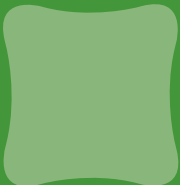






Asuris Medicare Script™ Enhanced (PDP) Asuris Medicare Script™ (PDP)



Medicare Prescription Drug Plan
2010 Abridged Formulary
(Partial List of Covered Drugs)



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

Welcome!

This document includes our **partial formulary** as of July 1, 2010. For a complete, updated formulary, please visit our website at the address on the back cover or call our Customer Service Department at 1-800-541-8981, from November 15 through March 1 our telephone hours are 8 a.m. to 8 p.m. seven days a week. After March 1 our telephone hours are 8 a.m. to 8 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day. (TTY/TDD users should call 711.)

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

What is the Formulary?

A formulary is a list of drugs selected in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. **This document is an abridged (partial) formulary** and only contains some of the drugs we cover. For a complete formulary listing all of the Part D drugs covered by our plan, please visit the website address on the back cover or contact our Customer Service Department. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

Generally, if you are taking a drug on our 2010 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2010 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 on a drug and/or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the date that the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. Periodically our formulary may change including medications changing tiers. When this results in a medication you may have been receiving moving to a higher cost share, we will send you an update outlining this change.

To get updated information about the drugs we cover, please visit our website at the address on the back cover or call our Customer Service Department at 1-800-541-8981, from November 15 through March 1 our telephone hours are 8 a.m. to 8 p.m. seven days a week. After March 1 our telephone hours are 8 a.m. to 8 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day. 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 7. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list that begins on page 7. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 43. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

We provide coverage for both brand-name drugs and generic drugs. A generic drug 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 other restrictions on coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Certain drugs require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, there is a limit on the amount of the drug we will cover. For example, we provide coverage for 12 tablets per a 30-day prescription for Imitrex. This may be in addition to a standard one month or three month supply.

You can find out if your drug has any additional requirements or limits by looking in the Notes column of the formulary that begins on page 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at the address listed on the back cover.

You can ask us to make an exception to these restrictions or limits. See the section, “How do I request an exception to the formulary?” on page 3 for more 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 Customer Service and ask if your drug is covered. **This document only includes a partial list of covered drugs**, so we may cover your drug. You can contact our Customer Service Department at 1-800-541-8981, from November 15 through March 1 our telephone hours are 8 a.m. to 8 p.m. seven days a week. After March 1 our telephone hours are 8 a.m. to 8 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day. (TTY/TDD users should call 711.)

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

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

How do I request an exception to the Formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred brand drug, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred brand 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 Tier 5 (Specialty) or Tier 2 (Preferred Brand Medications).

Generally, we will only approve your request for an exception if the alternative drugs included on our formulary, or additional utilization restrictions would not be as effective in treating your condition and/or cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting 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 prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

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

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 cover a temporary 31 day transition supply (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 member** and have a change in treatment setting due to a change in the level of care you require, you can ask us to make an exception for these types of unplanned transitions.

Such transitions include:

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

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

For more information

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

If you have questions about our plan, please call our Customer Service Department at 1-800-541-8981, from November 15 through March 1 our telephone hours are 8 a.m. to 8 p.m. seven days a week. After March 1 our telephone hours are 8 a.m. to 8 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day. (TTY/TDD users should call 711.) Or, visit our website at the address on the back cover.

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.

Tier Level Definitions

Asuris Medicare Script (PDP) – Plan Benefits			
Tier Name	Tier Level	² Retail Cost-Sharing (1-30 day supplies)	² Mail Order Cost-Sharing (1-30 day supplies)
Generic	1	\$4	\$4
Preferred Brand	2	\$30	\$30
Non-Preferred Brand	3	\$61	\$61
¹ Miscellaneous Injectables	4	27%	27%
¹ Specialty	5	27%	27%

Asuris Medicare Script Enhanced (PDP) – Plan Benefits			
Tier Name	Tier Level	² Retail Cost-Sharing (1-30 day supplies)	² Mail Order Cost-Sharing (1-30 day supplies)
³ Generic	1	\$4	\$4
Preferred Brand	2	\$30	\$30
Non-Preferred Brand	3	\$56	\$56
¹ Miscellaneous Injectables	4	30%	30%
¹ Specialty	5	30%	30%

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

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

For example:

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

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

³For Asuris Medicare Script Enhanced (PDP) members, we provide coverage for Generic medications in Tier 1 during the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Our Formulary

The abridged formulary that begins on the next page provides coverage information about some of the drugs we cover. If you have trouble finding your drug in the list, turn to the index that begins on page 43. Remember: **This is only a partial list of the drugs we cover.** If your prescription is not in this partial formulary, please visit our website at the address listed on the back cover, or call Customer Service at 1-800-541-8981, from November 15 through March 1 our telephone hours are 8 a.m. to 8 p.m. seven days a week. After March 1 our telephone hours are 8 a.m. to 8 p.m., Monday through Friday, and you may leave a message on Saturdays, Sundays and holidays. We will return your call on the next business day. (TTY/TDD users should call 711.)

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

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

Formulary Legend

FF Free First Fill Medications

This prescription drug will be provided at no charge (for up to a 30 day supply, 31 days for long-term care) the first time you fill it.

GC Gap Coverage Medications

For our members on Asuris Medicare Script Enhanced (PDP), we provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

HI Home Infusion Therapy Medications

For members on our plans that cover both medical and Rx, this prescription drug may be covered under your medical benefit. For more information, call Customer Service at 1-800-541-8981. (TTY/TDD users should call 711.)

LA Limited Access Medications

This prescription drug may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at 1-800-541-8981. (TTY/TDD users should call 711.)

MO Mail Order Medication

This prescription drug is available through our mail order pharmacy services.

PA Prior Authorization Medications

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

QL Quantity Level Limit Medications

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

Drug Name	Drug Tier	Notes
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
<i>diclofenac potassium</i>	1	GC; MO
<i>diclofenac sodium</i>	1	GC; MO
<i>diclofenac sodium ec</i>	1	GC; MO
<i>diflunisal</i>	1	GC; MO
<i>etodolac</i>	1	FF; GC; MO
<i>fenoprofen calcium</i>	1	GC; MO
<i>flurbiprofen</i>	1	GC; MO
<i>ketoprofen</i>	1	GC; MO
<i>ketorolac tromethamine tablet</i>	1	GC; MO
<i>nabumetone</i>	1	FF; GC; MO
<i>naproxen dr</i>	1	FF; GC; MO
<i>naproxen sodium</i>	1	FF MO GC
<i>oxaprozin</i>	1	GC; MO
Opioid Analgesics		
<i>acetaminophen/caffeine/dihydrocodeine bitartrate</i>	1	GC; MO
<i>acetaminophen/codeine</i>	1	GC; MO
<i>acetaminophen/codeine #3</i>	1	GC; MO
<i>acetaminophen/codeine #4</i>	1	GC; MO
<i>ascomp/codeine</i>	1	GC; MO
<i>balacet 325</i>	1	GC; MO
<i>buprenorphine hcl tablet sublingual</i>	1	MO GC
<i>butalbital /apap /caffeine /codeine</i>	1	GC; MO
<i>butorphanol tartrate solution</i>	1	GC; MO
<i>co-gesic</i>	1	GC; MO
<i>codeine sulfate tablet 15mg</i>	1	GC; MO
<i>codeine sulfate tablet 30mg</i>	1	GC; MO
<i>codeine sulfate tablet 60mg</i>	1	GC; MO
<i>endocet</i>	1	GC; MO
<i>endodan</i>	1	GC; MO
<i>fentanyl</i>	1	GC; MO
<i>fentanyl citrate oral transmucosal lollipop 200mcg</i>	1	GC; MO; PA - Prior authorization required for coverage; QL - When authorized, quantity limited #96 lollipops per 30 days.
<i>fentanyl citrate oral transmucosal lollipop 1200mcg, 1600mcg, 400mcg, 600mcg, 800mcg</i>	1	GC; MO; PA - Prior authorization required for coverage; QL - When authorized, quantity limited #96 lollipops per 30 days.
<i>hydrocodone /acetaminophen</i>	1	GC; MO
<i>hydrocodone /acetaminophen-hs</i>	1	GC; MO
<i>hydrocodone bitartrate/acetaminophen</i>	1	GC; MO
<i>hydromorphone hcl tablet</i>	1	GC; MO
<i>KADIAN</i>	2	MO
<i>levorphanol tartrate</i>	1	GC; MO
<i>margesic-h</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>meperidine hcl solution, tablet</i>	1	GC; MO
<i>methadone hcl concentrate, solution, tablet</i>	1	GC; MO
<i>methadose</i>	1	GC; MO
<i>morphine sulfate er</i>	1	GC; MO
<i>morphine sulfate tablet</i>	1	GC; MO
<i>morphine sulfate suppository</i>	1	MO GC; GC; MO
<i>morphine sulfate solution 10mg/5ml, 20mg/5ml</i>	1	GC; MO
<i>morphine sulfate solution 20mg/ml</i>	1	MO GC
<i>oramorph sr</i>	1	GC; MO
<i>oxycodone /acetaminophen</i>	1	GC; MO
<i>oxycodone /apap</i>	1	GC; MO
<i>oxycodone /aspirin</i>	1	GC; MO
<i>oxycodone /ibuprofen</i>	1	GC; MO
<i>oxycodone hcl</i>	1	GC; MO
<i>oxycodone hcl er</i>	1	GC; MO; QL - Quantity limited up to 160mg per day. All strengths of generic oxycodone HCL ER and brand Oxycontin accumulate together.
<i>oxycodone-apap</i>	1	GC; MO
<i>pentazocine /acetaminophen</i>	1	GC; MO
<i>pentazocine/naloxone hcl</i>	1	GC; MO
<i>propoxyphene /acetaminophen</i>	1	GC; MO
<i>propoxyphene hcl</i>	1	GC; MO
<i>propoxyphene-n /acetaminophen</i>	1	GC; MO
<i>roxicet</i>	1	GC; MO
<i>stagesic</i>	1	GC; MO
<i>tramadol hcl</i>	1	GC; MO
<i>tramadol hcl er</i>	1	MO GC
<i>tramadol hydrochloride/acetaminophen</i>	1	GC; MO
<i>trezix</i>	1	GC; MO
<i>vanacet</i>	1	GC; MO
<i>zerlor</i>	1	GC; MO

