Medicare Prescription Drug Plan

2010 Comprehensive Formulary

(List of Covered Drugs)

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Welcome!

This document includes a list of covered drugs on our formulary as of February 1, 2010. To get updated information about covered drugs, 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 a comprehensive (complete) formulary** and only contains all of the Part D drugs we cover. 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 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 84. 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:** We 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 formulary, you should first contact Customer Service and confirm that your drug is not covered. If you learn that we don't cover your drug, you have two options:

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

How do I request an exception to the Formulary?

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

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred brand drug, you can ask us to cover it 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 would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your 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%

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

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

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

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

[3]For 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 formulary that begins on the following pages provides coverage information about the drugs we cover. If you have trouble finding your drug in the list, turn to the index that begins on page 84.

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.

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Drug Name	Drug Tier	Notes
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
diclofenac potassium	1	GC; MO
diclofenac sodium	1	GC; MO
diclofenac sodium ec	1	GC; MO
diflunisal	1	GC; MO
etodolac	1	FF; GC; MO
fenoprofen calcium	1	GC; MO
FLECTOR	3	MO
flurbiprofen	1	GC; MO
ketoprofen	1	GC; MO
ketorolac tromethamine tablet	1	GC; MO
ketorolac tromethamine injection	4	HI
nabumetone	1	FF; GC; MO
naproxen dr	1	FF; GC; MO
oxaprozin	1	GC; MO
Opioid Analgesics		
acetaminophen/caffeine/dihydrocodeine bitartrate	1	GC; MO
acetaminophen/codeine	1	GC; MO
acetaminophen/codeine #3	1	GC; MO
acetaminophen/codeine #4	1	GC; MO
ACTIQ	3	MO; PA - Prior authorization required for coverage. QL - When authorized quantity limited to #96 lollipops per 30 days.
ascomp/codeine	1	GC; MO
ASTRAMORPH	4	MO
AVINZA	3	MO
balacet 325	1	GC; MO
BUPRENEX	4	HI
buprenorphine hcl	4	HI
butalbital /apap /caffeine /codeine	1	GC; MO
butorphanol tartrate nasal solution	1	GC; MO
butorphanol tartrate injection	4	HI
CAPITAL/CODEINE	3	MO
co-gesic	1	GC; MO
codeine sulfate	1	GC; MO
COMBUNOX	3	MO
DARVOCET A500	3	MO
DARVOCET-N 100	3	MO
DARVOCET-N 50	3	MO
DARVON	3	MO
DARVON-N	3	MO
DEMEROL TABLET	3	MO
DEMEROL INJECTION	4	MO
DILAUDID-5	3	MO

Drug Name	Drug Tier	Notes
DILAUDID-HP	4	MO
DILAUDID TABLET	3	MO
DILAUDID INJECTION	4	MO
DOLOPHINE	3	MO
DOLOPHINE HCL	3	MO
DURAGESIC	3	MO
duramorph	4	MO
endocet	1	GC; MO
endodan	1	GC; MO
fentanyl	1	GC; MO
fentanyl citrate	4	HI
fentanyl citrate oral transmucosal	1	GC; MO; PA - Prior authorization required for coverage; QL - When authorized, quantity limited #96 lollipops per 30 days.
FENTORA	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #84 tablets per 30 days.
FIORICET /CODEINE	3	MO
FIORINAL/CODEINE #3	3	MO
HYCET	3	MO
hydrocodone /acetaminophen	1	GC; MO
hydrocodone /acetaminophen-hs	1	GC; MO
hydrocodone bitartrate/acetaminophen	1	GC; MO
hydromorphone hcl tablet	1	GC; MO
hydromorphone hcl injection	4	MO
INFUMORPH 200	4	MO
INFUMORPH 500	4	MO
KADIAN	2	MO
LEVO DROMORAN	4	HI
levorphanol tartrate	1	GC; MO
LORCET 10/650	3	MO
LORCET PLUS	3	MO
LORTAB	3	MO
LORTAB 10	3	MO
LORTAB 5	3	MO
LORTAB 7.5	3	MO
MAGNACET	3	MO
margesic-h	1	GC; MO
MAXIDONE	3	MO
meperidine hcl oral solution, tablet	1	GC; MO
meperidine hcl injection 10mg/ml	4	HI
meperidine hcl injection 100mg/ml, 25mg/ml, 50mg/ml, 75mg/ml	4	MO
methadone hcl concentrate, oral solution, tablet	1	GC; MO
methadone hcl injection	4	HI

Drug Name	Drug Tier	Notes
methadose	1	GC; MO
morphine sulfate er	1	GC; MO
morphine sulfate suppository	1	GC; GC; MO
morphine sulfate oral solution, tablet	1	GC; MO
morphine sulfate injection	4	MO
MS CONTIN	3	MO
nalbuphine hcl	4	HI
NORCO	3	MO
OPANA	3	MO
OPANA ER	3	MO; QL - Quantity limited up to 80mg per day. All strengths of Opana ER accumulate together.
oramorph sr	1	GC; MO
oxycodone /acetaminophen	1	GC; MO
oxycodone /apap	1	GC; MO
oxycodone /aspirin	1	GC; MO
oxycodone /ibuprofen	1	GC; MO
oxycodone hcl	1	GC; MO
oxycodone hcl er	1	GC; MO; QL - Quantity limited up to 160mg per day. All strengths of generic oxycodone HCL ER and brand Oxycontin accumulate together.
oxycodone-apap	1	GC; MO
OXYCONTIN	3	MO; QL - Quantity limited up to 160mg per day. All strengths of generic oxycodone HCL ER and brand Oxycontin accumulate together.
PANLOR DC	3	MO
PANLOR SS	3	MO
pentazocine /acetaminophen	1	GC; MO
pentazocine/naloxone hcl	1	GC; MO
PERCOCET	3	MO
PERCODAN	3	MO
propoxyphene /acetaminophen	1	GC; MO
propoxyphene hcl	1	GC; MO
propoxyphene-n /acetaminophen	1	GC; MO
REPREXAIN	3	MO
roxicet	1	GC; MO
ROXICODONE	3	MO
RYZOLT	3	MO
STADOL	4	HI
stagesic	1	GC; MO
SUBOXONE	3	MO
SUBUTEX	3	MO
SYNALGOS-DC	3	MO

Drug Name	Drug Tier	Notes
TALACEN	3	MO
TALWIN	4	MO
TALWIN NX	3	MO
tramadol hcl	1	GC; MO
tramadol hydrochloride/acetaminophen	1	GC; MO
trezix	1	GC; MO
TYLENOL/CODEINE #3	3	MO
TYLENOL/CODEINE #4	3	MO
TYLOX	3	MO
ULTRACET	3	MO
ULTRAM	3	MO
ULTRAM ER	3	MO
vanacet	1	GC; MO
VICODIN	3	MO
VICODIN ES	3	MO
VICODIN HP	3	MO
VICOPROFEN	3	MO
XODOL	3	MO
ZAMICET	3	MO
zerlor	1	GC; MO
ZYDONE	3	MO
Anesthetics		
Local Anesthetics		
anestacon	1	GC; MO
EMLA	3	MO
lidocaine	1	GC; MO
lidocaine hcl jelly	1	GC; MO
lidocaine hcl gel, external solution	1	GC; MO
lidocaine hcl injection	4	HI
lidocaine viscous	1	GC; MO
lidocaine/prilocaine	1	GC; MO
LIDODERM	3	MO; Potential preferred options: amitriptyline, gabapentin, nortriptyline
SYNERA	3	MO
XYLOCAINE JELLY	3	MO
XYLOCAINE EXTERNAL SOLUTION	3	MO
XYLOCAINE INJECTION	4	HI
Anti-Inflammatory Agents		
Glucocorticoids		
DERMATOP	3	MO
DIPROLENE	3	MO
DIPROLENE AF	3	MO
ELOCON	3	MO
HALOG	3	MO
KENALOG	3	MO
prednisone	1	GC; MO

Drug Name	Drug Tier	Notes
TEXACORT	3	MO
ULTRAVATE	3	MO
WESTCORT	3	MO
Nonsteroidal Anti-inflammatory Drugs		
ARTHROTEC 50	3	MO
ARTHROTEC 75	3	MO
choline magnesium trisalicylate	1	GC; MO
diclofenac sodium ec	1	GC; MO
diclofenac sodium xr	1	GC; MO
etodolac	1	FF; GC; MO
etodolac er	1	GC; MO
flurbiprofen	1	GC; MO
hydrocodone /ibuprofen	1	GC; MO
ibu	1	FF; GC; MO
ibuprofen tablet	1	FF; GC; MO
ibuprofen suspension	1	GC; MO
INDOCIN	3	MO
indomethacin	1	GC; MO
indomethacin er	1	GC; MO
ketoprofen	1	GC; MO
ketoprofen er	1	GC; MO
meclofenamate sodium	1	GC; MO
meloxicam	1	GC; MO
NALFON	3	MO
NAPRELAN	3	MO
NAPROSYN TABLET 250MG, 500MG	3	MO
naproxen sodium	1	FF; GC; MO
naproxen tablet	1	FF; GC; MO
naproxen suspension	1	GC; MO
piroxicam	1	GC; MO
PONSTEL	3	MO
salsalate	1	GC; MO
sulindac	1	GC; MO
tolmetin sodium	1	GC; MO
ZIPSOR	3	MO
Antibacterials		
Aminoglycosides		
amikacin sulfate	4	HI
AMIKIN	4	HI
GENOPTIC	3	MO
gentamicin sulfate/0.9% sodium chloride	4	HI
gentamicin sulfate/sodium chloride	4	HI
gentamicin sulfate cream, external ointment	1	GC; MO
gentamicin sulfate injection	4	HI
ISOTONIC GENTAMICIN	4	HI
kanamycin sulfate	4	HI

Drug Name	Drug Tier	Notes
NEO-FRADIN	3	MO
neomycin sulfate	1	GC; MO
streptomycin sulfate	4	MO
TOBI	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
tobramycin sulfate	4	HI
tobramycin sulfate/sodium chloride	4	HI
Antibacterials, Other		
ak-poly-bac	1	GC; MO
ALTABAX	3	MO
baciim	4	MO
bacitracin/polymyxin b	1	GC; MO
bacitracin ointment	1	GC; MO
bacitracin injection	4	MO
BACTROBAN	3	MO
BACTROBAN NASAL	2	MO
chloramphenicol sodium succinate	4	HI
CLEOCIN	3	MO
CLEOCIN GALAXY	4	HI
CLEOCIN PEDIATRIC GRANULES	3	MO
CLEOCIN PHOSPHATE	4	MO
CLEOCIN-T	3	MO
CLINDAGEL	3	MO
clindamycin hcl	1	GC; MO
clindamycin phosphate	1	GC; MO
clindamycin phosphate add-vantage	4	MO
CLINDESSE	3	MO
colistimethate sodium	4	HI
COLY-MYCIN M	4	HI
COLY-MYCIN S	3	MO
CORTISPORIN	3	MO
CORTISPORIN-TC	3	MO
CUBICIN	4	HI
EVOCLIN	3	MO
FLAGYL	3	MO
FLAGYL ER	3	MO
FURADANTIN	2	MO
HELIDAC	2	MO
HIPREX	3	MO
LINCOCIN	4	HI
MACROBID	3	MO
MACRODANTIN	3	MO
MAXITROL	3	MO
methenamine hippurate	1	GC; MO
METROCREAM	3	MO

Drug Name	Drug Tier	Notes
METROGEL	2	MO
METROGEL-VAGINAL	3	MO
METROLOTION	3	MO
metronidazole	1	GC; MO
metronidazole in nacl 0.79%	4	HI
metronidazole vaginal	1	GC; MO
MONUROL	3	MO
mupirocin	1	GC; MO
neomycin /bacitracin /polymyxin	1	GC; MO
neomycin /polymyxin /dexamethasone	1	GC; MO
neomycin /polymyxin /gramicidin	1	GC; MO
neomycin /polymyxin /hydrocortisone	1	GC; MO
neomycin/polymyxin b sulfates	1	GC; MO
NEOSPORIN	3	MO
nitrofurantoin macrocrystalline	1	GC; MO
nitrofurantoin monohydrate	1	GC; MO
NORITATE	2	MO
PEDIOTIC	3	MO
PHISOHEX	3	MO
POLY-PRED	3	MO
polycin b	1	GC; MO
polymyxin b sulfate	4	HI
POLYTRIM	3	MO
PRIMSOL	3	MO
SILVADENE	3	MO
silver sulfadiazine	1	GC; MO
SSD	3	MO
SULFAMYLON	3	MO
SYNERCID	4	HI
thermazene	1	GC; MO
trimethoprim	1	GC; MO
trimethoprim sulfate/polymyxin b sulfate	1	GC; MO
TYGACIL	4	HI
UREX	3	MO
VANCOCIN HCL	3	MO
vancomycin hcl	4	HI
VANCOMYCIN HCL ISO-OSMOTIC DEXTROSE	4	HI
VANDAZOLE	3	MO
XIFAXAN	3	MO
ZYVOX SUSPENSION RECONSTITUTED, TABLET	2	MO
ZYVOX INJECTION	4	HI
Beta-lactam, Cephalosporins		
CEDAX	3	MO
cefaclor	1	GC; MO
cefaclor er	1	GC; MO
cefadroxil	1	GC; MO
cefazolin sodium	4	HI

