

Network Health Plan 2010 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.

RELATIVE COST INDEX

Most listings are preceded by a "relative cost index," represented by a series of one to five dollar signs (\$) or five exclamation points (!!!!!). This is a relative indication of the cost to NHP for medications within selected therapeutic categories:

| | |
|------------|--|
| \$ | product A least expensive |
| \$\$ | product B more expensive than "A" |
| \$\$\$ | product C more expensive than "B" |
| \$\$\$\$ | product D more expensive than "C" I |
| \$\$\$\$\$ | product E more expensive than "D" |
| !!!!! | product F is substantially more expensive than "A-E" |

Cost ranges reflect cost per day of a typical prescription.

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.

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 |
| DIOVAN | 40mg | Use ½ 80mg tablet |
| | 80mg | Use ½ 160mg tablet |
| | 160mg | Use ½ 320mg 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.

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 | | |
| \$ | cefaclor | 1 |
| \$ | cefaclor er | 1 |
| \$ | cefdinir | 1 |
| \$ | cefprozil | 1 |
| \$ | cefuroxime tablet | 1 |
| \$ | cephalexin | 1 |
| \$\$ | SPECTRACEF | 3 |
| \$\$ | SUPRAX | 3 |
| \$\$\$ | CEDAX | 3 |
| \$\$\$ | CEFTIN SUSPENSION | 2 |
| \$\$\$ | 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 |
| \$\$ | clarithromycin | 1 |
| \$\$\$ | BIAXIN XL | 2 |
| 2.1.5 PENICILLINS | | |
| \$ | amox tr/potassium clavulanate | 1 |
| \$ | amoxicillin | 1 |

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 |
|--|-------------------------------|---|------|
| \$ | ampicillin | | 1 |
| \$ | dicloxacillin | | 1 |
| \$ | penicillin v potassium | | 1 |
| \$\$ | AUGMENTIN ES-600 | | 2 |
| \$\$\$ | AUGMENTIN XR | | 3 |
| 2.1.6 SULFONAMIDES | | | |
| \$ | erythromycin/sulfisoxazole | | 1 |
| \$ | sulfamethoxazole/trimethoprim | | 1 |
| \$ | GANTRISIN PEDIATRIC | | 2 |
| 2.1.7 TETRACYCLINES | | | |
| \$ | doxycycline hyclate | | 1 |
| \$ | minocycline | | 1 |
| \$ | tetracycline | | 1 |
| \$\$ | doxycycline monohydrate | | 3 |
| 2.1.8 URINARY ANTIINFECTIVES | | | |
| \$ | nitrofurantoin | | 1 |
| \$ | trimethoprim | | 1 |
| \$ | MACROBID | | 2 |
| 2.1.9 QUINOLONES | | | |
| \$ | ciprofloxacin | | 1 |
| \$ | ofloxacin | | 1 |
| \$\$ | CIPRO XR | | 3 |
| \$\$\$ | NOROXIN | | 3 |
| \$\$\$\$ | AVELOX | | 3 |
| \$\$\$\$ | FACTIVE | | 3 |
| \$\$\$\$ | LEVAQUIN | | 2 |
| 2.2 TOPICAL ANTIBACTERIAL DRUGS | | | |
| \$ | silver sulfadiazine | | 1 |
| \$\$ | mupirocin | | 1 |
| \$\$\$\$ | ALTABAX 1% | | 3 |
| 2.3 ORAL ANTIFUNGAL DRUGS | | | |
| \$ | clotrimazole | | 1 |
| \$ | fluconazole | | 1 |
| \$ | ketoconazole | | 1 |
| \$ | nystatin | | 1 |
| \$\$\$\$ | itraconazole | PAR / capsules: QL=34 | 1 |
| \$\$\$\$ | LAMISIL | PAR | 2 |
| \$\$\$\$ | LAMISIL GRANULES | PAR – exclusion: not required for age 10 years or less | 3 |
| \$\$\$\$ | terbinafine 250 mg tablet | PAR | 1 |
| !!!! | NOXAFIL | see Chapter 19, Specialty Products | |
| !!!! | VFEND | | 2 |
| 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 |
| \$ | ketoconazole | | 1 |
| \$ | nystatin | | 1 |

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| DRUG NAME | | COMMENTS | TIER |
|--|----------------------------|--|------|
| \$ | EXELDERM | | 3 |
| \$\$ | MENTAX | | 3 |
| \$\$ | NAFTIN | | 2 |
| \$\$ | OXISTAT | | 2 |
| \$\$\$ | ERTACZO | | 3 |
| \$\$\$ | LAMISIL SOLUTION | | 3 |
| \$\$\$ | PENLAC | | 3 |
| 2.4.3 TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB. | | | |
| \$ | clotrimazole/betamethasone | | 1 |
| \$ | nystatin/triamcinolone | | 1 |
| 2.5.1 ANTIRETROVIRALS & PROTEASE INHIBITORS | | | |
| !!!! | FUZEON | 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 | |
| !!!! | VIREAD | see Chapter 19, Specialty Products | |
| 2.5.2 OTHER ANTIVIRAL DRUGS | | | |
| \$ | acyclovir | | 1 |
| \$ | amantadine | | 1 |
| \$\$ | RELENZA | QL=20 blisters | 2 |
| \$\$ | TAMIFLU | capsules: QL=34; 25ml bottle: QL=3 | 2 |
| \$\$ | TYZEKA | | 2 |
| \$\$\$ | famciclovir | 125mg tablets: QL=21; 250mg tablets: QL=68; 500mg tablets: QL=21 | 1 |
| \$\$\$ | valacyclovir | 500mg caplets: QL=34; 1000mg (1gm) caplets: QL=34 | 1 |
| \$\$\$\$ | FAMVIR | 125mg tablets: QL=21; 250mg tablets: QL=68; 500mg tablets: QL=21 | 2 |
| \$\$\$\$ | ribavirin capsules/tablets | see Chapter 19, Specialty Products | |
| \$\$\$\$\$ | REBETOL SOLN | see Chapter 19, Specialty Products | |
| !!!! | EPZICOM | | 2 |
| !!!! | ganciclovir inj | see Chapter 19, Specialty Products | |
| !!!! | VIRAZOLE | see Chapter 19, Specialty Products | |
| 2.7.1 AMEBICIDES | | | |
| \$ | paromomycin | | 1 |
| 2.7.2 ANTITUBERCULOSIS DRUGS | | | |
| \$ | isoniazid | | 1 |
| \$ | rifampin | | 1 |
| 2.7.3 PLASMODICIDES | | | |
| \$ | chloroquine | PAR | 1 |
| \$ | hydroxychloroquine sulfate | PAR | 1 |
| \$ | primaquine | PAR | 2 |
| \$\$\$ | COARTEM | PAR | 2 |
| \$\$\$ | FANSIDAR | PAR | 2 |
| \$\$\$ | MALARONE | PAR | 2 |
| \$\$\$\$ | mefloquine | PAR | 1 |
| 2.7.5 TRICHOMONOCIDES | | | |
| \$ | metronidazole | | 1 |
| \$\$\$\$ | TINDAMAX | | 3 |

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| DRUG NAME | | COMMENTS | TIER |
|--|--------------------------|------------------------------------|------|
| 2.8 OTHER ANTIINFECTIVE DRUGS | | | |
| \$\$\$\$ | NEBUPENT | QL=1 container | 2 |
| !!!! | ALINIA | | 2 |
| !!!! | XIFAXAN | QL=9 tablets | 2 |
| !!!! | ZYVOX | see Chapter 19, Specialty Products | |
| 2.8.2 AMINOGLYCOSIDES | | | |
| !!!! | TOBI | see Chapter 19, Specialty Products | |
| CHAPTER 3: ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS | | | |
| 3.1 DRUGS FOR THE TREATMENT OF CANCER | | | |
| \$ | azathioprine | | 1 |
| \$\$\$ | ARIMIDEX | | 2 |
| \$\$\$ | CELLCEPT | | 2 |
| \$\$\$ | FEMARA | | 2 |
| \$\$\$ | tamoxifen citrate | | 1 |
| \$\$\$ | mercaptopurine | | 1 |
| \$\$\$\$ | CASODEX | | 2 |
| !!!! | AFINITOR | see Chapter 19, Specialty Products | |
| !!!! | CAMPATH | see Chapter 19, Specialty Products | |
| !!!! | CAMPTOSAR | see Chapter 19, Specialty Products | |
| !!!! | ELLENC | see Chapter 19, Specialty Products | |
| !!!! | GEMZAR | see Chapter 19, Specialty Products | |
| !!!! | GLEEVEC | see Chapter 19, Specialty Products | |
| !!!! | HERCEPTIN | see Chapter 19, Specialty Products | |
| !!!! | HYCANTIN | see Chapter 19, Specialty Products | |
| !!!! | IDAMYCIN | see Chapter 19, Specialty Products | |
| !!!! | IRESSA | see Chapter 19, Specialty Products | |
| !!!! | 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 | |
| !!!! | SPRYCEL | see Chapter 19, Specialty Products | |
| !!!! | SUTENT | see Chapter 19, Specialty Products | |
| !!!! | 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 | | | |