Anesthetics

Local Anesthetics

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

Anti-Inflammatory Agents

Glucocorticoids

<i>prednisone</i>	1	GC; MO
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Drug Name	Drug Tier	Notes
Nonsteroidal Anti-inflammatory Drugs		
<i>choline magnesium trisalicylate</i>	1	GC; MO
<i>diclofenac sodium ec</i>	1	GC; MO
<i>diclofenac sodium xr</i>	1	GC; MO
<i>etodolac</i>	1	FF; GC; MO
<i>etodolac er</i>	1	GC; MO
<i>flurbiprofen</i>	1	GC; MO
<i>hydrocodone /ibuprofen</i>	1	GC; MO
<i>ibuprofen suspension</i>	1	GC; MO
<i>ibuprofen tablet 800mg</i>	1	FF; GC; MO
<i>ibuprofen tablet 400mg, 600mg</i>	1	FF; GC; MO
<i>indomethacin</i>	1	GC; MO
<i>indomethacin er</i>	1	GC; MO
<i>ketoprofen</i>	1	GC; MO
<i>ketoprofen er</i>	1	GC; MO
<i>meclofenamate sodium</i>	1	GC; MO
<i>meloxicam</i>	1	GC; MO
<i>naproxen suspension</i>	1	GC; MO
<i>naproxen tablet 500mg</i>	1	FF MO GC
<i>naproxen tablet 250mg, 375mg</i>	1	FF; GC; MO
<i>piroxicam capsule 10mg</i>	1	GC; MO
<i>piroxicam capsule 20mg</i>	1	GC; MO
<i>salsalate</i>	1	GC; MO
<i>sulindac</i>	1	GC; MO
<i>tolmetin sodium</i>	1	GC; MO
Antibacterials		
Aminoglycosides		
<i>gentamicin sulfate cream, external ointment</i>	1	GC; MO
<i>neomycin sulfate</i>	1	GC; MO
Antibacterials, Other		
<i>ak-poly-bac</i>	1	GC; MO
<i>bacitracin/polymyxin b</i>	1	GC; MO
<i>bacitracin ointment</i>	1	GC; MO
BACTROBAN NASAL	2	MO
<i>clindamycin hcl</i>	1	GC; MO
<i>clindamycin phosphate</i>	1	GC; MO
FURADANTIN	2	MO
HELIDAC	2	MO
<i>methenamine hippurate</i>	1	GC; MO
METROGEL	2	MO
<i>metronidazole</i>	1	GC; MO
<i>metronidazole vaginal</i>	1	GC; MO
<i>mupirocin</i>	1	GC; MO
<i>neomycin /bacitracin /polymyxin</i>	1	GC; MO
<i>neomycin /polymyxin /dexamethasone</i>	1	GC; MO
<i>neomycin /polymyxin /gramicidin</i>	1	GC; MO
<i>neomycin /polymyxin /hydrocortisone</i>	1	GC; MO
<i>neomycin/polymyxin b sulfates</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>nitrofurantoin macrocrystalline</i>	1	GC; MO
<i>nitrofurantoin monohydrate</i>	1	GC; MO
NORITATE	2	MO
<i>polycin b</i>	1	GC; MO
<i>silver sulfadiazine</i>	1	GC; MO
<i>thermazene</i>	1	GC; MO
<i>trimethoprim</i>	1	GC; MO
<i>trimethoprim sulfate/polymyxin b sulfate</i>	1	GC; MO
ZYVOX SUSPENSION RECONSTITUTED, TABLET	2	MO
Beta-lactam, Cephalosporins		
<i>cefaclor</i>	1	GC; MO
<i>cefaclor er</i>	1	GC; MO
<i>cefadroxil</i>	1	GC; MO
<i>cefdinir</i>	1	GC; MO
<i>cefepodoxime proxetil</i>	1	GC; MO
<i>cefprozil</i>	1	GC; MO
<i>cefuroxime axetil</i>	1	GC; MO
<i>cephalexin</i>	1	GC; MO
Beta-lactam, Penicillins		
<i>amoclan</i>	1	GC; MO
<i>amoxicillin</i>	1	GC; MO
<i>amoxicillin/clavulanate potassium</i>	1	GC; MO
<i>amoxicillin/clavulanate potassium er</i>	1	GC; MO
<i>amoxicillin/potassium clavulanate</i>	1	GC; MO
<i>ampicillin</i>	1	GC; MO
AUGMENTIN ES-600	2	MO
<i>dicloxacillin sodium</i>	1	GC; MO
<i>penicillin v potassium</i>	1	GC; MO
<i>veetids</i>	1	GC; MO
Macrolides		
<i>azithromycin suspension reconstituted</i>	1	GC; MO
<i>azithromycin tablet 250mg</i>	1	GC; MO
<i>azithromycin tablet 500mg, 600mg</i>	1	GC; MO
<i>clarithromycin</i>	1	GC; MO
<i>clarithromycin er</i>	1	GC; MO
<i>ery</i>	1	GC; MO
<i>erythromycin</i>	1	GC; MO
<i>erythromycin /sulfisoxazole</i>	1	GC; MO
<i>erythromycin base</i>	1	GC; MO
<i>romycin</i>	1	GC; MO
Quinolones		
AVELOX ABC PACK	2	MO
AVELOX TABLET	2	MO
<i>ciprofloxacin er</i>	1	GC; MO
<i>ciprofloxacin extended-release</i>	1	GC; MO
<i>ciprofloxacin hcl</i>	1	GC; MO
LEVAQUIN SOLUTION, TABLET	3	MO; Potential preferred options: ciprofloxacin, ofloxacin

Drug Name	Drug Tier	Notes
<i>ofloxacin</i>	1	GC; MO
Sulfonamides		
<i>bleph-10</i>	1	GC; MO
<i>ocusulf-10</i>	1	GC; MO
<i>sodium sulfacetamide</i>	1	GC; MO
<i>sulfadiazine</i>	1	GC; MO
<i>sulfamethoxazole /trimethoprim suspension, tablet</i>	1	GC; MO
<i>sulfamethoxazole/trimethoprim ds</i>	1	GC; MO
<i>sulfatrim</i>	1	GC; MO
Tetracyclines		
<i>demeclocycline hcl</i>	1	GC; MO
<i>doxycycline hyclate capsule delayed release particles 75mg</i>	1	GC; MO
<i>doxycycline hyclate capsule delayed release particles 100mg</i>	1	MO GC
<i>doxycycline hyclate capsule</i>	1	GC; MO
<i>doxycycline monohydrate</i>	1	GC; MO
<i>minocycline hcl</i>	1	GC; MO
<i>minocycline hcl er</i>	1	MO GC
<i>tetracycline hcl</i>	1	GC; MO
Anticonvulsants		
Anticonvulsants, Other		
<i>levetiracetam</i>	1	GC; MO
Calcium Channel Modifying Agents		
CELONTIN	2	MO
<i>ethosuximide</i>	1	GC; MO
LYRICA CAPSULE 300MG	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #60 capsules per 30 days.
LYRICA CAPSULE 100MG, 150MG, 200MG, 225MG, 25MG, 50MG, 75MG	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #90 capsules per 30 days.
<i>zonisamide</i>	1	GC; MO
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
<i>divalproex sodium</i>	1	GC; MO
<i>gabapentin</i>	1	FF; GC; MO
GABITRIL	2	MO
<i>primidone</i>	1	GC; MO
<i>valproic acid</i>	1	GC; MO
Glutamate Reducing Agents		
FELBATOL	2	MO
<i>lamotrigine</i>	1	GC; MO
<i>topiramate</i>	1	GC; MO
Sodium Channel Inhibitors		
<i>carbamazepine er</i>	1	GC; MO
<i>carbamazepine tablet chewable, tablet</i>	1	GC; MO

Drug Name	Drug Tier	Notes
DILANTIN	2	MO
DILANTIN INFATABS	2	MO
<i>oxcarbazepine tablet</i>	1	GC; MO
<i>oxcarbazepine suspension</i>	1	MO GC
PHENYTEK	2	MO
<i>phenytoin</i>	1	GC; MO
<i>phenytoin sodium extended capsule 100mg</i>	1	GC; MO
<i>phenytoin sodium extended capsule 200mg, 300mg</i>	1	MO GC
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100MG	2	MO

Antidementia Agents

Antidementia Agents, Other

<i>ergoloid mesylates</i>	1	GC; MO
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Cholinesterase Inhibitors

ARICEPT	2	MO
ARICEPT ODT	2	MO
EXELON	2	MO
<i>galantamine hydrobromide</i>	1	GC; MO
RAZADYNE SOLUTION	2	MO

Glutamate Pathway Modifiers

NAMENDA	3	MO; Potential preferred options: ARICEPT, EXELON
NAMENDA TITRATION PAK	3	MO; Potential preferred options: ARICEPT, EXELON

Antidepressants

Antidepressants, Other

<i>budeprion sr</i>	1	FF; GC; MO
<i>budeprion xl</i>	1	GC; MO
<i>bupropion hcl</i>	1	GC; MO
<i>bupropion hcl sr tablet extended release 12 hour 100mg, 200mg</i>	1	FF; GC; MO
<i>bupropion hcl sr tablet extended release 12 hour 150mg</i>	1	GC; MO
<i>maprotiline hcl</i>	1	GC; MO
<i>mirtazapine</i>	1	GC; MO
<i>mirtazapine odt</i>	1	GC; MO
<i>nefazodone hcl</i>	1	GC; MO
<i>trazodone hcl</i>	1	GC; MO