Drug Name	Drug Tier	Notes
cefdinir	1	GC; MO
cefepime	4	HI
CEFIZOX IN DEXTROSE 5%	4	HI
cefotaxime sodium	4	HI
CEFOTETAN	4	HI
cefoxitin sodium	4	HI
cefpodoxime proxetil	1	GC; MO
cefprozil	1	GC; MO
ceftazidime	4	HI
CEFTIN	3	MO
ceftriaxone sodium	4	HI
ceftriaxone/dextrose	4	HI
cefuroxime axetil	1	GC; MO
cefuroxime sodium	4	HI
cefuroxime/dextrose	4	HI
cephalexin	1	GC; MO
CLAFORAN	4	HI
CLAFORAN/D5W	4	HI
FORTAZ	4	HI
KEFLEX	3	MO
MAXIPIME	4	HI
OMNICEF	3	MO
RANICLOR	3	MO
ROCEPHIN	4	HI
ROCEPHIN IN ISO-OSMOTIC DEXTROSE	4	HI
SPECTRACEF	3	MO
SUPRAX	3	MO
TAZICEF	4	HI
VANTIN	3	MO
ZINACEF	4	HI
ZINACEF IN ISO-OSMOTIC DEXTROSE	4	HI
ZINACEF IN ISO-OSMOTIC DILUENT	4	HI
Beta-lactam, Other		
AZACTAM	4	HI
AZACTAM IN DEXTROSE	4	HI
DORIBAX	4	HI
INVANZ	4	HI
MERREM	4	HI
PRIMAXIN I.M.	4	MO
PRIMAXIN IV	4	HI
Beta-lactam, Penicillins		
amoclan	1	GC; MO
amoxicillin	1	GC; MO
amoxicillin/clavulanate potassium	1	GC; MO
amoxicillin/potassium clavulanate	1	GC; MO
AMOXIL	3	MO
ampicillin	1	GC; MO

Drug Name	Drug Tier	Notes
ampicillin sodium	4	HI
ampicillin-sulbactam	4	HI
AUGMENTIN	3	MO
AUGMENTIN ES-600	2	MO
AUGMENTIN XR	3	MO
bactocill in dextrose	4	HI
BICILLIN C-R	4	MO
BICILLIN L-A	4	MO
dicloxacillin sodium	1	GC; MO
MOXATAG	3	MO
nafcillin sodium	4	HI
nallpen/dextrose	4	HI
oxacillin sodium	4	HI
penicillin g potassium	4	HI
PENICILLIN G POTASSIUM IN ISO-OSMOTIC DEXTROSE	4	HI
penicillin g procaine	4	MO
penicillin g sodium	4	HI
penicillin v potassium	1	GC; MO
pfizerpen-g	4	HI
piperacillin sodium	4	HI
TIMENTIN	4	HI
TRIMOX	3	MO
UNASYN	4	HI
UNASYN BULK PACK	4	HI
veetids	1	GC; MO
ZOSYN	4	HI
Macrolides		
AKNE-MYCIN	3	MO
AZASITE	3	MO
azithromycin suspension reconstituted, tablet	1	GC; MO
azithromycin injection	4	HI
BIAXIN	3	MO
BIAXIN XL	3	MO
BIAXIN XL PAC	3	MO
clarithromycin	1	GC; MO
clarithromycin er	1	GC; MO
E.E.S. 400	3	MO
E.E.S. GRANULES	3	MO
ery	1	GC; MO
ERY-TAB	3	MO
ERYPED 200	3	MO
ERYPED 400	3	MO
ERYTHROCIN LACTOBIONATE	4	HI
ERYTHROCIN STEARATE	3	MO
erythromycin	1	GC; MO
erythromycin /sulfisoxazole	1	GC; MO

Drug Name	Drug Tier	Notes
erythromycin base	1	GC; MO
KETEK	3	MO
PCE	3	MO
romycin	1	GC; MO
ZITHROMAX TRI-PAK	3	MO
ZITHROMAX Z-PAK	3	MO
ZITHROMAX SUSPENSION RECONSTITUTED, TABLET	3	MO
ZITHROMAX INJECTION	4	HI
ZMAX	3	MO
Quinolones		
AVELOX ABC PACK	2	MO
AVELOX TABLET	2	MO
AVELOX INJECTION	4	HI
BESIVANCE	3	MO
CETRAXAL	3	MO
CIPRO	3	MO
CIPRO I.V.-IN D5W	4	HI
ciprofloxacin	4	HI
ciprofloxacin er	1	GC; MO
ciprofloxacin extended-release	1	GC; MO
ciprofloxacin hcl	1	GC; MO
FACTIVE	3	MO
FLOXIN OTIC	3	MO
IQUIX	3	MO
LEVAQUIN PREMIX	4	HI
LEVAQUIN ORAL SOLUTION, TABLET	3	MO; Potential preferred options: ciprofloxacin, ofloxacin
LEVAQUIN INJECTION	4	HI
NOROXIN	3	MO
ofloxacin	1	GC; MO
PROQUIN XR	3	MO
QUIXIN	3	MO
Sulfonamides		
BACTRIM	3	MO
BACTRIM DS	3	MO
bleph-10	1	GC; MO
GANTRISIN PEDIATRIC	3	MO
KLARON	3	MO
ocusulf-10	1	GC; MO
SEPTRA	3	MO
SEPTRA DS	3	MO
sodium sulfacetamide	1	GC; MO
sulfadiazine	1	GC; MO
sulfamethoxazole /trimethoprim suspension, tablet	1	GC; MO
sulfamethoxazole /trimethoprim injection	4	HI
sulfamethoxazole/trimethoprim ds	1	GC; MO

Drug Name	Drug Tier	Notes
sulfatrim	1	GC; MO
Tetracyclines		
ADOXA	3	MO
ADOXA PAK 1/100	3	MO
ADOXA PAK 1/150	3	MO
ADOXA PAK 1/75	3	MO
ADOXA PAK 2/100	3	MO
DECLOMYCIN	3	MO
demeclocycline hcl	1	GC; MO
doxycycline hyclate capsule, capsule delayed release particles	1	GC; MO
doxycycline hyclate injection	4	HI
doxycycline monohydrate	1	GC; MO
DYNACIN	3	MO
MINOCIN	3	MO
minocycline hcl	1	GC; MO
MONODOX	3	MO
PERIOSTAT	3	MO
tetracycline hcl	1	GC; MO
VIBRAMYCIN	3	MO
VIBRATAB	3	MO
Anticonvulsants		
Anticonvulsants, Other		
KEPPRA XR	3	MO
KEPPRA ORAL SOLUTION, TABLET	3	MO
KEPPRA INJECTION	4	HI
levetiracetam	1	GC; MO
VIMPAT TABLET	3	MO
VIMPAT INJECTION	4	MO
Calcium Channel Modifying Agents		
CELONTIN	2	MO
ethosuximide	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.
ZARONTIN	3	MO
ZONEGRAN	3	MO
zonisamide	1	GC; MO
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
DEPACON	4	HI
DEPAKENE	3	MO
DEPAKOTE	3	MO

Drug Name	Drug Tier	Notes
DEPAKOTE ER	3	MO
DEPAKOTE SPRINKLES	3	MO
divalproex sodium	1	GC; MO
gabapentin	1	FF; GC; MO
GABITRIL	2	MO
MYSOLINE	3	MO
NEURONTIN	3	MO
primidone	1	GC; MO
STAVZOR	3	MO
valproate sodium	4	HI
valproic acid	1	GC; MO
Glutamate Reducing Agents		
FELBATOL	2	MO
LAMICTAL	3	MO
LAMICTAL CHEWABLE DISPERSIBLE	3	MO
LAMICTAL ODT	3	MO
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	3	MO
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	3	MO
LAMICTAL STARTER/TAKING VALPROATE	3	MO
LAMICTAL XR	3	MO
lamotrigine	1	GC; MO
TOPAMAX	3	MO
TOPAMAX SPRINKLE	3	MO
topiramate	1	GC; MO
Sodium Channel Inhibitors		
BANZEL	3	MO
carbamazepine	1	GC; MO
carbamazepine er	1	GC; MO
CEREBYX	4	HI
DILANTIN	2	MO
DILANTIN INFATABS	2	MO
EPITOL	3	MO
fosphenytoin sodium	4	HI
oxcarbazepine	1	GC; MO
PEGANONE	3	MO
PHENYTEK	2	MO
phenytoin	1	GC; MO
phenytoin sodium	4	HI
phenytoin sodium extended	1	GC; MO
TEGRETOL	3	MO
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100MG	2	MO
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 200MG, 400MG	3	MO
TRILEPTAL	3	MO

Drug Name	Drug Tier	Notes
Antidementia Agents		
Antidementia Agents, Other		
ergoloid mesylates	1	GC; MO
Cholinesterase Inhibitors		
ARICEPT	2	MO
ARICEPT ODT	2	MO
COGNEX	3	MO
EXELON	2	MO
galantamine hydrobromide	1	GC; MO
RAZADYNE ER	3	MO
RAZADYNE SOLUTION	2	MO
RAZADYNE TABLET	3	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		
budeprion sr	1	FF; GC; MO
budeprion xl	1	GC; MO
bupropion hcl	1	GC; MO
bupropion hcl sr tablet extended release 12 hour 100mg, 200mg	1	FF; GC; MO
bupropion hcl sr tablet extended release 12 hour 150mg	1	GC; MO
maprotiline hcl	1	GC; MO
mirtazapine	1	GC; MO
mirtazapine odt	1	GC; MO
nefazodone hcl	1	GC; MO
trazodone hcl	1	GC; MO
Monoamine Oxidase Inhibitors		
EMSAM	3	MO
MARPLAN	3	MO
NARDIL	2	MO
tranylcypromine sulfate	1	GC; MO
Serotonin/ Norepinephrine Reuptake Inhibitors		
citalopram hydrobromide tablet	1	FF; GC; MO
citalopram hydrobromide solution	1	GC; MO
CYMBALTA	3	MO; PA - Prior authorization required for coverage.
fluoxetine hcl capsule, tablet	1	FF; GC; MO
fluoxetine hcl solution	1	GC; MO
fluvoxamine maleate	1	GC; MO
paroxetine hcl	1	FF; GC; MO
paroxetine hcl er	1	GC; MO
PEXEVA	3	MO

Drug Name	Drug Tier	Notes
PRISTIQ	3	MO; PA - Prior authorization required for coverage.
PROZAC WEEKLY	3	MO
selfemra	1	GC; MO
sertraline hcl	1	FF; GC; MO
SYMBYAX	3	MO
venlafaxine hcl	1	GC; MO
venlafaxine hcl er	1	GC; MO
Tricyclics		
amitriptyline hcl	1	GC; MO
amoxapine	1	GC; MO
chlordiazepoxide /amitriptyline	1	GC; MO
clomipramine hcl	1	GC; MO
desipramine hcl	1	GC; MO
imipramine hcl	1	GC; MO
imipramine pamoate	1	GC; MO
nortriptyline hcl	1	GC; MO
protriptyline hcl	1	GC; MO
trimipramine maleate	1	GC; MO
Antidotes, Deterrents, and Toxicologic Agents		
Antidotes		
ACETADOTE	4	HI
ANTIZOL	4	HI
CHEMET	2	MO
EXJADE	5	MO
fomepizole	4	HI
KAYEXALATE	3	MO
KIONEX	3	MO
sodium polystyrene sulfonate	1	GC; MO
Deterrents		
ANTABUSE	2	MO
budeprion xl	1	GC; MO
buproban	1	GC; MO
CAMPRAL	3	MO
CHANTIX	3	MO; Potential preferred options: budeprion SR, bupropion SR
NICOTROL INHALER	3	MO
NICOTROL NS	3	MO
ZYBAN	3	MO
Toxicologic Agents		
depade	1	GC; MO
naloxone hcl	4	HI
naltrexone hcl	1	GC; MO
REVIA	3	MO
SUBOXONE	3	MO
VIVITROL	4	MO

Drug Name	Drug Tier	Notes
Antiemetics		
Antiemetics		
ALOXI	5	HI
ANTIVERT	3	MO
ANZEMET TABLET	3	MO; PA - Prior authorization required for coverage. QL - When authorized quantity limited to #4 tablets per 30 days.
ANZEMET INJECTION	4	HI
CESAMET	3	MO
compro	1	GC; MO
dronabinol	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.
granisetron hcl tablet	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
granisetron hcl injection	4	HI
granisol	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
KYTRIL TABLET	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
KYTRIL INJECTION	4	HI
MARINOL	3	MO
meclizine hcl	1	GC; MO
metoclopramide hcl oral solution, tablet	1	GC; MO
metoclopramide hcl injection	4	HI
ondansetron hcl oral solution, tablet	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
ondansetron hcl injection	4	HI

Drug Name	Drug Tier	Notes
ondansetron odt	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
phenadoz	1	GC; MO
PHENERGAN	4	MO
prochlorperazine	1	GC; MO
prochlorperazine edisylate	4	
prochlorperazine maleate	1	GC; MO
promethazine hcl suppository	1	GC; MO
promethazine hcl injection	4	MO
promethegan	1	GC; MO
REGLAN TABLET	3	MO
REGLAN INJECTION	4	HI
SANCUSO	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #2 patches per 30 days.
TIGAN CAPSULE	3	MO
TIGAN INJECTION	4	MO
TRANSDERM-SCOP	3	MO
trimethobenzamide hcl capsule	1	GC; MO
trimethobenzamide hcl injection	4	MO
ZOFRAN ODT	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
ZOFRAN ORAL SOLUTION, TABLET	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details. QL - Quantity limit applies.
ZOFRAN INJECTION	4	HI
Antifungals		
Antifungals		
ABELCET	4	HI
AMBISOME	4	HI
AMPHOTEC	4	HI
amphotericin b	4	HI
ANCOBON	2	MO
CANCIDAS	4	HI
ciclopirox	1	GC; MO
ciclopirox nail lacquer	1	GC; MO
ciclopirox olamine	1	GC; MO
clotrimazole	1	GC; MO

