

Blue Shield Medicare Enhanced Plan (PDP)

2013 Formulary

(List of Covered Drugs)

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

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

This document includes Blue Shield Medicare Enhanced Plan (PDP) **partial formulary** as of January 1, 2013. For a complete, updated formulary, please visit our Web site at blueshieldca.com/med_formulary or call Member Services at (888) 239-6469, 7:00 a.m. - 8:00 p.m. seven days a week from October 1 through February 14. However, after February 14 your call will be handled by our automated phone system on weekends and holidays. TTY/TDD users should call (888) 239-6482.

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2014.

A Medicare-approved Part D sponsor.

This information is available for free in other languages. Please contact Member Services at (888) 239-6469 [TTY: (888) 239-6482] 7 a.m. to 8 p.m., seven days a week, from October 1 through February 14 for additional information. However, after February 14 your call will be handled by our automated phone system on weekends and holidays..

Esta información está disponible gratis en otros idiomas. Comuníquese con nuestro Servicio para Miembros al (888) 239-6469 [TTY (888) 239-6482] de 7 a.m. a 8 p.m., los siete días de la semana, desde el 1 de octubre hasta el 14 de febrero. Sin embargo, después del 14 de febrero, nuestro sistema telefónico automático atenderá su llamada durante los fines de semana y los días feriados.

What is the Blue Shield Medicare Enhanced Plan (PDP) Formulary?

A formulary is a list of covered drugs selected by Blue Shield Medicare Enhanced Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Blue Shield Medicare Enhanced Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Blue Shield Medicare Enhanced Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Blue Shield Medicare Enhanced Plan. For a complete listing of all prescription drugs covered by Blue Shield Medicare Enhanced Plan, please visit our Web site at blueshieldca.com/med_formulary or call Member Services at (888) 239-6469, 7:00 a.m. - 8:00 p.m. seven days a week from October 1 through February 14. However, after February 14 your call will be handled by our automated phone system on weekends and holidays. TTY/TDD users should call (888) 239-6482.

Can the Formulary change?

Generally, if you are taking a drug on our 2013 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2013 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. You may use this written notification as an update to your printed formulary. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of **January 1, 2013**. To get updated information about the drugs covered by Blue Shield Medicare Enhanced Plan, please visit our Web site at blueshieldca.com/med_formulary or call Member Services at (888) 239-6469, 7:00 a.m. - 8:00 p.m. seven days a week from October 1 through February 14. However, after February 14 your call will be handled by our automated phone system on weekends and holidays. TTY/TDD users should call (888) 239-6482.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart

condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 12. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Blue Shield Medicare Enhanced Plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Blue Shield Medicare Enhanced Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Blue Shield Medicare Enhanced Plan before you fill your prescriptions. If you don’t get approval, Blue Shield Medicare Enhanced Plan may not cover the drug.
- **Quantity Limits:** For certain drugs, Blue Shield Medicare Enhanced Plan limits the amount of the drug that Blue Shield Medicare Enhanced Plan will cover. For example, Blue Shield Medicare Enhanced Plan provides 18 tablets per 30 days for *sumatriptan* (IMITREX). This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, Blue Shield Medicare Enhanced Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Blue Shield Medicare Enhanced Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Blue Shield Medicare Enhanced Plan will then cover Drug B.

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

You can ask Blue Shield Medicare Enhanced Plan to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Blue Shield Medicare Enhanced Plan formulary?” on page iii for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this list of covered drugs, you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so Blue Shield Medicare Enhanced Plan may cover your drug. You can contact Member Services at (888) 239-6469, 7:00 a.m. - 8:00 p.m. seven days a week from October 1 through February 14. However, after February 14 your call will be handled by our automated phone system on weekends and holidays. TTY/TDD users should call (888) 239-6482.

If you learn that Blue Shield Medicare Enhanced Plan does not cover your drug, you have two options:

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

How do I request an exception to the Blue Shield Medicare Enhanced Plan Formulary?

You can ask Blue Shield Medicare Enhanced Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Blue Shield Medicare Enhanced Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Non-Preferred Brand Drugs tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand Drugs tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Tier Drugs tier.

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

You should contact us to ask us for an initial coverage decision for a formulary, tiering, or utilization restriction exception. **When you are requesting a formulary, tiering, or utilization restriction exception you should submit a statement from your prescriber's or physician supporting your request.**

Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could

be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber's or prescribing physician's supporting statement.