Monoamine Oxidase Inhibitors

NARDIL	2	MO
<i>tranylcypromine sulfate</i>	1	GC; MO

Serotonin/ Norepinephrine Reuptake Inhibitors

<i>citalopram hydrobromide tablet</i>	1	FF; GC; MO
<i>citalopram hydrobromide solution</i>	1	GC; MO
CYMBALTA	3	MO; PA - Prior authorization required for coverage.
<i>fluoxetine dr</i>	1	GC; MO
<i>fluoxetine hcl capsule, tablet</i>	1	FF; GC; MO
<i>fluoxetine hcl solution</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>fluvoxamine maleate</i>	1	GC; MO
<i>paroxetine hcl</i>	1	FF; GC; MO
<i>paroxetine hcl er</i>	1	GC; MO
<i>selfemra</i>	1	GC; MO
<i>sertraline hcl tablet 25mg</i>	1	FF; GC; MO
<i>sertraline hcl tablet 100mg, 50mg</i>	1	FF; GC; MO
<i>venlafaxine hcl</i>	1	GC; MO
<i>venlafaxine hcl er</i>	1	GC; MO
Tricyclics		
<i>amitriptyline hcl</i>	1	GC; MO
<i>amoxapine</i>	1	GC; MO
<i>chlordiazepoxide /amitriptyline</i>	1	GC; MO
<i>clomipramine hcl</i>	1	GC; MO
<i>desipramine hcl</i>	1	GC; MO
<i>imipramine hcl</i>	1	GC; MO
<i>imipramine pamoate</i>	1	GC; MO
<i>nortriptyline hcl</i>	1	GC; MO
<i>protriptyline hcl</i>	1	GC; MO
<i>trimipramine maleate</i>	1	GC; MO
Antidotes, Deterrents, and Toxicologic Agents		
Antidotes		
CHEMET	2	MO
<i>sodium polystyrene sulfonate</i>	1	GC; MO
Deterrents		
ANTABUSE	2	MO
<i>budeprion xl</i>	1	GC; MO
<i>buproban</i>	1	GC; MO
CHANTIX	3	MO; Potential preferred options: budeprion SR, bupropion SR
Toxicologic Agents		
<i>depade</i>	1	GC; MO
<i>naltrexone hcl</i>	1	GC; MO
Antiemetics		
Antiemetics		
<i>compro</i>	1	GC; MO
<i>dronabinol</i>	1	GC; MO
EMEND CAPSULE 0, 125MG, 80MG	2	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
EMEND CAPSULE 40MG	2	MO; QL - Quantity limited to #4 capsules per 30 days.
<i>granisetron hcl tablet</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.

Drug Name	Drug Tier	Notes
<i>granisol</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>meclizine hcl</i>	1	GC; MO
<i>metoclopramide hcl solution, tablet</i>	1	GC; MO
<i>ondansetron hcl solution, tablet</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>ondansetron odt</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
<i>phenadoz</i>	1	GC; MO
<i>prochlorperazine</i>	1	GC; MO
<i>prochlorperazine maleate</i>	1	GC; MO
<i>promethazine hcl suppository</i>	1	GC; MO
<i>promethegan</i>	1	GC; MO
<i>trimethobenzamide hcl capsule</i>	1	GC; MO

Antifungals

Antifungals

ANCOBON	2	MO
<i>ciclopirox nail lacquer</i>	1	GC; MO
<i>ciclopirox olamine</i>	1	GC; MO
<i>ciclopirox gel, suspension</i>	1	GC; MO
<i>ciclopirox shampoo</i>	1	MO GC
<i>clotrimazole</i>	1	GC; MO
<i>clotrimazole/betamethasone dipropionate</i>	1	GC; MO
<i>econazole nitrate</i>	1	GC; MO
<i>fluconazole</i>	1	GC; MO
<i>grifulvin v</i>	1	GC; MO
<i>griseofulvin microsize</i>	1	GC; MO
<i>itraconazole</i>	1	GC; MO
<i>ketoconazole</i>	1	GC; MO
<i>kuric</i>	1	GC; MO
<i>miconazole 3</i>	1	GC; MO
NATACYN	2	MO
<i>nyamyc</i>	1	GC; MO
<i>nystatin</i>	1	GC; MO
<i>nystatin/triamcinolone</i>	1	GC; MO
<i>nystop</i>	1	GC; MO
SPORANOX SOLUTION	2	MO
<i>terbinafine hcl</i>	1	GC; MO
<i>terconazole</i>	1	GC; MO

Drug Name	Drug Tier	Notes
VFEND	2	MO
<i>zazole</i>	1	GC; MO
Antigout Agents		
<i>Antigout Agents</i>		
<i>allopurinol</i>	1	GC; MO
COLCRYS	2	MO
<i>probenecid</i>	1	GC; MO
<i>probenecid/colchicine</i>	1	GC; MO
Antimigraine Agents		
<i>Abortive</i>		
ERGOMAR	2	MO
<i>ergotamine tartrate/caffeine</i>	1	GC; MO
MAXALT	2	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #12 tablets per 30 days.
MAXALT-MLT	2	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #12 tablets per 30 days.
<i>migergot</i>	1	GC; MO
MIGRANAL	2	MO
RELPAX	2	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #12 tablets per 30 days.
<i>sumatriptan</i>	1	GC; MO; QL - Quantity limited to #6 canisters per 30 days.
<i>sumatriptan succinate tablet</i>	1	GC; MO; QL - Quantity limited to #12 tablets per 30 days.
<i>sumatriptan succinate injection 6mg/0.5ml</i>	1	GC; MO; QL - Quantity limited to #3ml (6 injections) per 30 days.
<i>sumatriptan succinate injection 4mg/0.5ml</i>	1	GC; MO; QL - Quantity limited to #4ml (8 injections) per 30 days.
ZOMIG ZMT	2	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #12 tablets per 30 days.
ZOMIG TABLET	2	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #12 tablets per 30 days.
ZOMIG SOLUTION	2	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #6 canisters per 30 days.
<i>Prophylactic</i>		
<i>divalproex sodium</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>propranolol hcl er</i>	1	GC; MO
<i>propranolol hcl tablet</i>	1	GC; MO
<i>timolol maleate</i>	1	GC; MO
Antimyasthenic Agents		
Parasympathomimetics		
<i>guanidine hcl</i>	1	GC; MO
<i>pyridostigmine bromide</i>	1	GC; MO
Antimycobacterials		
Antimycobacterials, Other		
<i>dapsone</i>	1	GC; MO
MYCOBUTIN	2	MO
Antituberculars		
<i>ethambutol hcl</i>	1	GC; MO
<i>isonarif</i>	1	GC; MO
<i>isoniazid syrup, tablet</i>	1	GC; MO
<i>pyrazinamide</i>	1	GC; MO
<i>rifampin capsule</i>	1	GC; MO
SEROMYCIN	2	MO
Antineoplastics		
Alkylating Agents		
CEENU	2	MO
<i>cyclophosphamide tablet</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
HEXALEN	2	MO
LEUKERAN	2	MO
Antiangiogenic Agents		
REVLIMID	5	LA; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #30 capsules per 30 days.
THALOMID	5	MO
Antiestrogens/Modifiers		
FARESTON	2	MO
<i>tamoxifen citrate</i>	1	GC; MO
Antimetabolites		
<i>allopurinol</i>	1	GC; MO
DROXIA	2	MO
<i>mercaptopurine</i>	1	GC; MO
TABLOID	2	MO
Antineoplastics, Other		
<i>hydroxyurea</i>	1	GC; MO
<i>leucovorin calcium</i>	1	GC; MO
MATULANE	2	MO
MESNEX TABLET	2	MO
Aromatase Inhibitors, 3rd Generation		
ARIMIDEX	2	MO

Drug Name	Drug Tier	Notes
AROMASIN	2	MO
FEMARA	2	MO
<i>Molecular Target Inhibitors</i>		
GLEEVEC	5	MO; PA - Prior authorization required for coverage.
NEXAVAR	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #120 tablets per 30 days.
SPRYCEL TABLET 20MG, 50MG, 70MG	5	MO; PA - Prior authorization required for coverage.
SUTENT CAPSULE 25MG, 50MG	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #30 capsules per 30 days.
SUTENT CAPSULE 12.5MG	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #60 capsules per 30 days.
TARCEVA	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited up to 150mg per day.
<i>Retinoids</i>		
TARGRETIN CAPSULE	3	MO
<i>tretinoin</i>	1	GC; MO
Antiparasitics		
<i>Anthelmintics</i>		
ALBENZA	2	MO
BILTRICIDE	2	MO
<i>mebendazole</i>	1	GC; MO
STROMECTOL	2	MO
<i>Antiprotozoals</i>		
ALINIA	2	MO
<i>chloroquine phosphate</i>	1	GC; MO
COARTEM	2	MO
DARAPRIM	2	MO
FANSIDAR	2	MO
<i>hydroxychloroquine sulfate</i>	1	GC; MO
<i>mefloquine hcl</i>	1	GC; MO
MEPRON	2	MO
PRIMAQUINE PHOSPHATE	2	MO
<i>Pediculicides/ Scabicides</i>		
<i>acticin</i>	1	GC; MO
EURAX	2	MO
<i>lindane</i>	1	GC; MO
<i>malathion</i>	1	GC; MO
OVIDE	2	MO