Drug Name	Drug Tier	Notes
clotrimazole/betamethasone dipropionate	1	GC; MO
DIFLUCAN	3	MO
DIFLUCAN IN NACL	4	HI
econazole nitrate	1	GC; MO
ERAXIS	4	HI
ERTACZO	3	MO
EXELDERM	3	MO
EXTINA	3	MO
fluconazole	1	GC; MO
fluconazole in dextrose	4	HI
grifulvin v	1	GC; MO
GRIS-PEG	3	MO
griseofulvin microsize	1	GC; MO
GYNAZOLE-1	3	MO
itraconazole	1	GC; MO
ketoconazole	1	GC; MO
kuric	1	GC; MO
LAMISIL	3	MO
LOPROX	3	MO
LOPROX SHAMPOO	3	MO
LOTRISONE	3	MO
MENTAX	3	MO
miconazole 3	1	GC; MO
MYCAMINE	4	HI
MYCOSTATIN	3	MO
NAFTIN	3	MO
NATACYN	2	MO
NIZORAL	3	MO
NOXAFIL	3	MO
nyamyc	1	GC; MO
nystatin	1	GC; MO
nystatin/triamcinolone	1	GC; MO
nystop	1	GC; MO
OXISTAT	3	MO
PEDI-DRI	3	MO
PENLAC NAIL LACQUER	3	MO
SPORANOX PULSEPAK	3	MO
SPORANOX SOLUTION	2	MO
SPORANOX CAPSULE	3	MO
TERAZOL 3	3	MO
TERAZOL 7	3	MO
terbinafine hcl	1	GC; MO
terconazole	1	GC; MO
VFEND	2	MO
VFEND IV	4	HI
XOLEGEL	3	MO
zazole	1	GC; MO

Drug Name	Drug Tier	Notes
Antigout Agents		
Antigout Agents		
allopurinol	1	GC; MO
COLCRYS	3	MO
probenecid	1	GC; MO
probenecid/colchicine	1	GC; MO
ULORIC	3	MO
ZYLOPRIM	3	MO
Antimigraine Agents		
Abortive		
CAFERGOT	3	MO
D.H.E. 45	4	
dihydroergotamine mesylate	4	
ERGOMAR	2	MO
ergotamine tartrate/caffeine	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.
migergot	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.
sumatriptan succinate tablet	1	GC; MO; QL - Quantity limited to #12 tablets per 30 days.
sumatriptan succinate injection 6mg/0.5ml	1	GC; MO; QL - Quantity limited to #3ml (6 injections) per 30 days.
sumatriptan succinate injection 4mg/0.5ml	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.

Drug Name	Drug Tier	Notes
Prophylactic		
DEPAKOTE	3	MO
divalproex sodium	1	GC; MO
propranolol hcl	1	GC; MO
propranolol hcl er	1	GC; MO
timolol maleate	1	GC; MO
TOPAMAX SPRINKLE	3	MO
Antimyasthenic Agents		
Parasympathomimetics		
guanidine hcl	1	GC; MO
MESTINON	3	MO
MESTINON TIMESPAN	3	MO
MYTELASE	3	MO
pyridostigmine bromide	1	GC; MO
REGONOL	4	HI
Antimycobacterials		
Antimycobacterials, Other		
dapsone	1	GC; MO
MYCOBUTIN	2	MO
Antituberculars		
CAPASTAT SULFATE	4	HI
ethambutol hcl	1	GC; MO
isonarif	1	GC; MO
isoniazid syrup, tablet	1	GC; MO
isoniazid injection	4	MO
MYAMBUTOL	3	MO
PASER	3	MO
PRIFTIN	3	MO
pyrazinamide	1	GC; MO
RIFADIN CAPSULE	3	MO
RIFADIN INJECTION	4	HI
RIFAMATE	3	MO
rifampin capsule	1	GC; MO
rifampin injection	4	HI
RIFATER	3	MO
SEROMYCIN	2	MO
TRECATOR	3	MO
Antineoplastics		
Alkylating Agents		
ALKERAN	5	HI
BICNU	4	HI
BUSULFEX	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
CEENU	2	MO
cyclophosphamide tablet	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
cyclophosphamide injection	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CYTOXAN INJECTION 2GM	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CYTOXAN INJECTION 500MG	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
dacarbazine	4	HI
HEXALEN	2	MO
IFEX	4	HI
ifosfamide	4	HI
ifosfamide/mesna	4	HI
LEUKERAN	2	MO
melphalan hydrochloride	4	HI
MUSTARGEN	4	HI
thiotepa	4	HI
TREANDA	5	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ZANOSAR	4	HI
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
FASLODEX	4	MO
tamoxifen citrate	1	GC; MO
Antimetabolites		
ALIMTA	5	HI
allopurinol	1	GC; MO
allopurinol sodium	4	HI
aloprim	4	HI

Drug Name	Drug Tier	Notes
cladribine	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLOLAR	4	HI
cytarabine	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
cytarabine aqueous	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
DROXIA	2	MO
ELITEK	4	HI
fludara	4	HI
fludarabine phosphate	4	HI
fluorouracil	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
GEMZAR	4	HI
HYDREA	3	MO
LEUSTATIN	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
mercaptopurine	1	GC; MO
methotrexate sodium	4	HI
NIPENT	4	HI
pentostatin	4	HI
PURINETHOL	3	MO
TABLOID	2	MO
TREXALL	3	MO
VIDAZA	4	HI
Antineoplastics, Other		
ABRAXANE	4	HI
adriamycin	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
amifostine	4	HI
ARRANON	4	HI
bleomycin sulfate	4	HI

Drug Name	Drug Tier	Notes
CAMPTOSAR	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
carboplatin	4	HI
CERUBIDINE	4	HI
cisplatin	4	HI
COSMEGEN	4	HI
DACOGEN	4	HI
daunorubicin hcl	4	HI
DAUNOXOME	4	HI
dexrazoxane	4	HI
DOXIL	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
doxorubicin hcl	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ELLENCE	4	HI
ELOXATIN	5	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ELSPAR	4	HI
epirubicin hcl	4	HI
ETHYOL	4	HI
ETOPOPHOS	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
etoposide	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
FIRMAGON	4	MO
FUSILEV	4	HI
HYCAMTIN	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
hydroxyurea	1	GC; MO
IDAMYCIN PFS	4	HI
idarubicin hcl	4	HI

Drug Name	Drug Tier	Notes
IRINOTECAN	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
IXEMPRA KIT	5	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
leucovorin calcium tablet	1	GC; MO
leucovorin calcium injection	4	HI
MATULANE	2	MO
mesna	4	HI
MESNEX TABLET	2	MO
MESNEX INJECTION	4	HI
mitomycin	4	HI
mitoxantrone hcl	4	HI
NAVELBINE	4	HI
NOVANTRONE	4	HI
ONCASPAR	4	MO
ONTAK	4	HI
onxol	4	HI
oxaliplatin	5	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
paclitaxel	4	HI
PHOTOFRIN	4	HI
PLATINOL AQ	4	HI
PROLEUKIN	4	HI
TAXOTERE	4	HI
toposar	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRISENOX	4	HI
vinblastine sulfate	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
vincasar pfs	4	HI
vincristine sulfate	4	HI
vinorelbine tartrate	4	HI
ZINECARD	4	HI
ZOLINZA	5	MO; PA - Prior authorization required for coverage. QL- When authorized, quantity limited to #120 capsules per 30 days.

Drug Name	Drug Tier	Notes
Aromatase Inhibitors, 3rd Generation		
ARIMIDEX	2	MO
AROMASIN	2	MO
FEMARA	2	MO
Molecular Target Inhibitors		
AFINITOR	5	MO; PA - Prior authorization required for coverage. When authorized, quantity limited to #30 tablets per 30 days.
GLEEVEC	5	MO; PA - Prior authorization required for coverage.
IRESSA	5	LA
NEXAVAR	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #120 tablets per 30 days.
SPRYCEL	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.
TASIGNA	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #120 capsules per 30 days.
TORISEL	5	HI
TYKERB	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #150 tablets per 30 days.
VELCADE	4	HI
Monoclonal Antibodies		
AVASTIN	5	HI
CAMPATH	5	HI
ERBITUX	5	HI
HERCEPTIN	5	HI
MYLOTARG	5	HI
RITUXAN	5	HI
VECTIBIX	5	HI

Drug Name	Drug Tier	Notes
Retinoids		
PANRETIN	3	MO
TARGRETIN	3	MO
tretinoin	1	GC; MO
VESANOID	3	MO
Antiparasitics		
Anthelmintics		
ALBENZA	2	MO
BILTRICIDE	2	MO
mebendazole	1	GC; MO
STROMECTOL	2	MO
Antiprotozoals		
ALINIA	2	MO
ARALEN	3	MO
chloroquine phosphate	1	GC; MO
DARAPRIM	2	MO
FANSIDAR	2	MO
hydroxychloroquine sulfate	1	GC; MO
LARIAM	3	MO
MALARONE	3	MO
mefloquine hcl	1	GC; MO
MEPRON	2	MO
NEBUPENT	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
NEUTREXIN	4	HI
PAROMOMYCIN SULFATE	3	MO
PENTAM 300	4	HI
PLAQUENIL	3	MO
PRIMAQUINE PHOSPHATE	2	MO
QUALAQUIN	3	MO; PA - Prior authorization required for coverage.
TINDAMAX	3	MO
Pediculicides/ Scabicides		
acticin	1	GC; MO
ELIMITE	3	MO
EURAX	2	MO
lindane	1	GC; MO
malathion	1	GC; MO
OVIDE	2	MO
permethrin	1	GC; MO
ULESFIA	3	MO
Antiparkinson Agents		
Antiparkinson Agents		
amantadine hcl	1	GC; MO
APOKYN	5	MO

Drug Name	Drug Tier	Notes
atamet	1	GC; MO
AZILECT	3	MO
benztropine mesylate tablet	1	GC; MO
benztropine mesylate injection	4	HI
bromocriptine mesylate	1	GC; MO
carbidopa/levodopa	1	GC; MO
carbidopa/levodopa cr	1	GC; MO
carbidopa/levodopa odt	1	GC; MO
carbidopa/levodopa sr	1	GC; MO
COGENTIN	4	HI
COMTAN	2	MO
LODOSYN	3	MO
MIRAPEX	2	MO
PARCOPA	3	MO
PARLODEL	3	MO
REQUIP	3	MO
REQUIP XL	3	MO
ropinirole hcl	1	GC; MO
selegiline hcl	1	GC; MO
SINEMET	3	MO
SINEMET CR	3	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
TASMAR	3	MO
trihexyphenidyl hcl	1	GC; MO
ZELAPAR	3	MO
Antipsychotics		
Atypicals		
ABILIFY TABLET	2	MO
ABILIFY INJECTION	4	MO
clozapine	1	GC; MO
CLOZARIL	3	MO
FAZACLO	3	MO
INVEGA	3	MO
RISPERDAL	3	MO
RISPERDAL CONSTA	4	MO
RISPERDAL M-TAB	3	MO
risperidone	1	GC; MO
risperidone odt	1	GC; MO
SAPHRIS	3	MO
SEROQUEL	2	MO
SEROQUEL XR	2	MO
SYMBYAX	3	MO

Drug Name	Drug Tier	Notes
ZYPREXA ZYDIS	2	MO
ZYPREXA TABLET	2	MO
ZYPREXA INJECTION	4	MO
Conventional		
chlorpromazine hcl tablet	1	GC; MO
chlorpromazine hcl injection	4	HI
clozapine	1	GC; MO
fluphenazine decanoate	4	MO
fluphenazine hcl concentrate, elixir, tablet	1	GC; MO
fluphenazine hcl injection	4	MO
HALDOL	4	MO
HALDOL DECANOATE-100	4	MO
HALDOL DECANOATE-50	4	MO
haloperidol	1	GC; MO
haloperidol decanoate	4	MO
haloperidol lactate	4	MO
loxapine succinate	1	GC; MO
LOXITANE	3	MO
MOBAN	2	MO
NAVANE	3	MO
ORAP	2	MO
perphenazine	1	GC; MO
perphenazine /amitriptyline	1	GC; MO
thioridazine hcl	1	GC; MO
thiothixene	1	GC; MO
trifluoperazine hcl	1	GC; MO
Antispasticity Agents		
Antispasticity Agents		
MYOBLOC	4	MO; PA - Prior authorization required for coverage.
NORFLEX	4	MO
orphenadrine citrate	4	MO
orphenadrine citrate er	1	GC; MO
tizanidine hcl	1	GC; MO
ZANAFLEX	3	MO
Antivirals		
Anti-cytomegalovirus (CMV) Agents		
CYTOVENE	4	HI
FOSCAVIR	4	HI
ganciclovir	1	GC; MO
VALCYTE	3	MO
VISTIDE	4	HI
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors		
INTELENCE	5	MO
RESCRIPTOR	2	MO
SUSTIVA	2	MO

Drug Name	Drug Tier	Notes
VIRAMUNE	2	MO
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors		
ATRIPLA	5	MO
COMBIVIR	5	MO
didanosine	1	GC; MO
EMTRIVA	2	MO
EPIVIR	2	MO
EPIVIR HBV	2	MO
EPZICOM	5	MO
RETROVIR	3	MO
RETROVIR IV INFUSION	4	HI
stavudine	1	GC; MO
TRIZIVIR	5	MO
TRUVADA	5	MO
TYZEKA	5	MO
VIDEX EC	3	MO
VIDEX PEDIATRIC	2	MO
VIREAD	2	MO
ZERIT	3	MO
ZIAGEN	2	MO
zidovudine	1	GC; MO
Anti-HIV Agents, Other		
FUZEON	5	MO
ISENTRESS	5	MO
SELZENTRY	5	MO
Anti-HIV Agents, Protease Inhibitors		
APTIVUS SOLUTION	3	MO
APTIVUS CAPSULE	5	MO
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
VIRACEPT TABLET	5	MO
Anti-influenza Agents		
amantadine hcl	1	GC; MO
FLUMADINE	3	MO
RELENZA DISKHALER	3	MO
rimantadine hcl	1	GC; MO

