	B/D
<i>etidronate disodium</i>	1	
FORTEO	2	QL (3 per 30 days) PA
<i>fortical</i>	1	QL (4 per 30 days)
FOSAMAX PLUS D	3	QL (4 per 28 days)
FOSAMAX SOLN	3	
HECTOROL	2	B/D
MIACALCIN INJ	3	
PAMIDRONATE DISODIUM INJ 6MG/ML	3	
<i>pamidronate disodium inj 30mg/10ml, 90mg/10ml</i>	1	
PROLIA	3	

Drug Name	Drug Tier	Requirements/Limits
RECLAST	3	PA
SKELID	3	
XGEVA	2	
ZEMPLAR	2	B/D
ZOMETA	2	PA
<b>Miscellaneous Therapeutic Agents</b>		
<b>Miscellaneous Therapeutic Agents</b>		
ALCOHOL PREPS	2	
<i>anagrelide hydrochloride</i>	1	
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	2	
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	2	
BD PEN NEEDLE/ULTRAFINE/29G X 12.7MM	2	
CURITY GAUZE PADS 2"X2"	2	
<i>leucovorin calcium inj</i>	1	
LEUCOVORIN CALCIUM TABS 10MG, 15MG	2	
<i>leucovorin calcium tabs 25mg, 5mg</i>	1	
<i>levocarnitine</i>	1	B/D
<i>pentopak</i>	1	
<i>pentoxifylline er</i>	1	
<i>sodium chloride</i>	1	
XENAZINE TABS 25MG	2	QL (120 per 30 days) PA LA
XENAZINE TABS 12.5MG	2	QL (240 per 30 days) PA LA
<b>MUSCULOSKELETAL / RHEUMATOLOGY</b>		
<b>OTHER RHEUMATOLOGICALS</b>		
ENBREL SURECLICK	2	QL (4.08 per 30 days) PA
<b>Ophthalmic Agents</b>		
<b>Glucocorticoids, Ophthalmic</b>		
<i>fluor-op</i>	1	
<b>Ophthalmic Agents, Other</b>		
<i>ak-con</i>	1	
LACRISERT	2	
<i>mydral</i>	1	
<i>parcaine</i>	1	
<i>proparacaine hcl</i>	1	
RESTASIS	2	
<i>tropicamide</i>	1	
<b>Ophthalmic Anti-allergy Agents</b>		
ALAMAST	3	
ALOCRIL	3	
ALOMIDE	3	
<i>azelastine hcl</i>	1	
BEPREVE	2	
<i>cromolyn sodium</i>	1	
EMADINE	3	
<i>epinastine hcl</i>	1	
LASTACAPT	3	
PATADAY	2	
PATANOL	2	

Drug Name	Drug Tier	Requirements/Limits
<b>Ophthalmic Anti-inflammatories</b>		
ACUVAIL	2	
ALREX	2	
BLEPHAMIDE	3	
BLEPHAMIDE S.O.P.	3	
BROMDAY	2	
<i>bromfenac</i>	1	
CORTISPORIN	3	
<i>dexamethasone sodium phosphate</i>	1	
<i>diclofenac sodium</i>	1	
DUREZOL	3	
FLAREX	3	
<i>fluorometholone</i>	1	
<i>flurbiprofen sodium</i>	1	
FML	2	
FML FORTE	2	
<i>ketorolac tromethamine</i>	1	
LOTEMAX	2	
MAXIDEX	3	
<i>neomycin/polymyxin/bacitracin/hydrocortisone</i>	1	
<i>neomycin/polymyxin/dexamethasone</i>	1	
NEVANAC	2	
<i>poly-dex</i>	1	
POLY-PRED	3	
PRED MILD	3	
PRED-G	3	
PRED-G S.O.P.	3	
<i>prednisolone acetate</i>	1	
<i>prednisolone sodium phosphate</i>	1	
<i>sulfacetamide sodium/prednisolone sodium phosphate</i>	1	
TOBRADEX ST	3	
TOBRADEX OINT	3	
<i>tobramycin/dexamethasone</i>	1	
VEXOL	3	
ZYLET	2	
<b>Ophthalmic Antiglaucoma Agents</b>		
<i>acetazolamide</i>	1	
<i>acetazolamide er</i>	1	
ALPHAGAN P SOLN 0.1%	2	
<i>apraclonidine</i>	1	
AZOPT	2	
<i>betaxolol hcl</i>	1	
BETIMOL	3	
BETOPTIC-S	3	
<i>brimonidine tartrate</i>	1	
<i>carteolol hcl</i>	1	
COMBIGAN	2	
<i>dorzolamide hcl</i>	1	
<i>dorzolamide hcl/timolol maleate</i>	1	
IOPIDINE SOLN 1%	3	