Drug Name	Drug Tier	Notes
<i>permethrin</i>	1	GC; MO
Antiparkinson Agents		
Antiparkinson Agents		
<i>amantadine hcl tablet</i>	1	GC; MO
<i>amantadine hcl syrup</i>	1	MO GC
APOKYN	5	MO
<i>atamet</i>	1	GC; MO
<i>benztropine mesylate tablet</i>	1	GC; MO
<i>bromocriptine mesylate</i>	1	GC; MO
<i>carbidopa/levodopa</i>	1	GC; MO
<i>carbidopa/levodopa cr</i>	1	GC; MO
<i>carbidopa/levodopa odt</i>	1	GC; MO
<i>carbidopa/levodopa sr</i>	1	GC; MO
COMTAN	2	MO
MIRAPEX	2	MO
<i>pramipexole dihydrochloride</i>	1	MO GC
<i>ropinirole hcl</i>	1	GC; MO
<i>selegiline hcl</i>	1	GC; MO
STALEVO 100	2	MO
STALEVO 125	2	MO
STALEVO 150	2	MO
STALEVO 200	2	MO
STALEVO 50	2	MO
STALEVO 75	2	MO
<i>trihexyphenidyl hcl</i>	1	GC; MO
Antipsychotics		
Atypicals		
ABILIFY TABLET	2	MO
<i>clozapine</i>	1	GC; MO
<i>risperidone</i>	1	GC; MO
<i>risperidone odt tablet dispersible 0.25mg, 0.5mg, 2mg</i>	1	GC; MO
<i>risperidone odt tablet dispersible 1mg</i>	1	MO GC
SEROQUEL	2	MO
SEROQUEL XR	2	MO
ZYPREXA RELPREVV	4	MO
ZYPREXA ZYDIS	2	MO
ZYPREXA TABLET	2	MO
Conventional		
<i>chlorpromazine hcl tablet</i>	1	GC; MO
<i>clozapine</i>	1	GC; MO
<i>fluphenazine hcl concentrate, elixir, tablet</i>	1	GC; MO
<i>haloperidol</i>	1	GC; MO
<i>loxapine succinate</i>	1	GC; MO
MOBAN	2	MO
ORAP	2	MO
<i>perphenazine</i>	1	GC; MO
<i>perphenazine /amitriptyline</i>	1	GC; MO
<i>thioridazine hcl</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>thiothixene</i>	1	GC; MO
<i>trifluoperazine hcl</i>	1	GC; MO
Antispasticity Agents		
Antispasticity Agents		
<i>orphenadrine citrate er</i>	1	GC; MO
<i>tizanidine hcl</i>	1	GC; MO
Antivirals		
Anti-cytomegalovirus (CMV) Agents		
<i>ganciclovir</i>	1	GC; MO
VALCYTE	3	MO
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors		
RESCRIPTOR	2	MO
SUSTIVA	2	MO
VIRAMUNE	2	MO
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors		
ATRIPLA	5	MO
COMBIVIR	5	MO
<i>didanosine</i>	1	GC; MO
EMTRIVA	2	MO
EPIVIR	2	MO
EPIVIR HBV	2	MO
EPZICOM	5	MO
<i>stavudine</i>	1	GC; MO
TRIZIVIR	5	MO
TRUVADA	5	MO
VIDEX PEDIATRIC	2	MO
VIREAD	2	MO
ZIAGEN	2	MO
<i>zidovudine</i>	1	GC; MO
Anti-HIV Agents, Other		
FUZEON	5	MO
ISENTRESS	5	MO
SELZENTRY	5	MO
Anti-HIV Agents, Protease Inhibitors		
CRIXIVAN	2	MO
INVIRASE	2	MO
KALETRA	2	MO
LEXIVA SUSPENSION	2	MO
LEXIVA TABLET	5	MO
NORVIR CAPSULE	2	MO
NORVIR SOLUTION	5	MO
PREZISTA TABLET 75MG	2	MO
PREZISTA TABLET 400MG, 600MG	5	MO
REYATAZ CAPSULE 100MG, 150MG	2	MO
REYATAZ CAPSULE 200MG, 300MG	5	MO
VIRACEPT POWDER	2	MO

Drug Name	Drug Tier	Notes
VIRACEPT TABLET	5	MO
Anti-influenza Agents		
<i>amantadine hcl</i>	1	GC; MO
<i>rimantadine hcl</i>	1	GC; MO
TAMIFLU	2	MO
Antihepatitis Agents		
BARACLUDE	2	MO
HEPSERA	2	MO
<i>ribapak</i>	1	GC; MO
<i>ribasphere</i>	1	GC; MO
<i>ribavirin</i>	1	GC; MO
Antiherpetic Agents		
<i>acyclovir capsule, tablet</i>	1	FF; GC; MO
<i>acyclovir suspension</i>	1	GC; MO
<i>famciclovir</i>	1	GC; MO
<i>trifluridine</i>	1	GC; MO
<i>valacyclovir hcl</i>	1	MO GC
VALTREX	2	MO
Anxiolytics		
Antidepressants		
<i>doxepin hcl</i>	1	GC; MO
<i>paroxetine hcl tablet</i>	1	FF; GC; MO
<i>paroxetine hcl suspension</i>	1	GC; MO
<i>sertraline hcl concentrate</i>	1	GC; MO
Anxiolytics, Other		
<i>bupirone hcl</i>	1	GC; MO
<i>meprobamate</i>	1	GC; MO
Bipolar Agents		
Bipolar Agents		
ABILIFY DISCMELT	2	MO
ABILIFY SOLUTION, TABLET	2	MO
<i>carbamazepine suspension 100mg/5ml</i>	1	GC; MO
CARBATROL	2	MO
GEODON	2	MO
<i>lithium carbonate</i>	1	GC; MO
<i>lithium carbonate er tablet extended release 450mg</i>	1	GC; MO
<i>lithium carbonate er tablet extended release 300mg</i>	1	GC; MO
<i>lithium citrate</i>	1	GC; MO
<i>risperidone odt</i>	1	GC; MO
Blood Glucose Regulators		
Antidiabetic Agents		
<i>acarbose</i>	1	GC; MO
ACTOPLUS MET	2	MO; PA - Prior authorization required for coverage.
ACTOS	2	MO; PA - Prior authorization required for coverage.
AVANDIA	2	MO; PA - Prior authorization required for coverage.

Drug Name	Drug Tier	Notes
<i>chlorpropamide</i>	1	GC; MO
DUETACT	2	MO; PA - Prior authorization required for coverage.
<i>glimepiride</i>	1	GC; MO
<i>glipizide</i>	1	FF; GC; MO
<i>glipizide er</i>	1	FF; GC; MO
<i>glipizide xl</i>	1	FF; GC; MO
<i>glipizide/metformin hcl</i>	1	GC; MO
<i>glyburide</i>	1	FF; GC; MO
<i>glyburide micronized</i>	1	GC; MO
<i>glyburide/metformin hcl</i>	1	GC; MO
<i>glycron</i>	1	GC; MO
<i>metformin hcl</i>	1	FF; GC; MO
<i>metformin hcl er</i>	1	FF; GC; MO
<i>nateglinide</i>	1	MO GC
PRANDIN	2	MO
<i>tolazamide</i>	1	GC; MO
<i>tolbutamide</i>	1	GC; MO
Glycemic Agents		
GLUCAGEN HYPOKIT	2	MO
GLUCAGON EMERGENCY KIT	2	MO
PROGLYCEM	2	MO
Insulins		
HUMALOG	2	MO
HUMALOG MIX 50/50	2	MO
HUMALOG MIX 50/50 KWIKPEN	2	MO
HUMALOG MIX 50/50 PEN	2	MO
HUMALOG MIX 75/25	2	MO
HUMALOG MIX 75/25 KWIKPEN	2	MO
HUMALOG MIX 75/25 PEN	2	MO
HUMALOG PEN	2	MO
HUMULIN 50/50	2	MO
HUMULIN 70/30	2	MO
HUMULIN 70/30 PEN	2	MO
HUMULIN N	2	MO
HUMULIN N U-100 PEN	2	MO
HUMULIN R	2	MO
HUMULIN R U-500 (CONCENTRATED)	2	MO
LANTUS	2	MO
LANTUS FOR OPTICLIK	2	MO
LANTUS SOLOSTAR	2	MO
NOVOLIN 70/30	2	MO
NOVOLIN 70/30 INNOLET	2	MO
NOVOLIN N	2	MO
NOVOLIN N INNOLET	2	MO
NOVOLIN R	2	MO
NOVOLIN R INNOLET	2	MO
NOVOLOG	2	MO

Drug Name	Drug Tier	Notes
NOVOLOG FLEXPEN	2	MO
NOVOLOG MIX 70/30	2	MO
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	2	MO
NOVOLOG PENFILL	2	MO
RELION 70/30	2	MO
RELION N	2	MO
RELION R	2	MO
Blood Products/Modifiers/ Volume Expanders		
Anticoagulants		
ARIXTRA INJECTION 2.5MG/0.5ML	4	MO
ARIXTRA INJECTION 10MG/0.8ML, 5MG/0.4ML, 7.5MG/0.6ML	5	MO
FRAGMIN INJECTION 2500UNIT/0.2ML, 5000UNIT/0.2ML	4	MO
FRAGMIN INJECTION 10000UNIT/ML, 25000UNIT/ML, 7500UNIT/0.3ML	5	MO
<i>heparin sodium</i>	4	HI
<i>heparin sodium dcu</i>	4	HI
<i>heparin sodium/nacl 0.9%</i>	4	HI
<i>jantoven</i>	1	GC; MO
LOVENOX INJECTION 30MG/0.3ML, 40MG/0.4ML	4	MO
LOVENOX INJECTION 100MG/ML, 120MG/0.8ML, 150MG/ML, 300MG/3ML, 60MG/0.6ML, 80MG/0.8ML	5	MO
<i>warfarin sodium</i>	1	GC; MO
Blood Formation Products		
ARANESP ALBUMIN FREE INJECTION 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML	4	MO
ARANESP ALBUMIN FREE INJECTION 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML	5	MO
EPOGEN INJECTION 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	MO
EPOGEN INJECTION 10000UNIT/ML, 20000UNIT/ML, 40000UNIT/ML	5	MO
LEUKINE	5	HI
NEUPOGEN	5	MO
PROCRIT INJECTION 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	MO
PROCRIT INJECTION 20000UNIT/ML, 40000UNIT/ML	5	MO
Coagulants		
<i>aminocaproic acid syrup, tablet</i>	1	GC; MO
<i>aminocaproic acid injection</i>	4	MO
Platelet Aggregation Inhibitors		
AGGRENOX	3	MO; Potential preferred options: cilostazol, dipyridamole + ticlopidine, PLAVIX 75mg

