

Network Health Plan 2012 Preferred Drug List



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PURPOSE OF THE PREFERRED DRUG LIST

The Network Health Plan (NHP) Preferred Drug List was developed to provide members and practitioners with a listing of the most commonly prescribed medications. This listing includes preferred and non-preferred medications and indicates which copay/coinsurance tier applies. Tiers 1, 2, and 4 indicate preferred medications. Tiers 3 and 5 indicate non-preferred medications.

DEVELOPMENT OF THE PREFERRED DRUG LIST

The Preferred Drug List document was developed by the Network Health Plan/Network Health Insurance Corporation's Pharmacy and Therapeutics Committee (P&T Committee). This committee, composed of practitioners from various medical specialties, reviewed the medications in all therapeutic categories based on safety, effectiveness, and cost.

Preferred Drug List development and maintenance is a dynamic process. The P&T Committee will regularly review new and existing medications to ensure the Preferred Drug List remains responsive to the needs of members and health care providers. The Preferred Drug List will be updated periodically. For the latest version of the Network Health Plan Preferred Drug List, log onto <http://www.networkhealth.com> or contact NHP's Customer Service department at 1-800-826-0940 or 920-720-1300 to request a copy.

PREFERRED DRUG LIST MEDICATIONS

The Preferred Drug List applies to prescription medications provided to outpatients. For the most part this is limited to medications obtained from participating pharmacies. Copays may also apply to medications administered in the practitioner's office. Please refer to your Summary of Member Responsibility Table and your Prescription Drug (Rx) Rider for which copays apply to your benefit. The Preferred Drug List does not apply to medications given in the hospital setting.

UNAPPROVED USE OF PREFERRED DRUG LIST MEDICATIONS

The Certificate of Coverage states a medication will be eligible for coverage only if it is an FDA approved medication used for non-experimental indications. Non-experimental indications include the labeled indication(s) (FDA-approved) and other indications accepted as effective by the balance of currently available scientific evidence and informed professional opinion. Experimental and investigational drugs, and drugs used for cosmetic purposes, weight loss or erectile dysfunction are examples of products not eligible for coverage. Members should refer to the Certificate of Coverage for a detailed list of exclusions.

COPAY/COINSURANCE DETERMINATION

The information listed in this document contains the most commonly prescribed medications and was current at the time of printing, however, changes occur frequently. The member's actual copay/coinsurance will be determined at the time the prescription is filled. The member will only pay the applicable copay/coinsurance for the prescription unless one of the following conditions apply:

Generic Medications

If the practitioner indicates "Dispense As Written", or if the member requests the brand name product for a medication where a generic is available, the member must pay the applicable copay/coinsurance plus the ancillary charge. The ancillary charge is the cost difference between the brand name product and the generic product. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescriber to use the generic equivalent.

Non-Prescription Medications

Unless a specific exception is made, non-prescription or over-the-counter (OTC) products are not covered. If a prescription is written for a medication available as an OTC product, the prescription product will not be covered. If the member or practitioner insists on the prescription product, the member will be responsible for the entire cost of the prescription.

Specialty Products

The P&T Committee has designated certain pharmaceutical products as Specialty Products. Chapter 19 lists these products and indicates if they are preferred or non-preferred. For members with a five tier prescription benefit, these products will be covered as Tier 4 (preferred products) and Tier 5 (non-preferred products). For members with a three tier prescription benefit, these products will be covered as Tier 2 (preferred products) and Tier 3 (non-preferred products). Specialty Products (Chapter 19) must be obtained through NHP's contracted specialty pharmacy. (Unless otherwise indicated in the Network Health Plan Preferred Drug List, or in your Prescription Drug (RX) Rider, or if the medication is administered in the practitioner's office.)

Compounded Prescriptions

Compounded prescriptions will be covered at the Tier 3 copay/coinsurance amount.

Please refer to the Prescription Benefit Summary of Member Responsibility Table located under the Prescription Coverage tab in the Member Handbook for specific copay/coinsurance information.

PREFERRED DRUG LIST ORGANIZATION

Medications are grouped by drug class categories. Please refer to the INDEX section at the back of this document for an alphabetical listing of medications, as well as a reference to the specific page number each medication falls on. Members will need to locate the medication within the chapter section to verify which tier the medication falls within, as well as determine if there are any special requirements, or limitations for using the medication. When a medication is only available as a brand name product, it is listed in CAPITAL LETTERS. When a generic is available, it is only listed using the generic name in **bolded lowercase**. It should be noted that even if a medication is listed, it does not necessarily mean that all strengths and dosage forms have the same copay/coinsurance and/or limitations. Some of the common exceptions have been indicated, however, due to the size of the Preferred Drug List, a comprehensive listing of all dosage forms and names was not possible. For information on medications that are not listed, please call Express Scripts at 1-800-417-3380 or log onto www.express-scripts.com.

PRIOR AUTHORIZATION, QUANTITY LIMITS, STEP THERAPY

To promote the most appropriate utilization, certain medications have additional restrictions applied to them. These restrictions have been established by the P&T Committee with input from local practitioners and consideration of the current medical literature, and are indicated in the COMMENTS column of the Preferred Drug List. In the case of medications requiring Prior Authorization, the member's practitioner must request approval for coverage prior to the prescription being filled. These medications contain the letters "PAR" in the COMMENTS column. Prescriptions for medications with Quantity Limits may not be dispensed in quantities greater than is listed. The COMMENTS column identifies these medications with "QL=" followed by the limit. Finally, some medications follow Step Therapy rules. That means different product(s) must be tried before NHP will cover the requested medication. These medications are indicated in the COMMENTS column with the phrase "requires trial of..." followed by the medication(s) that need to be tried first. If the member and their practitioner feel that any of the above restrictions do not meet the needs of the member, the practitioner may call Express Scripts, Inc. (ESI) to have a request for an exception reviewed.

Authorization requests should be directed to:

COMMERCIAL MEMBERS

Express Scripts Commercial Prior Authorization Center

PH: 1-877-415-9978

FAX: 1-800-357-9577 (takes two business days)

Denial Questions can be addressed by calling

PH: 1-800-570-8090 (leave a message for call back)

To request that a new or existing medication be added to the Preferred Drug List, a letter indicating the significant advantages of the medication over current preferred medications should be mailed or emailed to the addresses below. Factors to consider are effectiveness, side effects, drug interactions, and cost.

Network Health Plan
ATTN: Pharmacy Benefits
1570 Midway Place
PO Box 120
Menasha, WI 54952

OR

EMAIL: pharmacybenefits@networkhealth.com

SELF-ADMINISTERED INJECTABLES

Self-Administered Injectable refers to an injection given by the PARTICIPANT or Caregiver in the home. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion. In order to promote the appropriate level of care, those medications that can safely be self-administered will only be available under the prescription benefit. That means that if these medications are administered in the office, they will only be covered for one dose unless prior-authorization has been obtained. These medications contain the letters "SA" in the COMMENTS column. These injections must be obtained with a prescription and from a NHP Participating Specialty Pharmacy.

SPLIT THE BILL PROGRAM

The Split the Bill (STB) program allows members to pay only one-half of the regular copay/coinsurance for splitting certain tablets (see table below). The medications in this program will be designated with STB in the COMMENTS column in the Preferred Drug List. This program is available at both retail and mail order pharmacies.

The purpose of reducing copays/coinsurance to members is to provide an incentive for splitting tablets when they otherwise wouldn't need to. If the only way the appropriate dose can be given is to split a tablet, the copay/coinsurance will not be reduced. **Therefore, only the specific doses of the medications listed in the tables below are eligible for reduced copays/coinsurance.** For example, paroxetine 15mg isn't listed on the table below. Therefore, if a member is splitting a 30mg tablet to obtain a 15mg dose, there won't be a copay/coinsurance reduction.

Drug Name	Dose	Comments
BENICAR	20mg	Use ½ 40mg tablet
BENICAR HCT	20-12.5mg	Use ½ 40-25mg tablet
citalopram	20mg	Use ½ 40mg tablet
	10mg	Use ½ 20mg tablet
COZAAR	25mg	Use ½ 50mg tablet
	50mg	Use ½ 100mg tablet
CRESTOR	20mg	Use ½ 40mg tablet
	10mg	Use ½ 20mg tablet
	5mg	Use ½ 10mg tablet
LEXAPRO	10mg	Use ½ 20mg tablet
	5mg	Use ½ 10mg tablet

Drug Name	Dose	Comments
lovastatin	10mg	Use ½ 20mg tablet
	20mg	Use ½ 40mg tablet
paroxetine	20mg	Use ½ 40mg tablet
	10mg	Use ½ 20mg tablet
sertraline	50mg	Use ½ 100mg tablet
	25mg	Use ½ 50mg tablet
simvastatin	40mg	Use ½ 80mg tablet
	20mg	Use ½ 40mg tablet
	10mg	Use ½ 20mg tablet
	5mg	Use ½ 10mg tablet
VYTORIN	10/40	Use ½ 10/80 tablet
	10/20	Use ½ 10/40 tablet
	10/10	Use ½ 10/20 tablet

It is common that as the strength of a medication increases, the price also increases. However, in some cases this does not hold true. Some medications are "flat priced", or are similarly priced at all strengths. This means that *Prescription 10mg* costs similar or the same per tablet as *Prescription 20mg* (see example below).

Old Prescription 10mg (#30) Directions: Take 1 tablet daily	New Prescription 20mg (#15) Directions: Take ½ tablet daily
Cost: \$2.65 per tablet	Cost: \$2.65 per tablet
\$79.50 (total prescription cost)	\$39.75 (total prescription cost)
-\$15.00 (copay)	-\$7.50 (copay)
\$64.50 (Network Health Plan's cost)	\$32.25 (Network Health Plan's cost)

By splitting tablets that are "flat priced", members will not only save on the copay/coinsurance but will help control prescription drug costs that can drive up premium expenses.

To start taking advantage of these savings for medications in the program, members need to obtain a new prescription from the practitioner. The prescription should be written to dispense one-half tablet of the appropriate strength to achieve the necessary dosage. For example, if the member needs 15mg dose daily, their practitioner would have to write a prescription for ½ of a 30mg tablet daily.

Please refer to the member's Certificate of Coverage, Prescription Drug Rider, and Prescription Benefit Summary of Member Responsibility Table for particular plan design limitations. NHP's Preferred Drug List and Prior Authorization policies govern the rules and restrictions outlined in this document.

The information listed in this document contains the most commonly prescribed medications and was current at the time of printing, however, changes occur frequently. The actual copay/coinsurance will be determined at the time the prescription is filled. For additional prescription drug information, log onto www.express-scripts.com or call Express Scripts at 1-800-417-3380.