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

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

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

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

Our transition policy applies to the member categories listed below whom are stabilized on:

- Medicare Part D drugs not on the formulary
- Medicare Part D drugs on the formulary with a prior authorization, step therapy or quantity limit requirement, or
- Medicare Part D drugs as listed above, where a distinction cannot be made at point of service whether it is a new or ongoing prescription drug

And are members in any of the following scenarios:

- new members at the beginning of a contract year,
- newly eligible members transitioning from other coverage at the beginning of a contract year,
- transitioning individuals who switch from one plan to another after the beginning of a contract year,
- enrollees residing in long-term care (LTC) facilities, or
- in some cases, current enrollees affected by formulary changes from one contract year to the next

For more information

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

If you have questions about Blue Shield Medicare Enhanced Plan, please call Member Services at (888) 239-6469, 7:00 a.m. - 8:00 p.m. seven days a week from October 1 through February 14. However, after February 14 your call will be handled by our automated phone system on weekends and holidays. TTY users should call (888) 239-6482. Or visit www.blueshieldca.com/findamedicareplan.

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

Blue Shield Medicare Enhanced Plan Formulary

The abridged formulary that begins on page 1 provides coverage information about some of the drugs covered by Blue Shield Medicare Enhanced Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 12. Remember: This is only a partial list of drugs covered by Blue Shield Medicare Enhanced Plan. If your prescription is not in this partial formulary, please visit our Web site at blueshieldca.com/med_formulary or call Member Services at (888) 239-6469, 7:00 a.m. - 8:00 p.m. seven days a week from October 1 through February 14. However, after February 14 your call will be handled by our automated phone system on weekends and holidays. TTY users should call (888) 239-6482 for additional help.

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

The information in the Requirements/Limits column tells you if Blue Shield Medicare Enhanced Plan has any special requirements for coverage of your drug.

Key to Formulary Abbreviations

Drug Tiers

Tier	Supply	Blue Shield Medicare Enhanced Plan
1 Preferred Generic Drugs	Network Preferred or Other Network Pharmacy or Out-of-Network Pharmacy (30-day supply)	\$5 Copay
	Network Preferred or Mail Service Pharmacy (90-day supply)	\$10 Copay
	Other Network Pharmacy (90-day supply)	\$15 Copay
	Network Long-Term Care Pharmacy (31-day supply)	\$5 Copay
2 Preferred Brand Drugs	Network Preferred or Other Network Pharmacy or Out-of-Network Pharmacy (30-day supply)	\$45 Copay
	Network Preferred or Mail Service Pharmacy (90-day supply)	\$90 Copay
	Other Network Pharmacy (90-day supply)	\$135 Copay
	Network Long-Term Care Pharmacy (31-day supply)	\$45 Copay
3 Non- Preferred Brand Drugs	Network Preferred or Other Network Pharmacy or Out-of-Network Pharmacy (30-day supply)	\$90 Copay
	Network Preferred or Mail Service Pharmacy (90-day supply)	\$180 Copay
	Other Network Pharmacy (90-day supply)	\$270 Copay
	Network Long-Term Care Pharmacy (31-day supply)	\$90 Copay

Tier	Supply	Blue Shield Medicare Enhanced Plan
4 Injectable Drugs	Network Preferred or Other Network Pharmacy (30-day supply)	25% of Blue Shield's contracted rate
	Network Preferred or Other Network Pharmacy or Mail Service Pharmacy (90-day supply)	25% of Blue Shield's contracted rate
	Out-of-Network Pharmacy (30-day supply)	25% of the submitted cost
	Network Long-Term Care Pharmacy (31-day supply)	25% of Blue Shield's contracted rate
5 Specialty Tier Drugs	Network Preferred or Other Network Pharmacy (30-day supply)	33% of Blue Shield's contracted rate
	Network Preferred or Other Network Pharmacy or Mail Service Pharmacy (90-day supply)	33% of Blue Shield's contracted rate
	Out-of-Network Pharmacy (30-day supply)	33% of the submitted cost
	Network Long-Term Care Pharmacy (31-day supply)	33% of Blue Shield's contracted rate