Drug Name	Drug Tier	Requirements/Limits
ISTALOL	2	
<i>levobunolol hcl</i>	1	
<i>methazolamide</i>	1	
<i>metipranolol</i>	1	
PHOSPHOLINE IODIDE	3	
PILOPINE HS	2	
PROPINE	3	
<i>timolol maleate</i>	1	
<i>timolol maleate ophthalmic gel forming</i>	1	
TIMOPTIC OCUDOSE	2	
<b>Ophthalmic Prostaglandin and Prostanamide Analogs</b>		
<i>latanoprost</i>	1	QL (3 per 30 days)
LUMIGAN SOLN 0.01%	2	QL (2 per 30 days)
LUMIGAN SOLN 0.03%	2	QL (3 per 30 days)
TRAVATAN Z	2	QL (3 per 30 days)
<b>OPHTHALMOLOGY</b>		
<b>ANTIBIOTICS</b>		
<i>ak-poly-bac</i>	1	
<b>CYCLOPLEGIC MYDRIATICS</b>		
<i>tropicacyl</i>	1	
<b>Otic Agents</b>		
<b>Otic Agents</b>		
<i>neomycin/polymyxin/hydrocortisone susp</i>	1	
<b>Respiratory Tract Agents</b>		
<b>Anti-inflammatories, Inhaled Corticosteroids</b>		
ADVAIR DISKUS	2	QL (60 per 30 days)
ADVAIR HFA	2	QL (12 per 30 days)
ALVESCO	3	QL (14 per 30 days)
ASMANEX 120 METERED DOSES	2	QL (2 per 30 days)
ASMANEX 14 METERED DOSES	2	QL (2 per 30 days)
ASMANEX 30 METERED DOSES	2	QL (2 per 30 days)
ASMANEX 60 METERED DOSES	2	QL (2 per 30 days)
BECONASE AQ	3	QL (50 per 30 days)
<i>budesonide</i>	1	QL (120 per 30 days) B/D
DULERA	3	
FLOVENT DISKUS	2	
FLOVENT HFA AERO 44MCG/ACT	2	QL (11 per 30 days)
FLOVENT HFA AERO 110MCG/ACT, 220MCG/ACT	2	QL (12 per 30 days)
<i>flunisolide</i>	1	QL (75 per 30 days)
<i>fluticasone propionate</i>	1	QL (32 per 30 days)
NASONEX	2	QL (68 per 30 days)
OMNARIS	3	QL (13 per 30 days)
PULMICORT FLEXHALER	3	QL (1 per 30 days)
PULMICORT SUSP 1MG/2ML	2	QL (120 per 30 days) B/D
QVAR	3	QL (14.6 per 25 days)
RHINOCORT AQUA	3	QL (18 per 30 days)
SYMBICORT	2	QL (10.2 per 30 days)
VERAMYST	2	QL (10 per 30 days)
<b>Antihistamines</b>		
ALLEGRA	3	

