

Trillium Advantage Rx (HMO)

2012 Formulary (List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

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

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

Trillium Community Health Plan[®] is a health plan with a Medicare contract
To receive this material in an alternate format or language call: (800) 910-3906
H2174_RX42V2 File & Use 08/31/2011

[Formulary 00012222, Version 6]

What is the Trillium Advantage Rx Formulary?

A formulary is a list of covered drugs selected by Trillium Advantage Rx 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. Trillium Advantage Rx will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Trillium Advantage Rx 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 contract 2012 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2012 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, and/or quantity limits on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of 01/01/2012. To get updated information about the drugs covered by Trillium Advantage Rx, please visit our Web site at www.TrilliumAdvantage.com or call Member Services at (800) 910-3906, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call (866) 279-9750. An updated formulary will be mailed to you upon request within 3 business days.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. 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. If you know what your drug is used for, look for the category name in the list that begins VIII. 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 62. 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?

Trillium Advantage Rx covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Trillium Advantage Rx requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from Trillium Advantage Rx before you fill your prescriptions. If you don't get approval, Trillium Advantage Rx may not cover the drug.
- **Quantity Limits:** For certain drugs, Trillium Advantage Rx limits the amount of the drug that Trillium Advantage Rx will cover. For example, Trillium Advantage Rx provides 9 tablets per prescription for sumatriptan succinate. This may be in addition to a standard one month or three month supply.
- **B versus D:** A drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at www.TrilliumAdvantage.com.

You can ask Trillium Advantage Rx to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Trillium Advantage Rx's formulary?" on page IV for information about how to request an exception.

What are over-the counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Trillium Advantage Rx pays for certain OTC drugs; Loratadine 10 mg tablets, Loratadine D 24hr tablets and Loratadine 5mg/ml syrup. Trillium Advantage Rx will provide these OTC drugs at no cost to you. The cost to Trillium Advantage Rx of these OTC drugs will not count toward your total drug costs.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Member Services and confirm that your drug is not covered. If you learn that Trillium Advantage Rx does not cover your drug, you have two options:

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

How do I request an exception to the Trillium Advantage Rx's Formulary?

You can ask Trillium Advantage Rx 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, Trillium Advantage Rx 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. If your drug is contained in our non-preferred tier 3, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier 2 instead. This would lower the amount you must pay for your drug. Please note, if we

grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, Trillium Advantage Rx will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

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

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 91-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

A level of care change is a change in treatment setting; e.g. a change from home to a Long Term Care facility, or a discharge from an Acute Care setting. Trillium Advantage Rx understands that members fluctuate in their level of care. Therefore, members who experience a level of care change will be given a

onetime transition supply, upon request at the point of sale of a non-formulary Part D drug, or an override for refill too soon due to dosage changes by the prescriber before the regularly scheduled refill date.

For more information

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

If you have questions about Trillium Advantage Rx, please call Member Services at (800) 910-3906, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call (866) 279-9750. Or visit www.TrilliumAdvantage.com.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

Trillium Advantage Rx's Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by Trillium Advantage Rx. If you have trouble finding your drug in the list, turn to the Index that begins on page 62.

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

The information in the Requirements/Limits column tells you if Trillium Advantage Rx has any special requirements for coverage of your drug.

Notes Abbreviation	Utilization Management Procedure
B/D	This drug may be covered under Medicare Part B or D depending upon the circumstances
GC	We provide coverage of this prescription drug in the Coverage Gap. Please refer to our Evidence of Coverage for more information about this coverage
LA	This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at (800) 910-3906, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call (866) 279-9750
M	This prescription drug is available through mail order. For more information consult your Pharmacy Directory or call Member Services at (800) 910-3906, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call (866) 279-9750
PA	Drug Requires Prior Authorization
QL	Drug has Quantity Limit

The chart below lists the co-pay/coinsurance you will be responsible for during the Initial Coverage Limit. You remain in the Initial Coverage Limit until your total drug costs reach \$2,930.00; please refer to your Explanation of Benefits for your current benefit coverage.

Formulary Drug Tier	Description	31-Day Supply Retail Pharmacy Co-pay	90-Day Supply Mail-Order or Selected Retail Pharmacy Co-pay
Tier 1	Includes preferred generic drugs. May include multiple source drugs.	You pay \$9.00	You pay \$18.00
Tier 2	Includes preferred brand drugs.	You pay \$40.00	You pay \$80.00
Tier 3	Includes non-preferred generic drugs and non-preferred brand drugs. If Trillium Advantage Rx approves an exception request for a non-formulary drug, the Tier 3 co-pay will apply.	You pay \$60.00	You pay \$ 120.00

Trillium Advantage Rx List of Covered Drugs

Drug Category	Page
Analgesics	1
Anesthetics	4
Anti-Infectives	4
Antineoplastic Agents	11
Cardiovascular	14
Central Nervous System	22
Endocrine and Metabolic	30
Gastrointestinal	39
Genitourinary	43
Hematologic	44
Immunologic Agents	45
Nutritional/Supplements	47
Ophthalmic	50
Respiratory	53
Topical	56

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
GOUT		
<i>allopurinol</i>	1	M
<i>allopurinol inj 500mg</i>	1	
ALOPRIM	3	
<i>colchicine w/ probenecid</i>	1	M
COLCRYS	2	QL (60 tabs / 30 days)
<i>probenecid</i>	1	M
ULORIC	2	M
ZYLOPRIM	3	M
MISCELLANEOUS		
ARTHROTEC 50	3	M
ARTHROTEC 75	3	M
VIMOVO	2	M
NARCOTIC ANALGESICS		
<i>acetaminophen w/ codeine</i>	1	
<i>acetaminophen-caff-dihydrocod</i>	1	
<i>butalbital-acetaminophen-caffeine w/ codeine</i>	1	
<i>butalbital-aspirin-caffeine w/cod</i>	1	
<i>butorphanol tartrate</i>	1	
CAPITAL/CODEINE	3	
FIORICET/CODEINE	3	
FIORINAL/CODEINE #3	3	
HYCET	3	
<i>hydrocodone-acetaminophen</i>	1	
<i>hydrocodone-ibuprofen</i>	1	
LORCET 10/650	3	
LORCET PLUS	3	
LORTAB	3	
MAXIDONE	3	
NORCO	3	
PANLOR SS	3	
REPREXAIN	3	
STADOL	3	
SYNALGOS-DC	3	
TYLENOL/CODEINE #3	3	
TYLENOL/CODEINE #4	3	
VICODIN	3	
VICODIN ES	3	
VICOPROFEN	3	

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 1

Drug Name	Drug Tier	Requirements/Limits
XODOL	3	
ZAMICET	3	
ZYDONE	3	
<i>NARCOTIC ANALGESICS, CII</i>		
ABSTRAL	3	PA
ACTIQ	3	PA
AVINZA	3	
<i>codeine sulfate</i> 30mg, 60mg	1	
CODEINE SULFATE 15mg	1	
DILAUDID 1mg/ml, 2mg/ml, 4mg/ml	3	B/D
DILAUDID 2mg, 4mg, 8mg	3	
DILAUDID-5	2	
DILAUDID-HP	3	B/D
DOLOPHINE	3	
DURAGESIC	3	
EMBEDA	3	
EXALGO	2	
<i>fentanyl citrate inj</i> 0.05 mg/ml	1	B/D
FENTANYL CITRATE ORAL TRA	3	PA
<i>fentanyl patch</i>	1	
FENTORA	3	PA
<i>hydromorphone hcl</i> 10mg/ml	1	B/D
<i>hydromorphone hcl</i> 2mg, 4mg, 8mg	1	
INFUMORPH 200	3	B/D
INFUMORPH 500	3	B/D
KADIAN	2	
<i>levorphanol tartrate</i>	1	
MAGNACET	3	
<i>methadone hcl</i> 10mg, 10mg/5ml, 10mg/ml, 5mg, 5mg/5ml	1	
METHADONE HCL 10mg/ml	3	
MORPHINE SUL 20MG/ML ORAL SOL	1	oral solution
<i>morphine sulfate</i> .5mg/ml, 1mg/ml	1	B/D
<i>morphine sulfate</i> 100mg, 15mg, 30mg, 60mg	1	ext rel
<i>morphine sulfate</i> 200mg	1	
MORPHINE SULFATE 15mg, 30mg	1	
MORPHINE SULFATE 10mg/5ml, 20mg/5ml	2	oral solution
MS CONTIN	3	
NUCYNTA	3	
ONSOLIS	3	PA
OPANA	3	
OPANA ER	3	

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Drug Name	Drug Tier	Requirements/Limits
ORAMORPH SR	3	
<i>oxycodone hcl</i> 15mg, 30mg, 5mg	1	
OXYCODONE HCL 20mg/ml, 5mg	1	
<i>oxycodone w/ acetaminophen</i>	1	
<i>oxycodone w/ aspirin</i>	1	
<i>oxycodone-ibuprofen</i>	1	
OXYCONTIN	2	
<i>oxymorphone hcl</i>	1	
PERCOCET	3	
PERCODAN	3	
ROXICET	3	
ROXICET SOL 5-325/5	2	
ROXICODONE	3	
TYLOX	3	

NON-NARCOTIC ANALGESICS

RYZOLT	3	
<i>tramadol hcl</i>	1	
<i>tramadol hcl tab 50 mg</i>	1	
<i>tramadol-acetaminophen</i>	1	
ULTRACET	3	
ULTRAM	3	
ULTRAM ER	3	

NSAIDS

ANAPROX	3	M
ANAPROX DS	3	M
CATAFLAM	3	M
CELEBREX	3	M, PA
CLINORIL	3	M
DAYPRO	3	M
<i>diclofenac potassium</i>	1	M
<i>diclofenac sodium</i>	1	M
<i>diflunisal</i>	1	M
EC-NAPROSYN	3	M
<i>etodolac</i>	1	M
FELDENE	3	M
FENOPROFEN CALCIUM	1	M
<i>flurbiprofen</i>	1	M
<i>ibuprofen</i> 100mg/5ml	1	
<i>ibuprofen</i> 400mg, 600mg, 800mg	1	M
INDOCIN	2	M; suspension
<i>indomethacin</i>	1	M
<i>ketoprofen</i>	1	M
<i>mefenamic acid</i>	1	M

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Drug Name	Drug Tier	Requirements/Limits
<i>meloxicam</i>	1	M
MOBIC	3	M
<i>nabumetone</i>	1	M
NALFON	3	M
NAPRELAN	3	M
NAPROSYN	3	M
<i>naproxen</i>	1	M
<i>naproxen sodium</i>	1	M
<i>oxaprozin</i>	1	M
<i>piroxicam</i>	1	M
PONSTEL	3	M
<i>sulindac</i>	1	M
<i>tolmetin sodium</i>	1	M
VOLTAREN-XR	3	M
ZIPSOR	3	

ANESTHETICS

LOCAL ANESTHETICS

<i>lidocaine hcl (local anesth.)</i>	1	
XYLOCAINE 1%	3	

ANTI-INFECTIVES

ANTIBACTERIALS

ADOXA	3	
ADOXA PAK 1/100	3	
ADOXA PAK 1/150	3	
ADOXA PAK 1/75	3	
ADOXA PAK 2/100	3	
<i>amikacin sulfate</i>	1	
<i>amoxicillin</i>	1	
<i>amoxicillin & pot clavulanate</i>	1	
<i>ampicillin</i>	1	
<i>ampicillin & sulbactam sodium</i>	1	
<i>ampicillin sodium</i>	1	
AVELOX	2	
AVELOX ABC PACK	2	
<i>azithromycin</i>	1	
BACTOCILL IN DEXTROSE	3	
BIAXIN	3	
BIAXIN XL	3	
BIAXIN XL PAC	3	
BICILLIN C-R	2	
BICILLIN L-A	2	
CEDAX	3	
<i>cefactor</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
CEFACTOR ER	2	
<i>cefadroxil</i>	1	
CEFAZOLIN INJ 1GM/50ML	2	
<i>cefazolin sodium</i>	1	
<i>cefdinir</i>	1	
<i>cefepime hcl</i>	1	
<i>cefotaxime sodium</i>	1	
CEFOTETAN	3	
<i>cefoxitin sodium</i> 10gm, 1gm, 2gm	1	
CEFOXITIN SODIUM	3	
<i>cefpodoxime proxetil</i>	1	
<i>cefprozil</i>	1	
<i>ceftazidime</i>	1	
CEFTIN	3	
<i>ceftriaxone sodium</i>	1	
<i>cefuroxime axetil</i>	1	
<i>cefuroxime sodium</i>	1	
<i>cephalexin</i>	1	
CIPRO 500mg/5ml, 5gm/100ml	2	suspension
CIPRO 250mg, 500mg, 750mg	3	
<i>cipro i.v.</i>	1	
CIPRO I.V.-IN D5W	3	
<i>ciprofloxacin hcl</i>	1	
<i>ciprofloxacin-ciprofloxacin hcl</i>	1	ext rel
CLAFORAN	3	
<i>clarithromycin</i>	1	
DEMECLOCYCLINE HCL 150mg	1	
DEMECLOCYCLINE HCL 300mg	3	
<i>dicloxacillin sodium</i>	1	
DORYX	3	
<i>doxycycline (monohydrate)</i>	1	
DOXYCYCLINE CAP DR PARTICLES 100 MG	3	
<i>doxycycline hyclate</i> 100mg, 20mg, 50mg, 1 75mg	1	
DOXYCYCLINE HYCLATE 75mg	3	
DYNACIN	3	
E.E.S. GRANULES	3	
ERY-TAB	3	
ERYPED 200	2	
ERYPED 400	3	
ERYTHROCIN LACTOBIONATE	2	
<i>erythromycin base</i>	1	
<i>erythromycin ethylsuccinate</i>	1	
<i>erythromycin stearate</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
FACTIVE	3	
FORTAZ	3	
<i>gentamicin in saline</i>	1	
<i>gentamicin sulfate</i>	1	
GENTAMICIN SULFATE/0.9% S	3	
KEFLEX	3	
LEVAQUIN	3	
MINOCIN	3	
<i>minocycline hcl</i>	1	
MONODOX	3	
MOXATAG	3	
<i>nafcillin sodium</i>	1	
NALLPEN/DEXTROSE	3	
<i>neomycin sulfate</i>	1	
NOROXIN	3	
<i>oxacillin sodium</i>	1	
<i>paromomycin sulfate</i>	1	
PCE	3	
<i>penicillin g potassium</i>	1	
PENICILLIN G POTASSIUM IN	3	
PENICILLIN G PROCAINE	2	
<i>penicillin g sodium</i>	1	
<i>penicillin v potassium</i>	1	
PERIOSTAT	3	
PFIZERPEN-G	3	
PIPERACILLIN SODIUM	3	
<i>piperacillin sodium-tazobactam sodium</i>	1	
PROQUIN XR	3	
ROCEPHIN	3	
SOLODYN	3	
<i>streptomycin sulfate</i>	1	
SULFADIAZINE	2	
SUPRAX	3	
TEFLARO	3	
<i>tetracycline hcl</i>	1	
TIMENTIN	3	
<i>tobramycin sulfate</i>	1	
TOBRAMYCIN SULFATE/SODIUM	3	
UNASYN	3	
UNASYN BULK PACK	3	
VIBRAMYCIN	3	
ZINACEF	3	
ZITHROMAX	3	
ZITHROMAX TRI-PAK	3	