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Network Health Plan Preferred Drug List		
DRUG NAME	COMMENTS	TIER
CHAPTER 2: ANTIINFECTIVES		
2.1.1 CEPHALOSPORINS		
CEDEX		3
cefactor		1
cefactor er		1
cefdinir		1
cefprozil		1
CEFTIN SUSPENSION		2
cefuroxime tablet		1
cephalexin		1
SPECTRACEF		3
SUPRAX		3
VANTIN		3
2.1.3 CLINDAMYCINS		
clindamycin hcl		1
2.1.4 ERYTHROMYCINS		
erythromycin		1
PCE		3
2.1.4.1 OTHER MACROLIDES		
azithromycin		1
BIAXIN XL		2
clarithromycin		1
2.1.5 PENICILLINS		

Tier 1 = generic drug
 Tier 2 = Preferred Brand Drug
 Tier 3 = Non-Preferred Brand Drug

QL = Quantity Limit per Fill
 PAR = Prior Authorization Required
 STB = Split the Bill

DRUG NAME	COMMENTS	TIER
amox tr/potassium clavulanate		1
amoxicillin		1
ampicillin		1
AUGMENTIN ES-600		2
AUGMENTIN XR		3
dicloxacillin		1
penicillin v potassium		1
2.1.6 SULFONAMIDES		
erythromycin/sulfisoxazole		1
GANTRISIN PEDIATRIC		2
sulfamethoxazole /trimethoprim		1
2.1.7 TETRACYCLINES		
doxycycline hyclate		1
doxycycline monohydrate		3
minocycline		1
tetracycline		1
2.1.8 URINARY ANTIINFECTIVES		
MACROBID		2
nitrofurantoin		1
nitrofurantoin suspension		1
trimethoprim		1
2.1.9 QUINOLONES		
AVELOX		3
CIPRO XR		3
ciprofloxacin		1
FACTIVE		3
levofloxacin		1
NOROXIN		3
ofloxacin		1
2.2 TOPICAL ANTIBACTERIAL DRUGS		
ALTABAX 1%		3
mupirocin		1
silver sulfadiazine		1
2.3 ORAL ANTIFUNGAL DRUGS		
clotrimazole		1
fluconazole		1
itraconazole	PAR / capsules: QL=34	1
ketoconazole		1
LAMISIL		2
LAMISIL GRANULES		3
NOXAFIL	see Chapter 19, Specialty Products	
nystatin		1
ORAVIG		3
SPORANOX	PAR / capsules: QL=34	2
terbinafine 250 mg tablet		1

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DRUG NAME	COMMENTS	TIER
voriconazole		1
2.4.1 VAGINAL ANTIFUNGALS		
MONISTAT DUAL-PAK	QL=1 box	2
TERAZOL	suppositories: QL=1 box; 20g cream: QL=1 tube; 45g cream: QL=1 tube	2
2.4.2 OTHER TOPICAL ANTIFUNGALS		
econazole		1
ERTACZO		3
EXELDERM		3
ketoconazole		1
LAMISIL SOLUTION		3
MENTAX		3
NAFTIN		2
nystatin		1
OXISTAT		2
PENLAC		3
2.4.3 TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.		
clotrimazole/betamethasone		1
nystatin/triamcinolone		1
2.5.1 ANTIRETROVIRALS & PROTEASE INHIBITORS		
EDURANT		2
FUZEON	see Chapter 19, Specialty Products	
INCIVEK	see Chapter 19, Specialty Products	
INTELENCE	see Chapter 19, Specialty Products	
ISENTRESS	see Chapter 19, Specialty Products	
KALETRA	see Chapter 19, Specialty Products	
SELZENTRY	see Chapter 19, Specialty Products	
VICTRELIS	see Chapter 19, Specialty Products	
VIREAD	see Chapter 19, Specialty Products	
2.5.2 OTHER ANTIVIRAL DRUGS		
acyclovir		1
amantadine		1
EPZICOM		2
famciclovir	125mg tablets: QL=21; 250mg tablets: QL=68; 500mg tablets: QL=21	1
FAMVIR	125mg tablets: QL=21; 250mg tablets: QL=68; 500mg tablets: QL=21	2
ganciclovir inj	see Chapter 19, Specialty Products	
REBETOL SOLN	see Chapter 19, Specialty Products	
RELENZA	QL=20 blisters	2
ribavirin capsule, tablet	see Chapter 19, Specialty Products	
TAMIFLU	capsules: QL=34; 25ml bottle: QL=3	2
TYZEKA		2
valacyclovir	500mg caplets: QL=34; 1000mg (1gm) caplets: QL=34	1
VIRAZOLE	see Chapter 19, Specialty Products	
2.7.1 AMEBICIDES		
paromomycin		1

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DRUG NAME	COMMENTS	TIER
2.7.2 ANTITUBERCULOSIS DRUGS		
isoniazid		1
rifampin		1
2.7.3 PLASMODICIDES		
ARALEN	PAR	2
atovaquone proguanil	PAR	1
chloroquine	PAR	1
COARTEM	PAR	2
FANSIDAR	PAR	2
hydroxychloroquine sulfate	PAR	1
LARIAM	PAR	2
MALARONE	PAR	2
mefloquine	PAR	1
PLAQUENIL	PAR	2
primaquine	PAR	2
2.7.5 TRICHOMONOCIDES		
metronidazole		1
TINDAMAX		3
2.8 OTHER ANTIINFECTIVE DRUGS		
ALINIA		2
CAYSTON	see Chapter 19, Specialty Products	
DIFICID	see Chapter 19, Specialty Products	
NEBUPENT	QL=1 container	2
XIFAXAN 200 mg	QL=9 tablets	2
XIFAXAN 550 mg	see Chapter 19, Specialty Products	
ZYVOX	see Chapter 19, Specialty Products	
2.8.2 AMINOGLYCOSIDES		
TOBI	see Chapter 19, Specialty Products	
CHAPTER 3: ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS		
3.0 ANTINEOPLASTIC IMMUNOSUPPRESSANT		
BENLYSTA	see Chapter 19, Specialty Products	
CAPRELSA	see Chapter 19, Specialty Products	
exemestane		1
NULOJIX	see Chapter 19, Specialty Products	
XALKORI	see Chapter 19, Specialty Products	
VANDETANIB	see Chapter 19, Specialty Products	
ZELBORAF	see Chapter 19, Specialty Products	
3.1 DRUGS FOR THE TREATMENT OF CANCER		
AFINITOR	see Chapter 19, Specialty Products	
ARIMIDEX		2
azathioprine		1
CAMPATH	see Chapter 19, Specialty Products	
CAMPTOSAR	see Chapter 19, Specialty Products	
CASODEX		2
CELLCEPT		2

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DRUG NAME	COMMENTS	TIER
ELLENCE	see Chapter 19, Specialty Products	
GEMZAR	see Chapter 19, Specialty Products	
GLEEVEC	see Chapter 19, Specialty Products	
HERCEPTIN	see Chapter 19, Specialty Products	
HYCAMTIN	see Chapter 19, Specialty Products	
IDAMYCIN	see Chapter 19, Specialty Products	
IRESSA	see Chapter 19, Specialty Products	
letrozole		1
mercaptopurine		1
MESNEX		2
mitoxantrone	see Chapter 19, Specialty Products	
MYLOTARG	see Chapter 19, Specialty Products	
NEXAVAR	see Chapter 19, Specialty Products	
octreotide	see Chapter 19, Specialty Products	
ONTAK	see Chapter 19, Specialty Products	
SANDOSTATIN LAR	see Chapter 19, Specialty Products	
SPRYCEL	see Chapter 19, Specialty Products	
SUTENT	see Chapter 19, Specialty Products	
tamoxifen citrate		1
TARCEVA	see Chapter 19, Specialty Products	
TARGRETIN	see Chapter 19, Specialty Products	
TASIGNA	see Chapter 19, Specialty Products	
TAXOL	see Chapter 19, Specialty Products	
TAXOTERE	see Chapter 19, Specialty Products	
TEMODAR	see Chapter 19, Specialty Products	
TREANDA	see Chapter 19, Specialty Products	
TYKERB	see Chapter 19, Specialty Products	
VANTAS	see Chapter 19, Specialty Products	
VOTRIENT	see Chapter 19, Specialty Products	
XELODA	see Chapter 19, Specialty Products	
ZOLADEX	see Chapter 19, Specialty Products	
ZOLINZA	see Chapter 19, Specialty Products	
3.4 IMMUNOSUPPRESSANT DRUGS		
cyclosporine		1
MYFORTIC		2
3.6 IMMUNE MODULATORS		
AMEVIVE	see Chapter 19, Specialty Products	
CIMZIA	see Chapter 19, Specialty Products	
ENBREL	see Chapter 19, Specialty Products	
HUMIRA	see Chapter 19, Specialty Products	
leflunomide	10mg tablets: QL=34; 20mg tablets: QL=34; 100mg tablets: QL=3	1
ORENCIA	see Chapter 19, Specialty Products	
REMICADE	see Chapter 19, Specialty Products	
REVLIMID	see Chapter 19, Specialty Products	
RITUXAN	see Chapter 19, Specialty Products	

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DRUG NAME	COMMENTS	TIER
SIMPONI	see Chapter 19, Specialty Products	
SOMATULINE	see Chapter 19, Specialty Products	
STELARA	see Chapter 19, Specialty Products	
TYSABRI	see Chapter 19, Specialty Products	
CHAPTER 4: CARDIOVASCULAR MEDICATIONS		
4.1 CARDIAC GLYCOSIDES		
digoxin		1
4.2 CALCIUM ANTAGONISTS		
amlodipine		1
CARDENE SR		3
CARDIZEM LA		3
cartia xt		1
diltiazem er		1
diltiazem hcl		1
diltiazem xr		1
DYNACIRC		3
DYNACIRC CR		3
felodipine er		1
nicardipine hcl		1
nifedipine		1
nifedipine er		1
nisoldipine		1
NORVASC		2
verapamil hcl		1
verapamil pellets generic		3
VERELAN PM		3
4.3 DIURETICS		
4.3.1 LOOP DIURETICS		
bumetanide		1
furosemide		1
torsemide		1
4.3.2 THIAZIDE AND RELATED DRUGS		
hydrochlorothiazide		1
indapamide		1
metolazone		1
4.3.3 POTASSIUM SPARING DIURETICS		
amiloride/hydrochlorothiazide		1
eplerenone	requires trial of spironolactone	1
INSPRA	requires trial of spironolactone	2
spironolactone		1
spironolactone/hydrochlorothiazide		1
triamterene/hydrochlorothiazide		1
4.4 BETA-ADRENERGIC ANTAGONIST DRUGS		
atenolol		1
bisoprolol		1