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

Drug Name	Drug Tier	Notes
INNOPRAN XL	2	MO
<i>labetalol hcl tablet</i>	1	GC; MO
<i>metoprolol /hydrochlorothiazide</i>	1	GC; MO
<i>metoprolol succinate er</i>	1	GC; MO
<i>metoprolol tartrate tablet</i>	1	FF; GC; MO
<i>nadolol</i>	1	GC; MO
<i>nadolol /bendroflumethiazide</i>	1	GC; MO
<i>pindolol</i>	1	GC; MO
<i>propranolol /hydrochlorothiazide</i>	1	GC; MO
<i>propranolol hcl er</i>	1	GC; MO
<i>propranolol hcl solution, tablet</i>	1	GC; MO
<i>timolol maleate</i>	1	GC; MO
Calcium Channel Blocking Agents		
<i>afeditab cr</i>	1	GC; MO
<i>amlodipine besylate</i>	1	GC; MO
<i>cartia xt</i>	1	GC; MO
<i>dilt-cd</i>	1	GC; MO
<i>dilt-xr</i>	1	GC; MO
<i>diltiazem cd</i>	1	GC; MO
<i>diltiazem hcl er</i>	1	GC; MO
<i>diltiazem hcl tablet</i>	1	GC; MO
<i>diltzac</i>	1	GC; MO
<i>felodipine er</i>	1	FF; GC; MO
<i>isradipine</i>	1	GC; MO
LOTREL	3	MO; Potential preferred option: amlodipine besylate/benazepril
<i>nicardipine hcl capsule</i>	1	GC; MO
<i>nifediac cc</i>	1	GC; MO
<i>nifedical xl</i>	1	GC; MO
<i>nifedipine</i>	1	GC; MO
<i>nifedipine er</i>	1	GC; MO
<i>nimodipine</i>	1	GC; MO
<i>nisoldipine</i>	1	GC; MO
SULAR	2	MO
<i>taztia xt</i>	1	GC; MO
Cardiovascular Agents, Other		
<i>digoxin solution, tablet</i>	1	GC; MO
<i>reserpine</i>	1	GC; MO
Diuretics		
<i>acetazolamide</i>	1	GC; MO
<i>amiloride /hydrochlorothiazide</i>	1	GC; MO
<i>amiloride hcl</i>	1	GC; MO
<i>bumetanide tablet</i>	1	GC; MO
<i>chlorothiazide</i>	1	GC; MO
<i>chlorthalidone</i>	1	GC; MO
<i>furosemide solution, tablet</i>	1	GC; MO
<i>hydrochlorothiazide capsule</i>	1	GC; MO
<i>hydrochlorothiazide tablet 25mg</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>hydrochlorothiazide tablet 12.5mg, 50mg</i>	1	GC; MO
<i>indapamide</i>	1	GC; MO
<i>methazolamide</i>	1	GC; MO
<i>methyclothiazide</i>	1	GC; MO
<i>methyl dopa /hydrochlorothiazide</i>	1	GC; MO
<i>metolazone</i>	1	GC; MO
<i>quinapril /hydrochlorothiazide</i>	1	GC; MO
<i>spironolactone</i>	1	GC; MO
<i>spironolactone /hydrochlorothiazide</i>	1	GC; MO
<i>toremide tablet 5mg</i>	1	GC; MO
<i>toremide tablet 10mg</i>	1	GC; MO
<i>toremide tablet 100mg, 20mg</i>	1	GC; MO
<i>triamterene /hydrochlorothiazide</i>	1	GC; MO
Dyslipidemics		
<i>cholestyramine</i>	1	GC; MO
<i>cholestyramine light</i>	1	GC; MO
<i>colestipol hcl</i>	1	GC; MO
CRESTOR	2	MO; PA - Prior authorization required for coverage.
<i>fenofibrate</i>	1	FF; GC; MO
<i>fenofibrate micronized</i>	1	FF; GC; MO
<i>gemfibrozil</i>	1	FF; GC; MO
<i>lofibra</i>	1	FF; GC; MO
<i>lovastatin</i>	1	FF; GC; MO
NIASPAN	2	MO
<i>pravastatin sodium</i>	1	GC; MO
<i>prevalite</i>	1	GC; MO
<i>simvastatin</i>	1	FF; GC; MO
TRICOR	3	MO; Potential preferred options: fenofibrate, gemfibrozil
ZETIA	3	MO; Potential preferred options: lovastatin, pravastatin sodium, simvastatin, CRESTOR
Renin-angiotensin-aldosterone System Inhibitors		
<i>amlodipine besylate/benazepril hydrochloride</i>	1	GC; MO
<i>benazepril hcl</i>	1	FF; GC; MO
<i>benazepril hcl/hydrochlorothiazide</i>	1	GC; MO
BENICAR	2	MO; PA - Prior authorization required for coverage.
BENICAR HCT	2	MO; PA - Prior authorization required for coverage.
<i>captopril</i>	1	GC; MO
<i>captopril /hydrochlorothiazide</i>	1	GC; MO
<i>enalapril maleate</i>	1	FF; GC; MO
<i>enalapril maleate/hydrochlorothiazide</i>	1	GC; MO
<i>eprenone</i>	1	GC; MO
<i>fosinopril sodium</i>	1	GC; MO
<i>fosinopril sodium/hydrochlorothiazide</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>lisinopril /hydrochlorothiazide</i>	1	FF; GC; MO
<i>lisinopril tablet 5mg</i>	1	FF; GC; MO
<i>lisinopril tablet 10mg, 2.5mg, 20mg, 30mg, 40mg</i>	1	FF; GC; MO
<i>losartan potassium</i>	1	GC; MO; PA - Prior authorization required for coverage.
<i>losartan potassium/hydrochlorothiazide</i>	1	GC; MO; PA - Prior authorization required for coverage.
LOTREL	3	MO; Potential preferred option: amlodipine besylate/benazepril
MICARDIS	2	MO; PA - Prior authorization required for coverage.
MICARDIS HCT	2	MO; PA - Prior authorization required for coverage.
<i>moexipril /hydrochlorothiazide</i>	1	GC; MO
<i>moexipril hcl</i>	1	GC; MO
<i>perindopril erbumine</i>	1	MO GC
<i>quinapril hcl</i>	1	GC; MO
<i>quinaretic</i>	1	GC; MO
<i>ramipril</i>	1	GC; MO
<i>trandolapril</i>	1	GC; MO
Vasodilators		
<i>hydralazine hcl tablet</i>	1	GC; MO
<i>isosorbide dinitrate</i>	1	GC; MO
<i>isosorbide dinitrate er</i>	1	GC; MO
<i>isosorbide mononitrate</i>	1	GC; MO
<i>isosorbide mononitrate er</i>	1	GC; MO
<i>minitran</i>	1	GC; MO
<i>minoxidil</i>	1	GC; MO
<i>nitroglycerin transdermal</i>	1	GC; MO
<i>nitroglycerin patch 24 hour, tablet sublingual</i>	1	GC; MO
Central Nervous System Agents		
Amphetamines, ADHD		
ADDERALL XR	2	MO
<i>amphetamine /dextroamphetamine</i>	1	GC; MO
<i>dextroamphetamine sulfate</i>	1	GC; MO
<i>dextroamphetamine sulfate er</i>	1	GC; MO
VYVANSE	2	MO
Non-amphetamines, ADHD		
<i>dexmethylphenidate hcl</i>	1	GC; MO
METADATE CD	2	MO
<i>methylin er</i>	1	GC; MO
<i>methylin solution, tablet</i>	1	GC; MO
<i>methylin tablet chewable 2.5mg</i>	1	GC; MO
<i>methylin tablet chewable 5mg</i>	1	GC; MO
<i>methylin tablet chewable 10mg</i>	1	GC; MO
<i>methylphenidate hcl</i>	1	GC; MO
<i>methylphenidate hcl sr</i>	1	GC; MO