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Drug Name	Drug Tier	Requirements/Limits
ZITHROMAX Z-PAK	3	
ZMAX	3	
ZOSYN	3	
ANTIFUNGALS		
ABELCET	3	B/D
AMBISOME	3	B/D
AMPHOTEC	3	B/D
<i>amphotericin b</i>	1	B/D
ANCOBON	2	
CANCIDAS	3	
<i>clotrimazole</i>	1	
DIFLUCAN	3	
DIFLUCAN IN NAACL	3	
ERAXIS	3	
<i>fluconazole</i>	1	
<i>fluconazole in dextrose</i>	1	
GRIFULVIN V	3	
GRIS-PEG	2	
<i>griseofulvin microsize</i>	1	
<i>itraconazole</i>	1	PA
<i>ketoconazole</i>	1	
LAMISIL	3	
MYCAMINE	3	
NOXAFIL	3	M
<i>nystatin</i>	1	
SPORANOX 100mg	3	PA
SPORANOX 10mg/ml	3	
SPORANOX PULSEPAK	3	PA
<i>terbinafine hcl</i>	1	QL (90 tabs / year)
VFEND	3	
VFEND IV	3	
VFEND SUS 40MG/ML	3	
<i>voriconazole</i>	3	
ANTIMALARIALS		
ARALEN	3	M
<i>chloroquine phosphate</i>	1	M
COARTEM	3	
DARAPRIM	2	
MALARONE	2	
<i>mefloquine hcl</i>	1	M
PRIMAQUINE PHOSPHATE	3	
QUALAQUIN	3	
ANTIRETROVIRAL AGENTS		

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Drug Name	Drug Tier	Requirements/Limits
APTIVUS	2	M
ATRIPLA	3	M
COMBIVIR	2	M
CRIXIVAN	2	M
<i>didanosine</i>	1	M
EDURANT	3	M
EMTRIVA	2	M
EPIVIR	2	M
EPZICOM	2	M
FUZEON	2	M
INTELENCE	2	M
INVIRASE	2	M
ISENTRESS	2	M
KALETRA	2	M
LEXIVA	2	M
NORVIR	2	M
PREZISTA 150mg, 75mg	2	M
PREZISTA 400mg, 600mg	3	M
RESCRIPTOR	2	M
RETROVIR	3	M
RETROVIR IV INFUSION	2	
REYATAZ	2	M
SELZENTRY	2	M
<i>stavudine</i>	1	M
SUSTIVA	2	M
TRIZIVIR	2	M
TRUVADA	2	M
VIDEX	2	M
VIDEX EC	3	M
VIRACEPT	2	M
VIRAMUNE	2	M
VIRAMUNE XR	2	M
VIREAD	2	M
ZERIT	3	M
ZIAGEN	2	M
<i>zidovudine</i>	1	M

ANTITUBERCULAR AGENTS

CAPASTAT SULFATE	3	
<i>ethambutol hcl</i>	1	
<i>isoniazid</i> 100mg, 300mg, 50mg/5ml	1	M
<i>isoniazid</i> 100mg/ml	1	
<i>isoniazid & rifampin</i>	1	
MYAMBUTOL	3	
MYCOBUTIN	2	

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Drug Name	Drug Tier	Requirements/Limits
PASER	3	
PRIFTIN	3	
<i>pyrazinamide</i>	1	
RIFADIN	3	
RIFAMATE	3	
<i>rifampin</i>	1	
RIFATER	3	
SEROMYCIN	3	
TRECTOR	3	
ANTIVIRALS		
<i>acyclovir</i>	1	
<i>acyclovir sodium</i>	1	
BARACLUDE .05mg/ml	2	M
BARACLUDE .5mg, 1mg	3	M
COPEGUS	3	PA
CYTOVENE	3	B/D
EPIVIR HBV	2	M
<i>famciclovir</i>	1	
FAMVIR	3	
<i>foscarnet sodium</i>	1	
<i>ganciclovir</i> 250mg	1	M
<i>ganciclovir</i> 500mg	3	M
<i>ganciclovir inj</i> 500mg	1	B/D
HEPSERA	3	M, PA
REBETOL	3	PA
RELENZA DISKHALER	2	
<i>ribavirin (hepatitis c)</i> 200mg	1	PA
<i>ribavirin (hepatitis c)</i> 200mg, 400mg, 600mg	3	PA
<i>rimantadine hydrochloride</i>	1	
TAMIFLU	2	
TYZEKA	3	M, PA
<i>valacyclovir hcl</i>	1	
VALCYTE	3	M
VALTREX	3	
VICTRELIS	3	PA
VIRAZOLE	3	
VISTIDE	3	
ZOVIRAX 200mg, 200mg/5ml, 400mg, 800mg	3	
MISCELLANEOUS		
ALBENZA	2	
ALINIA 100mg/5ml	2	QL (3 bottles / 30 days)
ALINIA 500mg	2	QL (12 tabs / 30 days)

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Drug Name	Drug Tier	Requirements/Limits
AZACTAM	3	
<i>aztreonam</i>	1	
BACTRIM	3	
BACTRIM DS	3	
BILTRICIDE	3	
CLEOCIN 150mg, 300mg	3	
CLEOCIN CAP 75MG	2	
CLEOCIN PED SOL 75MG/5ML	2	
CLEOCIN PHOSPHATE	3	
<i>clindamycin hcl</i>	1	
<i>clindamycin phosphate</i>	1	
<i>colistimethate sodium</i>	1	B/D
COLY-MYCIN M	3	B/D
CUBICIN	3	B/D
<i>dapsone</i>	1	M
DORIBAX	3	
<i>erythromycin-sulfisoxazole</i>	1	
FLAGYL	3	
FLAGYL ER	3	
FURADANTIN	3	
HIPREX	3	
INVANZ	2	
MACROBID	3	
MACRODANTIN	3	
MACRODANTIN CAP 25MG	2	
<i>mebendazole</i>	1	
MEPRON	3	
<i>meropenem</i>	1	
MERREM	3	
<i>methenamine hippurate</i>	1	
<i>metronidazole</i>	1	
<i>metronidazole in nacl</i>	1	
NEBUPENT	3	B/D
<i>nitrofurantoin</i>	1	
<i>nitrofurantoin macrocrystal</i>	1	
<i>nitrofurantoin monohyd macro</i>	1	
PENTAM 300	3	
<i>polymyxin b sulfate</i>	1	
PRIMAXIN	2	
PRIMSOL	3	
SEPTRA	3	
SEPTRA DS	3	
STROMECTOL	3	
<i>sulfamethoxazole-trimethoprim</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
<i>sulfamethoxazole/trimetho</i>	1	
SYNERCID	3	
<i>trimethoprim</i>	1	
TYGACIL	3	
VANCOCIN HCL	3	capsule
<i>vancomycin hcl</i>	1	B/D
VIBATIV	3	
XIFAXAN	3	
ZYVOX	3	

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

ALKERAN	3	B/D
BICNU	2	B/D
BUSULFEX	2	B/D
CEENU	2	
<i>cyclophosphamide</i>	1	B/D
<i>dacarbazine</i>	1	B/D
EMCYT	2	
HEXALEN	3	
IFEX	2	B/D
IFOSFAMIDE	3	B/D
LEUKERAN	2	
<i>melphalan hcl</i>	1	B/D
MUSTARGEN	2	B/D
THIOTEPA	3	B/D
TREANDA	3	B/D
ZANOSAR	3	B/D

ANTHRACYCLINES

CERUBIDINE	3	B/D
<i>daunorubicin hcl</i>	1	B/D
DAUNOXOME	3	B/D
DOXIL	3	B/D
<i>doxorubicin hcl</i>	1	B/D
ELLENCE	3	B/D
EPIRUBICIN HCL	3	B/D
IDAMYCIN PFS	3	B/D
<i>idarubicin hcl</i>	1	B/D

ANTIBIOTICS

<i>bleomycin sulfate</i>	1	B/D
COSMEGEN	2	B/D
<i>mitomycin</i>	1	B/D

ANTIMETABOLITES

ALIMTA	3	B/D
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Drug Name	Drug Tier	Requirements/Limits
ARRANON	3	B/D
CLOLAR	3	B/D
<i>cytarabine</i> 20mg/ml, 500mg	1	B/D
CYTARABINE 100mg/ml	3	B/D
DACOGEN	3	B/D
<i>fluorouracil</i>	1	B/D
<i>gemcitabine hcl</i>	3	B/D
GEMZAR	3	B/D
<i>mercaptopurine</i>	1	
<i>methotrexate sodium</i> 1gm, 25mg/ml	1	B/D
NIPENT	3	B/D
<i>pentostatin</i>	1	B/D
PURINETHOL	3	
TABLOID	2	
VIDAZA	3	B/D
ANTIMITOTIC, TAXOIDS		
ABRAXANE	3	B/D
<i>paclitaxel</i>	3	B/D
TAXOTERE	3	B/D
ANTIMITOTIC, VINCA ALKALOIDS		
VINBLASTINE SULFATE	2	B/D
<i>vincristine sulfate</i>	1	B/D
<i>vinorelbine tartrate</i>	1	B/D
BIOLOGIC RESPONSE MODIFIERS		
AVASTIN	3	B/D
CAMPATH	2	B/D
ERBITUX	3	B/D
HERCEPTIN	3	B/D
ISTODAX	3	B/D
ONTAK	2	B/D
PROLEUKIN	3	B/D
RITUXAN	2	PA
TORISEL	3	B/D
VECTIBIX	3	B/D
VELCADE	3	B/D
ZOLINZA	2	
HORMONAL ANTINEOPLASTIC AGENTS		
<i>anastrozole</i>	1	M
ARIMIDEX	3	M
AROMASIN	3	M
ARZERRA	3	B/D
<i>bicalutamide</i>	1	
CASODEX	3	

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Drug Name	Drug Tier	Requirements/Limits
DEPO-PROVERA INJ 400/ML	2	B/D
ELIGARD	3	B/D
<i>exemestane</i>	1	M
FARESTON	2	M
FASLODEX	3	B/D
FEMARA	3	M
FIRMAGON	3	B/D
<i>flutamide</i>	1	
<i>letrozole</i>	1	M
<i>leuprolide acetate</i>	1	PA
LUPRON DEPOT 11.25mg, 3.75mg	2	PA
LUPRON DEPOT 22.5mg, 30mg, 7.5mg	3	PA
LUPRON DEPOT-PED	3	PA
MEGACE ES	2	M
MEGACE ORAL	3	
<i>megestrol acetate</i>	1	
NILANDRON	2	
<i>tamoxifen citrate</i>	1	M
TRELSTAR DEPOT MIXJECT	2	B/D
TRELSTAR LA MIXJECT	2	B/D
TRELSTAR MIXJECT	3	B/D
ZYTIGA	3	PA

KINASE INHIBITORS

AFINITOR	3	
GLEEVEC	2	
IRESSA	2	
NEXAVAR	2	
SPRYCEL 100mg, 20mg, 50mg, 70mg	2	
SPRYCEL 140mg, 80mg	3	
SUTENT	2	
TARCEVA	2	
TASIGNA	2	
TYKERB	2	
VANDETANIB	3	
VOTRIENT	3	

MISCELLANEOUS

DROXIA	2	M
ELSPAR	2	B/D
HALAVEN	3	B/D
HYDREA	3	
<i>hydroxyurea</i>	1	
IRINOTECAN	3	B/D
IXEMPRA KIT	3	B/D

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Drug Name	Drug Tier	Requirements/Limits
LYSODREN	2	
MATULANE	3	
<i>mitoxantrone hcl</i>	2	B/D
NOVANTRONE	2	B/D
PHOTOFRIN	2	B/D
TARGRETIN 75mg	2	
TRETINOIN 10mg	2	capsule
TRISENOX	2	B/D
UVADEX	3	B/D

NUCLEOSIDE ANALOGS

<i>cladribine</i>	1	B/D
FLUDARA	3	B/D
FLUDARABINE PHOSPHATE	3	B/D
LEUSTATIN	3	B/D

PLATINUM COORDINATION COMPLEX

<i>carboplatin</i>	1	B/D
<i>cisplatin</i>	1	B/D
ELOXATIN	3	B/D
OXALIPLATIN	3	B/D

PROTECTIVE AGENTS

<i>amifostine crystalline</i>	3	B/D
<i>dexrazoxane</i>	1	B/D
ELITEK	3	B/D
ETHYOL	3	B/D
<i>ifosfamide & mesna</i>	1	B/D
KEPIVANCE	3	B/D
<i>leucovor ca inj</i>	1	B/D
<i>leucovorin calcium 25mg, 5mg</i>	1	
LEUCOVORIN CALCIUM 10mg, 15mg	2	
<i>mesna</i>	1	B/D
MESNEX 100mg/ml	3	B/D
MESNEX 400mg	3	
ZINECARD	3	B/D

TOPOISOMERASE INHIBITORS

CAMPTOSAR	3	B/D
ETOPOPHOS	3	B/D
<i>etoposide</i>	1	B/D
HYCAMTIN	3	B/D; injection
<i>topotecan hcl</i>	3	B/D