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DRUG NAME	COMMENTS	TIER
BYSTOLIC		3
carvedilol		1
COREG CR		3
labetalol		1
metoprolol		1
nadolol		1
propranolol		1
TOPROL XL		2
4.5 ANTIHYPERTENSIVE DRUGS		
4.5.1 VASODILATOR ANTIHYPERTENSIVES		
doxazosin		1
prazosin		1
terazosin		1
4.5.2 CENTRALLY ACTING ANTIHYPERTENSIVES		
CATAPRES-TTS	QL=5 patches	2
clonidine		1
methyldopa		1
NEXICLON XR		3
4.5.4.1 ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS		
benazepril		1
captopril		1
enalapril		1
fosinopril		1
lisinopril		1
moexipril		1
perindopril		1
quinapril		1
ramipril		1
trandolapril		1
4.5.4.2 ANGIOTENSIN II RECEPTOR ANTAGONISTS		
ATACAND	requires trial of losartan or losartan/hydrochlorothiazide	3
AVAPRO	requires trial of losartan or losartan/hydrochlorothiazide	3
BENICAR	STB / requires trial of losartan or losartan/hydrochlorothiazide	2
COZAAR	STB	3
DIOVAN	STB / requires trial of losartan or losartan/hydrochlorothiazide	3
EDARBI	requires trial of losartan or losartan/hydrochlorothiazide	3
losartan		1
losartan/hydrochlorothiazide		1
MICARDIS	requires trial of losartan or losartan/hydrochlorothiazide	3
TEVETEN	requires trial of losartan or losartan/hydrochlorothiazide	3
4.5.6 OTHER ANTIHYPERTENSIVES		
amlodipine/benazepril		1
ATACAND HCT	requires trial of losartan or losartan/hydrochlorothiazide	3
atenolol/chlorthalidone		1

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DRUG NAME	COMMENTS	TIER
AVALIDE	requires trial of losartan or losartan/hydrochlorothiazide	3
AZOR	requires trial of losartan or losartan/hydrochlorothiazide	3
benazepril/hydrochlorothiazide		1
BENICAR HCT	STB / requires trial of losartan or losartan/hydrochlorothiazide	2
bisoprolol/hydrochlorothiazide		1
captopril/hydrochlorothiazide		1
DIOVAN HCT	STB / requires trial of losartan or losartan/hydrochlorothiazide	3
enalapril/hydrochlorothiazide		1
EXFORGE	requires trial of losartan or losartan/hydrochlorothiazide	3
EXFORGE HCT	requires trial of losartan or losartan/hydrochlorothiazide	3
fosinopril/hydrochlorothiazide		1
HYZAAR		3
LEXXEL		3
lisinopril/hydrochlorothiazide		1
LOTENSIN HCT		2
MICARDIS HCT	requires trial of losartan or losartan/hydrochlorothiazide	3
quinapril/hydrochlorothiazide		1
TARKA		3
TEKAMLO	requires trial of ACE Inhibitor/ACE Combination	3
TEKURNA	requires trial of ACE Inhibitor/ACE Combination	3
TEKURNA HCT	requires trial of ACE Inhibitor/ACE Combination	3
TEVETEN HCT	requires trial of losartan or losartan/hydrochlorothiazide	3
TRIBENZOR	requires trial of losartan or losartan/hydrochlorothiazide	3
TWYNSTA	requires trial of losartan or losartan/hydrochlorothiazide	3
UNIRETIC		3
VALTURNA	requires trial of ACE Inhibitor/ACE Combination	3
4.6 VASODILATING DRUGS		
4.6.1 NITRATES		
isosorbide		1
nitroglycerin		1
4.6.2 OTHER VASODILATING DRUGS		
ADCIRCA	see Chapter 19, Specialty Products	
BIDIL		2
REVATIO	see Chapter 19, Specialty Products	
TYVASO	see Chapter 19, Specialty Products	
VENTAVIS	see Chapter 19, Specialty Products	
4.6.3 ENDOTHELIN RECEPTOR ANTAGONISTS		
LETAIRIS	see Chapter 19, Specialty Products	
TRACLEER	see Chapter 19, Specialty Products	
4.7.1.1 CLASS 1A		
procainamide		1
4.7.1.2 CLASS 1B		
mexiletine		1
4.7.1.3 CLASS 1C		
flecainide		1

Tier 1 = generic drug
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DRUG NAME	COMMENTS	TIER
propafenone		1
propafenone er		1
4.7.3 AMIODARONES		
amiodarone		1
4.7.5 OTHER ANTIARRHYTHMICS		
MULTAQ	must be prescribed by a cardiologist to be covered	2
sotalol		1
4.8 ANTILIPIDEMIC DRUGS		
4.8.1 HYPOLIPOPROTEINEMICS		
ANTARA	requires trial of fenofibrate or gemfibrozil	3
cholestyramine		1
fenofibrate		1
FENOGLIDE	requires trial of fenofibrate or gemfibrozil	3
FIBRICOR	requires trial of fenofibrate or gemfibrozil	3
gemfibrozil		1
LIPOFEN	requires trial of fenofibrate or gemfibrozil	3
LOFIBRA	requires trial of fenofibrate or gemfibrozil	2
LOVAZA		3
NIASPAN		2
TRICOR	requires trial of fenofibrate or gemfibrozil	2
TRIGLIDE	requires trial of fenofibrate or gemfibrozil	3
TRILIPIX	requires trial of fenofibrate or gemfibrozil	3
WELCHOL		2
ZETIA		2
4.8.2 HMG-COA REDUCTASE INHIBITORS		
ALTOPREV	requires trial of Crestor, Vytorin, Advicor, or Simcor	3
atorvastatin		1
CRESTOR	STB / requires trial of lovastatin, pravastatin, or simvastatin	2
LESCOL	requires trial of Crestor, Vytorin, Advicor, or Simcor	3
LESCOL XL	requires trial of Crestor, Vytorin, Advicor, or Simcor	3
LIPITOR	requires trial of Crestor, Vytorin, Advicor, or Simcor	3
LIVALO	requires trial of Crestor, Vytorin, Advicor, or Simcor	3
lovastatin	STB	1
pravastatin		1
simvastatin	STB	1
4.8.2.1 HMG-COA COMBINATIONS		
ADVICOR	requires trial of lovastatin, pravastatin, or simvastatin	2
CADUET	requires trial of Crestor, Vytorin, Advicor, or Simcor	3
SIMCOR	requires trial of lovastatin, pravastatin, or simvastatin	3
VYTORIN	STB / requires trial of lovastatin, pravastatin, or simvastatin	2
4.9 OTHER CARDIOVASCULAR DRUGS		
pentoxifylline		1
RANEXA		3

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DRUG NAME	COMMENTS	TIER
CHAPTER 5: AUTONOMIC AND CNS MEDICATIONS		
5.1.1 ANALGESICS		
tramadol hcl		1
5.1.1.1 CLASS II NARCOTICS		
AVINZA		3
EXALGO ER		3
fentanyl patch		1
KADIAN		3
meperidine		1
NUCYNTA		3
ONSOLIS	see Chapter 19, Specialty Products	
OPANA		3
oxycodone		1
oxycodone/acetaminophen		1
OXYCONTIN		2
oxymorphone er		1
5.1.1.2 CLASS III NARCOTICS		
acetaminophen/codeine		1
buprenorphine		1
BUTRANS PATCH		3
hydrocodone/acetaminophen		1
NORCO		3
SUBOXONE		2
5.1.2 DRUGS TO PREVENT AND TREAT HEADACHES		
AMERGE	QL=9 tablets	3
AXERT	requires trial of sumatriptan / QL=9 tablets	3
butalbital/acetaminophen/caffeine		1
butorphanol nasal spray	QL=2 bottles	1
FROVA	requires trial of sumatriptan / QL=9 tablets	3
IMITREX INJECTABLE, TABLET	Tablets: QL=9; Injectable: QL=8 injections	2
IMITREX NASAL SPRAY	PAR on 5mg nasal spray / QL=6 devices	3
MAXALT	requires trial of sumatriptan / QL=9 tablets	2
MAXALT MLT	requires trial of sumatriptan / QL=9 tablets	2
MIDRIN		2
MIGRANAL	QL=8 inhalers	2
naratriptan	QL=9 tablets	1
RELPAX	requires trial of sumatriptan / QL=9 tablets	3
sumatriptan	Tablets: QL=9; Nasal Spray: QL=6; Injectable: QL=8 injections (PAR on 5mg nasal spray)	1
SUMAVEL	requires trial of sumatriptan / QL=8 kits	3
TREXIMET	requires trial of sumatriptan / QL=9 tablets	3
ZOMIG NASAL SPRAY	requires trial of sumatriptan	2
ZOMIG TABLET	requires trial of sumatriptan / QL=9 tablets	2
ZOMIG ZMT	requires trial of sumatriptan / QL=9 tablets	2
5.2.1 ANXIOLYTICS		
alprazolam		1

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DRUG NAME	COMMENTS	TIER
buspirone		1
diazepam		1
lorazepam		1
5.2.2 SEDATIVE/HYPNOTIC DRUGS		
flurazepam		1
LUNESTA		3
ROZEREM		3
SILENOR		3
SONATA		3
temazepam		1
triazolam		1
zaleplon		1
zolpidem		1
zolpidem cr		1
ZOLPIMIST		3
5.3 ANTIMANIA DRUGS		
lithium carbonate		1
lithium citrate		1
5.4.1 CARBAMAZEPINES		
carbamazepine		1
carbamazepine er		1
oxcarbazepine		1
5.4.2 ANTICONVULSANT BENZODIAZEPINES		
clonazepam		1
5.4.3 HYDANTOINS		
PHENYTEK		2
phenytoin		1
phenytoin extended		1
5.4.4 VALPROIC ACID AND DERIVATIVES		
divalproex		1
valproic acid		1
5.4.5 SUCCINIMIDES		
ethosuximide		1
5.4.6 ANTICONVULSANT BARBITURATES		
phenobarbital		1
primidone		1
5.4.7 OTHER ANTICONVULSANTS		
gabapentin tablet, capsule, solution		1
HORIZANT	requires trial of pramipexole, ropinirole, or gabapentin	3
KEPPRA XR		3
LAMICTAL		2
lamotrigine		1
levetiracetam		1
LYRICA	requires trial of gabapentin	3
SABRIL	see Chapter 19, Specialty Products	