Requirements/Limit Codes

<i>Code</i>	<i>Definition</i>
AG	This prescription drug has coverage limits based on age groups. The limits may be based upon how the U.S. Food and Drug Administration (FDA) approved the drug for use or special cautions for use by people in certain age groups. For new prescriptions, discuss alternatives with your physician. Your pharmacy or physician may call Blue Shield for assistance with coverage for ongoing use.
B/D	This prescription drug requires prior authorization review to determine whether coverage is under Part B or Part D of the Medicare benefit, based on Medicare coverage rules. Call Blue Shield to provide the necessary information to determine coverage.
ED	This prescription drug is not normally covered in a Medicare Prescription Drug Plan; however, Blue Shield covers this drug as a supplemental benefit. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help from Medicare or Social Security to pay for your prescriptions, you will not get any extra help to pay for this drug.
LA	This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at (888) 239-6469, seven days a week, 7:00 a.m. - 8:00 p.m. TTY/TDD users should call (888) 239-6482.
QL	This medication has a dosing or prescription quantity limit. Maximum daily dose limits are defined by the FDA and listed in the drug package insert. Other quantity limits encourage consolidated dosing when possible.
PA	Coverage for this prescription requires prior authorization from Blue Shield. Call Blue Shield to provide the necessary information to determine coverage.
ST	Coverage for this prescription is provided when other first-line or preferred drug therapies have been tried (step therapy).
†	Medication is NOT available through Blue Shield's mail service pharmacy.

Form Codes

<i>Abbreviation</i>	<i>Definition</i>
AERS	Aerosol
CAPS	Capsule
CHEW	Chewable
CONC	Concentrate
CP24	Capsule - Extended Release 24-hour
CPDR	Capsule - Delayed-Release
CREA	Cream
ELIX	Elixir
FOAM	Foam
GEL	Gel
LOTN	Lotion
OIL	Oil
OINT	Ointment

<i>Abbreviation</i>	<i>Definition</i>
PACK	Pack
PTTW	Patch - Biweekly
PTWK	Patch - Weekly
SOLN	Solution
SOLR	Solution - Reconstituted
SUSP	Suspension
SUSR	Suspension - Reconstituted
SYRP	Syrup
TABS	Tablet
TB24	Tablet - Extended Release 24-hour
TBDP	Tablet - Dispersible
TBEC	Tablet - Enteric Coated
TBEF	Tablet - Effervescent

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Analgesics		
<i>butalbital/acetaminophen/cafeine</i>	1	QL (180 EA per 30 days) ED †
<i>butalbital/acetaminophen/cafeine/codeine</i>	1	QL (180 EA per 30 days) †
Nonsteroidal Anti-inflammatory Drugs		
<i>naproxen sodium</i>	1	
<i>oxycodone/ibuprofen</i>	1	QL (120 EA per 30 days)
Opioid Analgesics, Long-acting		
<i>methadone hcl tabs 5mg</i>	1	QL (1080 EA per 30 days) †
<i>methadone hcl tabs 10mg</i>	1	QL (540 EA per 30 days) †
<i>morphine sulfate er tb12 60mg</i>	1	QL (135 EA per 30 days) †
<i>morphine sulfate er tb12 15mg, 30mg</i>	1	QL (180 EA per 30 days) †
<i>morphine sulfate er tb12 100mg, 200mg</i>	1	QL (90 EA per 30 days) †
OXYCONTIN TB12 80MG	2	QL (120 EA per 30 days) †
OXYCONTIN TB12 15MG, 20MG, 30MG	2	QL (180 EA per 30 days) †
OXYCONTIN TB12 10MG	2	QL (270 EA per 30 days) †
OXYCONTIN TB12 60MG	2	QL (60 EA per 30 days) †
OXYCONTIN TB12 40MG	2	QL (90 EA per 30 days) †
Opioid Analgesics, Short-acting		
<i>acetaminophen/codeine tabs 300mg; 60mg</i>	1	QL (180 EA per 30 days) †
<i>acetaminophen/codeine tabs 300mg; 15mg</i>	1	QL (390 EA per 30 days) †
<i>hydrocodone/acetaminophen tabs 750mg; 7.5mg</i>	1	QL (150 EA per 30 days) †
<i>hydrocodone/acetaminophen tabs 650mg; 10mg, 650mg; 7.5mg, 660mg; 10mg</i>	1	QL (180 EA per 30 days) †
<i>hydrocodone/acetaminophen tabs 500mg; 2.5mg, 500mg; 5mg, 500mg; 7.5mg</i>	1	QL (240 EA per 30 days) †
<i>hydrocodone/acetaminophen tabs 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	QL (360 EA per 30 days) †
<i>hydromorphone hcl tabs 2mg</i>	1	QL (1800 EA per 30 days) †