Drug Name	Drug Tier	Notes
TAMIFLU	2	MO
Antihepatitis Agents		
BARACLUDE	2	MO
COPEGUS	3	MO
HEPSERA	2	MO
REBETOL	3	MO
ribapak	1	GC; MO
ribasphere	1	GC; MO
ribavirin	1	GC; MO
VIRAZOLE	3	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
Antiherpetic Agents		
acyclovir sodium	4	HI
acyclovir capsule, tablet	1	FF; GC; MO
acyclovir suspension	1	GC; MO
DENAVIR	3	MO
famciclovir	1	GC; MO
FAMVIR	3	MO
foscarnet sodium	4	HI
trifluridine	1	GC; MO
VALTREX	2	MO
VIROPTIC	3	MO
ZOVIRAX	3	MO
Anxiolytics		
Antidepressants		
doxepin hcl	1	GC; MO
paroxetine hcl tablet	1	FF; GC; MO
paroxetine hcl suspension	1	GC; MO
sertraline hcl	1	GC; MO
Anxiolytics, Other		
BUSPAR	3	MO
buspirone hcl	1	GC; MO
EQUAGESIC	3	MO
meprobamate	1	GC; MO
Bipolar Agents		
Bipolar Agents		
ABILIFY	2	MO
ABILIFY DISCMELT	2	MO
carbamazepine	1	GC; MO
CARBATROL	2	MO
EQUETRO	3	MO
GEODON CAPSULE	2	MO
GEODON INJECTION	4	MO
lithium carbonate	1	GC; MO
lithium carbonate er	1	GC; MO

Drug Name	Drug Tier	Notes
lithium citrate	1	GC; MO
LITHOBID	3	MO
RISPERDAL M-TAB	3	MO
risperidone odt	1	GC; MO
SYMBYAX	3	MO
Blood Glucose Regulators		
Antidiabetic Agents		
acarbose	1	GC; MO
ACTOPLUS MET	2	MO; PA - Prior authorization required for coverage.
ACTOS	2	MO; PA - Prior authorization required for coverage.
AMARYL	3	MO
AVANDAMET	3	MO; PA - Prior authorization required for coverage.
AVANDARYL	3	MO; PA - Prior authorization required for coverage.
AVANDIA	2	MO; PA - Prior authorization required for coverage.
BYETTA	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 2.4ml (#1 injection pen) per 30 days.
chlorpropamide	1	GC; MO
DIABETA	3	MO
DUETACT	2	MO; PA - Prior authorization required for coverage.
FORTAMET	3	MO
glimepiride	1	GC; MO
glipizide	1	FF; GC; MO
glipizide er	1	FF; GC; MO
glipizide xl	1	FF; GC; MO
glipizide/metformin hcl	1	GC; MO
GLUCOPHAGE	3	MO
GLUCOPHAGE XR	3	MO
GLUCOTROL	3	MO
GLUCOTROL XL	3	MO
GLUCOVANCE	3	MO
GLUMETZA	3	MO
glyburide	1	FF; GC; MO
glyburide micronized	1	GC; MO
glyburide/metformin hcl	1	GC; MO
glycron	1	GC; MO
GLYNASE	3	MO
GLYSET	3	MO

Drug Name	Drug Tier	Notes
JANUMET	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #60 tablets per 30 days.
JANUVIA	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #30 tablets per 30 days.
METAGLIP	3	MO
metformin hcl	1	FF; GC; MO
metformin hcl er	1	FF; GC; MO
PRANDIMET	3	MO
PRANDIN	2	MO
PRECOSE	3	MO
RIOMET	3	MO
STARLIX	3	MO
SYMLIN	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #20ml (4 vials) per 30 days.
SYMLINPEN 120	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 10.8ml (#4x2.7ml pen injectors) per 30 days.
SYMLINPEN 60	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 10.5ml (#7x1.5ml pen injectors) per 30 days.
tolazamide	1	GC; MO
tolbutamide	1	GC; MO
Glycemic Agents		
GLUCAGEN HYPOKIT	2	MO
GLUCAGON EMERGENCY KIT	2	MO
PROGLYCEM	2	MO
Insulins		
APIDRA	3	MO
APIDRA SOLOSTAR	3	MO
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

Drug Name	Drug Tier	Notes
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
LEVEMIR	3	MO
LEVEMIR FLEXPEN	3	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
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
COUMADIN TABLET	3	MO
COUMADIN INJECTION	4	HI
FRAGMIN INJECTION 2500UNIT/0.2ML, 5000UNIT/0.2ML	4	MO
FRAGMIN INJECTION 10000UNIT/ML, 25000UNIT/ML, 7500UNIT/0.3ML	5	MO
heparin sodium	4	HI
heparin sodium dcu	4	HI
heparin sodium/d5w	4	HI
heparin sodium/nacl 0.45%	4	HI
heparin sodium/nacl 0.9%	4	HI
heparin sodium/sodium chloride 0.9% premix	4	HI
INNOHEP	4	MO
jantoven	1	GC; MO
LOVENOX INJECTION 30MG/0.3ML, 40MG/0.4ML	4	MO

Drug Name	Drug Tier	Notes
LOVENOX INJECTION 100MG/ML, 120MG/0.8ML, 150MG/ML, 300MG/3ML, 60MG/0.6ML, 80MG/0.8ML	5	MO
warfarin sodium	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
NEULASTA	5	MO
NEUMEGA	5	MO
NEUPOGEN	5	MO
PROCRIT INJECTION 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	MO
PROCRIT INJECTION 20000UNIT/ML, 40000UNIT/ML	5	MO
PROMACTA	5	LA; PA - Prior authorization required for coverage.
Coagulants		
AMICAR	3	MO
aminocaproic acid syrup, tablet	1	GC; MO
aminocaproic acid injection	4	MO
CYKLOKAPRON	4	HI
Platelet Aggregation Inhibitors		
AGGRENOX	3	MO; Potential preferred options: cilostazol, dipyridamole + ticlopidine, PLAVIX 75mg
AGRYLIN	3	MO
anagrelide hydrochloride	1	GC; MO
cilostazol	1	GC; MO
dipyridamole	1	GC; MO
EFFIENT	3	MO
PENTOPAK	3	MO
pentoxifylline er	1	GC; MO
pentoxil	1	GC; MO
PERSANTINE	3	MO
PLAVIX TABLET 75MG	2	MO
PLAVIX TABLET 300MG	3	MO
PLETAL	3	MO
TICLID	3	MO
ticlopidine hcl	1	GC; MO

Drug Name	Drug Tier	Notes
TRENTAL	3	MO
Cardiovascular Agents		
Alpha-adrenergic Agonists		
CATAPRES	3	MO
CATAPRES-TTS-1	2	MO
CATAPRES-TTS-2	2	MO
CATAPRES-TTS-3	2	MO
clonidine hcl	1	GC; MO
CLORPRES	3	MO
guanabenz acetate	1	GC; MO
guanfacine hcl	1	GC; MO
methyldopa	1	GC; MO
methyldopate hcl	4	HI
midodrine hcl	1	GC; MO
PROAMATINE	3	MO
TENEX	3	MO
Alpha-adrenergic Blocking Agents		
DEMSER	3	MO
DIBENZYLINE	3	MO
doxazosin mesylate	1	FF; GC; MO
MINIPRESS	3	MO
prazosin hcl	1	GC; MO
terazosin hcl	1	GC; MO
Antiarrhythmics		
acebutolol hcl	1	GC; MO
amiodarone hcl tablet	1	GC; MO
amiodarone hcl injection	4	HI
BETAPACE	3	MO
BETAPACE AF	3	MO
CORDARONE	3	MO
DILACOR XR	3	MO
diltiazem hcl	1	GC; MO
diltiazem hcl er	1	GC; MO
disopyramide phosphate	1	GC; MO
flecainide acetate	1	GC; MO
ISOPTIN SR	3	MO
mexiletine hcl	1	GC; MO
MULTAQ	3	MO
NORPACE	3	MO
NORPACE CR	3	MO
pacerone	1	GC; MO
procainamide hcl	4	HI
propafenone hcl	1	GC; MO
quinidine gluconate	4	HI
quinidine gluconate cr	1	GC; MO
quinidine sulfate	1	GC; MO
quinidine sulfate er	1	GC; MO

Drug Name	Drug Tier	Notes
RYTHMOL	3	MO
RYTHMOL SR	3	MO
SECTRAL	3	MO
sorine	1	GC; MO
sotalol hcl	1	GC; MO
TAMBOCOR	3	MO
TIAZAC	3	MO
TIKOSYN	3	MO
verapamil hcl	1	GC; MO
verapamil hcl er	1	GC; MO
Beta-adrenergic Blocking Agents		
acebutolol hcl	1	GC; MO
atenolol	1	GC; MO
atenolol/chlorthalidone	1	GC; MO
betaxolol hcl	1	GC; MO
bisoprolol fumarate	1	GC; MO
bisoprolol fumarate/hydrochlorothiazide	1	GC; MO
BYSTOLIC	3	MO
CARTROL	3	MO
carvedilol	1	GC; MO
COREG	3	MO
COREG CR	3	MO
CORGARD	3	MO
CORZIDE	3	MO
INDERAL LA	3	MO
INNOPRAN XL	2	MO
KERLONE	3	MO
labetalol hcl tablet	1	GC; MO
labetalol hcl injection	4	HI
LEVATOL	3	MO
LOPRESSOR HCT	3	MO
LOPRESSOR TABLET	3	MO
LOPRESSOR INJECTION	4	HI
metoprolol /hydrochlorothiazide	1	GC; MO
metoprolol succinate er	1	GC; MO
metoprolol tartrate tablet	1	FF; GC; MO
metoprolol tartrate injection	4	HI
nadolol	1	GC; MO
nadolol /bendroflumethiazide	1	GC; MO
pindolol	1	GC; MO
propranolol /hydrochlorothiazide	1	GC; MO
propranolol hcl er	1	GC; MO
propranolol hcl oral solution, tablet	1	GC; MO
propranolol hcl injection	4	HI
TENORETIC 100	3	MO
TENORETIC 50	3	MO
TENORMIN	3	MO

Drug Name	Drug Tier	Notes
timolol maleate	1	GC; MO
TOPROL XL	3	MO
TRANDATE	3	MO
ZEBETA	3	MO
ZIAC	3	MO
Calcium Channel Blocking Agents		
ADALAT CC	3	MO
afeditab cr	1	GC; MO
amlodipine besylate	1	GC; MO
CALAN	3	MO
CALAN SR	3	MO
CARDENE I.V.	4	HI
CARDENE SR	3	MO
CARDIZEM	3	MO
CARDIZEM CD	3	MO
CARDIZEM LA	3	MO
cartia xt	1	GC; MO
COVERA-HS	3	MO
dilt-cd	1	GC; MO
dilt-xr	1	GC; MO
diltiazem cd	1	GC; MO
diltiazem hcl er	1	GC; MO
diltiazem hcl tablet	1	GC; MO
diltiazem hcl injection	4	HI
diltzac	1	GC; MO
DYNACIRC CR	3	MO
DYNACIRC-CR	3	MO
felodipine er	1	FF; GC; MO
isradipine	1	GC; MO
LOTREL	3	MO; Potential preferred option: amlodipine besylate/benazepril
nicardipine hcl capsule	1	GC; MO
nicardipine hcl injection	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
nifediac cc	1	GC; MO
nifedical xl	1	GC; MO
nifedipine	1	GC; MO
nifedipine er	1	GC; MO
nimodipine	1	GC; MO
nisoldipine	1	GC; MO
NORVASC	3	MO
PROCARDIA	3	MO
PROCARDIA XL	3	MO
SULAR	2	MO
taztia xt	1	GC; MO

Drug Name	Drug Tier	Notes
VERELAN	3	MO
VERELAN PM	3	MO
Cardiovascular Agents, Other		
digoxin oral solution, tablet	1	GC; MO
digoxin injection	4	HI
LANOXIN TABLET	3	MO
LANOXIN INJECTION	4	HI
RANEXA	3	MO
reserpine	1	GC; MO
Diuretics		
acetazolamide	1	GC; MO
acetazolamide sodium	4	HI
ALDACTAZIDE	3	MO
ALDACTONE	3	MO
amiloride /hydrochlorothiazide	1	GC; MO
amiloride hcl	1	GC; MO
bumetanide tablet	1	GC; MO
bumetanide injection	4	HI
BUMEX	3	MO
chlorothiazide	1	GC; MO
chlorthalidone	1	GC; MO
DEMADEX TABLET	3	MO
DEMADEX INJECTION	4	HI
DIAMOX	3	MO
DIURIL	3	MO
DIURIL IV	4	HI
DYAZIDE	3	MO
DYRENIUM	3	MO
EDECRIN	3	MO
furosemide oral solution, tablet	1	GC; MO
furosemide injection	4	HI
hydrochlorothiazide	1	GC; MO
indapamide	1	GC; MO
LASIX	3	MO
MAXZIDE	3	MO
MAXZIDE-25	3	MO
methazolamide	1	GC; MO
methyclothiazide	1	GC; MO
methyldopa /hydrochlorothiazide	1	GC; MO
metolazone	1	GC; MO
MICROZIDE	3	MO
quinapril /hydrochlorothiazide	1	GC; MO
SODIUM EDECRIN	4	HI
spironolactone	1	GC; MO
spironolactone /hydrochlorothiazide	1	GC; MO
THALITONE	3	MO
torsemide	1	GC; MO

Drug Name	Drug Tier	Notes
triamterene /hydrochlorothiazide	1	GC; MO
ZAROXOLYN	3	MO
Dyslipidemics		
ANTARA	3	MO
cholestyramine	1	GC; MO
cholestyramine light	1	GC; MO
COLESTID	3	MO
colestipol hcl	1	GC; MO
CRESTOR	2	MO; PA - Prior authorization required for coverage.
fenofibrate	1	FF; GC; MO
fenofibrate micronized	1	FF; GC; MO
FENOGLIDE	3	MO
gemfibrozil	1	FF; GC; MO
LIPITOR	3	MO; PA - Prior authorization required for coverage.
LIPOFEN	3	MO
lofibra	1	FF; GC; MO
LOPID	3	MO
lovastatin	1	FF; GC; MO
LOVAZA	3	MO
NIACOR	3	MO
NIASPAN	2	MO
pravastatin sodium	1	GC; MO
prevalite	1	GC; MO
QUESTRAN	3	MO
QUESTRAN LIGHT	3	MO
simvastatin	1	FF; GC; MO
TRICOR	3	MO; Potential preferred options: fenofibrate, gemfibrozil
TRIGLIDE	3	MO
TRILIPIX	3	MO
WELCHOL	3	MO
ZETIA	3	MO; Potential preferred options: lovastatin, pravastatin sodium, simvastatin, CRESTOR
Renin-angiotensin-aldosterone System Inhibitors		
ACCUPRIL	3	MO
ACCURETIC	3	MO
ACEON	3	MO
ALDACTONE	3	MO
ALTACE	3	MO
amlodipine besylate/benazepril hydrochloride	1	GC; MO
benazepril hcl	1	FF; GC; MO
benazepril hcl/hydrochlorothiazide	1	GC; MO
BENICAR	2	MO; PA - Prior authorization required for coverage.