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DRUG NAME	COMMENTS	TIER
topiramate		1
VIMPAT	requires trial of one generic anticonvulsant	2
zonisamide		1
5.5 ANTIDEPRESSANT DRUGS		
5.5.1.1 TERTIARY AMINES		
amitriptyline		1
doxepin		1
imipramine		1
TOFRANIL-PM		3
5.5.1.2 SECONDARY AMINES		
desipramine		1
nortriptyline		1
5.5.1.3 SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)		
citalopram	STB	1
fluoxetine		1
fluvoxamine		1
LEXAPRO	5mg tablets: QL=17; 10mg tablets: QL=17 / STB / requires trial of citalopram	2
paroxetine	STB	1
paroxetine er		1
PEXEVA		3
PROZAC WEEKLY		3
sertraline	STB	1
VIIBRYD	requires trial of one generic SSRI	2
5.5.1.4 OTHER ANTIDEPRESSANTS		
bupropion		1
bupropion sr, xl		1
CYMBALTA		2
EFFEXOR XR		2
mirtazapine		1
nefazodone		1
PRISTIQ		3
REMERON M TAB		3
SAVELLA		2
trazodone		1
venlafaxine		1
venlafaxine er		3
5.5.2 MAO INHIBITORS		
EMSAM		3
phenelzine		1
5.6 ANTIVERTIGO AND ANTIEMETIC DRUGS		
ANZEMET	tablets: QL=1	3
CESAMET		3
EMEND	80mg capsules: QL=2; 125mg capsules: QL=1; Trifold Pack: QL=1	2
granisetron	tablets: QL=2; 30ml bottle: QL=1	1

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DRUG NAME	COMMENTS	TIER
KYTRIL	tablets: QL=2; 30ml bottle: QL=1	2
ondansetron	4mg tablets: QL=12; 8mg tablets: QL=12; 24mg tablets: QL=1; 4mg/5ml vials: QL=3	1
ondansetron odt	tablets: QL=12	1
prochlorperazine		1
SANCUSO	QL = 1 patch	3
trimethobenzamide		1
5.7.1 ANTIPARKINSON ANTICHOLINERGIC DRUGS		
benztropine		1
5.7.2 OTHER ANTIPARKINSON DRUGS		
APOKYN	see Chapter 19, Specialty Products	
AZILECT		3
bromocriptine		1
carbidopa/levodopa		1
MIRAPEX ER		3
NEUPRO PATCH		2
pramipexole		1
REQUIP		2
REQUIP XL		3
selegiline		1
STALEVO		2
5.8 ANTIPSYCHOTIC DRUGS		
ABILIFY DISCMELT, SOLUTION, VIAL		3
ABILIFY TABLET		2
clozapine		1
CLOZARIL	requires trial of two antipsychotics	2
FANAPT	requires trial of two antipsychotics / 1mg, 2mg, 4mg tablets: QL=45; 6mg tablets: QL=62; titration pack: QL=55	3
FAZACLO	requires trial of two antipsychotics	3
GEODON		2
haloperidol		1
INVEGA	requires trial of two antipsychotics	3
INVEGA SUSTENNA	see Chapter 19, Specialty Products	
LATUDA	requires trial of two antipsychotics / 40mg tablets: QL=34	3
olanzapine	requires trial of two antipsychotics	1
RISPERDAL		3
risperidone		1
SAPHRIS	requires trial of two antipsychotics	3
SEROQUEL		2
SEROQUEL XR		3
thioridazine		1
ZYPREXA	requires trial of two antipsychotics	2
ZYPREXA RELPREVV	see Chapter 19, Specialty Products	
ZYPREXA ZYDIS	requires trial of two antipsychotics	3
5.8.2 NOVEL (ATYPICAL) ANTIPSYCHOTIC DRUGS		
RISPERDAL CONSTA	see Chapter 19, Specialty Products	

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DRUG NAME	COMMENTS	TIER
5.9.1 CNS STIMULANT DRUGS		
ADDERALL XR		2
amphetamine salt combo		1
CONCERTA	18mg & 27mg tablets: QL=34	2
DAYTRANA		3
dextroamphetamine		1
FOCALIN		3
FOCALIN XR		3
METADATE CD		3
METADATE ER		3
methylphenidate		1
methylphenidate er (generic for RITALIN SR & LA)		1
NUVIGIL	requires trial of two CNS Stimulants	2
PROVIGIL	requires trial of two CNS Stimulants	2
RITALIN LA		3
VYVANSE		2
5.9.2 OTHER CNS AUTONOMIC DRUGS		
CAMPRAL		2
NUDEXTA		2
XENAZINE	see Chapter 19, Specialty Products	
5.9.3 ANTIDEMENTIA DRUGS		
donepezil		1
EXELON		2
galantamine		1
galantamine er		1
NAMENDA SUSPENSION		3
NAMENDA TABLET		2
rivastigmine		1
5.9.4 DRUGS TO TREAT MULTIPLE SCLEROSIS		
AMPYRA ER	see Chapter 19, Specialty Products	
AVONEX	see Chapter 19, Specialty Products	
BETASERON	see Chapter 19, Specialty Products	
COPAXONE	see Chapter 19, Specialty Products	
GILENYA	see Chapter 19, Specialty Products	
REBIF	see Chapter 19, Specialty Products	
5.9.6 OTHER DRUGS FOR ADHD		
INTUNIV		2
KAPVAY		3
STRATTERA		2
CHAPTER 6: DERMATOLOGICAL MEDICATIONS		
6.1 TOPICAL CORTICOSTEROID DRUGS		
alclometasone		1
betamethasone dipropionate		1
clobetasol propionate		1
CLODERM		3

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DRUG NAME	COMMENTS	TIER
CORDRAN TAPE	QL=2 rolls	3
desoximetasone		1
diflorasone diacetate		1
fluocinonide		1
fluticasone		1
halobetasol propionate		1
HALOG		2
HALOG-E		2
hydrocortisone		1
KENALOG		2
LOCOID		3
mometasone		1
PRAMOSONE		2
triamcinolone acetonide		1
6.2 ANTIPRURITIC DRUGS		
hydroxyzine hcl		1
hydroxyzine pamoate		1
6.3 ANTIACNE DRUGS		
ACZONE		3
AZELEX		3
BENZACLIN GEL		2
clindamycin phosphate		1
DIFFERIN		2
DUAC CS		3
EPIDUO		2
erythromycin base		1
FINACEA 15% GEL		2
METROGEL TOPICAL		2
metronidazole		1
NORITATE		2
PLEXION		3
RETIN-A MICRO		2
RETIN-A TOPICAL		2
sodium sulfacetamide/sulfur		1
tretinoin topical		1
6.3.1 ACCUTANES		
amnesteam		1
claravis		1
sotret		1
6.7 KERATOLYTIC DRUGS		
CONDYLOX		2
6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS		
DOVONEX		2
KLARON		2
selenium sulfide		1

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DRUG NAME	COMMENTS	TIER
SORIATANE	see Chapter 19, Specialty Products	
TACLONEX		3
TAZORAC	PAR	2
6.9.2 TOPICAL DERMATOLOGICAL DRUGS		
ELIDEL		2
imiquimod		1
PANRETIN	PAR	3
PROTOPIC		2
REGRANEX	QL=1 tube	2
6.9.3 SCABICIDES		
EURAX		2
LINDANE		2
NATROBA	PAR	2
ULESFIA		2
CHAPTER 7: EAR-NOSE-THROAT MEDICATIONS		
7.1 DRUGS AFFECTING THE EAR		
CIPRO HC		2
CIPRODEX		2
FLOXIN EAR DROPS		2
neomycin/polymyxin/hc		1
7.2 DRUGS AFFECTING THE NOSE		
ASTELIN	QL=4 inhalers	3
ASTEPRO		3
ATROVENT	0.03%: QL=2; 0.06%: QL=1	3
BECONASE AQ	requires trial of one generic inhaled nasal corticosteroid / QL=4 inhalers	3
flunisolide	QL=4 inhalers	1
fluticasone	QL=4 inhalers	1
ipratropium	0.03%: QL=2; 0.06%: QL=1	1
NASACORT AQ	requires trial of one generic inhaled nasal corticosteroid / QL=4 inhalers	2
NASONEX	requires trial of one generic inhaled nasal corticosteroid / QL=4 inhalers	2
OMNARIS	requires trial of one generic inhaled nasal corticosteroid / QL=4 inhalers	3
PATANASE	QL=4 inhalers	3
RHINOCORT AQ	requires trial of one generic inhaled nasal corticosteroid / QL=4 inhalers	3
triamcinolone nasal spray	requires trial of one generic inhaled nasal corticosteroid / QL=4 inhalers	1
VERAMYST	requires trial of one generic inhaled nasal corticosteroid / QL=20 gm	3
CHAPTER 8: ENDOCRINE MEDICATIONS		
8.1 HYPOGLYCEMIC DRUGS		
8.1.1 INSULIN		
APIDRA		3
HUMALOG CARTRIDGE, KWIKPEN, PEN, VIAL		2
HUMALOG MIX 50/50 KWIKPEN, PEN, VIAL		2
HUMALOG MIX 75/25 KWIKPEN, PEN, VIAL		2
HUMULIN 50/50 VIAL		2

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DRUG NAME	COMMENTS	TIER
HUMULIN 70/30 PEN, VIAL		2
HUMULIN N PEN, VIAL		2
HUMULIN R VIAL		2
LANTUS CARTRIDGE		3
LANTUS VIAL		2
LEVEMIR FLEXPEN, VIAL		2
NOVOLIN 70/30 CARTRIDGE, INNOLET, VIAL		2
NOVOLIN N CARTRIDGE, INNOLET, VIAL		2
NOVOLIN R CARTRIDGE, INNOLET, VIAL		2
NOVOLOG CARTRIDGE, FLEXPEN, VIAL		2
NOVOLOG MIX 70/30 CARTRIDGE, FLEXPEN, VIAL		2
8.1.1.1.1 INSULIN - INHALED		
8.1.2 ORAL HYPOGLYCEMIC DRUGS		
acarbose		1
CYCLOSET		3
glimepiride		1
glipizide		1
GLUCOPHAGE XR		2
GLUCOTROL XL		2
GLUCOVANCE		2
glyburide		1
glyburide/metformin		1
metformin		1
metformin er		1
nateglinide		1
PRANDIN		2
PRECOSE		2
8.1.3 INSULIN SENSITIZERS		
ACTOPLUS MET	requires trial of metformin	3
ACTOPLUS MET XR	requires trial of metformin	3
ACTOS	requires trial of metformin / QL=34 tablets	2
AVANDAMET	requires trial of metformin	3
AVANDARYL	requires trial of metformin	3
AVANDIA	requires trial of metformin / 2mg tablets: QL=68; 4mg tablets: 68; 8mg tablets: QL=34	2
DUETACT	requires trial of metformin	3
8.1.5 1 INCRETIN MIMETICS		
VICTOZA		2
8.1.5 2 DIPEPTIDYL PEPTIDASE-IV INHIBITORS		
JANUMET	requires trial of metformin	2
JANUVIA	requires trial of metformin	2
ONGLYZA	requires trial of metformin	2
TRADJENTA	requires trial of metformin	3
8.3.1 GLUCOCORTICOID DRUGS		
dexamethasone		1
hydrocortisone		1