Drug Name	Drug Tier	Notes
Non-amphetamines, Other		
RILUTEK	2	MO
Dental and Oral Agents		
Dental and Oral Agents		
<i>chlorhexidine gluconate oral rinse</i>	1	GC; MO
<i>doxycycline hyclate</i>	1	GC; MO
EVOXAC	2	MO
<i>minocycline hcl capsule</i>	1	GC; MO
<i>minocycline hcl tablet 75mg</i>	1	GC; MO
<i>minocycline hcl tablet 50mg</i>	1	GC; GC; MO
<i>minocycline hcl tablet 75mg</i>	1	GC; GC; MO
<i>minocycline hcl tablet 100mg</i>	1	GC; GC; MO
<i>minocycline hcl tablet 50mg</i>	1	GC; MO
<i>minocycline hcl tablet 100mg</i>	1	GC; MO
<i>periogard</i>	1	GC; MO
<i>pilocarpine hcl</i>	1	GC; MO
<i>pilocarpine hydrochloride</i>	1	GC; MO
<i>triamcinolone in orabase</i>	1	GC; MO
Dermatological Agents		
Dermatological Agents		
8-MOP	2	MO
<i>alclometasone dipropionate</i>	1	GC; MO
<i>amcinonide</i>	1	GC; MO
<i>ammonium lactate</i>	1	GC; MO
<i>amnesteam</i>	1	GC; MO
<i>augmented betamethasone dipropionate</i>	1	GC; MO
AZELEX	2	MO
<i>benzoyl peroxide wash</i>	1	GC; MO
<i>benzoyl peroxide gel 10%, 5%, 2.5%</i>	1	GC; MO
<i>beta-val</i>	1	GC; MO
<i>betamethasone dipropionate</i>	1	GC; MO
<i>betamethasone valerate</i>	1	GC; MO
<i>calcipotriene</i>	1	GC; MO
CAPEX	2	MO
CARAC	2	MO
<i>claravis</i>	1	GC; MO
<i>clindamycin phosphate</i>	1	GC; MO
<i>clindamycin/benzoyl peroxide</i>	1	GC; MO
<i>clobetasol propionate</i>	1	GC; MO
<i>clobetasol propionate e</i>	1	GC; MO
CLODERM	2	MO
<i>clotrimazole/betamethasone dipropionate</i>	1	GC; MO
CORDRAN	2	MO
CORDRAN SP	2	MO
CORDRAN TAPE	2	MO
<i>del-beta</i>	1	GC; MO
DERMA-SMOOTHIE/FS BODY OIL	2	MO
<i>desonide</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>desoximetasone</i>	1	GC; MO
DIFFERIN	2	MO
<i>diflorasone diacetate</i>	1	GC; MO
DOVONEX CREAM	2	MO
<i>doxepin hcl</i>	1	GC; MO
<i>doxycycline monohydrate</i>	1	GC; MO
<i>erythromycin/benzoyl peroxide</i>	1	GC; MO
<i>fluocinolone acetonide</i>	1	GC; MO
<i>fluocinonide</i>	1	GC; MO
<i>fluocinonide emollient base</i>	1	GC; MO
FLUOROPLEX	2	MO
<i>fluorouracil</i>	1	GC; MO
<i>fluticasone propionate</i>	1	GC; MO
<i>halobetasol propionate</i>	1	GC; MO
<i>hydrocortisone</i>	1	GC; MO
<i>hydrocortisone butyrate</i>	1	GC; MO
<i>hydrocortisone in absorbbase</i>	1	GC; MO
<i>hydrocortisone valerate</i>	1	GC; MO
<i>imiquimod</i>	1	MO GC
LUXIQ	2	MO
<i>mometasone furoate</i>	1	GC; MO
<i>nystatin/triamcinolone</i>	1	GC; MO
OXSORALEN	2	MO
OXSORALEN ULTRA	2	MO
<i>podofilox</i>	1	GC; MO
<i>prednicarbate</i>	1	GC; MO
RETIN-A MICRO	2	MO; PA - Prior authorization required for coverage.
<i>selenium sulfide</i>	1	GC; MO
SORIATANE CK	5	MO
<i>sotret</i>	1	GC; MO
TAZORAC	2	MO
<i>tretinoin</i>	1	GC; MO; PA - Prior authorization required for coverage.
<i>triamcinolone acetonide</i>	1	GC; MO
<i>triamcinolone acetonide in absorbbase</i>	1	GC; MO
<i>triderm</i>	1	GC; MO
<i>urea</i>	1	GC; MO
<i>urea nail</i>	1	GC; MO
<i>urea nailstik</i>	1	GC; MO

Enzyme Replacements/ Modifiers

Enzyme Replacements/ Modifiers

BUPHENYL	2	MO
CREON	2	MO
CYSTADANE	2	MO
<i>lipram-ul12</i>	1	GC; MO
<i>lipram-ul18</i>	1	GC; MO
<i>lipram-ul20</i>	1	GC; MO

Drug Name	Drug Tier	Notes
PANCREASE MT 10	2	MO
PANCREASE MT 16	2	MO
PANCREASE MT 20	2	MO
PANCREASE MT 4	2	MO
PANCRECARB MS-16	2	MO
PANCRECARB MS-4	2	MO
PANCRECARB MS-8	2	MO
ULTRASE	2	MO
ULTRASE MT 12	2	MO
ULTRASE MT 18	2	MO
ULTRASE MT 20	2	MO
VIOKASE 16	2	MO

Gastrointestinal Agents

Antispasmodics, Gastrointestinal

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

Gastrointestinal Agents, Other

<i>diphenoxylate/atropine</i>	1	GC; MO
<i>gavilyte-c</i>	1	MO GC
<i>gavilyte-g</i>	1	GC; MO
<i>gavilyte-n/flipack</i>	1	MO GC
<i>generlac</i>	1	GC; MO
KRISTALOSE	2	MO
<i>lactulose</i>	1	GC; MO
<i>lonox</i>	1	GC; MO
<i>loperamide hcl</i>	1	GC; MO
<i>peg 3350/electrolytes</i>	1	GC; MO
<i>polyethylene glycol 3350</i>	1	MO GC
<i>trilyte</i>	1	GC; MO
<i>ursodiol</i>	1	GC; MO

Histamine2 (H2) Blocking Agents

<i>cimetidine</i>	1	GC; MO
<i>cimetidine hcl solution</i>	1	GC; MO
<i>famotidine tablet</i>	1	GC; MO
<i>nizatidine capsule</i>	1	GC; MO
<i>nizatidine solution</i>	1	MO GC
<i>ranitidine hcl capsule, syrup, tablet</i>	1	GC; MO

Irritable Bowel Syndrome Agents

LOTRONEX	3	MO
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Protectants

<i>misoprostol</i>	1	GC; MO
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Drug Name	Drug Tier	Notes
<i>sucralfate</i>	1	GC; MO
Proton Pump Inhibitors		
DEXILANT	2	MO; PA - Prior authorization required for coverage.
KAPIDEX	2	MO; PA - Prior authorization required for coverage.
<i>lansoprazole</i>	1	MO; PA - Prior authorization required for coverage.
<i>omeprazole capsule delayed release 10mg, 20mg</i>	1	FF; GC; MO
<i>omeprazole capsule delayed release 40mg</i>	1	GC; MO
<i>pantoprazole sodium</i>	1	GC; MO
PREVACID SOLUTAB	2	MO; PA - Prior authorization required for coverage.
PREVACID CAPSULE DELAYED RELEASE 30MG	2	MO; PA - Prior authorization required for coverage.
PREVACID CAPSULE DELAYED RELEASE 15MG	2	MO; PA - Prior authorization required for coverage.
PREVPAC	2	MO
Genitourinary Agents		
Antispasmodics, Urinary		
DETROL LA	2	MO
<i>flavoxate hcl</i>	1	GC; MO
<i>oxybutynin chloride er</i>	1	GC; MO
<i>oxybutynin chloride tablet</i>	1	FF; GC; MO
<i>oxybutynin chloride syrup</i>	1	GC; MO
VESICARE	3	MO; Potential preferred options: oxybutynin, oxybutynin chloride ER tablet, DETROL LA
Benign Prostatic Hypertrophy Agents		
AVODART	2	MO
<i>doxazosin mesylate</i>	1	FF; GC; MO
<i>finasteride</i>	1	GC; MO
FLOMAX	3	MO
<i>prazosin hcl</i>	1	GC; MO
<i>tamsulosin hcl</i>	1	MO GC
<i>terazosin hcl</i>	1	GC; MO
UROXATRAL	2	MO
Genitourinary Agents, Other		
<i>bethanechol chloride</i>	1	GC; MO
ELMIRON	2	MO
Phosphate Binders		
<i>calcium acetate</i>	1	GC; MO
ELIPHOS	2	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
Glucocorticoids/ Mineralocorticoids		
<i>alclometasone dipropionate</i>	1	GC; MO
<i>augmented betamethasone dipropionate</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>betamethasone valerate</i>	1	GC; MO
<i>clobetasol propionate</i>	1	GC; MO
<i>cortisone acetate</i>	1	GC; MO
<i>desonide</i>	1	GC; MO
<i>dexamethasone</i>	1	GC; MO
DEXAMETHASONE INTENSOL	2	MO
<i>fludrocortisone acetate</i>	1	GC; MO
<i>hydrocortisone</i>	1	GC; MO
<i>hydrocortisone butyrate</i>	1	GC; MO
<i>methylprednisolone</i>	1	GC; MO
PEDIAPRED	2	MO
<i>prednisolone sodium phosphate</i>	1	GC; MO
<i>prednisone</i>	1	GC; MO
PREDNISONE INTENSOL	2	MO
<i>sterapred 12 day</i>	1	GC; MO
<i>sterapred ds 12 day</i>	1	GC; MO
<i>triamcinolone acetonide</i>	1	GC; MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</i>		
<i>desmopressin acetate solution, tablet</i>	1	GC; MO
NUTROPIN	5	MO; PA - Prior authorization required for coverage.
NUTROPIN AQ	5	MO; PA - Prior authorization required for coverage.
NUTROPIN AQ PEN	5	MO; PA - Prior authorization required for coverage.
SAIZEN	5	MO; PA - Prior authorization required for coverage.
SAIZEN CLICK.EASY	5	MO; PA - Prior authorization required for coverage.
STIMATE	2	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)		
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)</i>		
<i>misoprostol</i>	1	GC; MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
<i>Anabolic Steroids</i>		
ANADROL-50	3	MO
<i>oxandrolone</i>	1	GC; MO
<i>Androgens</i>		
<i>danazol</i>	1	GC; MO
METHITEST	2	MO
TESTRED	2	MO