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| DRUG NAME | | COMMENTS | TIER |
|--|----------------------------------|---|------|
| \$ | cyclosporine | | 1 |
| \$\$\$\$ | MYFORTIC | | 2 |
| 3.6 IMMUNE MODULATORS | | | |
| \$\$\$ | leflunomide | 10mg tablets: QL=34; 20mg tablets: QL=34; 100mg tablets: QL=3 | 1 |
| !!!! | AMEVIVE | see Chapter 19, Specialty Products | |
| !!!! | CIMZIA | see Chapter 19, Specialty Products | |
| !!!! | ENBREL | see Chapter 19, Specialty Products | |
| !!!! | HUMIRA | see Chapter 19, Specialty Products | |
| !!!! | ORENCIA | see Chapter 19, Specialty Products | |
| !!!! | REMICADE | see Chapter 19, Specialty Products | |
| !!!! | REVLIMID | see Chapter 19, Specialty Products | |
| !!!! | RITUXAN | see Chapter 19, Specialty Products | |
| !!!! | 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 |
| \$ | cartia xt | | 1 |
| \$ | diltiazem er | | 1 |
| \$ | diltiazem hcl | | 1 |
| \$ | diltiazem xr | | 1 |
| \$ | felodipine er | | 1 |
| \$ | nicardipine hcl | | 1 |
| \$ | nifedipine | | 1 |
| \$ | nifedipine er | | 1 |
| \$ | verapamil hcl | | 1 |
| \$ | verapamil pellets generic | | 3 |
| \$\$ | SULAR | | 3 |
| \$\$\$ | CARDIZEM LA | | 3 |
| \$\$\$ | NORVASC | | 2 |
| \$\$\$ | VERELAN PM | | 3 |
| \$\$\$\$ | CARDENE SR | | 3 |
| \$\$\$\$ | DYNACIRC | | 3 |
| \$\$\$\$ | DYNACIRC CR | | 3 |
| 4.3 DIURETICS | | | |
| 4.3.1 LOOP DIURETICS | | | |
| \$ | bumetanide | | 1 |
| \$ | furosemide | | 1 |
| \$ | torseamide | | 1 |
| 4.3.2 THIAZIDE AND RELATED DRUGS | | | |
| \$ | hydrochlorothiazide | | 1 |
| \$ | indapamide | | 1 |
| \$ | metolazone | | 1 |
| 4.3.3 POTASSIUM SPARING DIURETICS | | | |

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| DRUG NAME | | COMMENTS | TIER |
|---|------------------------------------|--|------|
| \$ | amiloride/hydrochlorothiazide | | 1 |
| \$ | spironolactone | | 1 |
| \$ | spironolactone/hydrochlorothiazide | | 1 |
| \$ | triamterene/hydrochlorothiazide | | 1 |
| \$\$\$ | eplerenone | requires trial of spironolactone | 1 |
| \$\$\$ | INSPRA | requires trial of spironolactone | 2 |
| 4.4 BETA-ADRENERGIC ANTAGONIST DRUGS | | | |
| \$ | atenolol | | 1 |
| \$ | bisoprolol | | 1 |
| \$ | labetalol | | 1 |
| \$ | metoprolol | | 1 |
| \$ | nadolol | | 1 |
| \$ | propranolol | | 1 |
| \$\$ | carvedilol | | 1 |
| \$\$ | TOPROL XL | | 2 |
| \$\$\$ | BYSTOLIC | | 3 |
| \$\$\$\$ | COREG CR | | 3 |
| 4.5 ANTIHYPERTENSIVE DRUGS | | | |
| 4.5.1 VASODILATOR ANTIHYPERTENSIVES | | | |
| \$ | doxazosin | | 1 |
| \$ | prazosin | | 1 |
| \$ | terazosin | | 1 |
| 4.5.2 CENTRALLY ACTING ANTIHYPERTENSIVES | | | |
| \$ | clonidine | | 1 |
| \$ | methyldopa | | 1 |
| \$\$\$ | CATAPRES-TTS | QL=5 patches | 2 |
| 4.5.4.1 ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS | | | |
| \$ | benazepril | | 1 |
| \$ | captopril | | 1 |
| \$ | enalapril | | 1 |
| \$ | fosinopril | | 1 |
| \$ | lisinopril | | 1 |
| \$ | moexipril | | 1 |
| \$ | quinapril | | 1 |
| \$ | ramipril | | 1 |
| \$ | trandolapril | | 1 |
| \$\$ | perindopril | | 1 |
| 4.5.4.2 ANGIOTENSIN II RECEPTOR ANTAGONISTS | | | |
| \$\$ | losartan | | 1 |
| \$\$ | losartan/hydrochlorothiazide | | 1 |
| \$\$ | BENICAR | STB / requires trial of losartan or losartan/hydrochlorothiazide | 2 |
| \$\$ | TEVETEN | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | ATACAND | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | AVAPRO | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | COZAAR | STB | 3 |
| \$\$\$ | DIOVAN | STB / requires trial of losartan or losartan/hydrochlorothiazide | 2 |
| \$\$\$ | MICARDIS | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| 4.5.6 OTHER ANTIHYPERTENSIVES | | | |

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| DRUG NAME | | COMMENTS | TIER |
|--|--------------------------------|--|------|
| \$ | amlodipine/benazepril | | 1 |
| \$ | atenolol/chlorthalidone | | 1 |
| \$ | benazepril/hydrochlorothiazide | | 1 |
| \$ | bisoprolol/hydrochlorothiazide | | 1 |
| \$ | captopril/hydrochlorothiazide | | 1 |
| \$ | enalapril/hydrochlorothiazide | | 1 |
| \$ | fosinopril/hydrochlorothiazide | | 1 |
| \$ | lisinopril/hydrochlorothiazide | | 1 |
| \$ | quinapril/hydrochlorothiazide | | 1 |
| \$\$ | BENICAR HCT | STB / requires trial of losartan or losartan/hydrochlorothiazide | 2 |
| \$\$ | LOTENSIN HCT | | 2 |
| \$\$ | TEVETEN HCT | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$ | UNIRETIC | | 3 |
| \$\$\$ | ATACAND HCT | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | AVALIDE | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | AZOR | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | DIOVAN HCT | STB / requires trial of losartan or losartan/hydrochlorothiazide | 2 |
| \$\$\$ | EXFORGE | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | EXFORGE HCT | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | HYZAAR | | 3 |
| \$\$\$ | LEXXEL | | 3 |
| \$\$\$ | MICARDIS HCT | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | TARKA | | 3 |
| \$\$\$ | TEKTURNA | requires trial of ACE Inhibitor/ACE Combination | 3 |
| \$\$\$ | TEKTURNA HCT | requires trial of ACE Inhibitor/ACE Combination | 3 |
| \$\$\$ | TWYNSTA | requires trial of losartan or losartan/hydrochlorothiazide | 3 |
| \$\$\$ | VALTURNA | requires trial of ACE Inhibitor/ACE Combination | 3 |
| \$\$\$\$ | LOTREL | | 2 |
| 4.6 VASODILATING DRUGS | | | |
| 4.6.1 NITRATES | | | |
| \$ | isosorbide | | 1 |
| \$ | nitroglycerin | | 1 |
| 4.6.2 OTHER VASODILATING DRUGS | | | |
| !!!! | ADCIRCA | see Chapter 19, Specialty Products | |
| !!!! | 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 |
| \$ | propafenone | | 1 |
| \$\$\$\$ | RYTHMOL SR CAPSULE | | 3 |

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| DRUG NAME | | COMMENTS | TIER |
|---|-------------------------|---|------|
| 4.7.3 AMIODARONES | | | |
| \$ | amiodarone | | 1 |
| 4.7.5 OTHER ANTIARRHYTHMICS | | | |
| \$ | sotalol | | 1 |
| \$\$\$ | MULTAQ | must be prescribed by a cardiologist to be covered | 2 |
| 4.8 ANTILIPIDEMIC DRUGS | | | |
| 4.8.1 HYPOLIPOPROTEINEMICS | | | |
| \$ | cholestyramine | | 1 |
| \$ | fenofibrate | | 1 |
| \$ | gemfibrozil | | 1 |
| \$\$\$ | NIASPAN | | 2 |
| \$\$\$\$ | ANTARA | requires trial of fenofibrate or gemfibrozil | 3 |
| \$\$\$\$ | FENOGLIDE | requires trial of fenofibrate or gemfibrozil | 3 |
| \$\$\$\$ | LIPOFEN | requires trial of fenofibrate or gemfibrozil | 3 |
| \$\$\$\$ | LOFIBRA | requires trial of fenofibrate or gemfibrozil | 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 |
| \$\$\$\$ | ZETIA | | 2 |
| \$\$\$\$\$ | WELCHOL | | 2 |
| 4.8.2 HMG-COA REDUCTASE INHIBITORS | | | |
| \$ | lovastatin | STB | 1 |
| \$\$ | pravastatin | | 1 |
| \$\$\$ | simvastatin | STB | 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 |
| \$\$\$\$ | ALTOPREV | requires trial of Crestor, Vytorin, Advicor, or Simcor | 3 |
| \$\$\$\$ | LIPITOR | requires trial of Crestor, Vytorin, Advicor, or Simcor | 3 |
| 4.8.2.1 HMG-COA COMBINATIONS | | | |
| \$\$\$ | ADVICOR | requires trial of lovastatin, pravastatin, or simvastatin | 2 |
| \$\$\$ | SIMCOR | requires trial of lovastatin, pravastatin, or simvastatin | 3 |
| \$\$\$ | VYTORIN | STB / requires trial of lovastatin, pravastatin, or simvastatin | 2 |
| \$\$\$\$ | CADUET | requires trial of Crestor, Vytorin, Advicor, or Simcor | 3 |
| 4.9 OTHER CARDIOVASCULAR DRUGS | | | |
| \$ | pentoxifylline | | 1 |
| \$\$\$\$\$ | RANEXA | | 3 |
| CHAPTER 5: AUTONOMIC AND CNS MEDICATIONS | | | |
| 5.1.1 ANALGESICS | | | |
| \$ | tramadol hcl | | 1 |
| 5.1.1.1 CLASS II NARCOTICS | | | |
| \$ | meperidine | | 1 |
| \$ | oxycodone/acetaminophen | | 1 |
| \$\$ | fentanyl patch | | 1 |
| \$\$ | oxycodone | | 1 |
| \$\$\$\$\$ | NUCYNTA | | 3 |
| \$\$\$\$\$ | OPANA | | 3 |