Drug Name	Drug Tier	Requirements/Limits
<i>hydromorphone hcl tabs 8mg</i>	1	QL (450 EA per 30 days) †
<i>hydromorphone hcl tabs 4mg</i>	1	QL (900 EA per 30 days) †
<i>oxycodone hcl caps</i>	1	QL (360 EA per 30 days) †
<i>oxycodone hcl tabs 30mg, 5mg</i>	1	QL (360 EA per 30 days) †
<i>oxycodone hcl tabs 15mg</i>	1	QL (720 EA per 30 days) †
<i>oxycodone/acetaminophen caps</i>	1	QL (240 EA per 30 days) †
<i>oxycodone/acetaminophen tabs 650mg; 10mg</i>	1	QL (180 EA per 30 days) †
<i>oxycodone/acetaminophen tabs 500mg; 7.5mg</i>	1	QL (240 EA per 30 days) †
<i>oxycodone/acetaminophen tabs 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	QL (360 EA per 30 days) †
<i>tramadol hcl</i>	1	
Anesthetics		
Local Anesthetics		
<i>lidocaine viscous</i>	1	
LIDODERM	3	QL (90 EA per 30 days)
Anti-Addiction/Substance Abuse Treatment Agents		
Alcohol Deterrents/Anti-craving		
<i>disulfiram</i>	1	
<i>naltrexone hcl</i>	1	
Opioid Antagonists		
<i>buprenorphine hcl subl 8mg</i>	2	QL (120 EA per 30 days) PA
<i>buprenorphine hcl subl 2mg</i>	2	QL (480 EA per 30 days) PA
SUBOXONE SUBL 8MG; 2MG	3	QL (120 EA per 30 days) PA
SUBOXONE SUBL 2MG; 0.5MG	3	QL (480 EA per 30 days) PA
Smoking Cessation Agents		
<i>buproban</i>	1	QL (60 EA per 30 days)
NICOTROL NS	2	
Anti-inflammatory Agents		
Nonsteroidal Anti-inflammatory Drugs		
CELEBREX	3	QL (60 EA per 30 days) PA
<i>diclofenac sodium dr</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>ibuprofen</i>	1	
<i>meloxicam</i>	1	
<i>naproxen</i>	1	
Antibacterials		
Aminoglycosides		
<i>neomycin sulfate</i>	1	†
<i>tobramycin sulfate soln</i>	1	†
Antibacterials, Other		
<i>clindamycin hcl</i>	1	†
METROGEL	2	†
<i>metronidazole caps, tabs</i>	1	†
<i>mupirocin</i>	1	†
<i>neomycin/polymyxin/hydrocortisone</i>	1	†
Beta-lactam, Cephalosporins		
<i>cefuroxime axetil</i>	1	†
<i>cephalexin caps, susr</i>	1	†
Beta-lactam, Other		
CAYSTON	5	QL (84 ML per 30 days) PA †
INVANZ	4	B/D †
Beta-lactam, Penicillins		
<i>amoxicillin</i>	1	†
<i>amoxicillin/clavulanate potassium tabs</i>	1	†
<i>amoxicillin/potassium clavulanate</i>	1	†
Macrolides		
<i>azithromycin susr</i>	1	
<i>azithromycin tabs 500mg</i>	1	QL (3 EA per 3 days) †
<i>azithromycin tabs 250mg</i>	1	QL (6 EA per 5 days) †
<i>azithromycin tabs 600mg</i>	1	QL (8 EA per 30 days) †
<i>erythromycin cpep, gel, soln</i>	1	†
Quinolones		
<i>ciprofloxacin hcl tabs</i>	1	†
<i>levofloxacin soln</i>	1	†
<i>levofloxacin tabs</i>	1	QL (10 EA per 10 days) †
MOXEZA	2	†
VIGAMOX	2	†
Sulfonamides		
<i>sodium sulfacetamide</i>	1	†
<i>sulfamethoxazole/trimethoprim ds</i>	1	†
<i>sulfamethoxazole/trimethoprim susp, tabs</i>	1	†