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DRUG NAME	COMMENTS	TIER
methylprednisolone		1
ORAPRED		2
ORAPRED ODT		3
prednisolone		1
prednisone		1
8.3.2 MINERALOCORTICOID DRUGS		
fludrocortisone		1
8.4.1 THYROID SUPPLEMENTS		
CYTOMEL		2
levothroid		1
levothyroxine sodium		1
levoxyl		1
SYNTHROID		2
unithroid		1
8.4.2 ANTITHYROID DRUGS		
propylthiouracil		1
8.6 OTHER ENDOCRINE DRUGS		
ACTONEL	requires trial of alendronate / 5mg tablets: QL=34; 30mg tablets: QL=34; 35mg tablets: QL=5	2
ALDURAZYME	see Chapter 19, Specialty Products	
alendronate	5mg tablets: QL=34; 10mg tablets: QL=34; 35mg tablets: QL=5; 40mg tablets: QL=34; 70mg tablets: QL=5	1
AELVIA	requires trial of alendronate / QL=5	3
BONIVA	requires trial of alendronate	3
BYETTA		2
desmopressin acetate		1
ELAPRASE	see Chapter 19, Specialty Products	
etidronate		1
FABRAZYME	see Chapter 19, Specialty Products	
FORTEO	see Chapter 19, Specialty Products	
FOSAMAX	5mg tablets: QL=34; 10mg tablets: QL=34; 35mg tablets: QL=5; 40mg tablets: QL=34; 70mg tablets: QL=5	3
KUVAN	see Chapter 19, Specialty Products	
LUMIZYME	see Chapter 19, Specialty Products	
MIACALCIN		3
MYOZYME	see Chapter 19, Specialty Products	
NAGLAZYME	see Chapter 19, Specialty Products	
pamidronate disodium	see Chapter 19, Specialty Products	
PROLIA	requires trial of alendronate	3
RECLAST	see Chapter 19, Specialty Products	
SAMSCA	see Chapter 19, Specialty Products	
SENSIPAR		2
SOMAVERT	see Chapter 19, Specialty Products	
SYMLIN 0.6 MG/ML VIAL		2
SYMLINPEN		3
XGEVA	see Chapter 19, Specialty Products	
ZOMETA	see Chapter 19, Specialty Products	

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DRUG NAME	COMMENTS	TIER
CHAPTER 9: GASTROINTESTINAL MEDICATIONS		
9.2 ANTIDIARRHEAL DRUGS		
diphenoxylate/atropine		1
9.3 ANTISPASMODICS/DRUGS AFFECT GI MOTILITY		
CUVPOSA SOLUTION		3
dicyclomine		1
hyoscyamine		1
metoclopramide		1
NULEV		2
9.4 ANTIULCER DRUGS		
cimetidine		3
famotidine	excluded - use Maximum Strength Pepcid AC (over-the-counter)	
nizatidine		3
ZANTAC SYRUP		2
9.4.1 OTHER ANTIULCER DRUGS		
misoprostol		1
sucralfate		1
9.4.2 PROTON PUMP INHIBITORS (Continuous therapy of prescription products requires PAR)		
ACIPHEX	PAR	3
DEXILANT	PAR	3
lansoprazole prescription	excluded – use Prevacid OTC (over-the-counter)	
NEXIUM	PAR / 20mg capsules: QL=34	3
omeprazole OTC (over-the-counter)	requires practitioner prescription for coverage	1
omeprazole prescription	excluded - use Omeprazole OTC (over-the-counter)	
pantoprazole	20mg tablets: QL=34	1
PREVACID CAPSULE	excluded – use Prevacid OTC (over-the-counter)	
PREVACID OTC (over-the-counter)	requires practitioner prescription for coverage	1
PREVACID SOLUTAB	excluded – use Prevacid OTC (over-the-counter)	
PRILOSEC	excluded - use Omeprazole OTC (over-the-counter)	
9.4.3 HELICOBACTER PYLORI DRUGS		
HELIDAC		3
PREVPAC	QL=1 pack (14 units)	3
9.6 OTHER GI DRUGS		
ANALPRAM HC		2
APRISO		2
ASACOL		2
budesonide ec	must be prescribed by a gastroenterologist to be covered	1
CANASA		2
COLAZAL		3
COLYTE		3
CREON		2
CREON 5		2
DIPENTUM		3
GOLYTELY		3
HALFLYTELY-BISACODYL		3

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DRUG NAME	COMMENTS	TIER
hydrocortisone		1
LIALDA		3
MOVIPREP		3
NULYTELY		3
PANCRELIPASE 5,000		3
peg3350/electrolyte soln		1
PENTASA		2
PYLERA		3
RELISTOR		3
SFROWASA		2
sulfasalazine		1
ULTRASE		2
ULTRASE MT		2
URSO		2
9.7 IRRITABLE BOWEL DRUGS		
AMITIZA		3
LOTRONEX		2
CHAPTER 10: IMMUNOLOGICALS AND VACCINES		
10.0.0 IMMUNOLOGICALS AND VACCINES		
CARIMUNE NF	see Chapter 19, Specialty Products	
CYTOGAM	see Chapter 19, Specialty Products	
FLEBOGAMMA	see Chapter 19, Specialty Products	
GAMASTAN S/D	see Chapter 19, Specialty Products	
GAMMAGARD LIQUID	see Chapter 19, Specialty Products	
GAMMAGARD S/D	see Chapter 19, Specialty Products	
GAMUNEX	see Chapter 19, Specialty Products	
OCTAGAM	see Chapter 19, Specialty Products	
PRIVIGEN	see Chapter 19, Specialty Products	
VIVAGLOBIN	see Chapter 19, Specialty Products	
10.2.1 MYELOID STIMULANTS		
LEUKINE	see Chapter 19, Specialty Products	
NEULASTA	see Chapter 19, Specialty Products	
NEUPOGEN	see Chapter 19, Specialty Products	
10.2.2 ERYTHROID STIMULANTS		
ARANESP	see Chapter 19, Specialty Products	
EPOGEN	see Chapter 19, Specialty Products	
PROCRIT	see Chapter 19, Specialty Products	
10.2.3 INTERFERONS		
ACTIMMUNE	see Chapter 19, Specialty Products	
ALFERON N	see Chapter 19, Specialty Products	
EXTAVIA	see Chapter 19, Specialty Products	
INFERGEN	see Chapter 19, Specialty Products	
INTRON A	see Chapter 19, Specialty Products	
PEGASYS	see Chapter 19, Specialty Products	
PEG-INTRON	see Chapter 19, Specialty Products	

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DRUG NAME	COMMENTS	TIER
PEG-INTRON REDIPEN	see Chapter 19, Specialty Products	
REBETRON	see Chapter 19, Specialty Products	
ROFERON-A	see Chapter 19, Specialty Products	
SYLATRON KIT, PACK	see Chapter 19, Specialty Products	
10.2.4 GROWTH HORMONES AND RELATED DRUGS		
EGRIFTA VIAL	see Chapter 19, Specialty Products	
GENOTROPIN	see Chapter 19, Specialty Products	
GENOTROPIN MINIQUICK	see Chapter 19, Specialty Products	
HUMATROPE	see Chapter 19, Specialty Products	
NORDITROPIN	see Chapter 19, Specialty Products	
NORDITROPIN NORDIFLEX	see Chapter 19, Specialty Products	
NUTROPIN	see Chapter 19, Specialty Products	
NUTROPIN AQ	see Chapter 19, Specialty Products	
OMNITROPE	see Chapter 19, Specialty Products	
SAIZEN	see Chapter 19, Specialty Products	
SEROSTIM	see Chapter 19, Specialty Products	
TEV-TROPIN	see Chapter 19, Specialty Products	
ZORBTIVE	see Chapter 19, Specialty Products	
10.2.4.1 INSULIN LIKE GROWTH FACTORS-1		
INCRELEX	see Chapter 19, Specialty Products	
10.2.5 INTERLEUKINS		
NEUMEGA	see Chapter 19, Specialty Products	
PROLEUKIN	see Chapter 19, Specialty Products	
ZENAPAX	see Chapter 19, Specialty Products	
10.2.6 INTERLEUKIN RECEPTOR ANTAGONISTS		
ACTEMRA	see Chapter 19, Specialty Products	
ARCALYST	see Chapter 19, Specialty Products	
iLARIS	see Chapter 19, Specialty Products	
KINERET	see Chapter 19, Specialty Products	
10.2.7 IMMUNOGLOBULIN ANTIBODIES		
SOLIRIS	see Chapter 19, Specialty Products	
XOLAIR	see Chapter 19, Specialty Products	
10.2.9.1 DRUGS for HEREDITARY ANGIOEDEMA		
CINRYZE	see Chapter 19, Specialty Products	
FIRAZYR	see Chapter 19, Specialty Products	
10.2.11 THROMBOPOIETIC AGENTS		
NPLATE	see Chapter 19, Specialty Products	
PROMACTA	see Chapter 19, Specialty Products	
10.3 HEMATOPOIETIC AGENTS		
MOZOBIL	see Chapter 19, Specialty Products	
CHAPTER 11: MUSCULOSKELETAL MEDICATIONS		
11.1.1 SALICYLATES AND RELATED DRUGS		
diflunisal		1
salsalate		1
11.1.2 NON-STEROIDAL ANTIINFLAMMATORY AGENTS		

Tier 1 = generic drug
 Tier 2 = Preferred Brand Drug
 Tier 3 = Non-Preferred Brand Drug

QL = Quantity Limit per Fill
 PAR = Prior Authorization Required
 STB = Split the Bill

DRUG NAME	COMMENTS	TIER
FIRST LINE AGENTS		
diclofenac		1
etodolac		1
ibuprofen		1
indomethacin		1
ketoprofen		1
ketorolac	QL=20 tablets	1
meloxicam		1
naproxen		1
piroxicam		1
sulindac		1
SECOND LINE AGENTS		
ARTHROTEC	requires trial of 3 first line generics	2
CAMBIA	requires trial of 3 first line generics QL=9 packets	3
CELEBREX	requires trial of 3 first line generics	2
diclofenac er	requires trial of 3 first line generics	1
etodolac sa	requires trial of 3 first line generics	1
ketoprofen sa	requires trial of 3 first line generics	1
mefenamic acid	requires trial of 3 first line generics	1
nabumetone	requires trial of 3 first line generics	1
naproxen sr	requires trial of 3 first line generics	1
oxaprozin	requires trial of 3 first line generics	1
VIMOVO	requires trial of 3 first line generics	3
VOLTAREN XR	requires trial of 3 first line generics	3
ZIPSOR	requires trial of 3 first line generics	3
MISCELLANEOUS AGENTS		
FLECTOR PATCH		3
PENNSAID		3
SPRIX NASAL SPRAY		3
VOLTAREN 1% GEL		2
11.2 DRUGS TO PREVENT AND TREAT GOUT		
allopurinol		1
colchicine		1
KRYSTEXXA	see Chapter 19, Specialty Products	
probenecid		1
ULORIC	requires trial of allopurinol	2
11.3.1 DIRECT MUSCLE RELAXANTS		
baclofen		1
DYSPORT	see Chapter 19, Specialty Products	
MYOBLOC	see Chapter 19, Specialty Products	
tizanidine		1
XEOMIN	see Chapter 19, Specialty Products	
11.3.2 CNS MUSCLE RELAXANTS		
carisoprodol		1
cyclobenzaprine		1