CARDIOVASCULAR

ACE INHIBITOR COMBINATIONS

ACCURETIC	3	M
<i>amlodipine besylate-benazepril hcl</i>	1	M

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Drug Name	Drug Tier	Requirements/Limits
<i>benazepril & hydrochlorothiazide</i>	1	M
<i>captopril & hydrochlorothiazide</i>	1	M
<i>enalapril maleate & hydrochlorothiazide</i>	1	M
<i>fosinopril sodium & hydrochlorothiazide</i>	1	M
<i>lisinopril & hydrochlorothiazide</i>	1	M
LOTENSIN HCT	3	M
LOTREL	3	M; 5-40mg, 10-40mg
LOTREL	3	M
<i>moexipril-hydrochlorothiazide</i>	1	M
PRINZIDE	3	M
<i>quinapril-hydrochlorothiazide</i>	1	M
TARKA	3	M
UNIRETIC	3	M
VASERETIC	3	M
ZESTORETIC	3	M

ACE INHIBITORS

ACCUPRIL	3	M
ACEON	3	M
ALTACE	3	M
<i>benazepril hcl</i>	1	M
<i>captopril</i>	1	M
<i>enalapril maleate</i>	1	M
<i>fosinopril sodium</i>	1	M
<i>lisinopril</i>	1	M
LOTENSIN	3	M
MAVIK	3	M
<i>moexipril hcl</i>	1	M
<i>perindopril erbumine</i>	1	M
PRINIVIL	3	M
<i>quinapril hcl</i>	1	M
<i>ramipril</i>	1	M
<i>trandolapril</i>	1	M
UNIVASC	3	M
VASOTEC	3	M
ZESTRIL	3	M

ADRENOLYTICS, CENTRAL

CATAPRES	3	M
CATAPRES-TTS-1	3	M
CATAPRES-TTS-2	3	M
CATAPRES-TTS-3	3	M
<i>clonidine hcl</i>	1	M
<i>guanabenz acetate</i>	1	M
<i>guanfacine hcl</i>	1	M

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Drug Name	Drug Tier	Requirements/Limits
TENEX	3	M
ALDOSTERONE RECEPTOR ANTAGONISTS		
ALDACTONE	3	M
<i>eplerenone</i>	1	M
INSPRA	3	M
<i>spironolactone</i>	1	M
ALPHA BLOCKERS		
CARDURA	3	M
<i>doxazosin mesylate</i>	1	M
MINIPRESS	3	M
<i>prazosin hcl</i>	1	M
<i>terazosin hcl</i>	1	M
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
ATACAND HCT	3	M
AVALIDE	3	M
AZOR	2	M
BENICAR HCT	2	M
DIOVAN HCT	2	M
EXFORGE	2	M
EXFORGE HCT	2	M
HYZAAR	3	M
<i>losartan potassium & hydrochlorothiazide</i>	1	M
MICARDIS HCT	3	M
TEVETEN HCT	3	M
TRIBENZOR	2	M
TWYNSTA	3	M
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
ATACAND	3	M
AVAPRO	3	M
BENICAR	2	M
COZAAR	3	M
DIOVAN	2	M
EDARBI	3	M
<i>losartan potassium</i>	1	M
MICARDIS	3	M
TEVETEN	3	M
ANTIARRHYTHMICS		
<i>amiodarone hcl</i>	1	M
<i>amiodarone inj 50mg/ml</i>	1	B/D
BETAPACE	3	M
BETAPACE AF	3	M
CORDARONE	3	M
<i>disopyramide phosphate</i>	1	M

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Drug Name	Drug Tier	Requirements/Limits
<i>flecainide acetate</i>	1	M
<i>mexiletine hcl</i>	1	M
MULTAQ	2	M
NORPACE	3	M
NORPACE CR 100mg	2	M
NORPACE CR 150mg	3	M
PACERONE	3	M
PACERONE TAB 100MG	2	M
<i>propafenone hcl</i>	1	M
<i>quinidine gluconate</i>	1	M
<i>quinidine sulfate</i>	1	M
RYTHMOL	3	M
RYTHMOL SR	3	M
<i>sotalol hcl</i>	1	M
TAMBOCOR	3	M
TIKOSYN	2	M

ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS

ALTOPREV	3	M
CRESTOR	1	M
LESCOL	3	M
LESCOL XL	3	M
LIPITOR	1	M
LIVALO	3	M
<i>lovastatin</i>	1	M
MEVACOR	3	M
PRAVACHOL	3	M
<i>pravastatin sodium</i>	1	M
<i>simvastatin</i>	1	M
ZOCOR	3	M

ANTILIPEMICS, MISCELLANEOUS

ADVICOR	3	M
ANTARA	2	M
<i>cholestyramine light</i>	1	M
COLESTID	3	M
<i>colestipol hcl</i>	1	M
<i>fenofibrate</i>	1	M
<i>fenofibrate micronized</i>	1	M
FENOGLIDE	3	M
<i>gemfibrozil</i>	1	M
LIPOFEN	2	M
LOFIBRA	3	M
LOPID	3	M
LOVAZA	3	M

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Drug Name	Drug Tier	Requirements/Limits
<i>niacin</i>	1	
NIASPAN	2	M
QUESTRAN	3	M
SIMCOR	3	M
TRICOR	2	M
TRIGLIDE	3	M
TRILIPIX	2	M
VYTORIN	3	M
WELCHOL	2	M
ZETIA	3	M

BETA-BLOCKER/DIURETIC COMBINATIONS

<i>atenolol & chlorthalidone</i>	1	M
<i>bisoprolol & hydrochlorothiazide</i>	1	M
CORZIDE	3	M
LOPRESSOR HCT	3	M
<i>metoprolol & hydrochlorothiazide</i>	1	M
<i>nadolol & bendroflumethiazide</i>	1	M
<i>propranolol & hydrochlorothiazide</i>	1	M
PROPRANOLOL/HYDROCHLOROTH	1	M
TENORETIC 100	3	M
TENORETIC 50	3	M
ZIAC	3	M

BETA-BLOCKERS

<i>acebutolol hcl</i>	1	M
<i>atenolol</i>	1	M
<i>betaxolol hcl</i>	1	M
<i>bisoprolol fumarate</i>	1	M
BYSTOLIC	3	M
<i>carvedilol</i>	1	M
COREG	3	M
COREG CR	3	M
CORGARD	3	M
INDERAL LA	3	M
KERLONE	3	M
<i>labetalol hcl 100mg, 200mg, 300mg</i>	1	M
<i>labetalol hcl 5mg/ml</i>	1	
LEVATOL	3	M
LOPRESSOR 100mg, 50mg	3	M
LOPRESSOR 1mg/ml	3	
<i>metoprolol succinate</i>	1	M
<i>metoprolol tartrate 100mg, 25mg, 50mg</i>	1	M
<i>metoprolol tartrate 1mg/ml</i>	1	
<i>nadolol</i>	1	M

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Drug Name	Drug Tier	Requirements/Limits
<i>pindolol</i>	1	M
<i>propranolol hcl</i> 10mg, 120mg, 160mg, 20mg, 20mg/5ml, 40mg, 40mg/5ml, 60mg, 80mg	1	M
<i>propranolol hcl</i> 1mg/ml	1	
SECTRAL	3	M
TENORMIN	3	M
<i>timolol maleate</i>	1	M
TOPROL XL	3	M
TRANDATE	3	M
ZEBETA	3	M

CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS

CADUET	3	M
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CALCIUM CHANNEL BLOCKERS

ADALAT CC	3	M
<i>amlodipine besylate</i>	1	M
CALAN	3	M
CALAN SR	3	M
CARDIZEM	3	M
CARDIZEM CD 360mg	2	M
CARDIZEM CD 120mg, 180mg, 240mg, 300mg	3	M
CARDIZEM LA	3	M
COVERA-HS	3	M
DILACOR XR	3	M
<i>diltiazem hcl</i> 120mg, 180mg, 240mg, 30mg, 60mg, 90mg	1	M
<i>diltiazem hcl</i> 25mg/5ml	1	
DILTIAZEM HCL 100mg	3	
<i>diltiazem hcl coated beads</i>	1	M
<i>diltiazem hcl extended release beads</i>	1	M
DYNACIRC CR	3	M
<i>felodipine</i>	1	M
ISOPTIN SR	3	M
<i>isradipine</i>	1	M
<i>nicardipine hcl</i>	1	M
<i>nifediac cc</i>	1	M
<i>nifedical xl</i>	1	M
<i>nifedipine</i>	1	M
<i>nifedipine er</i>	1	M
NIMODIPINE	3	M
<i>nisoldipine</i>	1	M
NORVASC	3	M
PROCARDIA XL	3	M

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Drug Name	Drug Tier	Requirements/Limits
SULAR	3	M
TIAZAC	3	M
<i>verapamil hcl</i> 100mg, 120mg, 180mg, 200mg, 240mg, 300mg, 40mg, 80mg	1	M
<i>verapamil hcl</i> 2.5mg/ml	1	
VERELAN	3	M
VERELAN PM	3	M
<i>DIGITALIS GLYCOSIDES</i>		
<i>digoxin</i> .125mg, .25mg	1	M
<i>digoxin</i> .25mg/ml	1	
DIGOXIN SOL 50MCG/ML	1	M
LANOXIN .125mg, .25mg	2	M
LANOXIN .1mg/ml, .25mg/ml	3	
<i>DIRECT RENIN INHIBITORS/COMBINATIONS</i>		
AMTURNIDE	2	M
TEKAMLO	2	M
TEKTURNA	2	M
TEKTURNA HCT	2	M
VALTURNA	2	M
<i>DIURETICS</i>		
<i>acetazolamide</i>	1	M
<i>acetazolamide sodium</i>	1	
ALDACTAZIDE	3	M
<i>amiloride & hydrochlorothiazide</i>	1	M
<i>amiloride hcl</i>	1	M
<i>bumetanide</i> .25mg/ml	1	
<i>bumetanide</i> .5mg, 1mg, 2mg	1	M
<i>chlorothiazide</i>	1	M
<i>chlorthalidone</i>	1	M
DEMADEX	3	M
DIAMOX	3	M
DIURIL	3	M
DIURIL IV	3	
DYAZIDE	3	M
DYRENIUM	3	M
EDECIN	3	M
<i>furosemide</i> 10mg/ml	1	
<i>furosemide</i> 10mg/ml, 20mg, 40mg, 80mg	1	M
FUROSEMIDE 8mg/ml	3	M
<i>hydrochlorothiazide</i>	1	M
<i>indapamide</i>	1	M
LASIX	3	M
MAXZIDE	3	M

PA - Prior Authorization QL - Quantity Limits M - Available at mail-order B/D - Covered 20
under Medicare B or D LA - Limited Access GC - We provide coverage of this
prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more
information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
MAXZIDE-25	3	M
<i>methazolamide</i>	1	M
<i>methyclothiazide</i>	1	M
<i>metolazone</i>	1	M
MICROZIDE	3	M
SODIUM EDECRIN	3	
<i>spironolactone & hydrochlorothiazide</i>	1	M
THALITONE	3	M
<i>torseamide</i> 100mg, 10mg, 20mg, 5mg	1	M
TORSEMIDE 20mg/2ml	2	
<i>triamterene & hydrochlorothiazide</i>	1	M
ZAROXOLYN	3	M
MISCELLANEOUS		
BIDIL	2	M
CLORPRES	1	M
DEMSER	3	
DIBENZYLINE	3	
<i>hydralazine hcl</i> 100mg, 10mg, 25mg, 50mg	1	M
<i>hydralazine hcl</i> 20mg/ml	1	
<i>methyldopa</i>	1	M
<i>methyldopa & hydrochlorothiazide</i>	1	M
<i>midodrine hcl</i>	1	
<i>minoxidil</i>	1	M
RANEXA	2	M
NITRATES		
DILATRATE SR	3	M
ISORDIL TITRADOSE 40mg	2	M
ISORDIL TITRADOSE 5mg	3	M
<i>isosorbide dinitrate</i>	1	M
<i>isosorbide mononitrate</i>	1	M
<i>minitran</i>	1	M; patch
MONOKET	3	M
NITRO-BID	3	M
NITRO-DUR .3mg/hr, .8mg/hr	2	M; 0.3mg, 0.8mg
NITRO-DUR .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr	3	M
<i>nitroglycerin</i>	1	M; patch
NITROLINGUAL PUMPSPRAY	2	M
NITROMIST	3	M
NITROSTAT	2	M
PULMONARY ARTERIAL HYPERTENSION		
ADCIRCA	3	M, PA

PA - Prior Authorization QL - Quantity Limits M - Available at mail-order B/D - Covered under Medicare B or D LA - Limited Access GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 21

Drug Name	Drug Tier	Requirements/Limits
LETAIRIS	2	M, PA
REMODULIN	3	B/D
REVATIO	2	M, PA
TRACLEER	2	M, LA, PA
VENTAVIS	3	B/D, M

CENTRAL NERVOUS SYSTEM

ANTI-ANXIETY

<i>bupirone hcl</i>	1	
<i>fluvoxamine maleate</i>	1	M
LUVOX CR	3	M

ANTI-CONVULSANTS

BANZEL	3	M
<i>carbamazepine</i>	1	M
CARBATROL	3	M
CELONTIN	2	M
DEPACON	3	
DEPAKENE	3	M
DEPAKOTE	3	M
DEPAKOTE ER	3	M
DEPAKOTE SPRINKLES	3	M
DILANTIN	2	M
DILANTIN INFATABS	2	M
<i>divalproex sodium</i>	1	M
<i>ethosuximide</i>	1	M
FELBATOL	3	M
<i>gabapentin</i> 100mg	1	QL (1080 caps / 30 days), M
<i>gabapentin</i> 250mg/5ml	1	QL (5 bottles / 30 days), M
<i>gabapentin</i> 300mg	1	QL (360 caps / 30 days), M
<i>gabapentin</i> 400mg	1	QL (270 caps / 30 days), M
<i>gabapentin</i> 600mg	1	QL (180 tabs / 30 days), M
<i>gabapentin</i> 800mg	1	QL (120 tabs / 30 days), M
GABITRIL	3	M
KEPPRA 1000mg, 100mg/ml, 250mg, 500mg, 750mg	3	M
KEPPRA 500mg/5ml	3	injection
KEPPRA XR	3	M
LAMICTAL	3	M
LAMICTAL CHEWABLE DISPERS	3	M