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| DRUG NAME | | COMMENTS | TIER |
|---|--------------------------------------|---|------|
| \$\$\$\$ | OXYCONTIN | | 2 |
| !!!! | AVINZA | | 3 |
| !!!! | KADIAN | | 3 |
| !!!! | ONSOLIS | see Chapter 19, Specialty Products | |
| 5.1.1.2 CLASS III NARCOTICS | | | |
| \$ | acetaminophen/codeine | | 1 |
| \$ | hydrocodone/acetaminophen | | 1 |
| \$\$ | NORCO | | 3 |
| \$\$\$ | buprenorphine | | 1 |
| \$\$\$ | SUBOXONE | | 2 |
| 5.1.1.3 CLASS IV NARCOTICS | | | |
| \$ | propoxyphene hcl/acetaminophen | | 1 |
| \$ | propoxyphene hcl | | 1 |
| \$ | propoxyphene napsylate/acetaminophen | | 1 |
| 5.1.2 DRUGS TO PREVENT AND TREAT HEADACHES | | | |
| \$ | butalbital/acetaminophen/caffeine | | 1 |
| \$ | MIDRIN | | 2 |
| \$\$\$ | butorphanol nasal spray | QL=2 bottles | 1 |
| \$\$\$\$ | AXERT | requires trial of sumatriptan / QL=9 tablets | 3 |
| \$\$\$\$ | FROVA | requires trial of sumatriptan / QL=9 tablets | 3 |
| \$\$\$\$ | MAXALT | requires trial of sumatriptan / QL=9 tablets | 2 |
| \$\$\$\$ | MAXALT MLT | requires trial of sumatriptan / QL=9 tablets | 2 |
| \$\$\$\$ | MIGRANAL | QL=8 inhalers | 2 |
| \$\$\$\$ | RELPAX | requires trial of sumatriptan / QL=9 tablets | 3 |
| \$\$\$\$ | sumatriptan | Tablets: QL=9; Nasal Spray: QL=6; Injectable: QL=8 kits (PAR on 25mg tab & 5mg nasal spray) | 1 |
| \$\$\$\$ | ZOMIG | requires trial of sumatriptan / QL=9 tablets | 2 |
| \$\$\$\$ | ZOMIG ZMT | requires trial of sumatriptan / QL=9 tablets | 2 |
| \$\$\$\$ | AMERGE | requires trial of sumatriptan / QL=9 tablets | 3 |
| \$\$\$\$ | IMITREX | Tablets: QL=9; Nasal Spray: QL=6; Injectable: QL=8 kits (PAR on 25mg tab & 5mg nasal spray) | 2 |
| \$\$\$\$ | TREXIMET | requires trial of sumatriptan / QL=9 tablets | 3 |
| 5.2.1 ANXIOLYTICS | | | |
| \$ | alprazolam | | 1 |
| \$ | buspirone | | 1 |
| \$ | diazepam | | 1 |
| \$ | lorazepam | | 1 |
| 5.2.2 SEDATIVE/HYPNOTIC DRUGS | | | |
| \$ | flurazepam | | 1 |
| \$ | temazepam | | 1 |
| \$ | triazolam | | 1 |
| \$\$\$ | ROZEREM | | 3 |
| \$\$\$ | SONATA | | 3 |
| \$\$\$ | zaleplon | | 1 |
| \$\$\$ | zolpidem | | 1 |
| \$\$\$\$ | AMBIEN CR | | 3 |
| \$\$\$\$ | LUNESTA | | 3 |
| 5.3 ANTIMANIA DRUGS | | | |
| \$ | lithium carbonate | | 1 |

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| DRUG NAME | | COMMENTS | TIER |
|---|--------------------|--|------|
| \$ | lithium citrate | | 1 |
| 5.4.1 CARBAMAZEPINES | | | |
| \$ | carbamazepine | | 1 |
| \$\$\$ | oxcarbazepine | | 1 |
| \$\$\$ | TEGRETOL XR | | 2 |
| 5.4.2 ANTICONVULSANT BENZODIAZEPINES | | | |
| \$ | clonazepam | | 1 |
| 5.4.3 HYDANTOINS | | | |
| \$ | phenytoin | | 1 |
| \$ | phenytoin extended | | 1 |
| \$\$ | PHENYTEK | | 2 |
| 5.4.4 VALPROIC ACID AND DERIVATIVES | | | |
| \$ | valproic acid | | 1 |
| \$\$\$ | divalproex | | 1 |
| 5.4.5 SUCCINIMIDES | | | |
| \$ | ethosuximide | | 1 |
| 5.4.6 ANTICONVULSANT BARBITURATES | | | |
| \$ | phenobarbital | | 1 |
| \$ | primidone | | 1 |
| 5.4.7 OTHER ANTICONVULSANTS | | | |
| \$\$\$\$ | gabapentin | | 1 |
| \$\$\$\$ | levetiracetam | | 1 |
| \$\$\$\$ | topiramate | | 1 |
| \$\$\$\$ | zonisamide | | 1 |
| \$\$\$\$\$ | KEPPRA XR | | 3 |
| \$\$\$\$\$ | lamotrigine | | 1 |
| \$\$\$\$\$ | LYRICA | requires trial of gabapentin | 3 |
| \$\$\$\$\$ | SABRIL | see Chapter 19, Specialty Products | |
| !!!! | VIMPAT | requires trial of one generic anticonvulsant | 2 |
| 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 |
| \$ | paroxetine | STB | 1 |
| \$ | sertraline | STB | 1 |
| \$\$\$ | LEXAPRO | 5mg tablets: QL=17; 10mg tablets: QL=17 / STB / requires trial of citalopram | 2 |
| \$\$\$\$ | PAXIL CR | | 2 |
| \$\$\$\$ | PEXEVA | | 3 |
| \$\$\$\$ | PROZAC WEEKLY | | 3 |

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| DRUG NAME | | COMMENTS | TIER |
|--|--------------------|--|------|
| 5.5.1.4 OTHER ANTIDEPRESSANTS | | | |
| \$ | bupropion | | 1 |
| \$ | bupropion sr, xl | | 1 |
| \$ | nefazodone | | 1 |
| \$ | trazodone | | 1 |
| \$\$ | mirtazapine | | 1 |
| \$\$ | venlafaxine | | 1 |
| \$\$\$ | REMERON M TAB | | 3 |
| \$\$\$ | SAVELLA | | 2 |
| \$\$\$ | venlafaxine er | | 3 |
| \$\$\$\$ | CYMBALTA | | 2 |
| \$\$\$\$\$ | EFFEXOR XR | | 2 |
| \$\$\$\$\$ | PRISTIQ | | 3 |
| 5.5.2 MAO INHIBITORS | | | |
| !!!! | EMSAM | | 3 |
| 5.6 ANTIVERTIGO AND ANTIEMETIC DRUGS | | | |
| \$ | prochlorperazine | | 1 |
| \$ | trimethobenzamide | | 1 |
| \$\$\$\$ | CESAMET | | 3 |
| \$\$\$\$ | EMEND | 80mg capsules: QL=2; 125mg capsules: QL=1; Trifold Pack: QL 1 | 2 |
| \$\$\$\$ | ondansetron | 4mg tablets: QL=12; 8mg tablets: QL=12; 24mg tablets: QL=1; 4mg/5ml vials: QL=3 | 1 |
| \$\$\$\$\$ | ANZEMET | tablets: QL=1 | 3 |
| \$\$\$\$\$ | granisetron | tablets: QL=2; 30ml bottle: QL=1 | 1 |
| \$\$\$\$\$ | KYTRIL | tablets: QL=2; 30ml bottle: QL=1 | 2 |
| \$\$\$\$\$ | ondansetron odt | tablets: QL=12 | 1 |
| 5.7.1 ANTIPARKINSON ANTICHOLINERGIC DRUGS | | | |
| \$ | benztropine | | 1 |
| 5.7.2 OTHER ANTIPARKINSON DRUGS | | | |
| \$ | bromocriptine | | 1 |
| \$ | carbidopa/levodopa | | 1 |
| \$ | pramipexole | | 1 |
| \$ | selegiline | | 1 |
| \$\$\$\$\$ | AZILECT | | 3 |
| \$\$\$\$\$ | MIRAPEX ER | | 3 |
| \$\$\$\$\$ | NEUPRO PATCH | | 2 |
| \$\$\$\$\$ | REQUIP | | 2 |
| \$\$\$\$\$ | STALEVO | | 2 |
| !!!! | APOKYN | see Chapter 19, Specialty Products | |
| !!!! | REQUIP XL | | 3 |
| 5.8 ANTIPSYCHOTIC DRUGS | | | |
| \$ | clozapine | | 1 |
| \$ | haloperidol | | 1 |
| \$ | risperidone | | 1 |
| \$ | thioridazine | | 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 |