Drug Name	Drug Tier	Requirements/Limits
Tetracyclines		
<i>doxycycline hyclate caps, tabs</i>	1	†
<i>doxycycline hyclate tbec 100mg, 75mg</i>	2	†
ORACEA	2	†
Anticonvulsants		
Anticonvulsants, Other		
<i>levetiracetam tabs</i>	1	
<i>phenobarbital tabs</i>	1	PA
Calcium Channel Modifying Agents		
LYRICA CAPS 200MG, 225MG, 300MG	3	QL (60 EA per 30 days) PA
LYRICA CAPS 100MG, 150MG, 25MG, 50MG, 75MG	3	QL (90 EA per 30 days) PA
<i>zonisamide</i>	1	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
<i>divalproex sodium</i>	1	
<i>gabapentin</i>	1	
Glutamate Reducing Agents		
<i>lamotrigine tabs</i>	1	
<i>topiramate</i>	1	PA
Sodium Channel Agents		
<i>carbamazepine chew, tabs</i>	1	
<i>phenytoin</i>	1	
Antidementia Agents		
Cholinesterase Inhibitors		
ARICEPT TABS 23MG	2	QL (30 EA per 30 days) ST
<i>donepezil hcl tabs</i>	1	
EXELON PT24	2	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
NAMENDA TITRATION PAK	2	QL (60 EA per 30 days)
NAMENDA SOLN	2	QL (360 ML per 30 days)
NAMENDA TABS	2	QL (60 EA per 30 days)
Antidepressants		
Antidepressants, Other		
<i>bupropion hcl sr tb12 100mg</i>	1	QL (120 EA per 30 days)
<i>bupropion hcl sr tb12 200mg</i>	1	QL (60 EA per 30 days)
<i>bupropion hcl sr tb12 150mg</i>	1	QL (90 EA per 30 days)
<i>mirtazapine tabs</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>trazodone hcl tabs 100mg, 150mg, 50mg</i>	1	
<i>trazodone hcl tabs 300mg</i>	2	
Monoamine Oxidase Inhibitors		
MARPLAN	2	
<i>phenelzine sulfate</i>	1	
Serotonin/Norepinephrine Reuptake Inhibitors		
<i>citalopram hydrobromide</i>	1	
CYMBALTA CPEP 60MG	2	QL (60 EA per 30 days)
CYMBALTA CPEP 20MG, 30MG	2	QL (90 EA per 30 days)
<i>fluoxetine hcl</i>	1	
<i>paroxetine hcl</i>	1	
<i>sertraline hcl tabs</i>	1	
<i>sertraline hcl conc</i>	2	
<i>venlafaxine hcl er cp24 150mg, 37.5mg</i>	2	QL (60 EA per 30 days)
<i>venlafaxine hcl er cp24 75mg</i>	2	QL (90 EA per 30 days)
VENLAFAXINE HCL ER TB24 225MG	3	QL (30 EA per 30 days)
<i>venlafaxine hcl er tb24 150mg, 37.5mg, 75mg</i>	2	QL (30 EA per 30 days)
Tricyclics		
<i>amitriptyline hcl</i>	1	
<i>imipramine hcl</i>	1	
Antiemetics		
Antiemetics, Other		
ANTIVERT TABS 50MG	3	†
<i>meclizine hcl</i>	1	†
Emetogenic Therapy Adjuncts		
<i>granisetron hcl tabs</i>	2	QL (60 EA per 30 days) PA †
<i>ondansetron hcl tabs 4mg, 8mg</i>	1	QL (90 EA per 30 days) B/D †
Antifungals		
Antifungals		
<i>fluconazole tabs</i>	1	†
<i>ketoconazole tabs</i>	1	†
Antigout Agents		
Antigout Agents		
<i>allopurinol</i>	1	
COLCRYS	2	
ULORIC	2	QL (30 EA per 30 days) ST
Antimigraine Agents		
Abortive		

Drug Name	Drug Tier	Requirements/Limits
<i>butalbital/acetaminophen/caffeine</i>	1	QL (180 EA per 30 days) ED †
<i>margesic</i>	1	QL (180 EA per 30 days) ED †
Ergot Alkaloids		
<i>ergotamine tartrate/caffeine</i>	1	†
<i>migergot</i>	2	†
Serotonin (5-HT) 1b/1d Receptor Agonists		
MAXALT	2	QL (24 EA per 30 days) †
MAXALT-MLT	2	QL (24 EA per 30 days) †
<i>sumatriptan succinate tabs</i>	1	QL (18 EA per 30 days) †
Antimyasthenic Agents		
Parasympathomimetics		
MESTINON TIMESPAN	3	
MESTINON SYRP	3	
<i>pyridostigmine bromide</i>	1	
Antimycobacterials		
Antimycobacterials, Other		
<i>dapsone</i>	1	
MYCOBUTIN	3	
Antituberculars		
<i>ethambutol hcl</i>	1	
<i>rifampin caps</i>	1	
Antineoplastics		
Alkylating Agents		
<i>cyclophosphamide</i>	1	PA
LEUKERAN	2	
Antiangiogenic Agents		
CAPRELSA TABS 300MG	5	QL (30 EA per 30 days) PA †
CAPRELSA TABS 100MG	5	QL (60 EA per 30 days) PA †
REVLIMID CAPS 5MG	5	QL (150 EA per 30 days) PA LA †
REVLIMID CAPS 15MG, 25MG	5	QL (30 EA per 30 days) PA LA †
REVLIMID CAPS 10MG	5	QL (60 EA per 30 days) PA LA †
Antiastrogens/Modifiers		
EMCYT	2	
<i>tamoxifen citrate</i>	1	
Antimetabolites		
<i>hydroxyurea</i>	1	