Drug Name	Drug Tier	Notes
Estrogens		
ALORA	2	MO
<i>apri</i>	1	GC; MO
<i>aranelle</i>	1	GC; MO
<i>aviane</i>	1	GC; MO
<i>brevicon-28</i>	1	GC; MO
CENESTIN	2	MO
<i>cryselle-28</i>	1	GC; MO
DIVIGEL	2	MO
<i>enpresse-28</i>	1	GC; MO
ESTRADERM	2	MO
<i>estradiol/norethindrone acetate</i>	1	GC; MO
<i>estradiol tablet</i>	1	FF; GC; MO
<i>estradiol patch weekly</i>	1	GC; MO
ESTROGEL	2	MO
<i>estropipate</i>	1	GC; MO
<i>junel 1.5/30</i>	1	GC; MO
<i>junel 1/20</i>	1	GC; MO
<i>junel fe 1.5/30</i>	1	GC; MO
<i>junel fe 1/20</i>	1	GC; MO
<i>kariva</i>	1	GC; MO
<i>kelnor 1/35</i>	1	GC; MO
<i>leena</i>	1	GC; MO
<i>lessina-28</i>	1	GC; MO
<i>levora 0.15/30-28</i>	1	GC; MO
LOESTRIN FE 1.5/30	2	MO
LOESTRIN FE 1/20	2	MO
LOSEASONIQUE	2	MO
<i>low-ogestrel</i>	1	GC; MO
<i>lutra</i>	1	GC; MO
<i>menest</i>	1	GC; MO
<i>microgestin 1.5/30</i>	1	GC; MO
<i>microgestin 1/20</i>	1	GC; MO
<i>microgestin fe</i>	1	GC; MO
<i>microgestin fe 1.5/30</i>	1	GC; MO
<i>mononessa</i>	1	GC; MO
<i>necon 0.5/35-28</i>	1	GC; MO
<i>necon 1/35-28</i>	1	GC; MO
<i>necon 1/50-28</i>	1	GC; MO
<i>necon 10/11-28</i>	1	GC; MO
<i>necon 7/7/7</i>	1	GC; MO
NORDETTE-28	2	MO
NORINYL 1+35	2	MO
<i>nortrel 0.5/35 (28)</i>	1	GC; MO
<i>nortrel 1/35 (21)</i>	1	GC; MO
<i>nortrel 1/35 (28)</i>	1	GC; MO
<i>nortrel 7/7/7</i>	1	GC; MO
ORTHO EVRA	2	MO

Drug Name	Drug Tier	Notes
ORTHO TRI-CYCLEN LO	2	MO
<i>portia-28</i>	1	GC; MO
PREMARIN W/APPLICATOR	2	MO
PREMARIN TABLET	2	MO
PREMPHASE	2	MO
PREMPRO	2	MO
<i>previfem</i>	1	GC; MO
<i>quasense</i>	1	GC; MO
<i>reclipsen</i>	1	GC; MO
<i>sprintec 28</i>	1	GC; MO
<i>sronyx</i>	1	GC; MO
<i>tri-legest fe</i>	1	GC; MO
TRI-NORINYL 28	2	MO
<i>tri-previfem</i>	1	GC; MO
<i>tri-sprintec</i>	1	GC; MO
<i>trinessa</i>	1	GC; MO
<i>trivora-28</i>	1	GC; MO
VAGIFEM	2	MO
<i>velivet</i>	1	GC; MO
VIVELLE-DOT	2	MO
<i>zovia 1/35e</i>	1	GC; MO
<i>zovia 1/50e</i>	1	GC; MO
Progestins		
<i>camila</i>	1	GC; MO
<i>cesia</i>	1	GC; MO
DESOGEN	2	MO
<i>errin</i>	1	GC; MO
FEMHRT 1/5	2	MO
FEMHRT LOW DOSE	2	MO
<i>jolivette</i>	1	GC; MO
LO/OVRAL-28	2	MO
LOESTRIN 1.5/30-21	2	MO
LOESTRIN 1/20-21	2	MO
LOESTRIN 24 FE	2	MO
<i>medroxyprogesterone acetate tablet</i>	1	GC; MO
<i>megestrol acetate</i>	1	GC; MO
MODICON-28	2	MO
<i>next choice tablet 0.75mg</i>	1	GC; MO
NOR-QD	2	MO
<i>nora-be</i>	1	GC; MO
<i>norethindrone acetate</i>	1	GC; MO
<i>ocella</i>	1	GC; MO
<i>ogestrel</i>	1	GC; MO
ORTHO MICRONOR	2	MO
ORTHO-CEPT-28	2	MO
ORTHO-CYCLEN	2	MO
ORTHO-NOVUM 7/7/7-28	2	MO
<i>solia</i>	1	GC; MO

Drug Name	Drug Tier	Notes
Selective Estrogen Receptor Modifying Agents		
EVISTA	2	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
ARMOUR THYROID	2	MO
LEVOTHROID	2	MO
<i>levothyroxine sodium</i>	1	FF; GC; MO
LEVOXYL	2	MO
<i>liothyronine sodium tablet</i>	1	GC; MO
SYNTHROID	2	MO
THYROLAR-1	2	MO
THYROLAR-1/2	2	MO
THYROLAR-1/4	2	MO
THYROLAR-2	2	MO
THYROLAR-3	2	MO
<i>unithroid</i>	1	GC; MO
Hormonal Agents, Suppressant (Adrenal)		
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	2	MO
Hormonal Agents, Suppressant (Parathyroid)		
Hormonal Agents, Suppressant (Parathyroid)		
SENSIPAR	2	MO
Hormonal Agents, Suppressant (Pituitary)		
Hormonal Agents, Suppressant (Pituitary)		
<i>bromocriptine mesylate</i>	1	GC; MO
<i>cabergoline</i>	1	GC; MO
<i>leuprolide acetate</i>	4	MO
OCTREOTIDE ACETATE INJECTION 50MCG/ML	4	MO
OCTREOTIDE ACETATE INJECTION 1000MCG/ML, 100MCG/ML, 200MCG/ML, 500MCG/ML	5	MO
Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)		
Antiandrogens		
<i>bicalutamide</i>	1	GC; MO
EMCYT	2	MO
<i>flutamide</i>	1	GC; MO
NILANDRON	2	MO
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
<i>methimazole</i>	1	GC; MO
<i>propylthiouracil</i>	1	GC; MO
Immunological Agents		
Immune Suppressants		
<i>azathioprine</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
CELLCEPT SUSPENSION RECONSTITUTED	2	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CUPRIMINE	2	MO
<i>cyclosporine modified capsule 50mg</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
<i>cyclosporine modified capsule 100mg</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
<i>cyclosporine modified solution</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
<i>cyclosporine capsule</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
DEPEN TITRATABS	2	MO
ENBREL SURECLICK	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 4ml (#4x50mg injections) per 30 days.
ENBREL INJECTION 50MG/ML	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 4ml (#4x50mg injections) per 30 days.
ENBREL INJECTION 25MG/0.5ML	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 4ml (#8x25mg injections) per 30 days.
<i>gengraf</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
HUMIRA PEN-CROHNS DISEASESTARTER	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 4.8ml (#6x40mg/0.8ml injections) for therapy initiation - one time use only.

Drug Name	Drug Tier	Notes
HUMIRA INJECTION 40MG/0.8ML	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 1.6ml (#2x40mg/0.8ml injections) per 30 days.
HUMIRA INJECTION 20MG/0.4ML	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 1.6ml (#4x20mg/0.4ml injections) per 30 days
<i>methotrexate</i>	1	GC; MO
<i>mycophenolate mofetil</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
MYFORTIC	2	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PROGRAF CAPSULE	2	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
RAPAMUNE	2	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
REMICADE	5	HI; PA - Prior authorization required for coverage.
SYPRINE	2	MO
<i>tacrolimus</i>	1	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
<i>Immunomodulators</i>		
AVONEX	5	MO
COPAXONE	5	MO
INTRON-A W/DILUENT	4	MO
INTRON-A INJECTION 3MU/0.2ML	4	MO
INTRON-A INJECTION 10MU/0.2ML, 5MU/0.2ML, 6000000UNIT/ML	5	MO
<i>leflunomide</i>	1	GC; MO
PEG-INTRON	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 2ml (#4 injections) per 30 days.

Drug Name	Drug Tier	Notes
PEG-INTRON REDIPEN	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 2ml (#4 injections) per 30 days.
PEG-INTRON REDIPEN PAK 4	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 2ml (#4 injections = 1 pak) per 30 days.
PEGASYS	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 2ml (#4 injections) per 30 days.
REBIF	5	MO
REBIF TITRATION PACK	5	MO
RIDAURA	2	MO
Vaccines		
HAVRIX	4	MO
RECOMBIVAX HB	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Inflammatory Bowel Disease Agents

Glucocorticoids

<i>colocort</i>	1	GC; MO
CORTIFOAM FOAM 90MG	2	MO
<i>hydrocortisone</i>	1	GC; MO
<i>procto-pak</i>	1	GC; MO
<i>proctosol hc</i>	1	GC; MO
<i>proctozone-hc</i>	1	GC; MO

Salicylates

ASACOL	2	MO
ASACOL HD	2	MO
<i>balsalazide disodium</i>	1	GC; MO
CANASA	2	MO
DIPENTUM	2	MO
<i>mesalamine</i>	1	GC; MO
PENTASA	2	MO

Sulfonamides

<i>sulfasalazine</i>	1	GC; MO
<i>sulfazine</i>	1	GC; MO
<i>sulfazine ec</i>	1	GC; MO

Metabolic Bone Disease Agents

Metabolic Bone Disease Agents

ACTONEL	2	MO; PA - Prior authorization required for coverage.
ACTONEL WITH CALCIUM	2	MO; PA - Prior authorization required for coverage.