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| DRUG NAME | | COMMENTS | TIER |
|---|-----------------------------------|--------------------------------------|------|
| \$\$\$ | RISPERDAL | | 3 |
| \$\$\$ | SEROQUEL | | 2 |
| \$\$\$\$ | GEODON | | 2 |
| \$\$\$\$ | SAPHRIS | requires trial of two antipsychotics | 3 |
| \$\$\$\$ | SEROQUEL XR | | 3 |
| \$\$\$\$ | ZYPREXA | requires trial of two antipsychotics | 2 |
| \$\$\$\$\$ | ABILIFY | | 2 |
| \$\$\$\$\$ | ZYPREXA ZYDIS | requires trial of two antipsychotics | 3 |
| !!!! | INVEGA | requires trial of two antipsychotics | 3 |
| !!!! | INVEGA SUSTENNA | see Chapter 19, Specialty Products | |
| 5.8.2 NOVEL (ATYPICAL) ANTIPSYCHOTIC DRUGS | | | |
| !!!! | RISPERDAL CONSTA | see Chapter 19, Specialty Products | |
| 5.9.1 CNS STIMULANT DRUGS | | | |
| \$ | amphetamine salt combo | | 1 |
| \$ | dextroamphetamine | | 1 |
| \$ | methylphenidate | | 1 |
| \$ | methylphenidate er | | 1 |
| \$\$ | FOCALIN | | 3 |
| \$\$ | METADATE ER | | 3 |
| \$\$\$ | METADATE CD | | 3 |
| \$\$\$ | RITALIN LA | | 3 |
| \$\$\$\$ | CONCERTA | 18mg & 27mg tablets: QL=34 | 2 |
| \$\$\$\$ | VYVANSE | | 2 |
| \$\$\$\$\$ | DAYTRANA | | 3 |
| !!!! | NUVIGIL | requires trial of two CNS Stimulants | 2 |
| !!!! | PROVIGIL | requires trial of two CNS Stimulants | 2 |
| 5.9.2 OTHER CNS AUTONOMIC DRUGS | | | |
| !!!! | CAMPRAL | | 2 |
| !!!! | XENAZINE | see Chapter 19, Specialty Products | |
| 5.9.3 ANTIDEMENTIA DRUGS | | | |
| \$\$\$\$\$ | ARICEPT | | 2 |
| \$\$\$\$\$ | EXELON | | 2 |
| !!!! | RAZADYNE | | 2 |
| !!!! | RAZADYNE ER | | 3 |
| 5.9.4 DRUGS TO TREAT MULTIPLE SCLEROSIS | | | |
| \$\$\$\$ | REBIF | see Chapter 19, Specialty Products | |
| !!!! | AVONEX | see Chapter 19, Specialty Products | |
| !!!! | BETASERON | see Chapter 19, Specialty Products | |
| !!!! | COPAXONE | see Chapter 19, Specialty Products | |
| 5.9.6 OTHER DRUGS FOR ADHD | | | |
| !!!! | STRATTERA | | 2 |
| CHAPTER 6: DERMATOLOGICAL MEDICATIONS | | | |
| 6.1 TOPICAL CORTICOSTEROID DRUGS | | | |
| \$ | alclometasone | | 1 |
| \$ | betamethasone dipropionate | | 1 |
| \$ | clobetasol propionate | | 1 |
| \$ | desoximetasone | | 1 |
| \$ | diflorasone diacetate | | 1 |

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| DRUG NAME | | COMMENTS | TIER |
|---|-----------------------------|------------------------------------|------|
| \$ | fluocinonide | | 1 |
| \$ | fluticasone | | 1 |
| \$ | hydrocortisone | | 1 |
| \$ | triamcinolone acetonide | | 1 |
| \$\$ | halobetasol propionate | | 1 |
| \$\$ | mometasone | | 1 |
| \$ | CLODERM | | 3 |
| \$ | CORDRAN TAPE | QL=2 rolls | 3 |
| \$\$ | LOCOID | | 3 |
| \$\$\$ | HALOG-E | | 2 |
| \$\$\$\$ | HALOG | | 2 |
| 6.2 ANTIPRURITIC DRUGS | | | |
| \$ | hydroxyzine hcl | | 1 |
| \$ | hydroxyzine pamoate | | 1 |
| 6.3 ANTIACNE DRUGS | | | |
| \$ | clindamycin phosphate | | 1 |
| \$ | erythromycin base | | 1 |
| \$ | metronidazole | | 1 |
| \$ | sodium sulfacetamide/sulfur | | 1 |
| \$ | tretinoin topical | | 1 |
| \$\$\$ | FINACEA 15% GEL | | 2 |
| \$\$\$ | NORITATE | | 2 |
| \$\$\$ | PLEXION | | 3 |
| \$\$\$\$ | ACZONE | | 3 |
| \$\$\$\$ | AZELEX | | 3 |
| \$\$\$\$ | DIFFERIN | | 2 |
| \$\$\$\$ | RETIN-A TOPICAL | | 2 |
| \$\$\$\$ | RETIN-A MICRO | | 2 |
| \$\$\$\$ | BENZACLIN GEL | | 2 |
| 6.3.1 ACCUTANES | | | |
| \$\$\$\$ | sotret | | 1 |
| !!!! | amnesteem | | 1 |
| !!!! | claravis | | 1 |
| 6.7 KERATOLYTIC DRUGS | | | |
| \$\$\$\$ | CONDYLOX | | 2 |
| 6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS | | | |
| \$ | selenium sulfide | | 1 |
| \$\$\$ | KLARON | | 2 |
| \$\$\$\$ | TAZORAC | PAR | 2 |
| !!!! | DOVONEX | | 2 |
| !!!! | SORIATANE | see Chapter 19, Specialty Products | |
| !!!! | TACLONEX | | 3 |
| 6.9.2 TOPICAL DERMATOLOGICAL DRUGS | | | |
| \$\$\$ | ELIDEL | | 2 |
| \$\$\$ | imiquimod | | 1 |
| \$\$\$ | REGRANEX | QL=1 tube | 2 |
| \$\$\$ | PANRETIN | PAR | 3 |
| \$\$\$\$ | PROTOPIC | | 2 |

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| DRUG NAME | | COMMENTS | TIER |
|---|--|--|------|
| 6.9.3 SCABICIDES | | | |
| \$\$ | ULESFIA | | 2 |
| \$\$\$ | LINDANE | | 2 |
| CHAPTER 7: EAR-NOSE-THROAT MEDICATIONS | | | |
| 7.1 DRUGS AFFECTING THE EAR | | | |
| \$ | neomycin/polymyxin/hc | | 1 |
| \$\$\$\$ | CIPRODEX | | 2 |
| \$\$\$\$ | FLOXIN EAR DROPS | | 2 |
| !!!! | CIPRO HC | | 2 |
| 7.2 DRUGS AFFECTING THE NOSE | | | |
| \$ | flunisolide | QL=4 inhalers | 1 |
| \$ | ipratropium | 0.03%: QL=2; 0.06%: QL=1 | 1 |
| \$\$ | fluticasone | QL=4 inhalers | 1 |
| \$\$\$ | ASTELIN | QL=4 inhalers | 3 |
| \$\$\$ | BECONASE AQ | requires trial of one generic inhaled nasal corticosteroid / QL=4 inhalers | 3 |
| \$\$\$ | 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 |
| \$\$\$ | VERAMYST | requires trial of one generic inhaled nasal corticosteroid / QL=20 gm | 3 |
| \$\$\$\$ | ATROVENT | 0.03%: QL=2; 0.06%: QL=1 | 3 |
| CHAPTER 8: ENDOCRINE MEDICATIONS | | | |
| 8.1 HYPOGLYCEMIC DRUGS | | | |
| 8.1.1 INSULIN | | | |
| \$ | HUMULIN 50/50 VIAL | | 2 |
| \$ | HUMULIN N PEN, VIAL | | 2 |
| \$ | HUMULIN R VIAL | | 2 |
| \$ | NOVOLIN 70/30 CARTRIDGE, INNOLET, VIAL | | 2 |
| \$ | NOVOLIN N CARTRIDGE, INNOLET, VIAL | | 2 |
| \$ | NOVOLIN R CARTRIDGE, INNOLET, VIAL | | 2 |
| \$\$\$ | APIDRA | | 3 |
| \$\$\$ | HUMALOG MIX 50/50 KWIKPEN, PEN, VIAL | | 2 |
| \$\$\$ | HUMALOG MIX 75/25 KWIKPEN, PEN, VIAL | | 2 |
| \$\$\$ | HUMALOG CARTRIDGE, KWIKPEN, PEN, VIAL | | 2 |
| \$\$\$ | LANTUS VIAL | | 2 |
| \$\$\$ | LEVEMIR FLEXPEN, VIAL | | 2 |
| \$\$\$ | NOVOLOG MIX 70/30 CARTRIDGE, FLEXPEN, VIAL | | 2 |
| \$\$\$ | NOVOLOG CARTRIDGE, FLEXPEN, VIAL | | 2 |
| \$\$\$\$ | HUMULIN 70/30 PEN, VIAL | | 2 |
| \$\$\$\$ | LANTUS CARTRIDGE | | 3 |
| 8.1.1.1 INSULIN - INHALED | | | |
| 8.1.2 ORAL HYPOGLYCEMIC DRUGS | | | |
| \$ | acarbose | | 1 |
| \$ | glimepiride | | 1 |
| \$ | glipizide | | 1 |