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 22

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL ODT	3	M
LAMICTAL STARTER/NOT TAKI	3	
LAMICTAL STARTER/TAKING C	3	
LAMICTAL STARTER/TAKING V	3	
LAMICTAL XR	3	
LAMICTAL XR 100mg, 200mg, 25mg, 50mg	3	M
<i>lamotrigine</i>	1	M
<i>levetiracetam</i> 1000mg, 100mg/ml, 250mg, 500mg, 750mg	1	M
<i>levetiracetam</i> 500mg/5ml	1	
LYRICA 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg	2	QL (120 caps / 30 days), M
LYRICA 300mg	2	QL (60 caps / 30 days), M
MYSOLINE	3	M
NEURONTIN 100mg	3	QL (1080 caps / 30 days), M
NEURONTIN 250mg/5ml	3	QL (5 bottles / 30 days), M; solution
NEURONTIN 300mg	3	QL (360 caps / 30 days), M
NEURONTIN 400mg	3	QL (270 caps / 30 days), M
NEURONTIN 600mg	3	QL (180 tabs / 30 days), M
NEURONTIN 800mg	3	QL (120 tabs / 30 days), M
<i>oxcarbazepine</i>	1	M
PEGANONE	2	M
PHENYTEK	3	M
<i>phenytoin</i>	1	M
<i>phenytoin inj 50mg/ml</i>	1	
<i>phenytoin sodium extended</i>	1	M
<i>primidone</i>	1	M
SABRIL	3	M
STAVZOR	3	M
TEGRETOL	3	M
TEGRETOL XR TAB 100MG	2	M
TEGRETOL-XR	3	M
TOPAMAX	3	M
TOPAMAX SPRINKLE	3	M
<i>topiramate</i>	1	M
TRILEPTAL	3	M
<i>valproate sodium</i> 100mg/ml	1	

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 23

Drug Name	Drug Tier	Requirements/Limits
<i>valproate sodium</i> 250mg/5ml	1	M
<i>valproic acid</i>	1	M
VIMPAT 100mg, 10mg/ml, 150mg, 200mg, 50mg	2	M
VIMPAT 200mg/20ml	2	
ZARONTIN	3	M
ZONEGRAN	3	M
<i>zonisamide</i>	1	M

ANTIDEMENTIA

ARICEPT 10mg, 5mg	3	M; 5mg, 10mg
ARICEPT 23mg	3	M
ARICEPT ODT	3	M; 5mg, 10mg
<i>donepezil hydrochloride</i>	1	M
EXELON 2mg/ml	2	M; soln
EXELON 4.6mg/24hr, 9.5mg/24hr	2	M; patch
EXELON 1.5mg, 3mg, 4.5mg, 6mg	3	M
<i>galantamine hydrobromide</i>	1	M
NAMENDA	2	M
NAMENDA TITRATION PAK	2	
RAZADYNE	3	M
RAZADYNE ER	3	M
<i>rivastigmine tartrate</i>	1	M

ANTIDEPRESSANTS

<i>amitriptyline hcl</i>	1	M
AMOXAPINE	2	M
ANAFRANIL	3	M
APLENZIN	3	M
<i>bupropion hcl</i>	1	M
CELEXA	3	M
<i>citalopram hydrobromide</i>	1	M
<i>clomipramine hcl</i>	1	M
CYMBALTA	2	M
<i>desipramine hcl</i>	1	M
<i>doxepin hcl</i>	1	M
EFFEXOR XR	3	M
EMSAM	2	M
<i>fluoxetine hcl</i>	1	M
<i>imipramine hcl</i>	1	M
<i>imipramine pamoate</i>	1	M
LEXAPRO	3	M
<i>maprotiline hcl</i>	1	M
MARPLAN	2	M
<i>mirtazapine</i>	1	M
NARDIL	3	M

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Drug Name	Drug Tier	Requirements/Limits
<i>nefazodone hcl</i>	1	M
NORPRAMIN	3	M
<i>nortriptyline hcl</i>	1	M
OLEPTRO	3	M
PAMELOR	3	M
PARNATE	3	M
<i>paroxetine hcl</i>	1	M
PAXIL	3	M
PAXIL CR	3	M
PEXEVA	3	M
<i>phenelzine sulfate</i>	1	M
PRISTIQ	3	M
<i>protriptyline hcl</i>	1	M
PROZAC	3	M
PROZAC WEEKLY	3	M
REMERON	3	M
REMERON SOLTAB	3	M
<i>sertraline hcl</i>	1	M
SURMONTIL 100mg	2	M
SURMONTIL 25mg, 50mg	3	M
TOFRANIL	3	M
TOFRANIL-PM	3	M
<i>tranylcypromine sulfate</i>	1	M
<i>trazodone hcl</i>	1	M
<i>venlafaxine hcl</i> 100mg, 150mg, 25mg, 37.5mg, 50mg, 75mg	1	M
<i>venlafaxine hcl</i> 150mg, 37.5mg, 75mg	3	M
VENLAFAXINE HCL ER	3	M
VIIBRYD	3	M
VIVACTIL	3	M
WELLBUTRIN	3	M
WELLBUTRIN SR	3	M
WELLBUTRIN XL	3	M
ZOLOFT	3	M

ANTIPARKINSONIAN AGENTS

<i>amantadine hcl</i>	1	M
APOKYN	3	
AZILECT	2	M
<i>benztropine mesylate</i> .5mg, 1mg, 2mg	1	M
<i>benztropine mesylate</i> 1mg/ml	1	
<i>bromocriptine mesylate</i>	1	M
<i>carbidopa-levodopa</i>	1	M
COGENTIN	3	
COMTAN	2	M

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 25

Drug Name	Drug Tier	Requirements/Limits
ELDEPRYL	3	M
LODOSYN	3	M
MIRAPEX	3	M
MIRAPEX ER	3	M
PARCOPA	3	M
PARLODEL	3	M
<i>pramipexole dihydrochloride</i>	1	M
REQUIP	3	M
REQUIP XL	3	M
<i>ropinirole hydrochloride</i>	1	M
<i>selegiline hcl</i>	1	M
SINEMET	3	M
SINEMET CR	3	M
STALEVO 100	2	M
STALEVO 125	2	M
STALEVO 150	2	M
STALEVO 200	2	M
STALEVO 50	2	M
STALEVO 75	2	M
<i>trihexyphenidyl hcl</i>	1	M
ZELAPAR	3	M

ANTIPSYCHOTICS

ABILIFY 10mg, 15mg, 1mg/ml, 20mg, 2mg, 30mg, 5mg	3	M
ABILIFY 9.75mg/1.3ml	3	
ABILIFY DISCMELT	3	M
CHLORPROMAZ INJ 25MG/ML	2	
<i>chlorpromazine hcl</i>	1	M
<i>clozapine</i>	1	
CLOZARIL	3	
FANAPT	3	
FANAPT TITRATION PACK	3	
FAZACLO	3	
<i>fluphenazine decanoate</i>	1	
<i>fluphenazine hcl</i> 10mg, 1mg, 2.5mg, 2.5mg/5ml, 5mg, 5mg/ml	1	M
<i>fluphenazine hcl</i> 2.5mg/ml	1	
GEODON	3	M
GEODON INJ	3	
HALDOL	3	
HALDOL DECANOATE 100	3	
HALDOL DECANOATE 50	3	
<i>haloperidol</i>	1	M
<i>haloperidol decanoate</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
<i>haloperidol lactate</i> 2mg/ml	1	M
<i>haloperidol lactate</i> 5mg/ml	1	
INVEGA	3	M
INVEGA SUSTENNA	3	
LATUDA	3	M
<i>loxapine succinate</i>	1	M
LOXITANE	3	M
NAVANE	3	M
ORAP	2	M
<i>perphenazine</i>	1	M
RISPERDAL	3	M
RISPERDAL CONSTA 12.5mg, 25mg	2	
RISPERDAL CONSTA 37.5mg, 50mg	3	
RISPERDAL M-TAB	3	M
<i>risperidone</i> .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	1	M; ODT
<i>risperidone</i> .25mg, .5mg, 1mg, 1mg/ml, 2mg, 3mg, 4mg	1	M
SAPHRIS	3	M
SEROQUEL	2	M
SEROQUEL XR	2	M
<i>thioridazine hcl</i>	1	M
<i>thiothixene</i>	1	M
<i>trifluoperazine hcl</i>	1	M
ZYPREXA 10mg	3	
ZYPREXA 10mg, 15mg, 2.5mg, 20mg, 5mg, 7.5mg	3	M
ZYPREXA ZYDIS	3	M
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
ADDERALL XR	3	M, PA
<i>amphetamine-dextroamphetamine</i>	1	M, PA
CONCERTA	3	M, PA
DAYTRANA	3	M, PA
DEXEDRINE	3	M, PA
<i>dextroamphetamine sulfate</i>	1	M, PA
INTUNIV	3	M
METADATE CD	3	M, PA
METHYLIN	3	M, PA
<i>methylphenidate hcl</i> 10mg, 20mg	1	M; ext rel
<i>methylphenidate hcl</i> 10mg, 10mg/5ml, 20mg, 5mg, 5mg/5ml	1	M, PA
RITALIN	3	M, PA
RITALIN LA	3	M, PA
RITALIN SR	3	M, PA

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 27

Drug Name	Drug Tier	Requirements/Limits
STRATTERA	2	M, PA
VYVANSE	3	M, PA
HYPNOTICS		
AMBIEN	3	QL (30 tabs / 30 days)
AMBIEN CR	3	QL (30 ea / 30 days)
EDLUAR	3	QL (30 ea / year)
LUNESTA	3	QL (30 tabs / 30 days)
ROZEREM	3	QL (30 tabs / 30 days), M
SONATA	3	QL (30 caps / 30 days)
<i>zaleplon</i>	1	QL (30 caps / 30 days)
<i>zolpidem tartrate</i> 10mg, 5mg	1	QL (30 tabs / 30 days)
<i>zolpidem tartrate</i> 12.5mg, 6.25mg	1	QL (30 ea / 30 days)
MIGRAINE		
AMERGE	3	QL (9 tabs / 30 days)
AXERT	3	QL (12 tabs / 30 days)
CAFERGOT	3	
D.H.E. 45	3	
<i>dihydroergotamine mesylate</i>	1	
ERGOMAR	3	
<i>ergotamine w/ caffeine</i>	1	
FROVA	3	QL (18 tabs / 30 days)
IMITREX 100mg, 25mg, 50mg	3	QL (9 tabs / 30 days)
IMITREX 20mg/act, 5mg/act	3	QL (12 inhalers / 30 days)
IMITREX 6mg/0.5ml	3	QL (20 vials / 30 days)
IMITREX STATDOSE REFILL	3	QL (4 boxes / 30 days)
MAXALT	2	QL (12 tabs / 30 days)
MAXALT-MLT	2	QL (12 ea / 30 days)
MIGERGOT	2	
MIGRANAL	3	QL (8 bottles / 30 days)
<i>naratriptan hcl</i>	1	QL (9 tabs / 30 days)
RELPAK	3	QL (12 tabs / 30 days)
<i>sumatriptan succinate</i> 100mg, 25mg, 50mg	1	QL (9 tabs / 30 days)
<i>sumatriptan succinate</i> 4mg/0.5ml, 6mg/0.5ml	1	QL (20 vials / 30 days)
TREXIMET	3	QL (9 tabs / 30 days)
ZOMIG 2.5mg, 5mg	3	QL (12 tabs / 30 days)
ZOMIG 5mg	3	QL (2 bottles / 30 days)
ZOMIG ZMT	3	QL (12 ea / 30 days)
MISCELLANEOUS		
EQUETRO	3	M
GUANIDINE HCL	2	

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 28

Drug Name	Drug Tier	Requirements/Limits
LITHIUM CARB TAB 300MG	1	M
<i>lithium carbonate</i>	1	M
LITHIUM CITRATE	2	M
LITHOBID	3	M
MESTINON 60mg/5ml	2	
MESTINON 60mg	3	
MESTINON TIMESPAN	2	
MYTELASE	3	
NUDEXTA	3	M, PA
<i>pyridostigmine bromide</i>	1	
REGONOL	2	
RILUTEK	3	M
SAVELLA	3	M
SAVELLA TITRATION PACK	3	
XENAZINE	3	M, PA

MULTIPLE SCLEROSIS AGENTS

AMPYRA	3	M, PA
AVONEX	3	QL (4 syringes / 28 days), M, PA
BETASERON	3	QL (14 vials / 28 days), M, PA
COPAXONE	3	QL (30 syringes / 30 days), M, PA
EXTAVIA	3	QL (14 syringes / 28 days), M, PA
GILENYA	3	M, PA
REBIF	3	QL (12 syringes / 28 days), M, PA
REBIF TITRATION PACK	3	QL (12 syringes / 28 days), M, PA
TYSABRI	3	LA, PA

MUSCULOSKELETAL THERAPY AGENTS

AMRIX	3	PA
<i>baclofen</i>	1	M
<i>carisoprodol</i>	1	QL (120 tabs / 30 days), PA
<i>carisoprodol w/ aspirin</i>	1	QL (240 tabs / 30 days), PA
<i>carisoprodol w/ aspirin & codeine</i>	1	QL (240 tabs / 30 days), PA
<i>chlorzoxazone</i>	1	PA
<i>cyclobenzaprine hcl</i> 10mg, 5mg	1	PA
<i>cyclobenzaprine hcl</i> 15mg, 30mg	1	
DANTRIUM	3	

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 29

Drug Name	Drug Tier	Requirements/Limits
<i>dantrolene sodium</i>	1	
FEXMID	3	PA
FLEXERIL	3	PA
<i>metaxalone</i>	1	PA
<i>methocarbamol</i>	1	PA
<i>orphenadrine citrate</i>	1	PA
<i>orphenadrine w/ aspirin & caff</i>	1	PA
PARAFON FORTE DSC	3	PA
ROBAXIN	3	PA
ROBAXIN INJ 100MG/ML	2	
SKELAXIN	3	PA
SOMA	3	QL (120 tabs / 30 days), PA
<i>tizanidine hcl</i>	1	M
ZANAFLEX	3	M