Drug Name	Drug Tier	Notes
BENICAR HCT	2	MO; PA - Prior authorization required for coverage.
CAPOTEN	3	MO
captopril	1	GC; MO
captopril /hydrochlorothiazide	1	GC; MO
DIOVAN	3	MO; PA - Prior authorization required for coverage.
DIOVAN HCT	3	MO; PA - Prior authorization required for coverage.
enalapril maleate	1	FF; GC; MO
enalapril maleate/hydrochlorothiazide	1	GC; MO
eplerenone	1	GC; MO
fosinopril sodium	1	GC; MO
fosinopril sodium/hydrochlorothiazide	1	GC; MO
INSPRA	3	MO
lisinopril	1	FF; GC; MO
lisinopril /hydrochlorothiazide	1	FF; GC; MO
LOTENSIN	3	MO
LOTENSIN HCT	3	MO
LOTREL	3	MO; Potential preferred option: amlodipine besylate/benazepril
MAVIK	3	MO
MICARDIS	2	MO; PA - Prior authorization required for coverage.
MICARDIS HCT	2	MO; PA - Prior authorization required for coverage.
moexipril /hydrochlorothiazide	1	GC; MO
moexipril hcl	1	GC; MO
MONOPRIL	3	MO
MONOPRIL HCT	3	MO
PRINIVIL	3	MO
PRINZIDE	3	MO
quinapril hcl	1	GC; MO
quinaretic	1	GC; MO
ramipril	1	GC; MO
TARKA	3	MO
TEKTURNA	3	MO
TEKTURNA HCT	3	MO
trandolapril	1	GC; MO
UNIRETIC	3	MO
UNIVASC	3	MO
VALTURNA	3	MO; PA - Prior authorization required for coverage.
VASERETIC	3	MO
VASOTEC	3	MO
ZESTORETIC	3	MO
ZESTRIL	3	MO

Drug Name	Drug Tier	Notes
Vasodilators		
BIDIL	3	MO
DILATRATE SR	3	MO
hydralazine hcl tablet	1	GC; MO
hydralazine hcl injection	4	HI
IMDUR	3	MO
ISMO	3	MO
ISOCHRON	3	MO
ISORDIL TITRADOSE	3	MO
isosorbide dinitrate	1	GC; MO
isosorbide dinitrate er	1	GC; MO
isosorbide mononitrate	1	GC; MO
isosorbide mononitrate er	1	GC; MO
minitran	1	GC; MO
minoxidil	1	GC; MO
MONOKET	3	MO
NITRO-BID	3	MO
NITRO-DUR	3	MO
nitroglycerin transdermal	1	GC; MO
nitroglycerin patch 24 hour, tablet sublingual	1	GC; MO
nitroglycerin injection	4	HI
NITROLINGUAL PUMPSPRAY	3	MO
NITROSTAT	3	MO
REMODULIN	5	HI
VENTAVIS	5	LA; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
Central Nervous System Agents		
Amphetamines, ADHD		
ADDERALL	3	MO
ADDERALL XR	2	MO
amphetamine /dextroamphetamine	1	GC; MO
amphetamine salt combo	1	GC; MO
DESOXYN	3	MO
DEXEDRINE	3	MO
dextroamphetamine sulfate	1	GC; MO
dextroamphetamine sulfate er	1	GC; MO
LIQUADD	3	MO
VYVANSE	2	MO
Non-amphetamines, ADHD		
CONCERTA	3	MO
DAYTRANA	3	MO
dexmethylphenidate hcl	1	GC; MO
FOCALIN	3	MO
FOCALIN XR	3	MO
METADATE CD	2	MO

Drug Name	Drug Tier	Notes
METADATE ER	3	MO
methylin	1	GC; MO
methylin er	1	GC; MO
methylphenidate hcl	1	GC; MO
methylphenidate hcl sr	1	GC; MO
RITALIN	3	MO
RITALIN LA	3	MO
RITALIN SR	3	MO
STRATTERA	3	MO
Non-amphetamines, Other		
PROVIGIL TABLET 200MG	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #30 tablets per 30 days.
PROVIGIL TABLET 100MG	3	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #60 tablets per 30 days
RILUTEK	2	MO
XYREM	3	LA; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #540ml per 30 days.
Dental and Oral Agents		
Dental and Oral Agents		
APHTHASOL	3	MO
chlorhexidine gluconate oral rinse	1	GC; MO
DORYX	3	MO
DOXY-CAPS	3	MO
doxycycline hyclate	1	GC; MO
EVOXAC	2	MO
KEPIVANCE	4	HI
minocycline hcl capsule	1	GC; MO
minocycline hcl tablet 75mg	1	GC; MO
minocycline hcl tablet 50mg	1	GC; GC; MO
minocycline hcl tablet 75mg	1	GC; GC; MO
minocycline hcl tablet 100mg	1	GC; GC; MO
minocycline hcl tablet 50mg	1	GC; MO
minocycline hcl tablet 100mg	1	GC; MO
PERIDEX ORAL RINSE	3	MO
periogard	1	GC; MO
pilocarpine hcl	1	GC; MO
pilocarpine hydrochloride	1	GC; MO
SALAGEN	3	MO
SOLODYN	3	MO
triamcinolone in orabase	1	GC; MO

Drug Name	Drug Tier	Notes
Dermatological Agents		
Dermatological Agents		
8-MOP	2	MO
ACANYA	3	MO
ACCUTANE	3	MO
ACLOVATE	3	MO
ACZONE	3	MO
ALA CORT	3	MO
ALA SCALP	3	MO
ALA-CORT	3	MO
alclometasone dipropionate	1	GC; MO
ALDARA	3	MO
amcinonide	1	GC; MO
AMEVIVE	5	MO; PA - Prior authorization required for coverage.
ammonium lactate	1	GC; MO
amnesteem	1	GC; MO
ATRALIN	3	MO; PA - Prior authorization required for coverage.
augmented betamethasone dipropionate	1	GC; MO
AVITA	3	MO; PA - Prior authorization required for coverage.
AZELEX	2	MO
BENZACLIN CARE KIT	3	MO
BENZAMYCIN	3	MO
benzoyl peroxide wash	1	GC; MO
benzoyl peroxide gel 10%, 5%, 2.5%	1	GC; MO
beta-val	1	GC; MO
betamethasone dipropionate	1	GC; MO
betamethasone valerate	1	GC; MO
calcipotriene	1	GC; MO
CAPEX	2	MO
CARAC	2	MO
CARMOL-HC	3	MO
claravis	1	GC; MO
clindamycin/benzoyl peroxide	1	GC; MO
clobetasol propionate	1	GC; MO
clobetasol propionate e	1	GC; MO
CLOBEX	3	MO
CLODERM	2	MO
clotrimazole/betamethasone dipropionate	1	GC; MO
CONDYLOX	3	MO
CORDRAN	2	MO
CORDRAN SP	2	MO
CORDRAN TAPE	2	MO
CORMAX	3	MO
CUTIVATE	3	MO

Drug Name	Drug Tier	Notes
del-beta	1	GC; MO
DERMA-SMOOTHE/FS BODY OIL	2	MO
DESONATE	3	MO
desonide	1	GC; MO
DESOWEN CREAM/CETAPHIL LOTION	3	MO
DESOWEN LOTION/CETAPHIL CREAM	3	MO
DESOWEN OINTMENT/CETAPHIL LOTION	3	MO
desoximetasone	1	GC; MO
DIFFERIN	2	MO
diflorasone diacetate	1	GC; MO
DIPROLENE	3	MO
DOVONEX CREAM	2	MO
DOVONEX SOLUTION	3	MO
doxepin hcl	1	GC; MO
doxycycline monohydrate	1	GC; MO
DRITHO-CREME HP	3	MO
DRITHO-SCALP	3	MO
EFUDEX	3	MO
ELIDEL	3	MO
EPIDUO	3	MO
erythromycin/benzoyl peroxide	1	GC; MO
FINACEA	3	MO
fluocinolone acetonide	1	GC; MO
fluocinonide	1	GC; MO
fluocinonide emollient base	1	GC; MO
FLUOROPLEX	2	MO
fluorouracil	1	GC; MO
fluticasone propionate	1	GC; MO
halobetasol propionate	1	GC; MO
hydrocortisone	1	GC; MO
hydrocortisone butyrate	1	GC; MO
hydrocortisone in absorbase	1	GC; MO
hydrocortisone valerate	1	GC; MO
KEROL	3	MO
LAC-HYDRIN	3	MO
LACLOTION	3	MO
LOCOID	3	MO
LOCOID LIPOCREAM	3	MO
LOKARA	3	MO
LUXIQ	2	MO
mometasone furoate	1	GC; MO
nystatin/triamcinolone	1	GC; MO
OLUX-E	3	MO
ORACEA	3	MO
OXSORALEN	2	MO
OXSORALEN ULTRA	2	MO
PANDEL	3	MO

Drug Name	Drug Tier	Notes
podofilox	1	GC; MO
prednicarbate	1	GC; MO
PROTOPIC	3	MO
REGRANEX	3	MO
RETIN-A	3	MO; PA - Prior authorization required for coverage.
RETIN-A MICRO	2	MO; PA - Prior authorization required for coverage.
SANTYL	3	MO
selenium sulfide	1	GC; MO
SELSUN SHAMPOO	3	MO
SOLARAZE	3	MO
SORIATANE CK	5	MO
sotret	1	GC; MO
TACLONEX	3	MO
TACLONEX SCALP	3	MO
TAZORAC	2	MO
TEMOVATE	3	MO
TOPICORT	3	MO
TOPICORT LP	3	MO
TRETIN-X	3	MO; PA - Prior authorization required for coverage.
tretinoin	1	GC; MO; PA - Prior authorization required for coverage.
triamcinolone acetonide	1	GC; MO
triamcinolone acetonide in absorbase	1	GC; MO
triderm	1	GC; MO
U-CORT	3	MO
urea	1	GC; MO
urea nail	1	GC; MO
urea nailstik	1	GC; MO
UVADEX	4	MO
VANOS	3	MO
VECTICAL	3	MO
VERDESO	3	MO
VEREGEN	3	MO
VOLTAREN	3	MO
ZIANA	3	MO
ZONALON	3	MO
Enzyme Replacements/ Modifiers		
Enzyme Replacements/ Modifiers		
ADAGEN	4	LA
ALDURAZYME	5	LA HI
BUPHENYL	2	MO
CEREDASE	5	LA HI
CEREZYME	5	HI; LA; PA - Prior authorization required for coverage.