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 |
|---|----------------------|--|------|
| \$ | glyburide | | 1 |
| \$ | glyburide/metformin | | 1 |
| \$ | metformin | | 1 |
| \$\$ | GLUCOTROL XL | | 2 |
| \$\$\$ | GLUCOPHAGE XR | | 2 |
| \$\$\$ | GLUCOVANCE | | 2 |
| \$\$\$ | nateglinide | | 1 |
| \$\$\$ | PRECOSE | | 2 |
| \$\$\$\$ | PRANDIN | | 2 |
| 8.1.3 INSULIN SENSITIZERS | | | |
| \$\$\$\$ | ACTOPLUS MET | requires trial of metformin | 3 |
| \$\$\$\$ | AVANDAMET | requires trial of metformin | 3 |
| \$\$\$\$ | AVANDIA | requires trial of metformin / 2mg tablets: QL=68; 4mg tablets: 68; 8mg tablets: QL=34 | 2 |
| \$\$\$\$\$ | ACTOS | requires trial of metformin / QL=34 tablets | 2 |
| \$\$\$\$\$ | AVANDARYL | requires trial of metformin | 3 |
| \$\$\$\$\$ | DUETACT | requires trial of metformin | 3 |
| 8.1.5 DIPEPTIDYL PEPTIDASE-IV INHIBITORS | | | |
| \$\$\$\$ | JANUMET | requires trial of metformin | 2 |
| \$\$\$\$ | JANUVIA | requires trial of metformin | 2 |
| \$\$\$\$ | ONGLYZA | requires trial of metformin | 3 |
| 8.3.1 GLUCOCORTICOID DRUGS | | | |
| \$ | dexamethasone | | 1 |
| \$ | hydrocortisone | | 1 |
| \$ | methylprednisolone | | 1 |
| \$ | prednisolone | | 1 |
| \$ | prednisone | | 1 |
| \$ | ORAPRED | | 2 |
| \$\$\$\$ | ORAPRED ODT | | 3 |
| 8.3.2 MINERALOCORTICOID DRUGS | | | |
| \$ | fludrocortisone | | 1 |
| 8.4.1 THYROID SUPPLEMENTS | | | |
| \$ | levothroid | | 1 |
| \$ | levothyroxine sodium | | 1 |
| \$ | levoxyl | | 1 |
| \$ | unithroid | | 1 |
| \$ | SYNTHROID | | 2 |
| 8.4.2 ANTITHYROID DRUGS | | | |
| \$ | propylthiouracil | | 1 |
| 8.6 OTHER ENDOCRINE DRUGS | | | |
| \$ | alendronate | 5mg tablets: QL=34; 10mg tablets: QL=34; 35mg tablets: QL=5; 40mg tablets: QL=34; 70mg tablets: QL=5 | 1 |
| \$ | desmopressin acetate | | 1 |
| \$ | etidronate | | 1 |
| \$\$\$ | ACTONEL | requires trial of alendronate / 5mg tablets: QL=34; 30mg tablets: QL=34; 35mg tablets: QL=5 | 2 |
| \$\$\$ | MIACALCIN | | 3 |
| \$\$\$\$ | BONIVA | requires trial of alendronate | 3 |

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 Tier 3 = Non-Preferred Brand Drug

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| DRUG NAME | | COMMENTS | TIER |
|--|--|--|------|
| \$\$\$\$ | FOSAMAX | 5mg tablets: QL=34; 10mg tablets: QL=34; 35mg tablets: QL=5; 40mg tablets: QL=34; 70mg tablets: QL=5 | 3 |
| \$\$\$\$\$ | BYETTA | | 2 |
| \$\$\$\$\$ | SYMLIN 0.6 MG/ML VIAL | | 2 |
| \$\$\$\$\$ | SYMLINPEN | | 3 |
| !!!! | ALDURAZYME | see Chapter 19, Specialty Products | |
| !!!! | ELAPRASE | see Chapter 19, Specialty Products | |
| !!!! | FABRAZYME | see Chapter 19, Specialty Products | |
| !!!! | FORTEO | see Chapter 19, Specialty Products | |
| !!!! | KUVAN | see Chapter 19, Specialty Products | |
| !!!! | MYOZYME | see Chapter 19, Specialty Products | |
| !!!! | NAGLAZYME | see Chapter 19, Specialty Products | |
| !!!! | pamidronate disodium | see Chapter 19, Specialty Products | |
| !!!! | RECLAST | see Chapter 19, Specialty Products | |
| !!!! | SAMSCA | see Chapter 19, Specialty Products | |
| !!!! | SENSIPAR | | 2 |
| !!!! | SOMAVERT | see Chapter 19, Specialty Products | |
| !!!! | ZOMETA | see Chapter 19, Specialty Products | |
| CHAPTER 9: GASTROINTESTINAL MEDICATIONS | | | |
| 9.2 ANTIDIARRHEAL DRUGS | | | |
| \$ | diphenoxylate/atropine | | 1 |
| 9.3 ANTISPASMODICS/DRUGS AFFECT GI MOTILITY | | | |
| \$ | 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) | | | |
| \$ | omeprazole OTC (over-the-counter) | requires practitioner prescription for coverage | 1 |
| \$ | PREVACID OTC (over-the-counter) | requires practitioner prescription for coverage | 1 |
| | omeprazole prescription | excluded - use Omeprazole OTC (over-the-counter) | |
| \$\$\$ | pantoprazole | PAR / 20mg tablets: QL=34 | 2 |
| \$\$\$ | lansoprazole prescription | excluded – use Prevacid OTC (over-the-counter) | |
| \$\$\$\$ | DEXILANT | PAR | 3 |
| \$\$\$\$ | NEXIUM | PAR / 20mg capsules: QL=34 | 3 |
| | PRILOSEC | excluded - use Omeprazole OTC (over-the-counter) | |
| \$\$\$\$ | PROTONIX | PAR / 20mg tablets: QL=34 | 3 |
| \$\$\$\$ | PREVACID CAPSULE | excluded – use Prevacid OTC (over-the-counter) | |
| \$\$\$\$ | PREVACID SOLUTAB | excluded – use Prevacid OTC (over-the-counter) | |
| \$\$\$\$\$ | ACIPHEX | PAR | 3 |
| 9.4.3 HELICOBACTER PYLORI DRUGS | | | |

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

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 PAR = Prior Authorization Required
 STB = Split the Bill

| DRUG NAME | | COMMENTS | TIER |
|--|--------------------------|--|------|
| \$\$\$\$ | HELIDAC | | 3 |
| !!!! | PREVPAC | QL=1 pack (14 units) | 3 |
| 9.6 OTHER GI DRUGS | | | |
| \$ | hydrocortisone | | 1 |
| \$ | peg3350/electrolyte soln | | 1 |
| \$ | sulfasalazine | | 1 |
| \$ | NULYTELY | | 2 |
| \$\$\$ | CREON 5 | | 3 |
| \$\$\$ | PANCREAZE | | 2 |
| \$\$\$\$ | ASACOL | | 2 |
| \$\$\$\$ | DIPENTUM | | 3 |
| \$\$\$\$\$ | CANASA | | 2 |
| \$\$\$\$\$ | COLAZAL | | 3 |
| \$\$\$\$\$ | ENTOCORT EC | must be prescribed by a gastroenterologist to be covered | 2 |
| \$\$\$\$\$ | GOLYTELY | | 2 |
| \$\$\$\$\$ | PENTASA | | 2 |
| \$\$\$\$\$ | PYLERA | | 3 |
| \$\$\$\$\$ | ULTRASE | | 2 |
| !!!! | CREON | | 3 |
| !!!! | RELISTOR | | 3 |
| !!!! | 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 | |
| !!!! | SOLIRIS | 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 | | | |
| \$\$ | INFERGEN | see Chapter 19, Specialty Products | |
| \$\$ | ROFERON-A | see Chapter 19, Specialty Products | |

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

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 PAR = Prior Authorization Required
 STB = Split the Bill

| DRUG NAME | | COMMENTS | TIER |
|---|-----------------------|------------------------------------|------|
| \$\$\$\$ | EXTAVIA | see Chapter 19, Specialty Products | |
| \$\$\$\$ | INTRON A | see Chapter 19, Specialty Products | |
| \$\$\$\$\$ | PEG-INTRON | see Chapter 19, Specialty Products | |
| !!!! | ACTIMMUNE | see Chapter 19, Specialty Products | |
| !!!! | ALFERON N | see Chapter 19, Specialty Products | |
| !!!! | PEGASYS | see Chapter 19, Specialty Products | |
| !!!! | REBETRON | see Chapter 19, Specialty Products | |
| 10.2.4 GROWTH HORMONES AND RELATED DRUGS | | | |
| \$\$\$\$ | GENOTROPIN MINIQUICK | see Chapter 19, Specialty Products | |
| \$\$\$\$ | NORDITROPIN | see Chapter 19, Specialty Products | |
| \$\$\$\$ | NORDITROPIN NORDIFLEX | see Chapter 19, Specialty Products | |
| \$\$\$\$ | OMNITROPE | see Chapter 19, Specialty Products | |
| \$\$\$\$ | SAIZEN | see Chapter 19, Specialty Products | |
| \$\$\$\$ | TEV-TROPIN | see Chapter 19, Specialty Products | |
| \$\$\$\$ | ZORBTIVE | see Chapter 19, Specialty Products | |
| \$\$\$\$\$ | GENOTROPIN | see Chapter 19, Specialty Products | |
| \$\$\$\$\$ | HUMATROPE | see Chapter 19, Specialty Products | |
| \$\$\$\$\$ | NUTROPIN | see Chapter 19, Specialty Products | |
| !!!! | NUTROPIN AQ | see Chapter 19, Specialty Products | |
| !!!! | SEROSTIM | see Chapter 19, Specialty Products | |
| 10.2.4.1 INSULIN LIKE GROWTH FACTORS-1 | | | |
| \$\$\$\$\$ | IPLX | see Chapter 19, Specialty Products | |
| !!!! | 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 | | | |
| !!!! | ARCALYST | see Chapter 19, Specialty Products | |
| !!!! | iLARIS | see Chapter 19, Specialty Products | |
| !!!! | KINERET | see Chapter 19, Specialty Products | |
| 10.2.7 IMMUNOGLOBULIN ANTIBODIES | | | |
| !!!! | XOLAIR | see Chapter 19, Specialty Products | |
| 10.2.9.1 C1 ESTERASE INHIBITORS | | | |
| !!!! | CINRYZE | 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 | | | |
| FIRST LINE AGENTS | | | |
| \$ | diclofenac sodium | | 1 |
| \$ | etodolac | | 1 |