NARCOLEPSY/CATAPLEXY

NUVIGIL	2	M, PA
PROVIGIL	3	M, PA
XYREM	3	LA, PA

PSYCHOTHERAPEUTIC-MISCELLANEOUS

ANTABUSE	2	M
<i>buprenorphine hcl</i>	1	PA
<i>bupropion hcl (smoking deterrent)</i>	1	
CAMPRAL	2	M, PA
CHANTIX	3	
<i>fluoxetine hcl (pmdd)</i>	1	M
<i>naloxone hcl</i>	1	
<i>naltrexone hcl</i>	1	
NICOTROL INHALER	3	
NICOTROL NS	3	
<i>perphenazine-amitriptyline</i>	1	M
REVIA	3	
SARAFEM	3	M
SUBOXONE	3	PA
SUBOXONE SL FILM	2	PA
SUBUTEX	3	PA
VIVITROL	3	
ZYBAN	3	

ENDOCRINE AND METABOLIC

ANDROGENS

ANADROL-50	3	PA
ANDRODERM	2	M, PA

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 30

Drug Name	Drug Tier	Requirements/Limits
ANDROGEL	2	QL (300 gm / 30 days), M, PA
ANDROGEL PUMP	2	QL (150 gm / 30 days), M, PA
ANDROXY	2	M, PA
AXIRON	3	M, PA
DEPO-TESTOSTERONE	3	
FORTESTA	3	M, PA
OXANDRIN	3	PA
<i>oxandrolone</i> 2.5mg	1	PA
<i>oxandrolone</i> 10mg	3	PA
STRIANT	3	M, PA
TESTIM	3	QL (300 gm / 30 days), M, PA
<i>testosterone cypionate</i>	1	
<i>testosterone enanthate</i>	1	

ANTIDIABETICS, INJECTABLE

ALCOHOL PREPS	2	
APIDRA	2	M
APIDRA SOLOSTAR	2	M
BYETTA	2	M, PA
HUMALOG	2	M
HUMALOG KWIKPEN	2	M
HUMALOG MIX 50/50	2	M
HUMALOG MIX 50/50 KWIKPEN	2	M
HUMALOG MIX 75/25	2	M
HUMALOG MIX 75/25 KWIKPEN	2	M
HUMULIN 70/30	2	M
HUMULIN 70/30 PEN	2	M
HUMULIN N	2	M
HUMULIN N U-100 PEN	2	M
HUMULIN R	2	M
HUMULIN R U-500 (CONCENTR	2	M
LANTUS	2	M
LANTUS SOLOSTAR	2	M
LEVEMIR	2	M
LEVEMIR FLEXPEN	2	M
NOVOLIN 70/30	2	M
NOVOLIN N	2	M
NOVOLIN R	2	M
NOVOLOG	2	M
NOVOLOG FLEXPEN	2	M
NOVOLOG MIX 70/30	2	M
NOVOLOG MIX 70/30 PREFILL	2	M

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 31

Drug Name	Drug Tier	Requirements/Limits
SYMLIN	2	M, PA
SYMLINPEN 120	2	M, PA
SYMLINPEN 60	2	M, PA
VICTOZA	2	QL (3 pens / 30 days), M

ANTIDIABETICS, ORAL

<i>acarbose</i>	1	M
ACTOPLUS MET	2	M
ACTOPLUS MET XR	3	M
ACTOS 15mg	2	QL (90 tabs / 30 days), M
ACTOS 30mg	2	QL (45 tabs / 30 days), M
ACTOS 45mg	2	QL (30 tabs / 30 days), M
AMARYL 1mg	3	QL (240 tabs / 30 days), M
AMARYL 2mg	3	QL (120 tabs / 30 days), M
AMARYL 4mg	3	QL (60 tabs / 30 days), M
DIABETA 1.25mg	3	QL (480 tabs / 30 days), M
DIABETA 2.5mg	3	QL (240 tabs / 30 days), M
DIABETA 5mg	3	QL (120 tabs / 30 days), M
DUETACT	2	M
FORTAMET	3	M
<i>glimepiride</i> 1mg	1	QL (240 tabs / 30 days), M
<i>glimepiride</i> 2mg	1	QL (120 tabs / 30 days), M
<i>glimepiride</i> 4mg	1	QL (60 tabs / 30 days), M
<i>glipizide</i> 10mg	1	QL (120 tabs / 30 days), M
<i>glipizide</i> 2.5mg	1	QL (240 ea / 30 days), M
<i>glipizide</i> 5mg	1	QL (120 ea / 30 days), M
<i>glipizide</i> 5mg	1	QL (240 tabs / 30 days), M
<i>glipizide er tab 10mg</i>	1	QL (60 ea / 30 days), M
<i>glipizide-metformin hcl</i>	1	M

PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 32

Drug Name	Drug Tier	Requirements/Limits
GLUCOPHAGE	3	M
GLUCOPHAGE XR	3	M
GLUCOTROL 10mg	3	QL (120 tabs / 30 days), M
GLUCOTROL 5mg	3	QL (240 tabs / 30 days), M
GLUCOTROL XL 10mg	3	QL (60 ea / 30 days), M
GLUCOTROL XL 2.5mg	3	QL (240 ea / 30 days), M
GLUCOTROL XL 5mg	3	QL (120 ea / 30 days), M
GLUCOVANCE	3	M
GLUMETZA	3	M
<i>glyburide</i> 1.25mg	1	QL (480 tabs / 30 days), M
<i>glyburide</i> 2.5mg	1	QL (240 tabs / 30 days), M
<i>glyburide</i> 5mg	1	QL (120 tabs / 30 days), M
<i>glyburide micronized</i> 1.5mg	1	QL (240 tabs / 30 days), M
<i>glyburide micronized</i> 3mg	1	QL (120 tabs / 30 days), M
<i>glyburide micronized</i> 6mg	1	QL (60 tabs / 30 days), M
<i>glyburide-metformin</i>	1	M
GLYCRON	3	QL (90 tabs / 30 days), M
GLYNASE 1.5mg	3	QL (240 tabs / 30 days), M
GLYNASE 3mg	3	QL (120 tabs / 30 days), M
GLYNASE 6mg	3	QL (60 tabs / 30 days), M
GLYSET	3	M
JANUMET	2	M
JANUVIA	2	M
KOMBIGLYZE XR	2	M
METAGLIP	3	M
<i>metformin hcl</i> 1000mg, 850mg	1	QL (90 tabs / 30 days), M
<i>metformin hcl</i> 500mg	1	QL (150 tabs / 30 days), M
<i>metformin hcl</i> 750mg	1	QL (90 ea / 30 days), M
<i>metformin tab</i> 500mg <i>er</i>	1	QL (120 ea / 30 days), M

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Drug Name	Drug Tier	Requirements/Limits
<i>nateglinide</i>	1	M
ONGLYZA	2	M
PRANDIMET	3	M
PRANDIN	2	M
PRECOSE	3	M
RIOMET	3	M
STARLIX	3	M
BISPHOSPHONATES		
ACTONEL 150mg, 35mg, 5mg	3	M
ACTONEL 30mg	3	
<i>alendronate sodium</i> 10mg, 35mg, 5mg, 70mg	1	M
<i>alendronate sodium</i> 40mg	1	
AREDIA	3	B/D
ATELVIA	3	M
BONIVA 150mg	2	M
BONIVA 3mg/3ml	2	B/D
FOSAMAX 10mg, 35mg, 5mg, 70mg, 70mg/75ml	3	M
FOSAMAX 40mg	3	
FOSAMAX PLUS D	3	M
<i>pamidronate disodium</i> 30mg/10ml, 90mg/10ml	1	B/D
PAMIDRONATE DISODIUM 6mg/ml	3	B/D
ZOMETA	3	B/D
CALCITONINS		
<i>calcitonin (salmon)</i>	1	M
MIACALCIN 200unit/ml	2	B/D; injection
MIACALCIN 200unit/act	3	M
CALCIUM RECEPTOR ANTAGONISTS		
SENSIPAR 30mg	2	M
SENSIPAR 60mg, 90mg	3	M
CHELATING AGENTS		
CHEMET	3	
EXJADE	3	M, PA
KAYEXALATE	3	
<i>sodium polystyrene sulfonate</i>	1	
SYPRINE	2	
CONTRACEPTIVES		
BEYAZ	3	M
BREVICON-28	3	M
CYCLESSA	3	M
DEPO-PROVERA CONTRACEPTIV	3	

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Drug Name	Drug Tier	Requirements/Limits
DEPO-SUBQ PROVERA 104	3	
DESOGEN	3	M
<i>desogestrel & ethinyl estradiol</i>	1	M
<i>desogestrel-ethinyl estradiol (triphasic)</i>	1	M
<i>drospirenone-ethinyl estradiol</i>	1	M
ESTROSTEP FE	3	M
<i>ethynodiol diacet & eth estrad</i>	1	M
<i>levonorgestrel & eth estradiol</i>	1	M
<i>levonorgestrel (emergency oc)</i>	1	
<i>levonorgestrel-eth estradiol (triphasic)</i>	1	M
<i>levonorgestrel-ethinyl estradiol (91-day)</i>	1	M
LO/OVRAL-28	3	M
LOESTRIN 1.5/30-21	3	M
LOESTRIN 1/20-21	3	M
LOESTRIN 24 FE	3	M
LOESTRIN FE 1.5/30	3	M
LOESTRIN FE 1/20	3	M
LOSEASONIQUE	3	M
LYBREL	3	M
<i>medroxyprogesterone acetate (contraceptive)</i>	1	
MODICON-28	3	M
NECON 10/11-28	2	M
NOR-QD	3	M
NORDETTE-28	3	M
<i>norethin acet & estrad-fe</i>	1	M
<i>norethindrone & eth estradiol</i>	1	M
<i>norethindrone (contraceptive)</i>	1	M
<i>norethindrone acet & eth estra</i>	1	M
<i>norethindrone acetate-ethinyl estradiol-fe</i>	1	M
<i>norethindrone-eth estradiol (triphasic)</i>	1	M
<i>norgestimate-ethinyl estradiol</i>	1	M
<i>norgestimate-ethinyl estradiol (triphasic)</i>	1	M
<i>norgestrel & ethinyl estradiol</i>	1	M
NORINYL 1+35	3	M
NUVARING	2	M
ORTHO EVRA	2	M
ORTHO MICRONOR	3	M
ORTHO TRI-CYCLEN LO	2	M
ORTHO-CEPT	3	M
ORTHO-CYCLEN	3	M
ORTHO-NOVUM 7/7/7-28	3	M
OVCON-35	3	M
OVCON-50 28	3	M

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Drug Name	Drug Tier	Requirements/Limits
SEASONALE	3	M
SEASONIQUE	3	M
TRI-NORINYL 28	3	M
YASMIN 28	3	M
YAZ	3	M
<i>zovia</i>	1	M
ENDOMETRIOSIS		
<i>danazol</i>	1	
SYNAREL	2	
ENZYME REPLACEMENTS		
ADAGEN	3	PA
ALDURAZYME	3	PA
BUPHENYL	3	M
BUPHENYL 500mg	3	M; tablet
CARNITOR 1gm/10ml, 330mg	3	B/D, M
CARNITOR 200mg/ml	3	B/D
CEREDASE	3	
CEREZYME	3	PA
CYSTADANE	3	M
CYSTAGON	2	
ELAPRASE	3	PA
FABRAZYME	3	PA
KUVAN	3	M, PA
<i>levocarnitine (metabolic modifiers)</i> 1gm/10ml, 330mg	1	B/D, M
<i>levocarnitine (metabolic modifiers)</i> 200mg/ml	1	B/D
MYOZYME	3	PA
NAGLAZYME	3	PA
ORFADIN	3	M, PA
VPRIV	3	PA
ZAVESCA	3	M, PA
ESTROGEN/PROGESTINS		
ACTIVELLA	3	M
CLIMARA PRO	3	M
COMBIPATCH	3	M
<i>estradiol & norethindrone acetate</i>	1	M
FEMHRT 1/5	3	M
FEMHRT LOW DOSE	3	M
<i>norethindrone acetate-ethinyl estradiol</i>	1	M
PREFEST	3	M
PREMPHASE	3	M, PA
PREMPRO	3	M, PA

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Drug Name	Drug Tier	Requirements/Limits
ESTROGENS		
ALORA	3	M
CENESTIN	3	M, PA
CLIMARA	3	M
DELESTROGEN	3	
DEPO-ESTRADIOL	3	
DIVIGEL	3	M
ELESTRIN	3	M
ENJUVIA	3	M, PA
ESTRACE	3	M
ESTRADERM	2	M
<i>estradiol</i>	1	M
<i>estradiol valerate</i>	1	
ESTRING	3	M
<i>estropipate</i>	1	M, PA
EVAMIST	3	M
FEMRING	3	M
FEMTRACE	3	M
MENEST	3	M, PA
MENOSTAR	3	M
PREMARIN .3mg, .45mg, .625mg, .9mg, 1.25mg	3	M, PA
PREMARIN 25mg	3	
PREMARIN W/APPLICATOR	3	M
VAGIFEM	3	M
VIVELLE-DOT	2	M
GLUCOCORTICOIDS		
CELESTONE	3	
CORTEF	3	
<i>cortisone acetate</i>	1	
DEPO-MEDROL	3	
<i>dexamethasone</i>	1	
DEXAMETHASONE INTENSOL	2	
<i>dexamethasone sodium phosphate</i>	1	
DEXPAK 13 DAY	3	
<i>fludrocortisone acetate</i>	1	M
<i>hydrocortisone</i>	1	
<i>hydrocortisone sod succinate</i>	1	
MEDROL	3	
MEDROL DOSEPAK	3	
<i>methylprednisolone</i>	1	
<i>methylprednisolone acetate</i>	1	
<i>methylprednisolone sod succ</i>	1	
MILLIPRED	3	