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DRUG NAME	COMMENTS	TIER
methocarbamol		1
SKELAXIN		2
SOMA		2
11.4 OTHER MUSCULOSKELETAL DRUGS		
methotrexate		1
RILUTEK	PAR	2
CHAPTER 12: NUTRITION, BLOOD		
12.1.2 VITAMINS & MINERALS & RELATED PRODUCTS		
FOLTX		2
12.1.3 THERAPEUTIC VITAMINS & MINERALS		
cyanocobalamin (vitamin B₁₂)		1
folic acid		1
HECTOROL AMPULE, CAPSULE		2
HECTOROL VIAL		3
PHOSLO		2
ZEMPLAR		3
12.2 POTASSIUM SUPPLEMENTS		
potassium chloride		1
12.3.1 ORAL ANTICOAGULANTS, VITAMIN K		
warfarin sodium		1
12.3.2 HEPARIN AND HEPARIN ANTAGONISTS		
enoxaparin sodium		1
fondaparinux		1
FRAGMIN		3
INNOHEP		3
LOVENOX		2
12.3.3 OTHER DRUGS AFFECTING COAGULATION		
IPRIVASK	see Chapter 19, Specialty Products	
XARELTO		2
12.3.5 THROMBIN INHIBITORS		
PRADAXA	QL=60 capsules	2
12.4 ANTIPLATELET DRUGS		
AGGRENOX		2
BRILINTA		2
dipyridamole		1
EFFIENT		2
PLAVIX		2
ticlopidine		1
12.5 HEMOSTATICS		
ADVATE	see Chapter 19, Specialty Products	
ALPHANATE	see Chapter 19, Specialty Products	
BENEFIX	see Chapter 19, Specialty Products	
CORIFACT KIT	see Chapter 19, Specialty Products	
FEIBA VH	see Chapter 19, Specialty Products	
HELIXATE FS	see Chapter 19, Specialty Products	

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DRUG NAME	COMMENTS	TIER
HEMOFIL M	see Chapter 19, Specialty Products	
HUMATE-P	see Chapter 19, Specialty Products	
KOATE-DVI	see Chapter 19, Specialty Products	
KOGENATE FS	see Chapter 19, Specialty Products	
LYSTEDA		3
MONARC-M	see Chapter 19, Specialty Products	
MONOCLATE-P	see Chapter 19, Specialty Products	
NOVOSEVEN	see Chapter 19, Specialty Products	
RECOMBINATE	see Chapter 19, Specialty Products	
REFACTO	see Chapter 19, Specialty Products	
THROMBATE III	see Chapter 19, Specialty Products	
XYNTHA	see Chapter 19, Specialty Products	
12.7 BLOOD DETOXICANTS		
FOSRENOL		3
KRISTALOSE		3
lactulose		1
RENVELA		3
CHAPTER 13: OBSTETRICAL & GYNECOLOGICAL MEDICATIONS		
13.1.1 PRENATAL VITAMINS		
prenatal vitamin		1
13.1.2 SPECIALIZED OB/GYN DRUGS		
CETROTIDE		2
leuprolide	see Chapter 19, Specialty Products	
LUPRON DEPOT	see Chapter 19, Specialty Products	
PREGNYL	QL = 3 vials	2
13.3 ANDROGEN DRUGS		
ANDRODERM	PAR	3
ANDROGEL	PAR	2
AXIRON	PAR	3
FORTESTA	PAR	3
STRIANT	PAR	3
TESTIM	PAR	3
13.4 ESTROGEN DRUGS		
ALORA	QL=10 patches	2
CENESTIN		2
CLIMARA	QL=5 patches	2
DIVIGEL	QL=34 packets	3
ELESTRIN	QL= 144 gm	3
ESTRACE CREAM		2
ESTRADERM	QL=10 patches	2
estradiol		1
estradiol transdermal patch		1
ESTRATEST		2
ESTRATEST H.S.		2
ESTROGEL		3

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DRUG NAME	COMMENTS	TIER
estropipate		1
FEMRING		3
MENEST		3
MENOSTAR	QL=5 patches	3
PREMARIN		2
VAGIFEM		2
VIVELLE	QL=10 patches	2
VIVELLE-DOT	QL=10 patches	2
13.4.1 ESTROGEN/PROGESTIN COMBINATIONS		
ACTIVELLA		3
ANGELIQ		3
CLIMARA PRO		2
COMBIPATCH		2
FEMHRT		2
jinteli		1
ORTHO-PREFEST		3
PREMPHASE		2
PREMPRO		2
13.4.3 SELECTIVE ESTROGEN RECEPTOR MODULATOR		
EVISTA		2
13.5 PROGESTIN DRUGS		
CRINONE	PAR - 8% only	2
DEPO-PROVERA		2
ENDOMETRIN	PAR	3
MAKENA	see Chapter 19, Specialty Products	
medroxyprogesterone acetate		1
norethindrone acetate		1
PROCHIEVE	PAR	2
PROMETRIUM		2
13.7 CONTRACEPTIVES		
PROGESTIN ONLY		
camila		1
ELLA		2
errin		1
nora-be		1
PLAN B	restricted to patients less than sixteen years old / QL = 2 tablets	3
MONO-PHASIC		
amethia	one dispenser = 3 copayments	1
amethyst		1
apri		1
aviane		1
briellyn		1
camrese	one dispenser = 3 copayments	1
cryselle		1
DESOGEN		3

Tier 1 = generic drug
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DRUG NAME	COMMENTS	TIER
GENERESS FE		3
lessina		1
LEVLEN		2
levora		1
LO/OVRAL		3
LOESTRIN		3
LOESTRIN FE		3
loryna		1
low-ogestrel		1
mononessa		1
necon .5/35, 1/35, 1/50		1
nortrel .5/35, 1/35		1
ogestrel		1
ORTHO-CYCLEN		2
ORTHO-NOVUM 1/35, 1/50		2
portia		1
SEASONALE	one dispenser = 3 copayments	3
sprintec		1
YASMIN 28		2
zeosa		1
zovia 1/50		1
BI-PHASIC		
kariva		1
MIRCETTE		3
TRI-PHASIC		
CYCLESSA		3
enpresse		1
ESTROSTEP FE		2
necon 7/7/7		1
nortrel 7/7/7		1
ORTHO TRI-CYCLEN		2
ORTHO TRI-CYCLEN LO		2
ORTHO-NOVUM 7/7/7		2
TRI-LEVLEN		2
TRI-NORINYL		3
tri-sprintec		1
trivora		1
FOUR-PHASIC		
NATAZIA		3
OTHER CONTRACEPTIVES		
NUVARING		2
ORTHO EVRA		2
CHAPTER 14: OPHTHALMIC MEDICATIONS		
14.1.1 OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS		
AZASITE		3

Tier 1 = generic drug
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DRUG NAME	COMMENTS	TIER
BESIVANCE		3
CILOXAN		2
erythromycin		1
gentamicin ophth		1
IQUIX		3
levofloxacin ophth		1
ofloxacin ophth		1
polymyxin b sul/trimethoprim		1
sulfacetamide sodium		1
tobramycin sulfate		1
VIGAMOX		2
ZYMAR		2
14.2 OPHTHALMIC CORTICOSTEROID DRUGS		
ALREX		3
fluorometholone		1
LOTEMAX		2
prednisolone		1
VEXOL		3
14.3 OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS		
neomycin/bacitracin/poly/hc		1
neomycin/polymyxin/dexameth		1
neomycin/polymyxin/hc		1
PRED-G		3
TOBRADEX		2
ZYLET		3
14.5 ANTIGLAUCOMA DRUGS		
ALPHAGAN P		2
apraclonidine		1
AZOPT		2
BETIMOL		3
brimonidine		1
COMBIGAN		3
COSOPT		2
latanoprost		1
levobunolol		1
LUMIGAN		2
metipranolol		1
pilocarpine		1
timolol		1
TRAVATAN		2
TRAVATAN Z		2
TRUSOPT		2
14.6 OTHER OPHTHALMIC DRUGS		
ACULAR PF		3
ACUVAIL		3

Tier 1 = generic drug
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DRUG NAME	COMMENTS	TIER
ALAMAST		3
ALOCRIL		2
ALOMIDE		3
BEPREVE		2
BOTOX	see Chapter 19, Specialty Products	
bromfenac		1
cromolyn		1
diclofenac sodium 0.1%		1
EMADINE		3
epinastine hcl		1
ketorolac ophthalmic solution		1
LASTACAPT		3
NEVANAC		2
OPTIVAR		3
PATADAY		2
PATANOL		2
RESTASIS	QL=68 single use vials	3
CHAPTER 15: RESPIRATORY MEDICATIONS		
15.1.0 BRONCHODILATORS AND RELATED DRUGS		
15.1.1 BETA-2 ADRENERGIC DRUGS		
ALUPENT	QL=4 inhalers	2
ARCAPTA	QL=60	3
BROVANA	QL=60 inhalations	3
FORADIL	box of 12: QL=1; box of 18: QL=2; box of 60: QL=1	2
levalbuterol 1.25 mg/0.5 mL	PAR	1
MAXAIR AUTOHALER	QL=4 inhalers	3
PERFORMIST		2
PROAIR HFA	QL=4 inhalers	3
PROVENTIL HFA	QL=4 inhalers	3
SEREVENT DISKUS	Box of 28: QL=1; box of 60: QL=2	2
VENTOLIN HFA	QL=4 inhalers	2
XOPENEX HFA	PAR / QL=4 inhalers	2
XOPENEX SOLUTION	PAR	2
15.1.2 METHYL XANTHINE DRUGS		
theophylline anhydrous		1
15.1.3 OTHER DRUGS FOR ASTHMA		
ADVAIR DISKUS	requires trial of asthma controller medication, QL=4 inhalers	2
ADVAIR HFA	requires trial of asthma controller medication, QL=4 inhalers	2
AEROBID	QL=4 inhalers	3
AEROBID-M	QL=4 inhalers	3
ALVESCO	QL=2 inhalers	3
ASMANEX	QL=120 inhalations	2
ATROVENT HFA	QL=4 inhalers	2
COMBIVENT	QL=4 inhalers	2
DULERA	requires trial of asthma controller medication, QL=2 inhalers	2