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| DRUG NAME | | COMMENTS | TIER |
|--|---|---|------|
| \$ | ibuprofen | | 1 |
| \$ | indomethacin | | 1 |
| \$ | ketoprofen | | 1 |
| \$ | ketorolac | QL=20 tablets | 1 |
| \$ | naproxen | | 1 |
| \$ | oxaprozin | requires trial of 3 first line generics | 1 |
| \$ | piroxicam | | 1 |
| \$ | sulindac | | 1 |
| \$\$ | meloxicam | | 1 |
| SECOND LINE AGENTS | | | |
| \$ | diclofenac er | requires trial of 3 first line generics | 1 |
| \$ | ketoprofen sa | 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 |
| \$\$\$\$ | ARTHROTEC | requires trial of 3 first line generics | 2 |
| \$\$\$\$ | etodolac sa | requires trial of 3 first line generics | 1 |
| \$\$\$\$ | ZIPSOR | requires trial of 3 first line generics | 3 |
| \$\$\$\$\$ | CELEBREX | requires trial of 3 first line generics | 2 |
| \$\$\$\$\$ | MOBIC | requires trial of 3 first line generics | 3 |
| \$\$\$\$\$ | PONSTEL | requires trial of 3 first line generics | 3 |
| \$\$\$\$\$ | VOLTAREN XR | requires trial of 3 first line generics | 3 |
| TOPICAL AGENTS | | | |
| \$\$\$ | VOLTAREN 1% GEL | | 2 |
| \$\$\$\$\$ | FLECTOR | | 3 |
| 11.2 DRUGS TO PREVENT AND TREAT GOUT | | | |
| \$ | allopurinol | | 1 |
| \$ | colchicine | | 1 |
| \$ | 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 | |
| 11.3.2 CNS MUSCLE RELAXANTS | | | |
| \$ | carisoprodol | | 1 |
| \$ | cyclobenzaprine | | 1 |
| \$ | methocarbamol | | 1 |
| \$\$\$\$ | SKELAXIN | | 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 B ₁₂) | | 1 |
| \$ | folic acid | | 1 |
| \$\$\$ | PHOSLO | | 2 |

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| DRUG NAME | | COMMENTS | TIER |
|--|--------------------|------------------------------------|------|
| \$\$\$\$ | 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 | | | |
| !!!! | ARIXTRA | | 3 |
| !!!! | FRAGMIN | | 3 |
| !!!! | INNOHEP | | 3 |
| !!!! | LOVENOX | | 2 |
| 12.4 ANTIPLATELET DRUGS | | | |
| \$ | dipyridamole | | 1 |
| \$ | ticlopidine | | 1 |
| !!!! | AGGRENOX | | 2 |
| !!!! | EFFIENT | | 2 |
| !!!! | PLAVIX | | 2 |
| 12.5 HEMOSTATICS | | | |
| !!!! | ADVATE | see Chapter 19, Specialty Products | |
| !!!! | ALPHANATE | see Chapter 19, Specialty Products | |
| !!!! | BENEFIX | see Chapter 19, Specialty Products | |
| !!!! | FEIBA VH | see Chapter 19, Specialty Products | |
| !!!! | HELIXATE FS | see Chapter 19, Specialty Products | |
| !!!! | HEMOPIL 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 | |
| !!!! | 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 | | | |
| \$ | lactulose | | 1 |
| \$\$\$\$ | KRISTALOSE | | 3 |
| !!!! | FOSRENOL | | 3 |
| !!!! | RENVELA | | 3 |
| CHAPTER 13: OBSTETRICAL & GYNECOLOGICAL MEDICATIONS | | | |
| 13.1.1 PRENATAL VITAMINS | | | |
| \$ | prenatal vitamin | | 1 |
| 13.1.2 SPECIALIZED OB/GYN DRUGS | | | |
| !!!! | leuprolide | see Chapter 19, Specialty Products | |
| !!!! | LUPRON DEPOT | see Chapter 19, Specialty Products | |
| !!!! | VIADUR | see Chapter 19, Specialty Products | |
| 13.3 ANDROGEN DRUGS | | | |
| \$\$\$\$ | ANDRODERM | PAR | 3 |
| \$\$\$\$ | ANDROGEL | PAR | 2 |

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| DRUG NAME | | COMMENTS | TIER |
|---|------------------------------------|---------------|------|
| \$\$\$\$ | TESTIM | PAR | 3 |
| !!!! | STRIANT | PAR | 3 |
| 13.4 ESTROGEN DRUGS | | | |
| \$ | estradiol | | 1 |
| \$ | estradiol transdermal patch | | 1 |
| \$ | estropipate | | 1 |
| \$ | ESTRACE CREAM | | 2 |
| \$ | MENEST | | 3 |
| \$\$ | ALORA | QL=10 patches | 2 |
| \$\$ | CENESTIN | | 2 |
| \$\$ | CLIMARA | QL=5 patches | 2 |
| \$\$ | DIVIGEL | QL=34 packets | 3 |
| \$\$ | ELESTRIN | QL= 144 gm | 3 |
| \$\$ | ESTRADERM | QL=10 patches | 2 |
| \$\$ | ESTROGEL | | 3 |
| \$\$ | FEMRING | | 3 |
| \$\$ | PREMARIN | | 2 |
| \$\$ | VIVELLE | QL=10 patches | 2 |
| \$\$ | VIVELLE-DOT | QL=10 patches | 2 |
| \$\$\$ | ESTRATEST | | 2 |
| \$\$\$ | ESTRATEST H.S. | | 2 |
| \$\$\$ | MENOSTAR | QL=5 patches | 3 |
| 13.4.1 ESTROGEN/PROGESTIN COMBINATIONS | | | |
| \$\$ | ACTIVELLA | | 3 |
| \$\$ | FEMHRT | | 2 |
| \$\$ | ORTHO-PREFEST | | 3 |
| \$\$ | PREMPHASE | | 2 |
| \$\$\$ | ANGELIQ | | 3 |
| \$\$\$ | COMBIPATCH | | 2 |
| \$\$\$ | PREMPRO | | 2 |
| 13.4.3 SELECTIVE ESTROGEN RECEPTOR MODULATOR | | | |
| \$\$\$\$ | EVISTA | | 2 |
| 13.5 PROGESTIN DRUGS | | | |
| \$ | medroxyprogesterone acetate | | 1 |
| \$ | norethindrone acetate | | 1 |
| \$\$ | CRINONE | PAR - 8% only | 2 |
| \$\$ | DEPO-PROVERA | | 2 |
| \$\$ | ENDOMETRIN | PAR | 3 |
| \$\$ | PROCHIEVE | PAR | 2 |
| \$\$ | PROMETRIUM | | 2 |
| 13.7 CONTRACEPTIVES | | | |
| PROGESTIN ONLY | | | |
| \$ | errin | | 1 |
| \$ | camila | | 1 |
| \$ | nora-be | | 1 |
| MONO-PHASIC | | | |
| \$ | apri | | 1 |
| \$ | aviane | | 1 |

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QL = Quantity Limit per Fill
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| DRUG NAME | | COMMENTS | TIER |
|--|-------------------------------------|------------------------------|------|
| \$ | cryselle | | 1 |
| \$ | lessina | | 1 |
| \$ | levora | | 1 |
| \$ | low-ogestrel | | 1 |
| \$ | mononessa | | 1 |
| \$ | necon .5/35, 1/35, 1/50 | | 1 |
| \$ | nortrel .5/35, 1/35 | | 1 |
| \$ | ogestrel | | 1 |
| \$ | portia | | 1 |
| \$ | sprintec | | 1 |
| \$ | zovia 1/50 | | 1 |
| \$\$ | DESOGEN | | 3 |
| \$\$ | LEVLEN | | 2 |
| \$\$ | LOESTRIN | | 3 |
| \$\$ | LOESTRIN FE | | 3 |
| \$\$ | LO/OVRAL | | 3 |
| \$\$ | ORTHO-CYCLEN | | 2 |
| \$\$ | ORTHO-NOVUM 1/35, 1/50 | | 2 |
| \$\$ | SEASONALE | one dispenser = 3 copayments | 3 |
| \$\$ | SEASONIQUE | one dispenser = 3 copayments | 3 |
| \$\$ | YASMIN 28 | | 2 |
| \$\$ | YAZ | | 2 |
| \$\$\$ | LYBREL | | 3 |
| BI-PHASIC | | | |
| \$ | kariva | | 1 |
| \$\$ | MIRCETTE | | 3 |
| TRI-PHASIC | | | |
| \$ | enpresse | | 1 |
| \$ | necon 7/7/7 | | 1 |
| \$ | nortrel 7/7/7 | | 1 |
| \$ | tri-sprintec | | 1 |
| \$ | trivora | | 1 |
| \$\$ | CYCLESSA | | 3 |
| \$\$ | ESTROSTEP FE | | 2 |
| \$\$ | ORTHO TRI-CYCLEN | | 2 |
| \$\$ | ORTHO TRI-CYCLEN LO | | 2 |
| \$\$ | ORTHO-NOVUM 7/7/7 | | 2 |
| \$\$ | TRI-NORINYL | | 3 |
| \$\$ | TRI-LEVLEN | | 2 |
| OTHER CONTRACEPTIVES | | | |
| \$\$ | NUVARING | | 2 |
| \$\$ | ORTHO EVRA | | 2 |
| CHAPTER 14: OPHTHALMIC MEDICATIONS | | | |
| 14.1.1 OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS | | | |
| \$ | erythromycin | | 1 |
| \$ | gentamicin ophth | | 1 |
| \$ | polymyxin b sul/trimethoprim | | 1 |
| \$ | sulfacetamide sodium | | 1 |