Drug Name	Drug Tier	Requirements/Limits
ASTEPRO	2	QL (60 per 30 days)
<i>azelastine hcl</i>	1	QL (60 per 30 days)
<i>carbinoxamine maleate</i>	1	
<i>cetirizine hcl</i>	1	
CLARINEX	2	
CLARINEX REDITABS	2	
<i>clemastine fumarate</i>	1	
<i>cyproheptadine hcl</i>	1	
DEXCHLORPHENIRAMINE MALEATE	3	
<i>diphenhydramine hcl</i>	1	
<i>fexofenadine hcl</i>	1	
<i>hydroxyzine hcl</i>	1	
<i>levocetirizine dihydrochloride</i>	1	
PALGIC TABS	3	
<i>palgic liqd</i>	1	
PATANASE	3	QL (31 per 30 days)
<i>promethazine hcl</i>	1	
XYZAL SOLN	3	
<b>Antileukotrienes</b>		
SINGULAIR	2	
<i>zafirlukast</i>	1	
ZYFLO CR	3	
<b>Bronchodilators, Anticholinergic</b>		
ATROVENT HFA	2	QL (26 per 30 days)
COMBIVENT	2	QL (30 per 30 days)
<i>ipratropium bromide/albuterol sulfate</i>	1	QL (540 per 30 days) B/D
<i>ipratropium bromide nasal soln</i>	1	
<i>ipratropium bromide inhalation soln</i>	1	QL (312.5 per 30 days) B/D
SPIRIVA HANDIHALER	2	QL (30 per 30 days)
<b>Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)</b>		
<i>aminophylline</i>	1	
ELIXOPHYLLIN	3	
LUFYLLIN	3	
THEO-24	3	
<i>theochron</i>	1	
<i>theophylline er</i>	1	
<b>Bronchodilators, Sympathomimetic</b>		
<i>albuterol sulfate er</i>	1	
<i>albuterol sulfate syrup, tabs</i>	1	
<i>albuterol sulfate nebu 0.5%</i>	1	QL (100 per 30 days) B/D
<i>albuterol sulfate nebu 0.63mg/3ml, 1.25mg/3ml</i>	1	QL (375 per 30 days) B/D
<i>albuterol sulfate nebu 0.083%</i>	1	QL (525 per 30 days) B/D
BROVANA	3	QL (120 per 30 days) B/D
<i>epinephrine hcl</i>	1	
FORADIL AEROLIZER	2	QL (60 per 30 days)
<i>levalbuterol</i>	1	QL (270 per 30 days) B/D
MAXAIR AUTOHALER	3	QL (14 per 30 days)
<i>metaproterenol sulfate</i>	1	
PERFOROMIST	2	QL (120 per 30 days) B/D

Drug Name	Drug Tier	Requirements/Limits
PROAIR HFA	2	QL (18 per 30 days)
PROVENTIL HFA	3	QL (14 per 30 days)
SEREVENT DISKUS	2	QL (60 per 30 days)
<i>terbutaline sulfate</i>	1	
VENTOLIN HFA	2	QL (36 per 30 days)
XOPENEX HFA	3	QL (30 per 30 days)
XOPENEX NEBU 1.25MG/3ML	3	QL (270 per 30 days) B/D
XOPENEX NEBU 0.31MG/3ML, 0.63MG/3ML	3	QL (540 per 30 days) B/D
<b>Mast Cell Stabilizers</b>		
<i>cromolyn sodium</i>	1	B/D
<b>Pulmonary Antihypertensives</b>		
LETAIRIS	2	QL (30 per 30 days) PA LA
REVATIO INJ	2	QL (1125 per 30 days) PA
REVATIO TABS	2	QL (90 per 30 days) PA
TRACLEER	2	QL (60 per 30 days) PA LA
TYVASO	2	QL (90 per 30 days) PA
TYVASO REFILL	2	QL (90 per 30 days) PA
TYVASO STARTER	2	QL (90 per 30 days) PA
<b>Respiratory Tract Agents, Other</b>		
DALIRESP	3	PA
TYZINE	2	
TYZINE PEDIATRIC NASAL DROPS	2	
XOLAIR	3	PA
<b>Sedatives/Hypnotics</b>		
<b>Sedatives/Hypnotics</b>		
EDLUAR	3	QL (30 per 30 days)
<i>hydroxyzine hcl</i>	1	
LUNESTA	3	QL (30 per 30 days)
ROZEREM	3	QL (30 per 30 days)
<i>zaleplon</i>	1	QL (30 per 30 days)
<i>zolpidem tartrate</i>	1	QL (30 per 30 days)
<i>zolpidem tartrate er</i>	1	QL (30 per 30 days)
ZOLPIMIST	3	QL (7.7 per 30 days)
<b>Skeletal Muscle Relaxants</b>		
<b>Skeletal Muscle Relaxants</b>		
<i>carisoprodol</i>	1	
<i>carisoprodol/aspirin</i>	1	
<i>carisoprodol/aspirin/codeine</i>	1	
<i>chlorzoxazone</i>	1	
<i>cyclobenzaprine hcl</i>	1	
<i>cyclobenzaprine hcl er</i>	1	
FEXMID	3	
<i>metaxalone</i>	1	
<i>methocarbamol</i>	1	
<i>orphenadrine citrate</i>	1	
<i>orphenadrine citrate er</i>	1	
<i>orphenadrine compound ds</i>	1	
<i>orphenadrine/asa/caffeine</i>	1	
ROBAXIN INJ	3	
<b>Therapeutic Nutrients/Minerals/ Electrolytes</b>		