Drug Name	Drug Tier	Notes
<i>alendronate sodium</i>	1	GC; MO
BONIVA TABLET	3	MO; PA - Prior authorization required for coverage.
<i>calcitonin-salmon</i>	1	GC; MO
<i>calcitriol capsule, solution</i>	1	GC; MO
<i>etidronate disodium</i>	1	GC; MO
MIACALCIN INJECTION	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Miscellaneous Therapeutic Agents

Miscellaneous Therapeutic Agents

ALCOHOL PREPS	2	MO
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	2	MO
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	2	MO
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	2	MO
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	2	MO
BD PEN NEEDLE/ULTRAFINE/29G X 12.7MM	2	MO
CURITY GAUZE PADS 2"X2"	2	MO
<i>sterile water irrigation</i>	1	GC; MO

Ophthalmic Agents

Ophthalmic Agents, Other

<i>ak-con</i>	1	GC; MO
<i>ak-tob</i>	1	GC; MO
CILOXAN	2	MO
<i>ciprofloxacin hcl</i>	1	GC; MO
<i>erythromycin</i>	1	GC; MO
<i>gentamicin sulfate</i>	1	GC; MO
<i>gentasol</i>	1	GC; MO
<i>mydral</i>	1	GC; MO
<i>naphazoline hcl</i>	1	GC; MO
<i>ofloxacin</i>	1	GC; MO
<i>proparacaine hcl</i>	1	GC; MO
<i>tobramycin sulfate</i>	1	GC; MO
<i>tobrasol</i>	1	GC; MO
<i>tropicamide</i>	1	GC; MO
VIGAMOX	3	MO; Potential preferred options: ciprofloxacin, ofloxacin
ZYMAR	3	MO

Ophthalmic Anti-allergy Agents

ALOCRIAL	2	MO
<i>azelastine hcl</i>	1	MO GC
<i>cromolyn sodium</i>	1	GC; MO
PATADAY	2	MO
PATANOL	2	MO

Ophthalmic Anti-inflammatories

ACULAR	2	MO
ACULAR LS	2	MO

Drug Name	Drug Tier	Notes
ALREX	2	MO
<i>bac /poly /neomy /hc</i>	1	GC; MO
BLEPHAMIDE S.O.P.	2	MO
<i>dexamethasone sodium phosphate</i>	1	GC; MO
<i>diclofenac sodium</i>	1	GC; MO
<i>fluor-op</i>	1	GC; MO
<i>fluorometholone</i>	1	GC; MO
<i>flurbiprofen sodium</i>	1	GC; MO
FML	2	MO
<i>ketorolac tromethamine</i>	1	MO GC
LOTEMAX	2	MO
<i>neomycin /polymyxin /dexamethasone</i>	1	GC; MO
<i>poly-dex</i>	1	GC; MO
PRED MILD	2	MO
<i>prednisolone acetate</i>	1	GC; MO
<i>prednisolone sodium phosphate</i>	1	GC; MO
<i>sulfacetamide sodium/prednisolone sodium phosphate</i>	1	GC; MO
TOBRADEX OINTMENT	2	MO
<i>tobramycin /dexamethasone</i>	1	GC; MO
Ophthalmic Antiglaucoma Agents		
<i>acetazolamide</i>	1	GC; MO
ALPHAGAN P	2	MO
<i>apraclonidine</i>	1	GC; MO
AZOPT	2	MO
<i>betaxolol hcl</i>	1	GC; MO
BETIMOL	2	MO
BETOPTIC-S	2	MO
<i>brimonidine tartrate 0.2%</i>	1	GC; MO
<i>carteolol hcl</i>	1	GC; MO
<i>dipivefrin hcl</i>	1	GC; MO
<i>dorzolamide hcl/timolol maleate</i>	1	GC; MO
<i>levobunolol hcl</i>	1	GC; MO
<i>metipranolol</i>	1	GC; MO
<i>pilocarpine hcl</i>	1	GC; MO
PILOPINE HS	2	MO
PROPINE	2	MO
<i>timolol maleate</i>	1	GC; MO
<i>timolol maleate ophthalmic gel forming</i>	1	MO GC
Ophthalmic Prostaglandin and Prostanoid Analogs		
<i>dorzolamide hcl</i>	1	GC; MO
LUMIGAN	2	MO
TRAVATAN	2	MO
TRAVATAN Z	2	MO
XALATAN	3	MO
Otic Agents		
Otic Agents		
<i>acetazol hc</i>	1	GC; MO
<i>acetic acid</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>acetic acid/aluminum acetate</i>	1	GC; MO
<i>acetic acid/hydrocortisone</i>	1	GC; MO
<i>antipyrine /benzocaine</i>	1	MO GC
<i>aurodex</i>	1	GC; MO
<i>borofair</i>	1	GC; MO
CIPRO HC	2	MO
CIPRODEX	2	MO
<i>cortomycin</i>	1	GC; MO
<i>neomycin /polymyxin /hc</i>	1	GC; MO
<i>neomycin /polymyxin /hydrocortisone</i>	1	GC; MO
<i>ofloxacin</i>	1	GC; MO

Respiratory Tract Agents

Anti-inflammatories, Inhaled Corticosteroids

ADVAIR DISKUS	2	MO
ALVESCO	2	MO
ASMANEX 120 METERED DOSES	2	MO
ASMANEX 14 METERED DOSES	2	MO
ASMANEX 30 METERED DOSES	2	MO
ASMANEX 60 METERED DOSES	2	MO
AZMACORT	2	MO
<i>budesonide</i>	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
FLOVENT DISKUS	2	MO
FLOVENT HFA	2	MO
<i>flunisolide</i>	1	GC; MO
<i>fluticasone propionate</i>	1	GC; MO
NASACORT AQ	2	MO; PA - Prior authorization required for coverage.
PULMICORT	2	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PULMICORT FLEXHALER	2	MO
QVAR	2	MO
<i>Antihistamines</i>		
ASTELIN	2	MO
ASTEPRO	2	MO
<i>carbinoxamine maleate</i>	1	GC; MO
<i>cetirizine hcl</i>	1	GC; MO
<i>clemastine fumarate</i>	1	GC; MO
<i>cyproheptadine hcl</i>	1	GC; MO
<i>dexchlorpheniramine maleate</i>	1	GC; MO
<i>diphenhydramine hcl capsule, elixir</i>	1	GC; MO
<i>fexofenadine hcl</i>	1	GC; MO
<i>hydroxyzine hcl syrup, tablet</i>	1	GC; MO
<i>hydroxyzine pamoate</i>	1	GC; MO

Drug Name	Drug Tier	Notes
<i>promethazine hcl syrup, tablet</i>	1	GC; MO
Antileukotrienes		
ACCOLATE	2	MO
SINGULAIR	2	MO
Bronchodilators, Anticholinergic		
ATROVENT HFA	2	MO
<i>ipratropium bromide solution</i>	1	GC; MO
SPIRIVA HANDIHALER	2	MO
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)		
<i>aminophylline tablet</i>	1	GC; MO
<i>elixophyllin</i>	1	GC; MO
<i>theochron</i>	1	GC; MO
<i>theophylline cr</i>	1	GC; MO
<i>theophylline er</i>	1	GC; MO
Bronchodilators, Sympathomimetic		
ADVAIR HFA	2	MO
<i>albuterol sulfate er</i>	1	GC; MO
<i>albuterol sulfate syrup, tablet</i>	1	GC; MO
COMBIVENT	2	MO
EPIPEN 2-PAK	2	MO
EPIPEN-JR 2-PAK	2	MO
FORADIL AEROLIZER	2	MO
<i>metaproterenol sulfate</i>	1	GC; MO
PROAIR HFA	2	MO
PROVENTIL HFA	2	MO
SEREVENT DISKUS	2	MO
<i>terbutaline sulfate tablet</i>	1	GC; MO
VENTOLIN HFA	2	MO
Mast Cell Stabilizers		
<i>cromolyn sodium</i>	1	GC; MO
Pulmonary Antihypertensives		
LETAIRIS	5	LA
REVATIO TABLET	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #90 tablets per 30 days.
TRACLEER	5	LA
Sedatives/Hypnotics		
Sedatives/Hypnotics		
<i>somnote</i>	1	GC
<i>zaleplon</i>	1	GC; MO; QL - Quantity limited to #30 capsules per 30 days. All strengths of zaleplon, zolpidem tartrate accumulate together.

Drug Name	Drug Tier	Notes
<i>zolpidem tartrate</i>	1	GC; MO; QL - Quantity limited to #30 tablets per 30 days. All strengths of zaleplon, zolpidem tartrate accumulate together.

Skeletal Muscle Relaxants

Skeletal Muscle Relaxants

<i>baclofen</i>	1	GC; MO
<i>carisoprodol</i>	1	GC; MO
<i>carisoprodol /aspirin</i>	1	GC; MO
<i>carisoprodol /aspirin /codeine</i>	1	GC; MO
<i>chlorzoxazone</i>	1	GC; MO
<i>cyclobenzaprine hcl</i>	1	GC; MO
<i>dantrolene sodium</i>	1	GC; MO
<i>metaxalone</i>	1	GC; MO
<i>methocarbamol</i>	1	GC; MO
<i>orphenadrine /asa /caffeine</i>	1	GC; MO
<i>orphenadrine compound ds</i>	1	GC; MO
<i>tizanidine hcl</i>	1	GC; MO

Therapeutic Nutrients/Minerals/ Electrolytes

Electrolytes/Minerals

<i>ed k+10</i>	1	GC; MO
<i>epiklor</i>	1	MO GC
<i>epiklor/25</i>	1	MO GC
<i>klor-con 10</i>	1	GC; MO
<i>klor-con 25</i>	1	MO GC
<i>klor-con 8</i>	1	GC; MO
<i>klor-con m15</i>	1	GC; MO
<i>klor-con m20</i>	1	GC; MO
<i>lactated ringers irrigation</i>	1	GC; MO
<i>levocarnitine oral solution, tablet</i>	1	GC; MO
<i>levocarnitine injection</i>	4	HI
<i>phospha 250 neutral</i>	1	GC; GC; MO
<i>physiolyte</i>	1	GC; MO
<i>potassium chloride cr</i>	1	GC; MO
<i>potassium chloride er</i>	1	GC; MO
<i>potassium chloride sr</i>	1	GC; MO
<i>potassium citrate extended-release</i>	1	GC; MO
<i>ringers irrigation</i>	1	GC; MO
<i>sodium chloride 0.9%</i>	1	GC; MO
<i>tricitrates</i>	1	MO GC

Vitamins

<i>epiflur</i>	1	MO GC
<i>prenatabs obn</i>	1	GC; MO
<i>sodium fluoride</i>	1	GC; MO

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