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Tier 3 = Non-Preferred Brand Drug

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| DRUG NAME | | COMMENTS | TIER |
|--|--------------------------------------|----------|------|
| \$ | tobramycin sulfate | | 1 |
| \$\$ | ofloxacin ophth | | 1 |
| \$\$\$ | BESIVANCE | | 3 |
| \$\$\$ | CILOXAN | | 2 |
| \$\$\$ | IQUIX | | 3 |
| \$\$\$ | QUIXIN | | 3 |
| \$\$\$\$ | VIGAMOX | | 2 |
| \$\$\$\$ | ZYMAR | | 2 |
| \$\$\$\$\$ | AZASITE | | 3 |
| 14.2 OPHTHALMIC CORTICOSTEROID DRUGS | | | |
| \$ | prednisolone | | 1 |
| \$ | fluorometholone | | 1 |
| \$\$\$ | ALREX | | 3 |
| \$\$\$ | LOTEMAX | | 2 |
| \$\$\$ | VEXOL | | 2 |
| 14.3 OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS | | | |
| \$ | neomycin/bacitracin/poly/hc | | 1 |
| \$ | neomycin/polymyxin/dexameth | | 1 |
| \$ | neomycin/polymyxin/hc | | 1 |
| \$\$ | TOBRADEX | | 2 |
| \$\$ | ZYLET | | 3 |
| \$\$\$ | PRED-G | | 3 |
| 14.5 ANTIGLAUCOMA DRUGS | | | |
| \$ | apraclonidine | | 1 |
| \$ | brimonidine | | 1 |
| \$ | levobunolol | | 1 |
| \$ | metipranolol | | 1 |
| \$ | pilocarpine | | 1 |
| \$ | timolol | | 1 |
| \$\$\$ | BETIMOL | | 3 |
| \$\$\$ | TRUSOPT | | 2 |
| \$\$\$\$ | AZOPT | | 2 |
| \$\$\$\$ | TRAVATAN | | 2 |
| \$\$\$\$ | XALATAN | | 2 |
| \$\$\$\$\$ | ALPHAGAN P | | 2 |
| \$\$\$\$\$ | COSOPT | | 2 |
| \$\$\$\$\$ | LUMIGAN | | 2 |
| 14.6 OTHER OPHTHALMIC DRUGS | | | |
| \$ | cromolyn | | 1 |
| \$ | diclofenac sodium 0.1% | | 1 |
| \$\$\$ | VOLTAREN 0.1% | | 2 |
| \$\$\$\$ | BEPREVE | | 2 |
| \$\$\$\$ | ALAMAST | | 3 |
| \$\$\$\$ | ALOMIDE | | 3 |
| \$\$\$\$ | EMADINE | | 3 |
| \$\$\$\$ | ketorolac ophthalmic solution | | 1 |
| \$\$\$\$ | OPTIVAR | | 3 |
| \$\$\$\$\$ | ALOCRIIL | | 2 |

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

QL = Quantity Limit per Fill
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 STB = Split the Bill

| DRUG NAME | | COMMENTS | TIER |
|---|-----------------------------|---|------|
| \$\$\$\$ | NEVANAC | | 3 |
| \$\$\$\$ | PATADAY | | 2 |
| \$\$\$\$ | PATANOL | | 2 |
| \$\$\$\$ | XIBROM | | 3 |
| !!!! | BOTOX | see Chapter 19, Specialty Products | |
| !!!! | 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 |
| \$\$ | levalbuterol 1.25 mg/0.5 mL | PAR | 1 |
| \$\$\$\$ | PROAIR HFA | QL=4 inhalers | 3 |
| \$\$\$\$ | PROVENTIL HFA | QL=4 inhalers | 3 |
| \$\$\$\$ | VENTOLIN HFA | QL=4 inhalers | 2 |
| \$\$\$\$ | XOPENEX SOLUTION | PAR | 2 |
| !!!! | BROVANA | QL=60 inhalations | 3 |
| !!!! | FORADIL | box of 12: QL=1; box of 18: QL=2; box of 60: QL=1 | 2 |
| !!!! | MAXAIR AUTOHALER | QL=4 inhalers | 3 |
| !!!! | PERFOROMIST | | 2 |
| !!!! | SEREVENT DISKUS | QL=120 blisters | 2 |
| !!!! | XOPENEX HFA | PAR / QL=4 inhalers | 2 |
| 15.1.2 METHYL XANTHINE DRUGS | | | |
| \$ | theophylline anhydrous | | 1 |
| 15.1.3 OTHER DRUGS FOR ASTHMA | | | |
| \$ | ipratropium | | 1 |
| \$\$ | EPINEPHRINE KIT | | 2 |
| \$\$ | EPIPEN | syringes: QL=3; kits: QL=2 | 2 |
| \$\$ | EPIPEN JR | syringes: QL=3; kits: QL=2 | 2 |
| \$\$ | QVAR | QL=4 inhalers | 3 |
| \$\$\$ | AEROBID | QL=4 inhalers | 3 |
| \$\$\$ | AEROBID-M | QL=4 inhalers | 3 |
| \$\$\$ | ASMANEX | QL=120 inhalations | 2 |
| \$\$\$ | AZMACORT | QL=4 inhalers | 3 |
| \$\$\$ | DUONEB | QL=205 vials | 2 |
| \$\$\$\$ | FLOVENT DISKUS | QL=2 inhalers | 2 |
| \$\$\$\$ | FLOVENT HFA | QL=4 inhalers | 2 |
| \$\$\$\$ | SPIRIVA | | 2 |
| \$\$\$\$ | ATROVENT HFA | QL=4 inhalers | 2 |
| \$\$\$\$ | PULMICORT MDI | QL=4 inhalers | 3 |
| \$\$\$\$ | PULMICORT RESPULES | restricted to patients less than four years old | 2 |
| \$\$\$\$ | SYMBICORT | requires trial of asthma controller medication, QL=4 inhalers | 2 |
| \$\$\$\$ | TILADE | QL=4 inhalers | 2 |
| !!!! | ADVAIR | requires trial of asthma controller medication, QL=4 inhalers | 2 |
| !!!! | ALVESCO | QL=2 inhalers | 3 |
| !!!! | COMBIVENT | QL=4 inhalers | 2 |
| !!!! | INTAL | QL=4 inhalers | 2 |
| 15.1.4 LEUKOTRIENE MODIFIERS | | | |
| \$\$\$\$ | ACCOLATE | requires trial of nasal spray AND antihistamine when used | 3 |

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| DRUG NAME | | COMMENTS | TIER |
|---|-------------------------|---|------|
| | | for allergic rhinitis | |
| \$\$\$\$ | SINGULAIR | requires trial of nasal spray AND antihistamine when used for allergic rhinitis | 2 |
| \$\$\$\$ | 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 | | | |
| \$ | cyproheptadine | | 1 |
| \$ | fexofenadine | | 1 |
| \$ | promethazine | | 1 |
| \$\$\$\$ | CLARINEX | | 3 |
| \$\$\$\$ | XYZAL | | 3 |
| 15.2.3 ANTIHISTAMINE/DECONGESTANT COMBINATIONS | | | |
| \$ | promethazine vc | | 1 |
| \$\$\$ | RYNATAN | | 3 |
| \$\$\$ | SEMPREX-D | | 3 |
| \$\$\$\$ | ALLEGRA-D | QL=68 tablets | 3 |
| 15.3 ANTITUSSIVE AND EXPECTORANT DRUGS | | | |
| \$ | benzonatate | | 1 |
| \$ | cheratussin | | 1 |
| \$ | guaifenesin | | 1 |
| \$ | guaifenesin/codeine | | 1 |
| \$ | guaifenex pse | | 1 |
| \$ | hydrocodone/guaifenesin | | 1 |
| \$ | promethazine/codeine | | 1 |
| \$ | promethazine/dm | | 1 |
| \$\$\$\$ | TUSSIONEX | | 2 |
| 15.4 OTHER RESPIRATORY DRUGS | | | |
| !!!! | ARALAST | see Chapter 19, Specialty Products | |
| !!!! | 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 | | | |
| \$ | oxybutynin chloride | | 1 |
| \$\$\$ | OXYTROL | requires trial of immediate release oxybutynin | 2 |
| \$\$\$\$ | DETROL | requires trial of immediate release oxybutynin | 2 |
| \$\$\$\$ | DETROL LA | requires trial of immediate release oxybutynin | 2 |
| \$\$\$\$ | 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 |
| \$\$\$\$ | 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 |
| \$\$\$\$ | VESICARE | requires trial of immediate release oxybutynin | 3 |
| 16.1.3 URINARY ANESTHETICS | | | |
| \$ | phenazopyridine hcl | | 1 |
| 16.1.4 OTHER GENITOURINARY PRODUCTS | | | |