Drug Name	Drug Tier	Requirements/Limits
<b>Electrolytes/Minerals</b>		
AMMONIUM CHLORIDE	3	
DEXTROSE 10%/NACL 0.45%	2	
DEXTROSE 5% /ELECTROLYTE #48 VIAFLEX	2	
<i>dextrose 10%/nacl 0.2%</i>	1	
<i>dextrose 2.5%/sodium chloride 0.45%</i>	1	
<i>dextrose 5%/nacl 0.2%</i>	1	
<i>dextrose 5%/nacl 0.225%</i>	1	
<i>dextrose 5%/nacl 0.33%</i>	1	
<i>dextrose 5%/nacl 0.45%</i>	1	
<i>dextrose 5%/nacl 0.9%</i>	1	
DEXTROSE 5%/POTASSIUM CHLORIDE 0.075%	3	
<i>ed k+10</i>	1	
<i>eliphos</i>	1	
IONOSOL-B/DEXTROSE 5%	2	
IONOSOL-MB/DEXTROSE 5%	2	
IONOSOL-T/DEXTROSE 5%	2	
ISOLYTE-H/DEXTROSE 5%	2	
<i>isolyte-m/dextrose 5%</i>	1	
ISOLYTE-P/DEXTROSE 5%	2	
ISOLYTE-S	2	
ISOLYTE-S/DEXTROSE 5%	2	
<i>kcl 0.075%/d5w/nacl 0.45%</i>	1	
KCL 0.15%/D10W/NAACL 0.2%	2	
<i>kcl 0.15%/d5w/lr</i>	1	
<i>kcl 0.15%/d5w/nacl 0.2%</i>	1	
KCL 0.15%/D5W/NAACL 0.225%	2	
<i>kcl 0.15%/d5w/nacl 0.9%</i>	1	
<i>kcl 0.3%/d5w/lr iv lac ring</i>	1	
<i>kcl 0.3%/d5w/nacl 0.2%</i>	1	
<i>kcl 0.3%/d5w/nacl 0.45%</i>	1	
<i>kcl 0.3%/d5w/nacl 0.9%</i>	1	
<i>klor-con 10</i>	1	
<i>klor-con 8</i>	1	
KLOR-CON M15	3	
<i>klor-con m20</i>	1	
<i>lactated ringers</i>	1	
MAGNESIUM SULFATE IN D5W	2	
MAGNESIUM SULFATE INJ 40MG/ML, 80MG/ML	2	
<i>magnesium sulfate inj 50%</i>	1	
<i>normosol-m in d5w</i>	1	
NORMOSOL-R	2	
<i>normosol-r in d5w</i>	1	
PLASMA-LYTE 56	3	
PLASMA-LYTE A	2	
PLASMA-LYTE-148	2	
PLASMA-LYTE-148/D5W	3	
PLASMA-LYTE-56/D5W	2	
<i>plasma-lyte-r</i>	1	
<i>potassium chloride</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride 0.075%/d5w/nacl 0.225%</i>	1	
<i>potassium chloride 0.15% /nacl 0.45% viaflex</i>	1	
<i>potassium chloride 0.15% d5w/nacl 0.33%</i>	1	
<i>potassium chloride 0.15% d5w/nacl 0.45% viaflex</i>	1	
<i>potassium chloride 0.15% nacl 0.9%</i>	1	
<i>potassium chloride 0.15%/d5w</i>	1	
<i>potassium chloride 0.22% d5w/nacl 0.45%</i>	1	
<i>potassium chloride 0.224%/d5w</i>	1	
<i>potassium chloride 0.224%d5w/nacl 0.33%</i>	1	
<i>potassium chloride 0.3%/d5w</i>	1	
<i>potassium chloride er</i>	1	
<i>potassium chloride sr</i>	1	
<i>potassium citrate extended-release</i>	1	
<i>ringers injection</i>	1	
<i>sodium bicarbonate</i>	1	
<i>sodium chloride</i>	1	
<i>sodium chloride 0.9%</i>	1	
<i>sodium chloride 0.45% viaflex</i>	1	
<i>sodium fluoride</i>	1	
<i>sodium lactate</i>	1	
<i>tpn electrolytes</i>	1	
<b>VITAMINS, HEMATINICS / ELECTROLYTES</b>		
<b>ELECTROLYTES</b>		
<i>kcl 0.224%/d5w/nacl 0.2%</i>	1	
<i>lactated ringers viaflex</i>	1	

**OTC products**

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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