Drug Name	Drug Tier	Notes
CREON	2	MO
CYSTADANE	2	MO
CYSTAGON	3	MO
ELAPRASE	5	LA HI
FABRAZYME	5	LA HI
KUVAN	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #420 tablets per 30 days.
lipram 4500	1	GC; MO
lipram-pn10	1	GC; MO
lipram-pn16	1	GC; MO
lipram-pn20	1	GC; MO
lipram-ul12	1	GC; MO
lipram-ul18	1	GC; MO
lipram-ul20	1	GC; MO
MYOZYME	5	LA HI
NAGLAZYME	5	HI
ORFADIN	3	MO
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
pancrelipase	1	GC; MO
pancrelipase mst-16	1	GC; MO
pancron 10	1	GC; MO
pancron 20	1	GC; MO
SUCRAID	3	MO
ULTRASE	2	MO
ULTRASE MT 12	2	MO
ULTRASE MT 18	2	MO
ULTRASE MT 20	2	MO
VIOKASE	2	MO
VIOKASE 16	2	MO
ZAVESCA	5	MO; PA - Prior authorization required for coverage.
Gastrointestinal Agents		
Antispasmodics, Gastrointestinal		
ANASPAZ	3	MO
atropine sulfate injection 0.05mg/ml	4	HI
atropine sulfate injection 0.1mg/ml	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
BENTYL CAPSULE, SYRUP, TABLET	3	MO
BENTYL INJECTION	4	MO
CANTIL	3	MO
dicyclomine hcl capsule, oral solution, tablet	1	GC; MO
dicyclomine hcl injection	4	MO
glycopyrrolate tablet	1	GC; MO
glycopyrrolate injection	4	MO
hyomax-ft	1	GC; MO
hyomax-sl	1	GC; MO
hyoscyamine sulfate	1	GC; MO
LEVSIN	3	MO
LEVSIN /SL	3	MO
methscopolamine bromide	1	GC; MO
PAMINE	3	MO
PAMINE FORTE	3	MO
propantheline bromide	1	GC; MO
ROBINUL FORTE	3	MO
ROBINUL TABLET	3	MO
ROBINUL INJECTION	4	MO
symax fastabs	1	GC; MO
symax-sl	1	GC; MO
Gastrointestinal Agents, Other		
ACTIGALL	3	MO
AMITIZA	3	MO
COLYTE	3	MO
CONSTULOSE	3	MO
diphenoxylate/atropine	1	GC; MO
ENULOSE	3	MO
GASTROCROM	3	MO
gavilyte-g	1	GC; MO
generlac	1	GC; MO
GOLYTELY	3	MO
HALFLYTELY BOWEL PREP	3	MO
KRISTALOSE	2	MO
lactulose	1	GC; MO
LOMOTIL	3	MO
lonox	1	GC; MO
loperamide hcl	1	GC; MO
MOTOFEN	3	MO
MOVIPREP	3	MO
NULYTELY/FLAVOR PACKS	3	MO
OPIUM	3	MO
OSMOPREP	3	MO
peg 3350/electrolytes	1	GC; MO
polyethylene glycol 3350	1	GC; MO
PYLERA	3	MO

Drug Name	Drug Tier	Notes
RELISTOR	4	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #8.4ml per 30 days
SANDOSTATIN	5	MO
SANDOSTATIN LAR DEPOT	5	MO
trilyte	1	GC; MO
URSO 250	3	MO
URSO FORTE	3	MO
ursodiol	1	GC; MO
VISICOL	3	MO
Histamine2 (H2) Blocking Agents		
AXID	3	MO
cimetidine	1	GC; MO
cimetidine hcl oral solution	1	GC; MO
cimetidine hcl injection	4	HI
famotidine premixed	4	HI
famotidine tablet	1	GC; MO
famotidine injection	4	HI
nizatidine	1	GC; MO
PEPCID	3	MO
PEPCID I.V.	4	HI
PEPCID PREMIXED	4	HI
ranitidine hcl capsule, syrup, tablet	1	GC; MO
ranitidine hcl injection	4	HI
ZANTAC PACKET, SYRUP, TABLET, TABLET EFFERVESCENT	3	MO
ZANTAC INJECTION	4	HI
Irritable Bowel Syndrome Agents		
LOTRONEX	3	MO
Protectants		
CARAFATE	3	MO
CYTOTEC	3	MO
misoprostol	1	GC; MO
sucralfate	1	GC; MO
Proton Pump Inhibitors		
NEXIUM I.V.	4	HI
omeprazole capsule delayed release 10mg, 20mg	1	FF; GC; MO
omeprazole capsule delayed release 40mg	1	GC; MO
pantoprazole sodium	1	GC; MO
PREVACID	2	MO; PA - Prior authorization required for coverage.
PREVACID SOLUTAB	2	MO; PA - Prior authorization required for coverage.
PREVPAC	2	MO
PROTONIX INJECTION	4	HI

Drug Name	Drug Tier	Notes
Genitourinary Agents		
Antispasmodics, Urinary		
DETROL	3	MO
DETROL LA	2	MO
DITROPAN XL	3	MO
ENABLEX	3	MO
flavoxate hcl	1	GC; MO
GELNIQUE	3	MO
oxybutynin chloride er	1	GC; MO
oxybutynin chloride tablet	1	FF; GC; MO
oxybutynin chloride syrup	1	GC; MO
OXYTROL	3	MO
SANCTURA	3	MO
SANCTURA XR	3	MO
TOVIAZ	3	MO
VESICARE	3	MO; Potential preferred options: oxybutynin, oxybutynin chloride ER tablet, DETROL LA
Benign Prostatic Hypertrophy Agents		
doxazosin mesylate	1	FF; GC; MO
finasteride	1	GC; MO
prazosin hcl	1	GC; MO
terazosin hcl	1	GC; MO
UROXATRAL	2	MO
Genitourinary Agents, Other		
bethanechol chloride	1	GC; MO
ELMIRON	2	MO
LITHOSTAT	3	MO
METHERGINE	3	MO
THIOLA	3	MO
URECHOLINE	3	MO
UROCIT-K 10	3	MO
UROCIT-K 5	3	MO
Phosphate Binders		
calcium acetate	1	GC; MO
ELIPHOS	2	MO
FOSRENOL	3	MO
PHOSLO	3	MO
RENVELA	3	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
Glucocorticoids/ Mineralocorticoids		
a-hydrocort	4	MO
a-methapred	4	HI
alclometasone dipropionate	1	GC; MO
augmented betamethasone dipropionate	1	GC; MO
betamethasone valerate	1	GC; MO

Drug Name	Drug Tier	Notes
CELESTONE	3	MO
clobetasol propionate	1	GC; MO
CORTEF	3	MO
cortisone acetate	1	GC; MO
DEPO-MEDROL	4	MO
desonide	1	GC; MO
dexamethasone	1	GC; MO
DEXAMETHASONE INTENSOL	2	MO
dexamethasone sodium phosphate	4	
DEXPAK 13 DAY	3	MO
fludrocortisone acetate	1	GC; MO
hydrocortisone	1	GC; MO
hydrocortisone butyrate	1	GC; MO
ISOVATE	3	MO
MEDROL	3	MO
MEDROL DOSEPAK	3	MO
methylprednisolone	1	GC; MO
methylprednisolone acetate	4	MO
methylprednisolone sodiumsuccinate	4	HI
MILLIPRED	3	MO
ORAPRED	3	MO
ORAPRED ODT	3	MO
PEDIAPRED	2	MO
prednisolone sodium phosphate	1	GC; MO
prednisone	1	GC; MO
PREDNISONE INTENSOL	2	MO
PRELONE	3	MO
SOLU-CORTEF	4	MO
SOLU-MEDROL	4	HI
STERAPRED	3	MO
sterapred 12 day	1	GC; MO
sterapred ds 12 day	1	GC; MO
TOPICORT	3	MO
triamcinolone acetonide	1	GC; MO
VERIPRED 20	3	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
CHORIONIC GONADOTROPIN	4	MO; PA - Prior authorization required for coverage.
DDAVP NASAL SOLUTION, TABLET	3	MO
DDAVP INJECTION	4	HI
desmopressin acetate nasal solution, tablet	1	GC; MO
desmopressin acetate injection	4	HI
GENOTROPIN	5	MO; PA - Prior authorization required for coverage.

Drug Name	Drug Tier	Notes
GENOTROPIN MINIQUICK INJECTION 0.2MG	4	MO; PA - Prior authorization required for coverage.
GENOTROPIN MINIQUICK INJECTION 0.4MG, 0.6MG, 0.8MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 1MG, 2MG	5	MO; PA - Prior authorization required for coverage.
HUMATROPE	5	MO; PA - Prior authorization required for coverage.
HUMATROPE COMBO PACK	5	MO; PA - Prior authorization required for coverage.
INCRELEX	5	LA; PA - Prior authorization required for coverage.
NORDITROPIN CARTRIDGE	5	MO; PA - Prior authorization required for coverage.
NORDITROPIN NORDIFLEX PEN	5	MO; PA - Prior authorization required for coverage.
NOVAREL	4	MO; PA - Prior authorization required for coverage.
NUTROPIN	5	MO; PA - Prior authorization required for coverage.
NUTROPIN AQ	5	MO; PA - Prior authorization required for coverage.
OMNITROPE	5	MO; PA - Prior authorization required for coverage.
PREGNYL W/DILUENT BENZYL ALCOHOL/NACL	4	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.
SEROSTIM	5	MO; PA - Prior authorization required for coverage.
STIMATE	2	MO
TEV-TROPIN	5	MO; PA - Prior authorization required for coverage.
ZORBTIVE	5	MO; PA - Prior authorization required for coverage.
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)		
CYTOTEC	3	MO
misoprostol	1	GC; MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
Anabolic Steroids		
ANADROL-50	3	MO
OXANDRIN	3	MO
oxandrolone	1	GC; MO

Drug Name	Drug Tier	Notes
Androgens		
ANDRODERM	3	MO
ANDROGEL	3	MO
ANDROID	3	MO
ANDROXY	3	MO
danazol	1	GC; MO
DELATESTRYL	4	MO
DEPO-TESTOSTERONE	4	MO
METHITEST	2	MO
STRIANT	3	MO
TESTIM	3	MO
testosterone cypionate	4	MO
testosterone enanthate	4	MO
TESTRED	2	MO
Estrogens		
ACTIVELLA	3	MO
ALORA	2	MO
apri	1	GC; MO
aranelle	1	GC; MO
aviane	1	GC; MO
BALZIVA	3	MO
brevicon-28	1	GC; MO
CENESTIN	2	MO
CLIMARA	3	MO
COMBIPATCH	3	MO
cryselle-28	1	GC; MO
DELESTROGEN	4	MO
DEPO-ESTRADIOL	4	MO
DIVIGEL	3	MO
ELESTRIN	3	MO
ENJUVIA	3	MO
enpresse-28	1	GC; MO
ESTRACE	3	MO
ESTRADERM	2	MO
estradiol valerate	4	MO
estradiol/norethindrone acetate	1	GC; MO
estradiol tablet	1	FF; GC; MO
estradiol patch weekly	1	GC; MO
ESTRASORB	3	MO
ESTRING	3	MO
ESTROGEL	3	MO
estropipate	1	GC; MO
ESTROSTEP FE	3	MO
EVAMIST	3	MO
FEMRING	3	MO
FEMTRACE	3	MO
GYNODIOL	3	MO

Drug Name	Drug Tier	Notes
junel 1.5/30	1	GC; MO
junel 1/20	1	GC; MO
junel fe 1.5/30	1	GC; MO
junel fe 1/20	1	GC; MO
kariva	1	GC; MO
kelnor 1/35	1	GC; MO
leena	1	GC; MO
lessina-28	1	GC; MO
levora 0.15/30-28	1	GC; MO
LOESTRIN FE 1.5/30	2	MO
LOESTRIN FE 1/20	2	MO
low-ogestrel	1	GC; MO
lutera	1	GC; MO
LYBREL	3	MO
menest	1	GC; MO
MENOSTAR	3	MO
microgestin 1.5/30	1	GC; MO
microgestin 1/20	1	GC; MO
microgestin fe	1	GC; MO
microgestin fe 1.5/30	1	GC; MO
mononessa	1	GC; MO
necon 0.5/35-28	1	GC; MO
necon 1/35-28	1	GC; MO
necon 1/50-28	1	GC; MO
necon 10/11-28	1	GC; MO
necon 7/7/7	1	GC; MO
NORDETTE-28	2	MO
NORINYL 1+35	2	MO
nortrel 0.5/35 (28)	1	GC; MO
nortrel 1/35 (21)	1	GC; MO
nortrel 1/35 (28)	1	GC; MO
nortrel 7/7/7	1	GC; MO
NUVARING	3	MO
OGEN	3	MO
ORTHO EVRA	2	MO
ORTHO TRI-CYCLEN LO	2	MO
ORTHO-EST	3	MO
OVCON-35	3	MO
OVCON-50 28	3	MO
portia-28	1	GC; MO
PREMARIN W/APPLICATOR	2	MO
PREMARIN TABLET	2	MO
PREMARIN INJECTION	4	HI
PREMPHASE	2	MO
PREMPRO	2	MO
previfem	1	GC; MO
quasense	1	GC; MO

Drug Name	Drug Tier	Notes
reclipsen	1	GC; MO
SEASONALE	3	MO
sprintec 28	1	GC; MO
sronyx	1	GC; MO
tri-legest fe	1	GC; MO
TRI-NORINYL 28	2	MO
tri-previfem	1	GC; MO
tri-sprintec	1	GC; MO
trinessa	1	GC; MO
trivora-28	1	GC; MO
VAGIFEM	2	MO
velivet	1	GC; MO
VIVELLE-DOT	2	MO
zovia 1/35e	1	GC; MO
zovia 1/50e	1	GC; MO
Progestins		
ANGELIQ	3	MO
AYGESTIN	3	MO
camila	1	GC; MO
cesia	1	GC; MO
CLIMARA PRO	3	MO
CRINONE	3	MO
CYCLESSA	3	MO
DEPO-PROVERA	4	MO
DEPO-PROVERA CONTRACEPTIVE	4	MO
DEPO-SUBQ PROVERA 104	4	MO
DESOGEN	2	MO
errin	1	GC; MO
FEMHRT 1/5	2	MO
FEMHRT LOW DOSE	2	MO
jolivette	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
medroxyprogesterone acetate tablet	1	GC; MO
medroxyprogesterone acetate injection	4	MO
MEGACE ES	3	MO
MEGACE ORAL	3	MO
megestrol acetate	1	GC; MO
MODICON-28	2	MO
next choice	1	GC; MO
NOR-QD	2	MO
nora-be	1	GC; MO
norethindrone acetate	1	GC; MO
ocella	1	GC; MO
ogestrel	1	GC; MO