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| DRUG NAME | | COMMENTS | TIER |
|---|-------------------------------------|---|------|
| | finasteride 1mg | excluded | |
| \$\$ | finasteride 5mg | | 1 |
| \$\$ | tamsulosin | | 1 |
| \$\$\$ | CARDURA XL | requires trial of terazosin, doxazosin, or tamsulosin | 3 |
| \$\$\$ | RAPAFLO | requires trial of terazosin, doxazosin, or tamsulosin | 3 |
| \$\$\$ | UROXATRAL | requires trial of terazosin, doxazosin, or tamsulosin | 2 |
| \$\$\$\$ | AVODART | | 3 |
| 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 | |
| !!!! | THALOMID | see Chapter 19, Specialty Products | |
| CHAPTER 18: MEDICAL (MISCELLANEOUS) SUPPLIES | | | |
| 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 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 INSTANT TEST STRIPS | | 2 |
| \$\$\$ | ACCU-CHEK SIMPLICITY TEST STRIPS | | 2 |
| \$\$\$ | ONETOUCH BASIC 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 |
| \$\$\$\$ | ACCU-CHEK COMPLETE METER | | 2 |
| \$\$\$\$ | ONETOUCH FASTTAKE TEST STRIPS | | 2 |
| \$\$\$\$ | ONETOUCH PROFILE SYSTEM KIT | | 2 |
| \$\$\$\$ | ONETOUCH ULTRASMART METER | | 2 |
| !!!! | ACCU-CHEK AVIVA METER | | 2 |
| !!!! | ACCU-CHEK VOICEMATE METER | | 2 |
| !!!! | ONETOUCH FASTTAKE METER | | 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 1-800-323-2445. | | | | |
| 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 | |
| !!!! | 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 | |
| !!!! | VIREAD (tenofovir disoproxil fumarate) | not restricted to Caremark | X | |
| 2.5.2 OTHER ANTIVIRAL DRUGS | | | | |
| \$\$\$\$ | ribavirin capsules/tablets | | X | |
| \$\$\$\$ | REBETOL soln (ribavirin) | | X | |
| !!!! | ganciclovir inj | not restricted to Caremark | X | |
| !!!! | VIRAZOLE (ribavirin inhalation solution) | not restricted to Caremark | X | |
| 2.8 OTHER ANTIINFECTIVE DRUGS | | | | |
| !!!! | ZYVOX (linezolid) | not restricted to Caremark | X | |
| 2.8.2 AMINOGLYCOSIDES | | | | |
| !!!! | TOBI (tobramycin) | QL=56 ampules / not restricted to Caremark | X | |
| 3.1 DRUGS FOR THE TREATMENT OF CANCER | | | | |
| !!!! | AFINITOR (everolimus) | | X | |
| !!!! | CAMPATH (alemtuzumab) | | X | |
| !!!! | CAMPTOSAR (irinotecan hcl) | | X | |
| !!!! | ELLENCE (epirubicin hcl) | | X | |
| !!!! | 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 | |
| !!!! | SPRYCEL (dasatinib) | | X | |
| !!!! | SUTENT (sunitinib malate) | | X | |
| !!!! | TARCEVA (erlotinib) | | 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 |
|---|--|---|-----------|---------------|
| !!!! | 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 | |
| !!!! | 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 |
| 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 | | | | |

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

| | | | Preferred | Non-Preferred |
|---|-------------------------------------|----------------------------------|-----------|---------------|
| DRUG NAME | | COMMENTS | | |
| \$\$\$\$ | REBIF (interferon beta-1a) | SA / QL=15 syringes | 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 | |
| 6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS | | | | |
| !!!! | SORIATANE (acitretin) | not restricted to Caremark | X | |
| 8.6 OTHER ENDOCRINE DRUGS | | | | |
| !!!! | ALDURAZYME (Iaronidase) | | X | |
| !!!! | ELAPRASE (idursulfase) | | X | |
| !!!! | FABRAZYME (agalsidase beta) | | X | |
| !!!! | FORTEO (teriparatide [rDNA origin]) | SA | X | |
| !!!! | KUVAN (sapropterin dihydrochloride) | PAR | X | |
| !!!! | MYOZYME (alglucosidase alfa) | | X | |
| !!!! | NAGLAZYME (galsulfase) | | X | |
| !!!! | pamidronate disodium | not restricted to Caremark | X | |
| !!!! | RECLAST (zoledronic acid) | | | X |
| !!!! | SAMSCA (tolvaptan) | PAR / not restricted to Caremark | | X |
| !!!! | SOMAVERT (pegvisomant) | | X | |
| !!!! | 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 |
| !!!! | SOLIRIS | | 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 | | | | |
| \$\$\$ | INFERGEN (interferon alfacon-1) | SA / QL=12 | X | |
| \$\$\$ | ROFERON-A (interferon alfa-2a) | | | X |
| \$\$\$\$ | EXTAVIA (interferon beta-1b) | SA | | X |
| \$\$\$\$ | INTRON A (interferon alfa-2b) | SA | X | |
| \$\$\$\$ | PEGASYS (peginterferon alfa-2a) | SA | X | |
| \$\$\$\$ | PEG-INTRON (peginterferon alfa-2b) | SA | X | |

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| | DRUG NAME | COMMENTS | Preferred | Non-Preferred |
|---|---|----------------------------|-----------|---------------|
| !!!! | ACTIMMUNE (interferon gamma-1b) | SA | X | |
| !!!! | ALFERON N (interferon alfa-n3) | | X | |
| !!!! | REBETRON (interferon alfa-2b/ribavirin) | QL=2 packs | X | |
| 10.2.4 GROWTH HORMONES AND RELATED DRUGS | | | | |
| \$\$\$\$ | GENOTROPIN MINIQUICK (somatropin [rDNA origin]) | SA / PAR | X | |
| \$\$\$\$ | NORDITROPIN (somatropin [rDNA origin]) | SA / PAR | | X |
| \$\$\$\$ | NORDITROPIN NORDIFLEX (somatropin [rDNA origin]) | SA / PAR | | X |
| \$\$\$\$ | OMNITROPE (somatropin [rDNA origin]) | SA / PAR | | X |
| \$\$\$\$ | SAIZEN (somatropin [rDNA origin]) | SA / PAR | | X |
| \$\$\$\$ | TEV-TROPIN (somatropin [rDNA origin]) | SA / PAR | | X |
| \$\$\$\$ | ZORBTIVE (somatropin [rDNA origin]) | SA / PAR | | X |
| \$\$\$\$\$ | GENOTROPIN (somatropin [rDNA origin]) | SA / PAR | X | |
| \$\$\$\$\$ | HUMATROPE (somatropin [rDNA origin]) | SA / PAR | | X |
| \$\$\$\$\$ | NUTROPIN (somatropin [rDNA origin]) | SA / PAR | X | |
| !!!! | NUTROPIN AQ (somatropin [rDNA origin]) | SA / PAR | X | |
| !!!! | SEROSTIM (somatropin [rDNA origin]) | SA / PAR | | X |
| 10.2.4.1 INSULIN LIKE GROWTH FACTORS-1 | | | | |
| \$\$\$\$\$ | IPLEX (mecasermin rinfabate [rDNA origin]) | not restricted to Caremark | X | |
| !!!! | INCRELEX (mecasermin [rDNA origin]) | | X | |
| 10.2.5 INTERLEUKINS | | | | |
| !!!! | NEUMEGA (oprelvekin) | SA / QL=21 vials | X | |
| !!!! | PROLEUKIN (aldesleukin) | PAR | X | |
| !!!! | ZENAPAX (daclizumab) | not restricted to Caremark | X | |
| 10.2.6 INTERLEUKIN RECEPTOR ANTAGONISTS | | | | |
| !!!! | ARCALYST (rilonacept) | SA / PAR | | X |
| !!!! | iLARIS (canakinumab) | PAR | X | |
| !!!! | KINERET (anakinra) | SA / PAR | X | |
| 10.2.7 IMMUNOGLOBULIN ANTIBODIES | | | | |
| !!!! | XOLAIR (omalizumab) | PAR | X | |
| 10.2.9.1 C1 ESTERASE INHIBITORS | | | | |
| !!!! | CINRYZE (esterase inhibitor) | PAR | X | |
| 10.2.11 THROMBOPOIETIC AGENTS | | | | |
| !!!! | NPLATE (romiplostim) | PAR | X | |
| !!!! | PROMACTA (eltrombopag olamine) | PAR | X | |
| 10.3 HEMATOPOIETIC AGENTS | | | | |
| !!!! | MOZOBIL (plerixafor) | | X | |
| 11.3.1 DIRECT MUSCLE RELAXANTS | | | | |
| !!!! | DYSPORT (abobotulinumtoxina) | PAR | | X |
| !!!! | MYOBLOC (botulinum toxin type b) | | X | |
| 12.5 HEMOSTATICS | | | | |
| !!!! | ADVATE (antihemophilic factor [recombinant]) | | X | |
| !!!! | ALPHANATE (antihemophilic factor [human]) | | X | |
| !!!! | BENEFIX (coagulation factor IX [recombinant]) | | X | |
| !!!! | FEIBA VH (anti-inhibitor coagulant complex) | | X | |
| !!!! | HELIXATE FS (antihemophilic factor [recombinant]) | | 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 |
|--|--|----------------------------|-----------|---------------|
| !!!! | 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 | |
| !!!! | RECOMBIMATE (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 | |
| !!!! | VIADUR (leuprolide acetate implant) | | 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 | |
| !!!! | THALOMID (thalidomide) | | X | |

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

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