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DRUG NAME	COMMENTS	TIER
DUONEB	QL=205 vials	2
EPINEPHRINE KIT		2
EPIPEN	syringes: QL=3; kits: QL=2	2
EPIPEN JR	syringes: QL=3; kits: QL=2	2
FLOVENT DISKUS	QL=2 inhalers	2
FLOVENT HFA	QL=4 inhalers	2
INTAL	QL=4 inhalers	2
ipratropium		1
PULMICORT FLEXHALER	QL=4 inhalers	3
PULMICORT RESPULES	restricted to patients less than four years old	2
QVAR	QL=4 inhalers	3
SPIRIVA		2
SYMBICORT	requires trial of asthma controller medication, QL=4 inhalers	2
TILADE	QL=4 inhalers	2
15.1.4 LEUKOTRIENE MODIFIERS		
SINGULAIR	requires trial of nasal spray AND antihistamine when used for allergic rhinitis	2
zafirlukast	requires trial of nasal spray AND antihistamine when used for allergic rhinitis	1
ZYFLO	requires trial of nasal spray AND antihistamine when used for allergic rhinitis	3
ZYFLO CR	requires trial of nasal spray AND antihistamine when used for allergic rhinitis	3
15.2.1 ANTIHISTAMINES		
CLARINEX		3
cyproheptadine		1
levocetirizine		1
promethazine		1
15.2.3 ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
promethazine vc		1
RYNATAN		3
SEMPREX-D		3
15.3 ANTITUSSIVE AND EXPECTORANT DRUGS		
benzonatate		1
guaifenesin pse		1
promethazine/codeine		1
promethazine/dm		1
TUSSIONEX		2
15.4 OTHER RESPIRATORY DRUGS		
ARALAST	see Chapter 19, Specialty Products	
DALIRESP		2
PROLASTIN	see Chapter 19, Specialty Products	
PULMOZYME	see Chapter 19, Specialty Products	
ZEMAIRA	see Chapter 19, Specialty Products	
CHAPTER 16: UROLOGICAL MEDICATIONS		
16.1.1 ANTICHOLINERGIC ANTISPASMODICS		
DETROL	requires trial of immediate release oxybutynin	2
DETROL LA	requires trial of immediate release oxybutynin	2

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DRUG NAME	COMMENTS	TIER
DITROPAN	requires trial of immediate release oxybutynin	2
DITROPAN XL	requires trial of immediate release oxybutynin	2
ENABLEX	requires trial of immediate release oxybutynin	3
GELNIQUE	requires trial of immediate release oxybutynin	3
oxybutynin chloride		1
OXYTROL	requires trial of immediate release oxybutynin	2
SANCTURA	requires trial of immediate release oxybutynin	3
SANCTURA XL	requires trial of immediate release oxybutynin	3
TOVIAZ	requires trial of immediate release oxybutynin	3
tropium		1
VESICARE	requires trial of immediate release oxybutynin	3
16.1.3 URINARY ANESTHETICS		
phenazopyridine hcl		1
16.1.4 OTHER GENITOURINARY PRODUCTS		
alfuzosin er 10mg	requires trial of terazosin, doxazosin, or tamsulosin	1
AVODART		3
CARDURA XL	requires trial of terazosin, doxazosin, or tamsulosin	3
finasteride 1mg	excluded	
finasteride 5mg		1
FLOMAX	requires trial of terazosin, doxazosin, or tamsulosin	2
JALYN	requires trial of terazosin, doxazosin, or tamsulosin	3
RAPAFLO	requires trial of terazosin, doxazosin, or tamsulosin	3
tamsulosin		1
UROXATRAL	requires trial of terazosin, doxazosin, or tamsulosin	2
CHAPTER 17: DIAGNOSTIC & MISCELLANEOUS DRUGS		
17.1 DIAGNOSTIC PRODUCTS		
EXJADE	see Chapter 19, Specialty Products	
17.2 MISCELLANEOUS DRUGS		
ADAGEN	see Chapter 19, Specialty Products	
BUPHENYL	see Chapter 19, Specialty Products	
CARBAGLU	see Chapter 19, Specialty Products	
THALOMID	see Chapter 19, Specialty Products	
CHAPTER 18: MEDICAL (MISCELLANEOUS) SUPPLIES		
18.0 MEDICAL (MISCELLANEOUS) SUPPLIES		
MINIMED INFUSION SET		2
PARADIGM RESERVOIR		2
PARADIGM INFUSION SET		2
PARADIGM SILHOUETTE		2
POLYFIN INFUSION SET		2
POLYFIN QR		2
QUICK RELEASE TEFLON CANNULA		2
SILHOUETTE INFUSION SET		2
SOF-SET INFUSION SET/COMBO SET		2
SOF-SET MICRO INFUSION SET		2
SURE-T INFUSION SET		2

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DRUG NAME	COMMENTS	TIER
SURE-T PARADIGM SET		3
18.1 DIABETIC SUPPLIES		
ONLY THE FOLLOWING BLOOD GLUCOSE METERS & TEST STRIPS ARE COVERED BY NETWORK HEALTH PLAN. NON-PREFERRED GLUCOSE METERS & TEST STRIPS ARE COVERED AT A NON-PREFERRED COPAY/COINSURANCE FOR THOSE MEMBERS WITH A FIVE TIER PHARMACY BENEFIT. ALL OTHER MEMBERS DO NOT HAVE COVERAGE FOR THESE PRODUCTS.		
ACCU-CHEK ACTIVE CARE KIT		2
ACCU-CHEK ACTIVE TEST STRIPS		2
ACCU-CHEK ADVANTAGE KIT		2
ACCU-CHEK ADVANTAGE TEST STRIPS		2
ACCU-CHEK AVIVA METER		2
ACCU-CHEK COMFORT CURVE TEST STRIPS		2
ACCU-CHEK COMPACT CARE KIT		2
ACCU-CHEK COMPACT TEST DRUM		2
ACCU-CHEK COMPACT TEST STRIPS		2
ACCU-CHEK COMPLETE METER		2
ACCU-CHEK INSTANT TEST STRIPS		2
ACCU-CHEK SIMPLICITY TEST STRIPS		2
ACCU-CHEK VOICEMATE METER		2
NOVOFINE 30G NEEDLES		2
NOVOFINE 32G NEEDLES		2
NOVOFINE AUTOCOVER		2
ONETOUCH BASIC SYSTEM KIT		2
ONETOUCH FASTTAKE METER		2
ONETOUCH FASTTAKE TEST STRIPS		2
ONETOUCH PROFILE SYSTEM KIT		2
ONETOUCH SURESTEP SYSTEM		2
ONETOUCH SURESTEP TEST STRIPS		2
ONETOUCH TEST STRIPS		2
ONETOUCH ULTRA SYSTEM KIT		2
ONETOUCH ULTRA TEST STRIPS		2
ONETOUCH ULTRASMART METER		2
PRECISION PCX PLUS TEST STR		3
PRECISION POINT OF CARE STR		2
PRECISION XTRA		2
PRODIGY PEN NEEDLE		2
SOFT TOUCH		2
SOFTCLIX		2

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Network Health Plan Specialty Products List			
DRUG NAME	COMMENTS	Preferred	Non-Preferred
CHAPTER 19: SPECIALTY PRODUCTS			
UNLESS OTHERWISE SPECIFIED BELOW OR IN YOUR PRESCRIPTION DRUG (RX) RIDER, OR ADMINISTERED IN THE OFFICE OR BY HOME INFUSION, ALL CHAPTER 19: SPECIALTY PRODUCTS <u>MUST</u> BE OBTAINED FROM CAREMARK SPECIALTY PHARMACY AT 1-800-237-2767.			
2.3 ORAL ANTIFUNGAL DRUGS			
NOXAFIL (posaconazole)	not restricted to Caremark	X	
2.5.1 ANTIRETROVIRALS & PROTEASE INHIBITORS			
FUZEON (enfuvirtide)	not restricted to Caremark	X	
INCIVEK (telaprevir)	PAR	X	
INTELENCE (etravirine)	not restricted to Caremark	X	
ISENTRESS (raltegravir)	not restricted to Caremark	X	
KALETRA (lopinavir/ritonavir)	not restricted to Caremark	X	
SELZENTRY (maraviroc)	not restricted to Caremark	X	
VICTRELIS (boceprevir)	PAR	X	
VIREAD (tenofovir disoproxil fumarate)	not restricted to Caremark	X	
2.5.2 OTHER ANTIVIRAL DRUGS			
ganciclovir inj	not restricted to Caremark	X	
REBETOL soln (ribavirin)		X	
ribavirin capsule, /tablet		X	
VIRAZOLE (ribavirin inhalation solution)	not restricted to Caremark	X	
2.8 OTHER ANTIINFECTIVE DRUGS			
CAYSTON (aztreonam lysine)		X	
DIFICID(fidaxomicin)	PAR / not restricted to Caremark	X	
XIFAXAN 550 MG (rifaximin)	not restricted to Caremark	X	
ZYVOX (linezolid)	not restricted to Caremark	X	
2.8.2 AMINOGLYCOSIDES			
TOBI (tobramycin)	QL=56 ampules / not restricted to Caremark	X	
3.0 ANTINEOPLASTIC IMMUNOSUPPRESSANT			
BENLYSTA(belimumab)		X	
CAPRELSA(vandetanib)		X	
NULOJIX(belatacept)		X	
VANDETANIB (vandetanib)	not restricted to Caremark	X	
XALKORI(crizotinib)	PAR	X	
ZELBORAF (vemurafenib)	PAR/ not restricted to Caremark	X	
ZYTIGA (abiraterone acetate)		X	
3.1 DRUGS FOR THE TREATMENT OF CANCER			
AFINITOR (everolimus)		X	
CAMPATH (alemtuzumab)		X	
CAMPTOSAR (irinotecan hcl)		X	
ELLENCE (epirubicin hcl)		X	

For Members with a 3 Tier Benefit:
 Preferred = Tier 2
 Non-Preferred = Tier 3

SA = Self Administered, Office Administration Requires Prior Authorization
 PAR = Prior Authorization Required
 QL = Quantity Limit per Fill