Drug Name	Drug Tier	Requirements/Limits
TABLOID	2	
Antineoplastics, Other		
leucovorin calcium tabs	1	
MESNEX TABS	2	
Aromatase Inhibitors, 3rd Generation		
anastrozole	1	
letrozole	2	
Enzyme Inhibitors		
etoposide soln	4	B/D †
topotecan hcl	4	B/D †
Molecular Target Inhibitors		
AFINITOR TABS 2.5MG, 5MG	5	QL (30 EA per 30 days) PA †
AFINITOR TABS 10MG, 7.5MG	5	QL (60 EA per 30 days) PA †
SUTENT CAPS 12.5MG	5	QL (210 EA per 30 days) PA †
SUTENT CAPS 50MG	5	QL (30 EA per 30 days) PA †
SUTENT CAPS 25MG	5	QL (90 EA per 30 days) PA †
Monoclonal Antibodies		
ARZERRA	5	PA †
RITUXAN	5	PA †
Retinoids		
TARGRETIN CAPS	5	†
tretinoin caps	5	†
Antiparasitics		
Anthelmintics		
BILTRICIDE	2	
STROMECTOL	3	
Antiprotozoals		
hydroxychloroquine sulfate	1	†
primaquine phosphate	1	†
Pediculicides/Scabicides		
malathion	2	
permethrin	1	
Antiparkinson Agents		
Anticholinergics		
benztropine mesylate tabs	1	
trihexyphenidyl hcl tabs	1	
Antiparkinson Agents, Other		
COMTAN	2	
TASMAR	3	QL (180 EA per 30 days)
Dopamine Agonists		
pramipexole dihydrochloride	1	

Drug Name	Drug Tier	Requirements/Limits
ropinirole er	2	
ropinirole hcl	1	
Dopamine Precursors/L- Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa	1	
STALEVO 100	2	
STALEVO 125	2	
STALEVO 150	2	
STALEVO 200	2	
STALEVO 50	2	
STALEVO 75	2	
Monoamine Oxidase B (MAO-B) Inhibitors		
AZILECT	2	QL (30 EA per 30 days)
Antipsychotics		
1st Generation/Typical		
chlorpromazine hcl tabs	1	
perphenazine	1	
2nd Generation/Atypical		
ABILIFY TABS	3	
quetiapine fumarate	1	
risperidone tabs	1	
SEROQUEL XR	2	
Treatment-Resistant		
clozapine	1	
FAZACLO	3	
Antispasticity Agents		
Antispasticity Agents		
baclofen	1	
tizanidine hcl tabs	1	
tizanidine hcl caps	2	
Antivirals		
Anti-cytomegalovirus (CMV) Agents		
ganciclovir caps	2	
VALCYTE TABS	5	†
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors		
SUSTIVA	2	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors		
stavudine	1	
zidovudine caps, tabs	1	
Anti-HIV Agents, Other		
FUZEON	5	†
SELZENTRY	5	†
Anti-HIV Agents, Protease Inhibitors		
CRIXIVAN	2	
REYATAZ	2	
Anti-influenza Agents		

Drug Name	Drug Tier	Requirements/Limits
<i>amantadine hcl caps, tabs</i>	1	
<i>rimantadine hcl</i>	1	
Antih hepatitis Agents		
BARACLUDGE SOLN	3	QL (630 ML per 30 days)
BARACLUDGE TABS	5	QL (30 EA per 30 days) †
INCIVEK	5	QL (168 EA per 28 days) PA †
PEGASYS	5	PA †
PEGASYS PROCLICK	5	QL (2 ML per 28 days) PA †
Antitherpetic Agents		
<i>acyclovir caps, tabs</i>	1	
<i>valacyclovir hcl</i>	2	
Anxiolytics		
Anxiolytics, Other		
<i>buspirone hcl</i>	1	
<i>lorazepam tabs 2mg</i>	1	QL (150 EA per 30 days)
<i>lorazepam tabs 1mg</i>	1	QL (300 EA per 30 days)
<i>lorazepam tabs 0.5mg</i>	1	QL (600 EA per 30 days)
Bipolar Agents		
Bipolar Agents		
SYMBYAX	3	
Mood Stabilizers		
<i>lithium carbonate</i>	1	
<i>lithium carbonate er</i>	1	
<i>lithium citrate</i>	1	
Blood Glucose Regulators		
Antidiabetic Agents		
ACTOS	3	ST
BYDUREON	4	QL (4 EA per 30 days) PA †
BYETTA	4	PA †
<i>glimepiride</i>	1	
<i>glipizide</i>	1	
<i>glipizide er</i>	1	
<i>glyburide</i>	1	
JANUMET	2	QL (60 EA per 30 days) ST
JANUMET XR TB24 1000MG; 100MG, 500MG; 50MG	2	QL (30 EA per 30 days) ST
JANUMET XR TB24 1000MG; 50MG	2	QL (60 EA per 30 days) ST