Drug Name	Drug Tier	Notes
ORTHO MICRONOR	2	MO
ORTHO-CEPT-28	2	MO
ORTHO-CYCLEN	2	MO
ORTHO-NOVUM 7/7/7-28	2	MO
PLAN B	2	MO
PREFEST	3	MO
PROCHIEVE	3	MO
PROMETRIUM	3	MO
PROVERA	3	MO
SEASONIQUE	3	MO
solia	1	GC; MO
YASMIN 28	3	MO
YAZ	3	MO
Selective Estrogen Receptor Modifying Agents		
EVISTA	2	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
ARMOUR THYROID	2	MO
CYTOMEL	3	MO
LEVOTHROID	2	MO
levothyroxine sodium	1	FF; GC; MO
LEVOXYL	2	MO
liothyronine sodium tablet	1	GC; MO
liothyronine sodium injection	4	HI
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
unithroid	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)		
bromocriptine mesylate	1	GC; MO
cabergoline	1	GC; MO
ELIGARD	4	MO
leuprolide acetate	4	MO
LUPRON 2 WEEK SUPPLY	5	MO
LUPRON DEPOT	5	MO

Drug Name	Drug Tier	Notes
LUPRON DEPOT-PED	5	MO
OCTREOTIDE ACETATE INJECTION 50MCG/ML	4	MO
OCTREOTIDE ACETATE INJECTION 1000MCG/ML, 100MCG/ML, 200MCG/ML, 500MCG/ML	5	MO
PARLODEL	3	MO
SOMATULINE DEPOT	5	MO
SOMAVERT	5	MO
SYNAREL	5	MO
TRELSTAR DEPOT	4	MO
TRELSTAR LA	4	MO
Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)		
Antiandrogens		
bicalutamide	1	GC; MO
CASODEX	3	MO
EMCYT	2	MO
flutamide	1	GC; MO
NILANDRON	2	MO
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
methimazole	1	GC; MO
propylthiouracil	1	GC; MO
TAPAZOLE	3	MO
Immunological Agents		
Immune Suppressants		
ARCALYST	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #9.2mls per 30 days.
AZASAN	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
azathioprine	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
azathioprine sodium	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CELLCEPT INTRAVENOUS	4	HI; 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.
CELLCEPT CAPSULE, TABLET	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CIMZIA	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 1 kit (2x200mg vials = 2ml) per 30 days.
CUPRIMINE	2	MO
cyclosporine modified capsule 50mg	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
cyclosporine modified capsule 100mg	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
cyclosporine modified solution	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
cyclosporine capsule	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
cyclosporine injection	4	HI; 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 (#4 injections) per 30 days.
ENBREL INJECTION 50MG/ML	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 4ml (#4 injections) per 30 days.
ENBREL INJECTION 25MG	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 4ml (#8 injections) per 30 days.

Drug Name	Drug Tier	Notes
gengraf	1	GC; MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
HUMIRA	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 1.6ml (#2x40mg/0.8ml injections) per 30 days.
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.
IMURAN	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
methotrexate	1	GC; MO
mycophenolate mofetil	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.
NEORAL	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ORENCIA	5	HI; PA - Prior authorization required for coverage.
ORTHOCLONE OKT3	4	HI; 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.
PROGRAF INJECTION	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
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.
RHEUMATREX	3	MO
SANDIMMUNE CAPSULE, ORAL SOLUTION	3	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
SANDIMMUNE INJECTION	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
SIMPONI	5	MO; PA - Prior authorization required for coverage. When authorized, quantity limited to #0.5ml per 30 days.
SIMULECT	5	HI
SYPRINE	2	MO
TREXALL	3	MO
ZENAPAX	5	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
Immunizing Agents, Passive		
ATGAM	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CARIMUNE NANOFILTERED	5	HI; PA - Prior authorization required for coverage.
flebogamma	5	HI; PA - Prior authorization required for coverage.
GAMASTAN S/D	4	MO
GAMMAGARD LIQUID	5	HI; PA - Prior authorization required for coverage.
GAMUNEX	5	HI; PA - Prior authorization required for coverage.
OCTAGAM	5	HI; PA - Prior authorization required for coverage.
POLYGAM S/D	5	HI; PA - Prior authorization required for coverage.
THYMOGLOBULIN	5	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
VIVAGLOBIN	5	HI; PA - Prior authorization required for coverage.
Immunomodulators		
ACTIMMUNE	5	MO
ALFERON N	5	MO
ARAVA	3	MO
AVONEX	5	MO
BETASERON	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 18ml (#15 injections) per 30 days.
COPAXONE	5	MO
EXTAVIA	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #15 injections per 30 days
INFERGEN	5	MO; QL - Quantity limited to 6ml (#12 injections) per 30 days.
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
KINERET	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to 20.1ml (#30 injections) per 30 days.
leflunomide	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.
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

Drug Name	Drug Tier	Notes
RIDAURA	2	MO
SYNAGIS	5	MO; PA - Prior authorization required for coverage.
TYSABRI	5	HI; LA; PA - Prior authorization required for coverage.
XOLAIR	5	LA; PA - Prior authorization required for coverage.
Vaccines		
ACTHIB	4	MO
ADACEL	4	MO
ATTENUVAX	4	MO
BOOSTRIX	4	MO
COMVAX	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
DAPTACEL	4	MO
DECAVAC	4	MO
DIPHTHERIA/TETANUS TOXOID PEDIATRIC	4	MO
ENGERIX-B	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
GARDASIL	4	MO
HAVRIX	4	MO
HIBERIX	4	
IMOVAX RABIES (H.D.C.V.)	4	MO
INFANRIX	4	MO
IPOL INACTIVATED IPV	4	MO
JE-VAX	4	MO
KINRIX	4	
M-M-R II W/DILUENT 10 DOSE	4	MO
MENACTRA	4	MO
MENOMUNE-A/C/Y/W-135	4	MO
MERUVAX II W/DILUENT 10 DOSE	4	MO
PEDIARIX	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PEDVAX HIB	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PENTACEL	4	
PROQUAD	4	MO
RABAVERT	4	MO

Drug Name	Drug Tier	Notes
RECOMBIVAX HB	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ROTARIX	3	
ROTATEQ	4	MO
TETANUS TOXOID ADSORBED	4	MO
TETANUS/DIPHTHERIA TOXOIDS-ADSORBED ADULT	4	MO
TRIHIBIT	4	MO
TRIPEDIA	4	MO
TWINRIX	4	MO
TYPHIM VI	4	MO
VAQTA	4	MO
VARIVAX	4	MO
VIVOTIF BERNA	4	MO
YF-VAX	4	MO
ZOSTAVAX	4	MO
Inflammatory Bowel Disease Agents		
Glucocorticoids		
ANUSOL-HC	3	MO
colocort	1	GC; MO
CORTENEMA	3	MO
CORTIFOAM	2	MO
ENTOCORT EC	3	MO
hydrocortisone	1	GC; MO
procto-pak	1	GC; MO
PROCTOCORT	3	MO
PROCTOCREAM-HC	3	MO
proctosol hc	1	GC; MO
proctozone-hc	1	GC; MO
Salicylates		
APRISO	3	MO
ASACOL	2	MO
ASACOL HD	2	MO
balsalazide disodium	1	GC; MO
CANASA	2	MO
COLAZAL	3	MO
DIPENTUM	2	MO
LIALDA	3	MO
mesalamine	1	GC; MO
PENTASA	2	MO
ROWASA	3	MO
Sulfonamides		
AZULFIDINE	3	MO
AZULFIDINE EN-TABS	3	MO
sulfasalazine	1	GC; MO

Drug Name	Drug Tier	Notes
sulfazine	1	GC; MO
sulfazine ec	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.
alendronate sodium	1	GC; MO
AREDIA	4	HI
BONIVA TABLET	3	MO; PA - Prior authorization required for coverage.
BONIVA INJECTION	4	HI; PA - Prior authorization required for coverage.
CALCIJEX	4	HI
calcitonin-salmon	1	GC; MO
calcitriol capsule, oral solution	1	GC; MO
calcitriol injection	4	HI
DIDRONEL	3	MO
etidronate disodium	1	GC; MO
FORTEO	5	MO; PA - Prior authorization required for coverage. QL - When authorized quantity limited to #1 x 2.4ml injection per 30 days, up to a lifetime maximum of 2 years of therapy.
FORTICAL	3	MO
FOSAMAX	3	MO
FOSAMAX PLUS D	3	MO
HECTOROL CAPSULE	3	MO
HECTOROL INJECTION	4	HI
MIACALCIN NASAL SOLUTION	3	MO
MIACALCIN INJECTION	4	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
pamidronate disodium	4	HI
ROCALTROL	3	MO
SKELID	3	MO
ZEMPLAR CAPSULE	3	MO
ZEMPLAR INJECTION	4	HI
ZOMETA	4	HI
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

Drug Name	Drug Tier	Notes
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	2	MO
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	2	MO
BD ULTRA-FINE ORIGINAL PEN NEEDLES/29G X 12.7MM	2	MO
CURITY GAUZE PADS 2"X2"	2	MO
sterile water irrigation	1	GC; MO
XENAZINE	5	LA; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #60 tablets per 30 days.
Ophthalmic Agents		
Ophthalmic Agents, Other		
ak-con	1	GC; MO
ak-tob	1	GC; MO
ALCAINE	3	MO
CILOXAN OINTMENT	2	MO
CILOXAN SOLUTION	3	MO
ciprofloxacin hcl	1	GC; MO
erythromycin	1	GC; MO
GENTAK	3	MO
gentamicin sulfate	1	GC; MO
gentasol	1	GC; MO
LACRISERT	3	MO
mydral	1	GC; MO
MYDRIACYL	3	MO
naphazoline hcl	1	GC; MO
OCUFLOX	3	MO
ofloxacin	1	GC; MO
PARCAINE	3	MO
proparacaine hcl	1	GC; MO
RESTASIS	3	MO
tobramycin sulfate	1	GC; MO
tobrasol	1	GC; MO
TOBREX	3	MO
TROPICACYL	3	MO
tropicamide	1	GC; MO
VIGAMOX	3	MO; Potential preferred options: ciprofloxacin, ofloxacin
ZYMAR	3	MO
Ophthalmic Anti-allergy Agents		
ALAMAST	3	MO
ALOCRIL	2	MO
ALOMIDE	3	MO
CROLOM	3	MO
cromolyn sodium	1	GC; MO
ELESTAT	3	MO
EMADINE	3	MO

Drug Name	Drug Tier	Notes
OPTIVAR	3	MO
PATADAY	3	MO
PATANOL	2	MO
Ophthalmic Anti-inflammatories		
ACULAR	2	MO
ACULAR LS	2	MO
ALREX	2	MO
bac /poly /neomy /hc	1	GC; MO
BLEPHAMIDE	3	MO
BLEPHAMIDE S.O.P.	2	MO
dexamethasone sodium phosphate	1	GC; MO
DEXASPORIN	3	MO
diclofenac sodium	1	GC; MO
DUREZOL	3	MO
FLAREX	3	MO
fluor-op	1	GC; MO
fluorometholone	1	GC; MO
flurbiprofen sodium	1	GC; MO
FML	2	MO
FML FORTE	3	MO
FML LIQUIFILM	3	MO
LOTEMAX	2	MO
MAXIDEX	3	MO
MAXITROL	3	MO
neomycin /polymyxin /dexamethasone	1	GC; MO
NEVANAC	3	MO
OCUFEN	3	MO
OMNIPRED	3	MO
poly-dex	1	GC; MO
PRED FORTE	3	MO
PRED MILD	2	MO
PRED-G	3	MO
PRED-G S.O.P.	3	MO
prednisolone acetate	1	GC; MO
prednisolone sodium phosphate	1	GC; MO
sulfacetamide sodium/prednisolone sodium phosphate	1	GC; MO
TOBRADEX OINTMENT	2	MO
TOBRADEX SUSPENSION	3	MO
tobramycin /dexamethasone	1	GC; MO
VEXOL	3	MO
VOLTAREN	3	MO
XIBROM	3	MO
ZYLET	3	MO
Ophthalmic Antiglaucoma Agents		
acetazolamide	1	GC; MO
ALPHAGAN P	2	MO
apraclonidine	1	GC; MO

Drug Name	Drug Tier	Notes
AZOPT	2	MO
BETAGAN	3	MO
BETAGAN WITHOUT C CAP	3	MO
betaxolol hcl	1	GC; MO
BETIMOL	2	MO
BETOPTIC-S	2	MO
brimonidine tartrate 0.2%	1	GC; MO
carteolol hcl	1	GC; MO
COMBIGAN	3	MO
COSOPT	3	MO
dipivefrin hcl	1	GC; MO
dorzolamide hcl/timolol maleate	1	GC; MO
IOPIDINE	3	MO
ISTALOL	3	MO
levobunolol hcl	1	GC; MO
metipranolol	1	GC; MO
OPTIPRANOLOL	3	MO
PHOSPHOLINE IODIDE	3	MO
pilocarpine hcl	1	GC; MO
PILOPINE HS	2	MO
PROPINE	2	MO
timolol maleate	1	GC; MO
TIMOPTIC OCUDOSE	3	MO
TIMOPTIC-XE	3	MO
Ophthalmic Prostaglandin and Prostamide Analogs		
dorzolamide hcl	1	GC; MO
LUMIGAN	2	MO
TRAVATAN	2	MO
TRAVATAN Z	2	MO
TRUSOPT	3	MO
XALATAN	3	MO
Otic Agents		
Otic Agents		
acetasol hc	1	GC; MO
acetic acid	1	GC; MO
acetic acid/aluminum acetate	1	GC; MO
acetic acid/hydrocortisone	1	GC; MO
aurodex	1	GC; MO
borofair	1	GC; MO
CIPRO HC	2	MO
CIPRODEX	2	MO
cortomycin	1	GC; MO
DERMOTIC	3	MO
neomycin /polymyxin /hc	1	GC; MO
neomycin /polymyxin /hydrocortisone	1	GC; MO
ofloxacin	1	GC; MO