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Drug Name	Drug Tier	Requirements/Limits
ORAPRED	3	
ORAPRED ODT	3	
PEDIAPRED	3	
<i>prednisolone sodium phosphate</i>	1	
<i>prednisone</i>	1	
PREDNISON INTENSOL	2	
SOLU-CORTEF 250mg	2	
SOLU-CORTEF 100mg	3	
SOLU-MEDROL	3	
VERIPRED 20	3	
GLUCOSE ELEVATING AGENTS		
GLUCAGEN HYPOKIT	2	
GLUCAGON EMERGENCY KIT	2	
PROGLYCEM	2	M
HUMAN GROWTH HORMONES		
GENOTROPIN	3	M, PA
GENOTROPIN MINIQUICK	3	M, PA
HUMATROPE	3	M, PA
HUMATROPE COMBO PACK	3	M, PA
NORDITROPIN FLEXPRO	3	M, PA
NORDITROPIN NORDIFLEX PEN	3	M, PA
NUTROPIN	3	M, PA
NUTROPIN AQ PEN	3	M, PA
OMNITROPE	3	M, PA
SAIZEN	3	M, PA
SAIZEN CLICK.EASY	3	M, PA
SEROSTIM	3	M, PA
TEV-TROPIN	3	M, PA
ZORBTIVE	3	M, PA
MISCELLANEOUS		
<i>cabergoline</i>	1	
<i>chorionic gonadotropin</i>	1	PA
INCRELEX	3	M, PA
METHERGINE	3	
<i>octreotide acetate</i>	3	M, PA
PROLIA	3	PA
SAMSCA	3	PA
SANDOSTATIN	3	M, PA
SANDOSTATIN LAR DEPOT	3	PA
SOMATULINE DEPOT	3	PA
SOMAVERT	3	M, PA
XGEVA	3	PA
PARATHYROID HORMONES		

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Drug Name	Drug Tier	Requirements/Limits
FORTEO	3	M, PA
PHOSPHATE BINDER AGENTS		
<i>calcium acetate (phosphate binder)</i>	1	M
ELIPHOS	3	M
FOSRENOL	2	M
PHOSLO	2	M
RENAGEL	2	M
REVELA	2	M
PROGESTINS		
AYGESTIN	3	M
CRINONE	3	
ENDOMETRIN	3	
<i>medroxyprogesterone acetate</i>	1	M
<i>norethindrone acetate</i>	1	M
PROMETRIUM	3	M
PROVERA	3	M
SELECTIVE ESTROGEN RECEPTOR MODULATORS		
EVISTA	2	M
THYROID AGENTS		
CYTOMEL	3	M
<i>levothyroxine sodium</i>	1	M
<i>liothyronine sodium 10mcg/ml</i>	1	
<i>liothyronine sodium 25mcg, 50mcg, 5mcg</i>	1	M
<i>methimazole</i>	1	M
<i>propylthiouracil</i>	1	M
SYNTHROID	2	M
TAPAZOLE	3	M
THYROLAR-1	3	M
THYROLAR-1/4	3	M
THYROLAR-2	3	M
THYROLAR-3	3	M
TIROSINT	3	M
VASOPRESSINS		
DDAVP .01%, .1mg, .2mg	3	M
DDAVP 4mcg/ml	3	
<i>desmopressin acetate .1mg, .2mg</i>	1	M
<i>desmopressin acetate 4mcg/ml</i>	1	
<i>desmopressin acetate refrigerated</i>	1	M
<i>desmopressin acetate spray refrigerated</i>	1	M
STIMATE	3	M
GASTROINTESTINAL		
ANTIEMETICS		
ALOXI	3	B/D

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Drug Name	Drug Tier	Requirements/Limits
ANTIVERT	3	
CESAMET	3	B/D, QL (60 caps / 30 days)
<i>dronabinol 2.5mg</i>	1	QL (60 caps / 30 days), PA
<i>dronabinol 10mg, 5mg</i>	3	QL (60 caps / 30 days), PA
EMEND 80mg	2	B/D, QL (4 caps / 30 days)
EMEND 125mg	2	B/D, QL (2 caps / 30 days)
EMEND 40mg	2	
<i>granisetron hcl</i>	1	B/D
GRANISOL	3	B/D
MARINOL	3	QL (60 caps / 30 days), PA
<i>meclizine hcl</i>	1	
<i>metoclopramide hcl</i>	1	
METOZOLV ODT	3	
<i>ondansetron</i>	1	B/D
<i>ondansetron hcl</i>	1	B/D
<i>ondansetron inj</i>	1	B/D
PHENERGAN	3	
<i>prochlorperazine</i>	1	
<i>prochlorperazine edisylate</i>	1	
<i>prochlorperazine maleate</i>	1	M
<i>promethazine hcl</i>	1	PA
<i>promethazine hcl inj</i>	1	
REGLAN	3	
SANCUSO	2	QL (4 ptch / 30 days)
TIGAN	3	PA
TRANSDERM-SCOP	2	QL (24 ea / year), PA
<i>trimethobenzamide hcl</i>	1	PA
ZOFRAN	3	B/D
ZOFRAN ODT	3	B/D
ZUPLENZ	3	B/D

ANTISPASMODICS

<i>atropine sulfate</i>	1	
BENTYL 10mg, 10mg/5ml, 20mg	3	PA
BENTYL 10mg/ml	3	
CANTIL	3	
<i>dicyclomine hcl</i>	1	PA
<i>dicyclomine inj</i>	1	
<i>glycopyrrolate</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
<i>methscopolamine bromide</i>	1	
PAMINE	3	
PAMINE FORTE	3	
ROBINUL	3	
ROBINUL FORTE	3	

H2-RECEPTOR ANTAGONISTS

AXID	3	M
<i>cimetidine</i> 200mg	1	
<i>cimetidine</i> 300mg, 400mg, 800mg	1	M
<i>cimetidine inj</i> 150mg/ml	1	
<i>cimetidine sol</i> 300/5ml	1	M
<i>famotidine</i> 10mg/ml	1	
<i>famotidine</i> 20mg, 40mg, 40mg/5ml	1	M
<i>nizatidine</i>	1	M
PEPCID 20mg, 40mg	3	M
PEPCID 40mg/5ml	3	M; suspension
PEPCID I.V.	3	
<i>ranitidine hcl</i> 150mg, 15mg/ml, 300mg	1	M
<i>ranitidine hcl</i> 150mg/6ml	1	
ZANTAC 25mg/ml	3	
ZANTAC 150mg, 15mg/ml, 25mg, 300mg	3	M

INFLAMMATORY BOWEL DISEASE

APRISO	2	M
ASACOL	3	M
ASACOL HD	3	
AZULFIDINE	3	M
AZULFIDINE EN-TABS	3	M
<i>balsalazide disodium</i>	1	
CANASA	2	
CIMZIA 200mg	3	PA
CIMZIA 200mg/ml	3	M, PA
COLAZAL	3	
CORTENEMA	3	
DIPENTUM	3	M
ENTOCORT EC	3	
<i>hydrocortisone (intrarectal)</i>	1	
LIALDA	2	
<i>mesalamine</i>	1	
PENTASA	2	M
ROWASA	3	
<i>sulfasalazine</i>	1	M

LAXATIVES

COLYTE-FLAVOR PACKS	3	
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Drug Name	Drug Tier	Requirements/Limits
GOLYTELY	3	
KRISTALOSE	3	M
<i>lactulose</i>	1	M
<i>lactulose (encephalopathy)</i>	1	M
MOVIPREP	3	
NULYTELY/FLAVOR PACKS	3	
OSMOPREP	3	
<i>peg 3350-kcl-sod bicarb-sod chloride-sod sulfate</i>	1	
<i>peg 3350-potassium chloride-sod bicarbonate-sod chloride</i>	1	
<i>polyethylene glycol 3350</i>	1	
RELISTOR	2	PA
SUPREP BOWEL PREP	3	
VISICOL	3	
MISCELLANEOUS		
ACTIGALL	3	M
AMITIZA	2	M
CARAFATE 1gm/10ml	2	M; suspension
CARAFATE 1gm	3	M
CYTOTEC	3	M
<i>diphenoxylate w/ atropine</i>	1	PA
GASTROCROM	3	M
HELIDAC	3	
LOMOTIL	3	PA
<i>loperamide hcl</i>	1	
LOTRONEX	2	M
<i>misoprostol</i>	1	M
MOTOFEN	3	PA
PYLERA	3	
<i>sucrafate</i>	1	M
URSO 250	3	M
URSO FORTE	3	M
<i>ursodiol</i>	1	M
XIFAXAN TAB 550MG	3	M, PA
PANCREATIC ENZYMES		
CREON	3	M
PANCREAZE	2	M
ZENPEP	2	M
PROTON PUMP INHIBITOR/ANTI-INFECTIVE COMBINATIONS		
PREVPAC	2	
PROTON PUMP INHIBITORS		
ACIPHEX	3	QL (30 ea / 30 days), M

PA - Prior Authorization QL - Quantity Limits M - Available at mail-order B/D - Covered under Medicare B or D LA - Limited Access GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 42

Drug Name	Drug Tier	Requirements/Limits
DEXILANT	2	QL (30 ea / 30 days), M
<i>lansoprazole</i>	1	QL (30 ea / 30 days), M
<i>lansoprazole odt</i>	1	QL (30 ea / 30 days), M
NEXIUM	2	QL (30 ea / 30 days), M
NEXIUM GRANULES	2	QL (30 / 30 days), M
NEXIUM I.V.	2	
<i>omeprazole</i> 10mg, 40mg	1	QL (30 ea / 30 days), M
<i>omeprazole</i> 20mg	1	QL (60 ea / 30 days), M
<i>pantoprazole sodium</i>	1	QL (30 ea / 30 days), M
PREVACID	3	QL (30 ea / 30 days), M
PREVACID SOLUTAB	3	QL (30 ea / 30 days), M
PRILOSEC 10mg, 40mg	3	QL (30 ea / 30 days), M
PRILOSEC 20mg	3	QL (60 ea / 30 days), M
PROTONIX 20mg, 40mg	3	QL (30 ea / 30 days), M
PROTONIX 40mg	3	injection
PROTONIX 40mg	3	QL (1 box / 30 days), M
ZEGERID	3	QL (1 packet / 30 days), M

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

AVODART	3	M
CARDURA XL	3	M
<i>finasteride</i>	1	M
FLOMAX	3	M
JALYN	3	M
PROSCAR	3	M
RAPAFLO	3	M
<i>tamsulosin hcl</i>	1	M
UROXATRAL	2	M

MISCELLANEOUS

<i>bethanechol chloride</i>	1	
ELMIRON	3	
<i>potassium citrate (alkalinizer)</i>	1	
URECHOLINE	3	

URINARY ANTISPASMODICS

DETROL	3	M
DETROL LA	2	M
DITROPAN XL	3	M
ENABLEX	2	M
GELNIQUE	2	M
<i>oxybutynin chloride</i>	1	M
OXYTROL	3	M
SANCTURA	3	M

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Drug Name	Drug Tier	Requirements/Limits
SANCTURA XR	3	M
TOVIAZ	3	M
<i>trospium chloride</i>	1	M
VESICARE	2	M

VAGINAL ANTI-INFECTIVES

CLEOCIN 2%	3	
CLEOCIN VAG SUPP 100MG	2	
<i>clindamycin cre 2% vag</i>	1	
CLINDESSE	3	
GYNAZOLE-1	3	
METROGEL-VAGINAL	3	
<i>metronidazole vaginal</i>	1	
<i>miconazole nitrate vaginal</i>	1	
TERAZOL 3	3	
TERAZOL 7	3	
<i>terconazole vaginal</i>	1	

HEMATOLOGIC

ANTICOAGULANTS

ARIXTRA	3	
COUMADIN 10mg, 1mg, 2.5mg, 2mg, 3mg, 4mg, 5mg, 6mg, 7.5mg	2	M
COUMADIN 5mg	3	
<i>enoxaparin sodium</i>	1	
FRAGMIN 2500unit/0.2ml	2	
FRAGMIN 10000unit/ml, 12500unit/0.5ml, 3 15000unit/0.6ml, 18000unt/0.72ml, 25000unit/ml, 5000unit/0.2ml, 7500unit/0.3ml		
HEP SOD/NAACL INJ 25000	2	B/D
<i>heparin (porcine) in sodium chloride</i>	1	B/D
<i>heparin sod (porcine) in d5w</i>	1	B/D
HEPARIN SOD INJ 2000/ML	2	B/D
<i>heparin sodium (porcine)</i>	1	B/D
INNOHEP	3	
LOVENOX	3	
PRADAXA	2	
<i>warfarin sodium</i>	1	M

HEMATOPOIETIC GROWTH FACTORS

ARANESP ALBUMIN FREE 25mcg/0.42ml, 25mcg/ml, 40mcg/0.4ml, 40mcg/ml, 60mcg/0.3ml, 60mcg/ml	2	PA
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PA - Prior Authorization **QL** - Quantity Limits **M** - Available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 44

Drug Name	Drug Tier	Requirements/Limits
ARANESP ALBUMIN FREE 100mcg/0.5ml, 100mcg/ml, 150mcg/0.3ml, 200mcg/0.4ml, 200mcg/ml, 300mcg/0.6ml, 300mcg/ml, 500mcg/ml	3	PA
EPOGEN	3	PA
LEUKINE	3	PA
MOZOBIL	3	PA
NEULASTA	3	PA
NEUPOGEN	3	PA
PROCRIT 10000unit/ml, 2000unit/ml, 3000unit/ml, 4000unit/ml	2	PA
PROCRIT 20000unit/ml, 40000unit/ml	3	PA

MISCELLANEOUS

AGRYLIN	3	M
<i>anagrelide hcl</i>	1	M, PA
<i>cilostazol</i>	1	M
CYKLOKAPRON	2	
<i>pentoxifylline</i>	1	M
PLETAL	3	M
PROMACTA	3	M, PA
TRENTAL	3	M

PLATELET AGGREGATION INHIBITORS

AGGRENOX	2	M
<i>dipyridamole</i>	1	M, PA
EFFIENT	2	M
PERSANTINE	3	M, PA
PLAVIX 300mg	2	
PLAVIX 75mg	2	M

IMMUNOLOGIC AGENTS

DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)

ACTEMRA	3	PA
ARAVA	3	M
ENBREL	3	M, PA
HUMIRA	3	M, PA
<i>hydroxychloroquine sulfate</i>	1	M
KINERET	3	M, PA
<i>leflunomide</i>	1	M
<i>methotrexate sodium 2.5mg</i>	1	
ORENCIA	3	M, PA
PLAQUENIL	3	M
REMICADE	3	PA
RHEUMATREX	2	M
SIMPONI	3	M, PA
TREXALL	3	B/D