Drug Name	Drug Tier	Requirements/Limits
JANUVIA	2	QL (30 EA per 30 days) ST
JUVISYNC	2	QL (30 EA per 30 days) ST
<i>metformin hcl</i>	1	
<i>metformin hcl er</i>	1	
Glycemic Agents		
GLUCAGON EMERGENCY KIT	2	QL (2 EA per 2 days)
PROGLYCEM	3	
Insulins		
HUMALOG VIAL	2	
HUMALOG KWIKPEN	2	
HUMALOG MIX 50/50 VIAL	2	
HUMALOG MIX 50/50 KWIKPEN	2	
HUMALOG MIX 75/25 VIAL	2	
HUMALOG MIX 75/25 KWIKPEN	2	
HUMULIN 70/30 VIAL	2	
HUMULIN N VIAL	2	
HUMULIN R VIAL	2	
HUMULIN R U-500 (CONCENTRATED) VIAL	2	
LANTUS VIAL	2	QL (40 ML per 30 days)
LANTUS SOLOSTAR	2	QL (45 ML per 30 days)
LEVEMIR VIAL	2	QL (40 ML per 30 days)
LEVEMIR FLEXPEN	2	QL (45 ML per 30 days)
Blood Products/Modifiers/Volume Expanders		
Anticoagulants		
<i>heparin sodium</i>	4	B/D †
<i>warfarin sodium</i>	1	
Blood Formation Modifiers		
<i>anagrelide hydrochloride</i>	1	
PROCRIT INJ 2000UNIT/ML	2	PA
PROCRIT INJ 10000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	PA †
PROCRIT INJ 20000UNIT/ML, 40000UNIT/ML	5	PA †

Drug Name	Drug Tier	Requirements/Limits
Blood Products/Modifiers/Volume Expanders		
CINRYZE	5	B/D †
Coagulants		
CYKLOKAPRON	4	B/D †
Platelet Modifying Agents		
AGGRENOX	3	
clopidogrel tabs 75mg	1	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine hcl tabs	1	
guanfacine hcl	1	
Alpha-adrenergic Blocking Agents		
prazosin hcl	1	
reserpine	1	
Angiotensin II Receptor Antagonists		
DIOVAN HCT TABS 12.5MG; 320MG, 12.5MG; 80MG, 25MG; 160MG, 25MG; 320MG	2	QL (30 EA per 30 days) ST
DIOVAN HCT TABS 12.5MG; 160MG	2	QL (60 EA per 30 days) ST
DIOVAN TABS 320MG, 40MG	2	QL (30 EA per 30 days) ST
DIOVAN TABS 160MG, 80MG	2	QL (60 EA per 30 days) ST
EDARBI	2	ST
EDARBYCLOR	2	ST
losartan potassium	1	QL (30 EA per 30 days)
losartan potassium/hydrochlorothiazide	1	QL (30 EA per 30 days)
Angiotensin-converting Enzyme (ACE) Inhibitors		
benazepril hcl/hydrochlorothiazide	1	
benazepril hcl tabs 10mg, 20mg, 5mg	1	QL (30 EA per 30 days)
benazepril hcl tabs 40mg	1	QL (60 EA per 30 days)
enalapril maleate	1	
lisinopril	1	QL (60 EA per 30 days)
lisinopril/hydrochlorothiazide tabs 12.5mg; 10mg	1	QL (30 EA per 30 days)
lisinopril/hydrochlorothiazide tabs 12.5mg; 20mg, 25mg; 20mg	1	QL (60 EA per 30 days)
quinapril hcl	1	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ramipril caps 10mg	1	QL (60 EA per 30 days)
ramipril caps 1.25mg, 2.5mg, 5mg	1	QL (90 EA per 30 days)
Antiarrhythmics		
amiodarone hcl tabs	1	
flecainide acetate	1	
MULTAQ	2	QL (60 EA per 30 days) PA
sotalol hcl	1	
Beta-adrenergic Blocking Agents		
atenolol	1	
carvedilol	1	
metoprolol succinate er	1	
metoprolol tartrate tabs	1	
propranolol hcl soln, tabs	1	
timolol maleate	1	
Calcium Channel Blocking Agents		
amlodipine besylate	1	
amlodipine besylate/benazepril hcl caps 10mg; 40mg	2	QL (30 EA per 30 days)
amlodipine besylate/benazepril hcl caps 5mg; 40mg	2	QL (60 EA per 30 days)
amlodipine besylate/benazepril hydrochloride	2	QL (30 EA per 30 days)
diltiazem cd	1	
diltiazem hcl er	1	
EXFORGE	3	QL (30 EA per 30 days) ST
EXFORGE HCT	3	QL (30 EA per 30 days) ST
felodipine er	1	
nifedipine er	1	
verapamil hcl er	1	
Cardiovascular Agents, Other		
digoxin soln, tabs	1	
pentoxifylline er	1	
Diuretics, Carbonic Anhydrase Inhibitors		
acetazolamide	1	
Diuretics, Loop		
furosemide soln, tabs	1	
toremide tabs	1	
Diuretics, Potassium-sparing		
spironolactone	1	
triamterene/hydrochlorothiazide	1	