For Members with a 5 Tier Benefit:
 Preferred = Tier 4
 Non-Preferred = Tier 5

DRUG NAME	COMMENTS	Preferred	Non-Preferred
GEMZAR (gemcitabine hcl)		X	
GLEEVEC (imatinib mesylate)		X	
HERCEPTIN (trastuzumab)		X	
HYCAMTIN (topotecan)		X	
IDAMYCIN (idarubicin hcl)		X	
IRESSA (gefitinib)	not restricted to Caremark	X	
mitoxantrone		X	
MYLOTARG (gemtuzumab ozogamicin)		X	
NEXAVAR (sorafenib)		X	
octreotide		X	
ONTAK (denileukin diftitox)		X	
SANDOSTATIN LAR (octreotide)		X	
SPRYCEL (dasatinib)		X	
SUTENT (sunitinib malate)		X	
TARCEVA (erlotinib)		X	
TARGRETIN (bexarotene)	not restricted to Caremark	X	
TASIGNA (nilotinib hydrochloride)		X	
TAXOL (paclitaxel)		X	
TAXOTERE (docetaxel)		X	
TEMODAR (temozolomide)		X	
TREANDA (bendamustine)		X	
TYKERB (lapatinib)		X	
VANTAS (histrelin ac)		X	
VOTRIENT (pazopanib)		X	
XELODA (capecitabine)		X	
ZOLADEX (goserelin acetate)		X	
ZOLINZA (vorinostat)		X	
3.6 IMMUNE MODULATORS			
AMEVIVE (alefacept)	PAR	X	
CIMZIA (certolizumab pegol)	SA / PAR		X
ENBREL (etanercept)	SA / PAR	X	
HUMIRA (adalimumab)	SA / PAR / QL=2 injections	X	
ORENCIA (abatacept)		X	
REMICADE (infliximab)		X	
REVLIMID (lenalidomide)		X	
RITUXAN (rituximab)		X	
SIMPONI (golimumab)	SA / PAR / QL=1 injections		X
SOMATULINE (lanreotide acetate)			X
STELARA (ustekinumab)	PAR		X
TYSABRI (natalizumab)		X	
4.6.2 OTHER VASODILATING DRUGS			
ADCIRCA (tadalafil)	PAR	X	

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DRUG NAME	COMMENTS	Preferred	Non-Preferred
REVATIO (sildenafil citrate)	PAR	X	
TYVASO (treprostinil)		X	
VENTAVIS (iloprost)		X	
4.6.3 ENDOTHELIN RECEPTOR ANTAGONISTS			
LETAIRIS (ambrisentan)		X	
TRACLEER (bosentan)		X	
5.1.1.1 CLASS II NARCOTICS			
ONSOLIS (fentanyl citrate)			X
5.4.7 OTHER ANTICONVULSANTS			
SABRIL (vigabatrin)		X	
5.7.2 OTHER ANTIPARKINSONS DRUGS			
APOKYN (apomorphine hcl)		X	
5.8 ANTIPSYCHOTIC DRUGS			
INVEGA SUSTENNA (paliperidone)	requires trial of two antipsychotics / not restricted to Caremark		X
ZYPREXA RELPREVV (olanzapine pamoate)	requires trial of two antipsychotics		X
5.8.2 NOVEL (ATYPICAL) ANTIPSYCHOTIC DRUGS			
RISPERDAL CONSTA (risperidone long-acting)		X	
5.9.2 OTHER CNS AUTONOMIC DRUGS			
XENAZINE (tetrabenazine)	PAR	X	
5.9.4 DRUGS TO TREAT MULTIPLE SCLEROSIS			
AMPYRA ER (dalfampridine)	must be prescribed by a neurologist to be covered	X	
AVONEX (interferon beta-1a)	QL=4 vials	X	
BETASERON (interferon beta-1b)	SA / QL=15 vials	X	
COPAXONE (glatiramer acetate)	SA / QL=32 vials	X	
GILENYA (fingolimod hydrochloride)		X	
REBIF (interferon beta-1a)	SA / QL=15 syringes	X	
6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS			
SORIATANE (acitretin)	not restricted to Caremark	X	
8.6 OTHER ENDOCRINE DRUGS			
ALDURAZYME (laronidase)		X	
ELAPRASE (idursulfase)		X	
FABRAZYME (agalsidase beta)		X	
FORTEO (teriparatide [rDNA origin])	SA	X	
KUVAN (sapropterin dihydrochloride)	PAR	X	
LUMIZYME (alglucosidase alfa)	restricted to patients greater than or equal to eight years old	X	
MYOZYME (alglucosidase alfa)	restricted to patients less than or equal to seven years old	X	
NAGLAZYME (galsulfase)		X	
pamidronate disodium	not restricted to Caremark	X	
RECLAST (zoledronic acid)			X
SAMSCA (tolvaptan)	PAR		X
SOMAVERT (pegvisomant)		X	
XGEVA (denosumab)		X	

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DRUG NAME	COMMENTS	Preferred	Non-Preferred
ZOMETA (zoledronic acid)		X	
10.0.0 IMMUNOLOGICALS AND VACCINES			
CARIMUNE NF		X	
CYTOGAM		X	
FLEBOGAMMA			X
GAMASTAN S/D		X	
GAMMAGARD LIQUID		X	
GAMMAGARD S/D		X	
GAMUNEX		X	
OCTAGAM			X
PRIVIGEN			X
VIVAGLOBIN		X	
10.2.1 MYELOID STIMULANTS			
LEUKINE (sargramostim)	SA	X	
NEULASTA (pegfilgrastim)	SA	X	
NEUPOGEN (filgrastim)	SA	X	
10.2.2 ERYTHROID STIMULANTS			
ARANESP (darbepoetin alfa)	SA / PAR	X	
EPOGEN (epoetin alfa)	SA / PAR		X
PROCRIT (epoetin alfa)	SA / PAR	X	
10.2.3 INTERFERONS			
ACTIMMUNE (interferon gamma-1b)	SA	X	
ALFERON N (interferon alfa-n3)		X	
EXTAVIA (interferon beta-1b)	SA		X
INFERGEN (interferon alfacon-1)	SA / QL=12	X	
INTRON A (interferon alfa-2b)	SA	X	
PEG-INTRON (peginterferon alfa-2b)	SA	X	
PEG-INTRON (peginterferon alfa-2b) REDIPEN	SA	X	
PEGASYS (peginterferon alfa-2a)	SA	X	
REBETRON (interferon alfa-2b/ribavirin)	QL=2 packs	X	
ROFERON-A (interferon alfa-2a)			X
SYLATRON KITS, PACKS (peginterferon alfa-2b)		X	
10.2.4 GROWTH HORMONES AND RELATED DRUGS			
EGRIFTA (tesamorelin acetate [rDNA origin])	SA / PAR	X	
GENOTROPIN (somatropin [rDNA origin])	SA / PAR	X	
GENOTROPIN MINIQUICK (somatropin [rDNA origin])	SA / PAR	X	
HUMATROPE (somatropin [rDNA origin])	SA / PAR		X
NORDITROPIN (somatropin [rDNA origin])	SA / PAR		X
NORDITROPIN NORDIFLEX (somatropin [rDNA origin])	SA / PAR		X
NUTROPIN (somatropin [rDNA origin])	SA / PAR	X	
NUTROPIN AQ (somatropin [rDNA origin])	SA / PAR	X	
OMNITROPE (somatropin [rDNA origin])	SA / PAR		X

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DRUG NAME	COMMENTS	Preferred	Non-Preferred
SAIZEN (somatropin [rDNA origin])	SA / PAR		X
SEROSTIM (somatropin [rDNA origin])	SA / PAR		X
TEV-TROPIN (somatropin [rDNA origin])	SA / PAR		X
ZORBTIVE (somatropin [rDNA origin])	SA / PAR		X
10.2.4.1 INSULIN LIKE GROWTH FACTORS-1			
INCRELEX (mecasermin [rDNA origin])		X	
10.2.5 INTERLEUKINS			
NEUMEGA (oprelvekin)	SA / QL=21 vials	X	
PROLEUKIN (aldesleukin)	PAR	X	
ZENAPAX (daclizumab)		X	
10.2.6 INTERLEUKIN RECEPTOR ANTAGONISTS			
ACTEMRA (tocilizumab)	PAR	X	
ARCALYST (rilonacept)	SA / PAR		X
iLARIS (canakinumab)	PAR	X	
KINERET (anakinra)	SA / PAR	X	
10.2.7 IMMUNOGLOBULIN ANTIBODIES			
SOLIRIS (eculizumab)		X	
XOLAIR (omalizumab)	PAR	X	
10.2.9.1 DRUGS for HEREDITARY ANGIOEDEMA			
CINRYZE (esterase inhibitor)	PAR	X	
FIRAZYR (icatibant)		X	
10.2.11 THROMBOPOIETIC AGENTS			
NPLATE (romiplostim)	PAR	X	
PROMACTA (eltrombopag olamine)	PAR	X	
10.3 HEMATOPOIETIC AGENTS			
MOZOBIL (plerixafor)			X
11.2 DRUGS TO PREVENT AND TREAT GOUT			
KRYSTEXXA (pegloticase)		X	
11.3.1 DIRECT MUSCLE RELAXANTS			
DYSPORE (abobotulinumtoxin a)	PAR		X
MYOBLOC (botulinum toxin type b)		X	
XEOMIN (incobotulinumtoxin a)	PAR	X	
12.3.3 OTHER DRUGS AFFECTING COAGULATION			
IPRIVASK (desirudin)			X
12.5 HEMOSTATICS			
ADVATE (antihemophilic factor [recombinant])		X	
ALPHANATE (antihemophilic factor [human])		X	
BENEFIX (coagulation factor IX [recombinant])		X	
CORIFACT KIT(factor XIII)		X	
FEIBA VH (anti-inhibitor coagulant complex)		X	
HELIXATE FS (antihemophilic factor [recombinant])		X	

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DRUG NAME	COMMENTS	Preferred	Non-Preferred
HEMOFIL M (antihemophilic factor [monoclonal], factor VIII)		X	
HUMATE-P (von Willebrand factor complex [human])		X	
KOATE-DVI (antihemophilic factor [human])		X	
NOVOSEVEN (coagulation factor VIIa [recombinant])		X	
RECOMBINATE (antihemophilic factor [recombinant])		X	
REFACTO (factor VIII [antihemophil])		X	
THROMBATE III (antithrombin III [human])	not restricted to Caremark	X	
XYNTHA (factor VIII [antihemophil])			X
13.1.2 SPECIALIZED OB/GYN DRUGS			
leuprolide	PAR	X	
LUPRON DEPOT (leuprolide acetate)		X	
13.5 PROGESTIN DRUGS			
MAKENA (hydroxyprogesterone caproate)			X
14.6 OTHER OPHTHALMIC DRUGS			
BOTOX (botulinum toxin type a)	PAR	X	
15.4 OTHER RESPIRATORY DRUGS			
ARALAST (alpha ₁ -proteinase inhibitor [human])		X	
PROLASTIN (alpha ₁ -proteinase inhibitor [human])	not restricted to Caremark	X	
PULMOZYME (dornase alfa)		X	
ZEMAIRA (alpha ₁ -proteinase inhibitor [human])	not restricted to Caremark	X	
17.1 DIAGNOSTIC PRODUCTS			
EXJADE (deferasirox)		X	
17.2 MISCELLANEOUS DRUGS			
ADAGEN (pegademase bovine)	not restricted to Caremark	X	
BUPHENYL (sodium phenylbutyrate)	not restricted to Caremark	X	
CARBAGLU (carglumic acid)			X
THALOMID (thalidomide)		X	

Injectable medications administered in a practitioner's office not listed here are considered preferred products.

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