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Drug Name	Drug Tier	Requirements/Limits
IMMUNOGLOBULINS		
CARIMUNE NANOFILTERED	3	PA
GAMASTAN S/D	2	B/D
GAMMAGARD LIQUID	3	PA
GAMMAPLEX	3	PA
GAMUNEX	3	PA
HIZENTRA	3	PA
VIVAGLOBIN	3	PA
IMMUNOMODULATORS		
ACTIMMUNE	3	M, PA
ARCALYST	3	M, PA
INFERGEN	3	PA
INTRON-A	3	B/D, M
INTRON-A W/DILUENT	3	B/D, M
PEG-INTRON	3	PA
PEG-INTRON REDIPEN	3	PA
PEGASYS	3	PA
REVLIMID	2	LA, PA
THALOMID	2	M, PA
IMMUNOSUPPRESSANTS		
ATGAM	3	B/D
AZASAN	2	B/D, M
<i>azathioprine</i>	1	B/D, M
<i>azathioprine inj 100mg</i>	1	B/D
CELLCEPT	2	B/D, M
CELLCEPT INTRAVENOUS	3	B/D
<i>cyclosporine 100mg, 25mg</i>	1	B/D, M
<i>cyclosporine 50mg/ml</i>	1	B/D
<i>cyclosporine modified (for microemulsion)</i>	1	B/D, M
IMURAN	3	B/D, M
<i>mycophenolate mofetil</i>	1	B/D, M
MYFORTIC	2	B/D, M
NEORAL	2	B/D, M
ORTHOCLONE OKT3	3	B/D
PROGRAF .5mg, 1mg	2	B/D, M
PROGRAF 5mg	3	B/D, M
PROGRAF 5mg/ml	3	B/D
RAPAMUNE	2	B/D, M
SANDIMMUNE 100mg, 100mg/ml, 25mg	2	B/D, M
SANDIMMUNE 50mg/ml	3	B/D
SIMULECT	3	B/D
<i>tacrolimus .5mg, 1mg</i>	1	B/D, M
<i>tacrolimus 5mg</i>	3	B/D, M

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Drug Name	Drug Tier	Requirements/Limits
THYMOGLOBULIN	3	B/D
ZORTRESS .25mg, .5mg	2	B/D, M
ZORTRESS .75mg	3	B/D, M

VACCINES

ACTHIB	2	
ADACEL	2	
BOOSTRIX	2	
CERVARIX	2	
COMVAX	2	
DAPTACEL	2	
DECAVAC	2	B/D
DIPHTHERIA/TETANUS TOXOID	2	B/D
ENGERIX-B	2	B/D
GARDASIL	2	
HAVRIX	2	
IMOVAX RABIES (H.D.C.V.)	2	
INFANRIX	2	
IPOL INACTIVATED IPV	2	
IXIARO	2	
JE-VAX	2	
M-M-R II W/DILUENT 10 DOS	2	
MENACTRA	2	
MENOMUNE-A/C/Y/W-135	2	
MENVEO	2	
PEDVAX HIB	2	
PROQUAD	2	
RABAVERT	2	
RECOMBIVAX HB	2	B/D
ROTATEQ	2	
SYNAGIS	3	
TETANUS TOXOID ADSORBED	2	B/D
TETANUS/DIPHTHERIA TOXOID	2	B/D
TRIPEDIA	2	
TWINRIX	2	
TYPHIM VI	2	
VAQTA	2	
VARIVAX	2	
YF-VAX	2	
ZOSTAVAX	2	

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES

AMMONIUM CHLORIDE	3	
K-TABS	3	M

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Drug Name	Drug Tier	Requirements/Limits
KLOR-CON M15	2	M
<i>magnesium sulfate</i> 50%	1	
MAGNESIUM SULFATE 40mg/ml, 80mg/ml	3	
<i>parenteral electrolytes</i>	1	B/D
<i>potassium chloride</i> 10meq, 8meq	1	M
<i>potassium chloride</i> 2meq/ml	1	
<i>potassium chloride microencapsulated crystals cr</i>	1	M
<i>sodium chloride</i> 2.5meq/ml	1	

IV NUTRITION

<i>amino acid electrolyte infusion</i>	1	B/D
<i>amino acid infusion</i>	1	B/D
AMINOSYN	2	B/D
AMINOSYN II	2	B/D
AMINOSYN II 3.5%/DEXTROSE	2	B/D
AMINOSYN II 3.5%/DEXTROSE	2	B/D
AMINOSYN II 4.25%/DEXTROSE	2	B/D
AMINOSYN II 5%/DEXTROSE 25	2	B/D
AMINOSYN II M 3.5%/DEXTRO	2	B/D
AMINOSYN M	2	B/D
AMINOSYN-HBC	2	B/D
AMINOSYN-PF	2	B/D
AMINOSYN-PF 7%	2	B/D
CLINIMIX 2.75%/DEXTROSE 5	2	B/D
CLINIMIX 4.25%/DEXTROSE 1	2	B/D
CLINIMIX 4.25%/DEXTROSE 2	2	B/D
CLINIMIX 4.25%/DEXTROSE 5	2	B/D
CLINIMIX 5%/DEXTROSE 15%	2	B/D
CLINIMIX 5%/DEXTROSE 20%	2	B/D
CLINIMIX 5%/DEXTROSE 25%	2	B/D
CLINIMIX E 2.75%/DEXTROSE	2	B/D
CLINIMIX E 4.25%/DEXTROSE	2	B/D
CLINIMIX E 5%/DEXTROSE 15	2	B/D
CLINIMIX E 5%/DEXTROSE 20	2	B/D
CLINIMIX E 5%/DEXTROSE 25	2	B/D
<i>fat emulsion</i>	1	B/D
FREAMINE III 3%	2	B/D
HEPATASOL	2	B/D
INTRALIPID	2	B/D
LIPOSYN II	2	B/D
LIPOSYN III	2	B/D
NEPHRAMINE	2	B/D
PREMASOL	2	B/D
PROCALAMINE	2	B/D

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Drug Name	Drug Tier	Requirements/Limits
PROSOL	2	B/D
TRAVASOL	2	B/D
TROPHAMINE	2	B/D

IV REPLACEMENT SOLUTIONS

<i>dextrose</i>	1	
DEXTROSE 5%	2	
DEXTROSE 5%/POTASSIUM CHL	2	
<i>dextrose w/ sodium chloride</i>	1	
<i>electrolyte-m in dextrose</i>	1	
<i>electrolyte-r</i>	1	
<i>electrolyte-r in dextrose</i>	1	
IONOSOL-B/DEXTROSE 5%	2	
IONOSOL-MB/DEXTROSE 5%	2	
IONOSOL-T/DEXTROSE 5%	2	
ISOLYTE-H/DEXTROSE 5%	2	
ISOLYTE-P/DEXTROSE 5%	2	
ISOLYTE-S	2	
ISOLYTE-S/DEXTROSE 5%	2	
KCL 0.15%/D10W/NACL 0.2%	2	
KCL 0.15%/D5W/LR	2	
KCL 0.15%/D5W/NACL 0.225%	2	
KCL 0.3%/D5W/NACL 0.9%	2	
<i>lactated ringer's</i>	1	
MAGNESIUM SULFATE IN D5W	2	
NORMOSOL-R	2	
PLASMA-LYTE 56	2	
PLASMA-LYTE A	2	
PLASMA-LYTE-148	2	
PLASMA-LYTE-148/D5W	2	
PLASMA-LYTE-56/D5W	2	
<i>potassium chloride .4meq/ml, 10meq/100ml, 10meq/50ml, 30meq/100ml</i>	1	
POTASSIUM CHLORIDE 0.3%/	2	
<i>potassium chloride in d5w lactated ringers</i>	1	
<i>potassium chloride in dextrose</i>	1	
<i>potassium chloride in dextrose & sodium chloride</i>	1	
<i>potassium chloride in nacl ringer's</i>	1	
<i>sodium chloride .45%, .9%, 3%, 5%</i>	1	

VITAMINS

CALCIJEX	3	B/D
<i>calcitriol .25mcg, .5mcg, 1mcg/ml</i>	1	B/D, M

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Drug Name	Drug Tier	Requirements/Limits
<i>calcitriol</i> 1mcg/ml	1	B/D
HECTOROL .5mcg, 1mcg, 2.5mcg	3	B/D, M
HECTOROL 4mcg/2ml	3	B/D
ROCALTROL	3	B/D, M
ZEMPLAR 1mcg, 2mcg, 4mcg	2	B/D, M
ZEMPLAR 2mcg/ml, 5mcg/ml	2	B/D

OPHTHALMIC

ANTI-INFECTIVE/ANTI-INFLAMMATORY

<i>bacitracin-poly-neomycin-hc</i>	1	
BLEPHAMIDE	3	
BLEPHAMIDE S.O.P.	2	
MAXITROL	3	
<i>neomycin-polymy-dexameth</i>	1	
<i>neomycin-polymyxin-hc (ophth)</i>	1	
POLY-PRED	3	
<i>sulfacetamide sod-prednisolone</i>	1	
TOBRADEX	3	
TOBRADEX ST	3	
<i>tobramycin-dexamethasone</i>	1	
ZYLET	3	

ANTI-INFECTIVES

AZASITE	2	
<i>bacitracin (ophthalmic)</i>	1	
<i>bacitracin-polymyxin b (ophth)</i>	1	
BESIVANCE	3	
BLEPH-10	3	
CILOXAN .3%	2	ointment
CILOXAN .3%	3	
<i>ciprofloxacin hcl (ophth)</i>	1	
<i>erythromycin (ophth)</i>	1	
<i>gentamicin sulfate (ophth)</i>	1	
<i>levofloxacin (ophth)</i>	1	
NATACYN	2	
<i>neomycin-bacitracin zn-polymyxin</i>	1	
<i>neomycin-polymy-gramicid</i>	1	
NEOSPORIN	3	
OCUFLOX	3	
<i>ofloxacin (ophth)</i>	1	
<i>polymyxin b-trimethoprim</i>	1	
POLYTRIM	3	
QUIXIN	3	
<i>sulfacetamide sodium (ophth)</i>	1	
<i>tobramycin sulfate (ophth)</i>	1	

PA - Prior Authorization QL - Quantity Limits M - Available at mail-order B/D - Covered 50
under Medicare B or D LA - Limited Access GC - We provide coverage of this
prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more
information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
TOBREX	3	
TOBREX OINT 0.3%	2	
<i>trifluridine</i>	1	
VIGAMOX	2	
VIROPTIC	3	
ZIRGAN	3	
ZYMAR	2	
ZYMAXID	2	

ANTI-INFLAMMATORIES

ACULAR	3	
ACULAR LS	3	
ACUVAIL	3	
BROMDAY	3	
<i>bromfenac sodium (ophth)</i>	1	
<i>dexamethasone sodium phosphate (ophth)</i>	1	
<i>diclofenac sodium (ophth)</i>	1	
DUREZOL	3	
FLAREX	3	
<i>fluorometholone (ophth)</i>	1	
<i>flurbiprofen sodium</i>	1	
FML	2	oint
FML FORTE	3	
FML LIQUIFILM	3	
<i>ketorolac tromethamine (ophth)</i>	1	
LOTEMAX	3	
MAXIDEX	3	
NEVANAC	3	
OCUFEN	3	
OMNIPRED	3	
PRED FORTE	3	
PRED MILD	3	
PRED-G	3	
PRED-G S.O.P.	3	
<i>prednisolone acetate (ophth)</i>	1	
PREDNISOLONE SODIUM PHOSP	2	
VEXOL	3	
VOLTAREN	3	

ANTIALLERGICS

ALAMAST	3	
ALOCRIAL	3	
ALOMIDE	3	
ALREX	2	
<i>azelastine hcl (ophth)</i>	1	

PA - Prior Authorization QL - Quantity Limits M - Available at mail-order B/D - Covered 51
under Medicare B or D LA - Limited Access GC - We provide coverage of this
prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more
information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
BEPREVE	3	
<i>cromolyn sodium (ophth)</i>	1	
ELESTAT	3	
EMADINE	3	
<i>epinastine hcl (ophth)</i>	1	
LASTACAFT	3	
OPTIVAR	3	
PATADAY	2	
PATANOL	2	
ANTI GLAUCOMA		
ALPHAGAN P .1%	2	M
ALPHAGAN P .15%	3	M
AZOPT	2	M
BETAGAN	3	M
<i>betaxolol hcl (ophth)</i>	1	M
BETIMOL	3	M
BETOPTIC-S	2	M
<i>brimonidine tartrate</i>	1	M
<i>carteolol hcl (ophth)</i>	1	M
COMBIGAN	2	M
COSOPT	3	M
<i>dorzolamide hcl</i>	1	M
<i>dorzolamide hcl-timolol maleate</i>	1	M
ISTALOL	3	M
<i>latanoprost</i>	1	M
<i>levobunolol hcl</i>	1	M
LUMIGAN	2	M
<i>metipranolol</i>	1	M
OPTIPRANOLOL	3	M
PHOSPHOLINE IODIDE	3	M
PILOPINE HS	2	M
<i>timolol maleate (ophth) .25%, .5%</i>	1	M; gel
<i>timolol maleate (ophth) .25%, .5%</i>	1	M
TIMOPTIC OCUDOSE	3	M
TIMOPTIC-XE	3	M
TRAVATAN Z	2	M
TRUSOPT	3	M
XALATAN	3	M
MISCELLANEOUS		
ALCAINE	3	
BOTOX	3	PA
LACRISERT	2	
<i>naphazoline hcl</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
<i>propracaine hcl</i>	1	
RESTASIS	2	M

RESPIRATORY

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

COMBIVENT	2	QL (2 inhalers / 30 days), M
DUONEB	3	B/D, M
<i>ipratropium-albuterol</i>	1	B/D, M

ANTICHOLINERGICS

ATROVENT	3	M
ATROVENT HFA	2	QL (2 inhalers / 30 days), M
<i>ipratropium bromide (nasal)</i>	1	M
<i>ipratropium sol inhal</i>	1	B/D, M
SPIRIVA HANDIHALER	2	QL (30 caps / 30 days), M

ANTI-HISTAMINE/DECONGESTANT COMBINATIONS

CLARINEX-D 12 HOUR	3	
CLARINEX-D 24 HOUR	3	
<i>promethazine & phenylephrine</i>	1	PA
SEMPREX-D	3	