Drug Name	Drug Tier	Notes
Respiratory Tract Agents		
Anti-inflammatories, Inhaled Corticosteroids		
ADVAIR DISKUS	2	MO
AEROBID-M	3	MO
ALVESCO	3	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
BECONASE AQ	3	MO; PA - Prior authorization required for coverage.
FLONASE	3	MO
FLOVENT DISKUS	2	MO
FLOVENT HFA	2	MO
flunisolide	1	GC; MO
fluticasone propionate	1	GC; MO
NASACORT AQ	2	MO; PA - Prior authorization required for coverage.
NASAREL	3	MO
NASONEX	3	MO; PA - Prior authorization required for coverage.
OMNARIS	3	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
RHINOCORT AQUA	3	MO; PA - Prior authorization required for coverage.
Antihistamines		
ALLEGRA	3	MO
ALLEGRA-D 12 HOUR	3	MO
ALLEGRA-D 24 HOUR	3	MO
ASTELIN	2	MO
ASTEPRO	2	MO
carbinoxamine maleate	1	GC; MO
cetirizine hcl	1	GC; MO
CLARINEX	3	MO
CLARINEX REDITABS	3	MO
CLARINEX-D 12 HOUR	3	MO
CLARINEX-D 24 HOUR	3	MO
clemastine fumarate	1	GC; MO
cyproheptadine hcl	1	GC; MO
dexchlorpheniramine maleate	1	GC; MO

Drug Name	Drug Tier	Notes
diphenhydramine hcl capsule, elixir	1	GC; MO
diphenhydramine hcl injection	4	HI
fexofenadine hcl	1	GC; MO
hydroxyzine hcl syrup, tablet	1	GC; MO
hydroxyzine hcl injection	4	MO
hydroxyzine pamoate	1	GC; MO
PALGIC	3	MO
PATANASE	3	MO
PHENERGAN	4	MO
promethazine hcl syrup, tablet	1	GC; MO
promethazine hcl injection	4	MO
PROMETHAZINE VC	3	MO
SEMPREX-D	3	MO
VISTARIL	3	MO
XYZAL	3	MO
Antileukotrienes		
ACCOLATE	2	MO
SINGULAIR	2	MO
ZYFLO CR	3	MO
Bronchodilators, Anticholinergic		
ATROVENT	3	MO
ATROVENT HFA	2	MO
ipratropium bromide nasal solution	1	GC; MO
ipratropium bromide inhalation solution	1	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
SPIRIVA HANDIHALER	2	MO
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)		
aminophylline tablet	1	GC; MO
aminophylline injection	4	HI
elixophyllin	1	GC; MO
LUFYLLIN	3	MO
THEO-24	3	MO
theochron	1	GC; MO
theophylline cr	1	GC; MO
theophylline er	1	GC; MO
UNIPHYL	3	MO
Bronchodilators, Sympathomimetic		
ACCUNEB NEBULIZATION SOLUTION 0.63MG/3ML	3	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
ACCUNEB NEBULIZATION SOLUTION 1.25MG/3ML	3	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ADVAIR HFA	2	MO
albuterol sulfate er	1	GC; MO
albuterol sulfate syrup, tablet	1	GC; MO
albuterol sulfate nebulization solution	1	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
BRETHINE TABLET	3	MO
BRETHINE INJECTION	4	MO
BROVANA	3	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
COMBIVENT	2	MO
DUONEB	3	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
epinephrine hcl	4	MO
EPIPEN 2-PAK	2	MO
EPIPEN-JR 2-PAK	2	MO
FORADIL AEROLIZER	2	MO
ipratropium bromide/albuterol sulfate	1	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
MAXAIR AUTOHALER	3	
metaproterenol sulfate	1	GC; MO
PERFOROMIST	3	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PROAIR HFA	2	MO
PROVENTIL HFA	2	MO
SEREVENT DISKUS	2	MO
terbutaline sulfate tablet	1	GC; MO
terbutaline sulfate injection	4	MO
TWINJECT	4	MO
VENTOLIN HFA	2	MO
VOSPIRE ER	3	MO

Drug Name	Drug Tier	Notes
XOPENEX	3	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
XOPENEX HFA	3	MO
Mast Cell Stabilizers		
cromolyn sodium	1	GC; MO
Pulmonary Antihypertensives		
ADCIRCA	5	MO; PA - Prior authorization required for coverage. When authorized, quantity limited to #60 tablets per 30 days.
LETAIRIS	5	LA
REVATIO	5	MO; PA - Prior authorization required for coverage. QL - When authorized, quantity limited to #90 tablets per 30 days.
TRACLEER	5	LA
Respiratory Tract Agents, Other		
acetylcysteine	1	MO; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ARALAST	5	LA HI
PROLASTIN	5	LA HI
PULMOZYME	2	PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
SYMBICORT	3	MO
TYZINE	3	MO
TYZINE PEDIATRIC NASAL DROPS	3	MO
VERAMYST	3	MO; PA - Prior authorization required for coverage.
ZEMAIRA	5	HI
Sedatives/Hypnotics		
Sedatives/Hypnotics		
somnote	1	GC
zaleplon	1	GC; MO; QL - Quantity limited to #30 capsules per 30 days. All strengths of zaleplon, zolpidem tartrate accumulate together.
zolpidem tartrate	1	GC; MO; QL - Quantity limited to #30 tablets per 30 days. All strengths of zaleplon, zolpidem tartrate accumulate together.

Drug Name	Drug Tier	Notes
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
AMRIX	3	MO
baclofen	1	GC; MO
BOTOX	4	MO; PA - Prior authorization required for coverage.
carisoprodol	1	GC; MO
carisoprodol /aspirin	1	GC; MO
carisoprodol /aspirin /codeine	1	GC; MO
chlorzoxazone	1	GC; MO
cyclobenzaprine hcl	1	GC; MO
DANTRIUM	3	MO
dantrolene sodium	1	GC; MO
FEXMID	3	MO
FLEXERIL	3	MO
methocarbamol	1	GC; MO
orphenadrine /asa /caffeine	1	GC; MO
orphenadrine compound ds	1	GC; MO
PARAFON FORTE DSC	3	MO
ROBAXIN-750	3	MO
ROBAXIN TABLET	3	MO
ROBAXIN INJECTION	4	HI
SKELAXIN	3	MO
SOMA	3	MO
tizanidine hcl	1	GC; MO
Therapeutic Nutrients/Minerals/ Electrolytes		
Electrolytes/Minerals		
ALCOHOL 5%/DEXTROSE 5%	4	HI
aminess	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN 7%/ELECTROLYTES	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN 8.5%/ELECTROLYTES	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
AMINOSYN II	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II 3.5%/DEXTROSE25%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II 3.5/DEXTROSE 25%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II 4.25/DEXTROSE10%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II 4.25/DEXTROSE20%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II 4.25/DEXTROSE25%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II 5/DEXTROSE 25	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II 8.5%/ELECTROLYTES	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN II M 3.5%/DEXTROSE 5%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN M	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN-HBC	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN-HF	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
AMINOSYN-PF	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
AMINOSYN-PF 7%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ammonium chloride	4	HI
CARNITOR ORAL SOLUTION, TABLET	3	MO
CARNITOR INJECTION	4	HI
CLINIMIX 2.75%/DEXTROSE 5%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
clinimix 4.25%/dextrose 10%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX 4.25%/DEXTROSE 20%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
clinimix 4.25%/dextrose 25%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX 4.25%/DEXTROSE 5%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX 5%/DEXTROSE 15%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX 5%/DEXTROSE 20%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX 5%/DEXTROSE 25%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX E 2.75%/DEXTROSE 10%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
CLINIMIX E 2.75%/DEXTROSE 5%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
clinimix e 4.25%/dextrose 25%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX E 4.25%/DEXTROSE 5%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX E 5%/DEXTROSE 15%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX E 5%/DEXTROSE 20%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX E 5%/DEXTROSE 25%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINIMIX E 5%/DEXTROSE 35%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
CLINISOL SF 15%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
DEXTROSE 10%/NACL 0.45%	4	HI
DEXTROSE 5% /ELECTROLYTE #48 VIAFLEX	4	HI
dextrose 10% flex container	4	HI
dextrose 10%/nacl 0.2%	4	HI
dextrose 2.5%/sodium chloride 0.45%	4	HI
dextrose 5%	4	HI
dextrose 5%/nacl 0.2%	4	HI
dextrose 5%/nacl 0.225%	4	HI
dextrose 5%/nacl 0.33%	4	HI
dextrose 5%/nacl 0.45%	4	HI
dextrose 5%/nacl 0.9%	4	HI
DEXTROSE 5%/POTASSIUM CHLORIDE 0.075%	4	HI
ed k+10	1	GC; MO

Drug Name	Drug Tier	Notes
FREAMINE HBC 6.9%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
FREAMINE III	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
FREAMINE III 3%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
hepatamine	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
hepatasol	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
INTRALIPID	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
IONOSOL-B/DEXTROSE 5%	4	HI
IONOSOL-MB/DEXTROSE 5%	4	HI
IONOSOL-T/DEXTROSE 5%	4	HI
ISOLYTE-H/DEXTROSE 5%	4	HI
ISOLYTE-M/DEXTROSE 5%	4	HI
ISOLYTE-P/DEXTROSE 5%	4	HI
ISOLYTE-S	4	HI
ISOLYTE-S/DEXTROSE 5%	4	HI
K-PHOS NEUTRAL	3	MO
K-TABS	3	MO
KAON-CL-10	3	MO
kcl 0.075%/d5w/nacl 0.45%	4	HI
KCL 0.15%/D10W/NACL 0.2%	4	HI
kcl 0.15%/d5w/lr	4	HI
kcl 0.15%/d5w/nacl 0.2%	4	HI
kcl 0.15%/d5w/nacl 0.225%	4	HI
kcl 0.15%/d5w/nacl 0.9%	4	HI
kcl 0.224%/d5w/nacl 0.2%	4	HI
kcl 0.3%/d5w/lr iv lac ring	4	HI
kcl 0.3%/d5w/nacl 0.2%	4	HI
kcl 0.3%/d5w/nacl 0.45%	4	HI
kcl 0.3%/d5w/nacl 0.9%	4	HI
klor-con 10	1	GC; MO

Drug Name	Drug Tier	Notes
klor-con 8	1	GC; MO
klor-con m15	1	GC; MO
klor-con m20	1	GC; MO
lactated ringers irrigation	1	GC; MO
lactated ringers viaflex	4	HI
levocarnitine oral solution, tablet	1	GC; MO
levocarnitine injection	4	HI
magnesium sulfate	4	HI
magnesium sulfate in d5w	4	HI
NEPHRAMINE	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
normosol-m in d5w	4	HI
NORMOSOL-R	4	HI
NORMOSOL-R IN D5W	4	HI
NOVAMINE	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
phospha 250 neutral	1	GC; GC; MO
physiolyte	1	GC; MO
PHYSIOSOL IRRIGATION	3	MO
PLASMA-LYTE 56	4	HI
PLASMA-LYTE A	4	HI
PLASMA-LYTE-148	4	HI
PLASMA-LYTE-148/D5W	4	HI
PLASMA-LYTE-56/D5W	4	HI
plasma-lyte-r	4	HI
potassium chloride	4	HI
potassium chloride 0.075%/d5w/nacl 0.225%	4	HI
POTASSIUM CHLORIDE 0.15% /NACL 0.45% VIAFLEX	4	HI
POTASSIUM CHLORIDE 0.15% D5W/NACL 0.33%	4	HI
POTASSIUM CHLORIDE 0.15% D5W/NACL 0.45% VIAFLEX	4	HI
POTASSIUM CHLORIDE 0.15% NACL 0.9%	4	HI
potassium chloride 0.15%/d5w	4	HI
potassium chloride 0.22% d5w/nacl 0.45%	4	HI
potassium chloride 0.224%/d5w	4	HI
potassium chloride 0.224%d5w/nacl 0.33%	4	HI
potassium chloride 0.3%/ nacl 0.9%	4	HI
potassium chloride 0.3%/d5w	4	HI
potassium chloride cr	1	GC; MO
potassium chloride er	1	GC; MO
potassium citrate extended-release	1	GC; MO

Drug Name	Drug Tier	Notes
premasol	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
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PROCALAMINE	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
PROSOL	4	HI; Contact Plan for coverage details.
RENAMIN	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
ringers injection	4	HI
ringers irrigation	1	GC; MO
sodium bicarbonate	4	HI
sodium chloride	4	HI
sodium chloride 0.9%	1	GC; MO
sodium chloride 0.45% viaflex	4	HI
sodium lactate	4	HI
TIS-U-SOL	3	MO
TPN ELECTROLYTES FTV	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRAVASOL	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRAVASOL 2.75%/DEXTROSE 10%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRAVASOL 2.75%/DEXTROSE 5%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRAVASOL 3.5%/ELECTROLYTES	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRAVASOL 8.5%/DEXTROSE 10%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.

Drug Name	Drug Tier	Notes
TRAVASOL 8.5%/DEXTROSE 20%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRAVASOL 8.5%/DEXTROSE 50%	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
TRAVASOL 8.5%/ELECTROLYTES	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
tricitrates	1	MO GC
TROPHAMINE	4	HI; PA - This drug may be covered under Medicare Part B or D. Contact Plan for coverage details.
Vitamins		
prenatabs obn	1	GC; MO
sodium fluoride	1	GC; MO

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