ANTI-HISTAMINES

ASTELIN	3	QL (2 bottles / 30 days)
ASTEPRO	2	QL (2 spray-bottles / 30 days)
<i>azelastine hcl</i>	1	QL (2 bottles / 30 days)
<i>carbinoxamine maleate</i>	1	
<i>cetirizine syrup hcl</i>	1	syrup
CLARINEX	3	
CLARINEX REDITABS	3	
<i>clemastine fumarate</i>	1	
<i>cyproheptadine hcl</i>	1	PA
<i>dexchlorpheniramine maleate</i>	1	
<i>diphenhydram inj 50mg/ml</i>	1	
<i>fexofenadine hcl</i>	1	
<i>hydroxyzine hcl</i>	1	PA
<i>hydroxyzine hcl inj</i>	1	
<i>hydroxyzine pamoate</i>	1	PA
<i>levocetirizine tab 5 mg</i>	1	
PALGIC	3	
PATANASE	3	
VISTARIL	3	PA
XYZAL	3	

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Drug Name	Drug Tier	Requirements/Limits
BETA AGONISTS		
ACCUNEB	3	B/D, M
<i>albuterol sulfate</i> .083%, .5%, .63mg/3ml, 1.25mg/3ml	1	B/D, M
<i>albuterol sulfate</i> 2mg, 2mg/5ml, 4mg, 8mg	1	M
BROVANA	3	B/D, M
FORADIL AEROLIZER	2	QL (60 caps / 30 days), M
<i>levalbuterol hcl</i>	1	B/D, M
PERFOROMIST	3	B/D, M
PROAIR HFA	2	QL (2 inhalers / 30 days), M
PROVENTIL HFA	3	QL (2 inhalers / 25 days), M
SEREVENT DISKUS	3	QL (1 inhaler / 30 days), M
<i>terbutaline sulfate</i> 1mg/ml	1	
<i>terbutaline sulfate</i> 2.5mg, 5mg	1	M
VENTOLIN HFA	3	QL (2 inhalers / 30 days), M
VOSPIRE ER	3	M
XOPENEX	3	B/D, M
XOPENEX HFA	3	QL (2 inhalers / 30 days), M
LEUKOTRIENE RECEPTOR ANTAGONISTS		
ACCOLATE	3	M
SINGULAIR	2	M
<i>zafirlukast</i>	1	M
ZYFLO CR	3	M
MAST CELL STABILIZERS		
<i>cromolyn sodium</i>	1	B/D, M
MISCELLANEOUS		
<i>acetylcysteine</i>	1	B/D
ARALAST NP	3	PA
CAYSTON	3	PA
<i>epinephrine hcl</i>	1	
EPIPEN 2-PAK	2	
EPIPEN-JR 2-PAK	2	
GLASSIA	3	PA
PROLASTIN	3	PA
PROLASTIN-C	3	PA
PULMOZYME	3	B/D, M
TOBI	3	B/D

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Drug Name	Drug Tier	Requirements/Limits
TWINJECT	3	
TYZINE	3	
TYZINE PEDIATRIC NASAL DR	3	
XOLAIR	3	PA
ZEMAIRA	3	PA
<i>NASAL STEROIDS</i>		
BECONASE AQ	3	QL (2 inhalers / 30 days)
FLONASE	3	QL (1 bottle / 30 days)
<i>flunisolide (nasal)</i>	1	QL (2 bottles / 30 days)
<i>fluticasone propionate (nasal)</i>	1	QL (1 bottle / 30 days)
NASACORT AQ	2	QL (1 inhaler / 30 days)
NASONEX	3	QL (2 inhalers / 30 days)
OMNARIS	3	QL (1 inhaler / 25 days)
RHINOCORT AQUA	3	QL (2 inhalers / 30 days)
VERAMYST	3	QL (1 bottle / 30 days)
<i>STERIOD INHALANTS</i>		
ALVESCO	3	QL (2 inhalers / 25 days), M
ASMANEX 120 METERED DOSES	2	QL (2 inhalers / 30 days), M
ASMANEX 14 METERED DOSES	2	QL (2 inhalers / 30 days), M
ASMANEX 30 METERED DOSES	2	QL (2 inhalers / 30 days), M
ASMANEX 60 METERED DOSES	2	QL (2 inhalers / 30 days), M
<i>budesonide (inhalation)</i>	1	B/D, M
FLOVENT DISKUS	3	QL (2 inhalers / 30 days), M
FLOVENT HFA 110mcg/act, 220mcg/act	3	QL (2 inhalers / 30 days), M
FLOVENT HFA 44mcg/act	3	QL (2 inhalers / 25 days), M
PULMICORT	3	B/D, M
PULMICORT FLEXHALER 180mcg/act	3	QL (2 inhalers / 30 days), M
PULMICORT FLEXHALER 90mcg/act	3	QL (4 inhalers / 30 days), M
QVAR	2	QL (3 inhalers / 30 days), M
<i>STERIOD/BETA-AGONIST COMBINATIONS</i>		
ADVAIR DISKUS	3	QL (1 kit / 30 days), M

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Drug Name	Drug Tier	Requirements/Limits
ADVAIR HFA	3	QL (1 inhaler / 30 days), M
DULERA	2	QL (1 inhaler / 25 days), M
SYMBICORT	2	QL (1 inhalers / 30 days), M

XANTHINES

<i>aminophylline</i> 100mg, 200mg	1	M
<i>aminophylline</i> 25mg/ml	1	
ELIXOPHYLLIN	2	M
LUFYLLIN	3	M
THEO-24	2	M
<i>theophylline</i>	1	M

TOPICAL

DERMATOLOGY, ACNE

ACANYA	3	
<i>adapalene</i>	1	
AKNE-MYCIN	3	
ATRALIN	3	
AZELEX	3	
BENZAACLIN WITH PUMP	3	
BENZAMYCIN	3	
<i>benzoyl peroxide-erythromycin</i>	1	
CLEOCIN-T	3	
CLINDAGEL	3	
<i>clindamycin phosphate (topical)</i>	1	
<i>clindamycin phosphate-benzoyl peroxide</i>	1	
DIFFERIN	3	
EPIDUO	3	
<i>erythromycin (acne aid)</i>	1	
EVOCLIN	3	
<i>isotretinoin cap 10 mg</i>	1	
KLARON	3	
RETIN-A	3	
RETIN-A MICRO	3	
<i>sulfacetamide sodium (acne)</i>	1	
TRETIN-X	3	
<i>tretinoin .01%, .025%, .05%, .1%</i>	1	
ZIANA	3	

DERMATOLOGY, ACTINIC KERATOSIS

CARAC	2	
EFUDEX	3	
FLUOROPLEX	3	

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Drug Name	Drug Tier	Requirements/Limits
<i>fluorouracil (topical)</i>	1	
SOLARAZE	2	
DERMATOLOGY, ANTIBIOTICS		
ALTABAX	3	
BACTROBAN 2%	2	cream
BACTROBAN 2%	3	ointment
BACTROBAN NASAL	3	
CORTISPORIN	3	
<i>gentamicin sulfate (topical)</i>	1	
<i>mupirocin</i>	1	
PHISOHEX	3	
SILVADENE	3	
<i>silver sulfadiazine</i>	1	
SULFAMYLON	3	
DERMATOLOGY, ANTIFUNGALS		
<i>ciclopirox</i>	1	
<i>ciclopirox olamine</i>	1	
<i>clotrimazole (topical)</i>	1	
<i>econazole nitrate</i>	1	
ERTACZO	3	
EXELDERM	3	
EXTINA	3	
<i>ketoconazole (topical) 2%</i>	1	
LOPROX	3	
LOPROX SHAMPOO	3	
MENTAX	3	
NAFTIN	3	
<i>nystatin (topical)</i>	1	
<i>nystatin pow 100000</i>	1	
OXISTAT	3	
DERMATOLOGY, ANTIPRURITIC		
ANUSOL-HC	3	
CORTIFOAM	3	
<i>hydrocortisone (rectal) 2.5%</i>	1	
ZONALON	2	
DERMATOLOGY, ANTIPSORIATICS		
8-MOP	3	
AMEVIVE	3	
<i>calcipotriene</i>	1	
DOVONEX	2	cream
DOVONEX SCALP	3	solution
OXSORALEN ULTRA	3	PA
SORIATANE	3	PA

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Drug Name	Drug Tier	Requirements/Limits
STELARA	3	PA
TAZORAC	3	
VECTICAL	3	
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole (topical) 2%</i>	1	
NIZORAL	3	
<i>selenium sulfide</i>	1	
DERMATOLOGY, ANTIVIRALS		
DENAVIR	2	
ZOVIRAX 5%	2	cream, ointment
DERMATOLOGY, CORTICOSTEROIDS		
ACLOVATE	3	
ALA SCALP	3	
<i>alclometasone dipropionate</i>	1	
<i>amcinonide .1%</i>	1	
AMCINONIDE .1%	3	
<i>betamethasone dipropionate (topical)</i>	1	
<i>betamethasone dipropionate augmented</i>	1	
<i>betamethasone valerate</i>	1	
CAPEX	3	
CARMOL-HC	3	
<i>clobetasol propionate</i>	1	
<i>clobetasol propionate emollient base</i>	1	
CLOBEX	3	
CLODERM	3	
CORDRAN	3	
CORDRAN SP	3	
CORDRAN TAPE	3	
CUTIVATE	3	
DERMA-SMOOTHIE/FS BODY OIL	2	
DERMATOP	3	
DESONATE	3	
<i>desonide</i>	1	
DESOWEN	3	
DESOWEN LOTION/CETAPHIL C	3	
DESOWEN OINTMENT/CETAPHIL	3	
<i>desoximetasone</i>	1	
<i>diflorasone diacetate</i>	1	
DIPROLENE	3	
DIPROLENE AF	3	
ELOCON	3	
<i>fluocinolone acetonide</i>	1	
<i>fluocinonide</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
<i>fluocinonide emulsified base</i>	1	
<i>fluticasone propionate</i>	1	
<i>halobetasol propionate</i>	1	
HALOG	3	
<i>hydrocortisone (rectal) 1%</i>	1	
<i>hydrocortisone (topical)</i>	1	
<i>hydrocortisone butyrate</i>	1	
<i>hydrocortisone valerate</i>	1	
KENALOG	3	
LOCOID	3	
LOCOID LIPOCREAM	3	
LUXIQ	3	
<i>mometasone furoate</i>	1	
OLUX-E	3	
PANDEL	3	
<i>prednicarbate</i>	1	
PROCTOCORT	3	
TACLONEX	3	
TACLONEX SCALP	3	
TEMOVATE	3	
TOPICORT	3	
TOPICORT LP	3	
<i>triamcinolone acetonide (topical)</i>	1	
TRIAMCINOLONE ACETONIDE I	3	.05% ointment
ULTRAVATE	3	
<i>urea-hc acetate</i>	1	
VANOS	3	
VERDESO	3	
WESTCORT	3	
DERMATOLOGY, IMMUNOMODULATORS		
ELIDEL	2	PA
PROTOPIC	2	PA
DERMATOLOGY, LOCAL ANESTHETICS		
EMLA	3	
<i>lidocaine</i>	1	
<i>lidocaine hcl</i>	1	
<i>lidocaine-prilocaine</i>	1	
LIDODERM	2	PA
SYNERA	3	
XYLOCAINE 4%	3	
XYLOCAINE JELLY	3	
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
ALDARA	3	

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information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
CONDYLOX	3	
<i>imiquimod</i>	1	
LAC-HYDRIN	3	
<i>lactic acid (ammonium lactate)</i>	1	
OXSORALEN	3	
PANRETIN	2	
PENNSAID	2	
<i>podofilox</i>	1	
TARGETIN 1%	2	
VOLTAREN GEL 1%	2	
ZYCLARA	2	
DERMATOLOGY, ROSACEA		
FINACEA	3	
METROCREAM	3	
METROGEL	2	
METROLOTION	3	
<i>metronidazole (topical)</i>	1	
NORITATE	3	
ORACEA	2	
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
EURAX	3	
<i>malathion</i>	1	
OVIDE	3	
<i>permethrin</i>	1	
ULESFIA	3	
DERMATOLOGY, WOUND CARE AGENTS		
<i>neomycin/polymyxin b gu</i>	1	
REGRANEX	3	PA
SANTYL	2	
<i>sodium chloride (gu irrigant)</i>	1	
MOUTH/THROAT/DENTAL AGENTS		
<i>chlorhexidine gluconate (mouth-throat)</i>	1	
EVOXAC	2	M
<i>lidocaine hcl (mouth-throat)</i>	1	
<i>nystatin (mouth-throat)</i>	1	
ORAVIG	2	
<i>pilocarpine hcl (oral)</i>	1	M
SALAGEN	3	M
<i>triamcinolone acetonide (mouth)</i>	1	
OTIC		
<i>acetic acid (otic)</i>	1	
CIPRO HC	3	
CIPRODEX	3	

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under Medicare B or D LA - Limited Access GC - We provide coverage of this
prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more
information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
COLY-MYCIN S	3	
CORTISPORIN	3	
CORTISPORIN-TC	3	
DERMOTIC	2	
<i>hydrocortisone w/acetic acid</i>	1	
<i>neomycin-polymyxin-hc (otic)</i>	1	
<i>ofloxacin (otic)</i>	1	

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<i>clindamycin hcl</i>	10	COMTAN.....	26
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<i>clindamycin phosphate (topical)</i>	56	CONCERTA	27
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<i>methyldopa</i>	21
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METROGEL	60
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<i>neomycin sulfate</i>	6	<i>norethindrone (contraceptive)</i>	35
<i>neomycin/polymyxin b gu</i>	60	<i>norethindrone acet & eth estra</i>	35
<i>neomycin-bacitracin zn-polymyxin</i>	50	<i>norethindrone acetate</i>	39
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<i>nystatin pow 100000</i>	57
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<i>ondansetron hcl</i>	40
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<i>penicillin v potassium</i>	6	<i>polymyxin b-trimethoprim</i>	50
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<i>probenecid</i>	1	<i>quinapril-hydrochlorothiazide</i>	15
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<i>terbutaline sulfate</i>	54	TOPICORT LP	59
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