Drug Name	Drug Tier	Requirements/Limits
Diuretics, Thiazide		
chlorothiazide	1	
hydrochlorothiazide	1	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate tabs 160mg	1	QL (30 EA per 30 days)
fenofibrate tabs 54mg	1	QL (60 EA per 30 days)
gemfibrozil	1	QL (75 EA per 30 days)
TRICOR TABS 145MG	2	QL (30 EA per 30 days)
TRICOR TABS 48MG	2	QL (60 EA per 30 days)
TRILIPIX	2	QL (30 EA per 30 days)
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium	1	QL (30 EA per 30 days)
lovastatin tabs 10mg, 20mg	1	QL (30 EA per 30 days)
lovastatin tabs 40mg	1	QL (60 EA per 30 days)
pravastatin sodium tabs 80mg	1	QL (30 EA per 30 days)
pravastatin sodium tabs 10mg, 20mg, 40mg	1	QL (60 EA per 30 days)
SIMCOR TB24 1000MG; 40MG, 500MG; 20MG, 500MG; 40MG	2	QL (30 EA per 30 days)
SIMCOR TB24 750MG; 20MG	2	QL (60 EA per 30 days)
simvastatin	1	QL (30 EA per 30 days)
Dyslipidemics, Other		
NIASPAN TBCR 500MG	2	QL (120 EA per 30 days)
NIASPAN TBCR 1000MG, 750MG	2	QL (60 EA per 30 days)
WELCHOL	2	
ZETIA	3	PA
Vasodilators, Direct-acting Arterial/Venous		
isosorbide mononitrate er	1	
NITROSTAT	2	
Vasodilators, Direct-acting Arterial		
hydralazine hcl tabs	1	
minoxidil	1	
Central Nervous System Agents		

Drug Name	Drug Tier	Requirements/Limits
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine/dextroamphetamine tabs 5mg, 7.5mg, 10mg, 15mg	1	QL (120 EA per 30 days) PA
amphetamine/dextroamphetamine tabs 12.5mg	1	QL (150 EA per 30 days) PA
amphetamine/dextroamphetamine tabs 30mg	1	QL (60 EA per 30 days) PA
amphetamine/dextroamphetamine tabs 20mg	1	QL (90 EA per 30 days) PA
methamphetamine hcl tabs	1	QL (240 EA per 30 days) PA
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
KAPVAY	3	PA
STRATTERA CAPS 100MG, 60MG, 80MG	2	QL (30 EA per 30 days)
STRATTERA CAPS 10MG, 18MG, 25MG, 40MG	2	QL (60 EA per 30 days)
Central Nervous System Agents		
butalbital/acetaminophen	1	QL (180 EA per 30 days) ED
Central Nervous System, Other		
NUEDEXTA	2	QL (60 EA per 30 days)
XENAZINE TABS 25MG	5	QL (120 EA per 30 days) PA †
XENAZINE TABS 12.5MG	5	QL (240 EA per 30 days) PA †
Multiple Sclerosis Agents		
COPAXONE	5	QL (1 EA per 30 days) †
GILENYA	5	QL (30 EA per 30 days) PA †
Dental and Oral Agents		
Dental and Oral Agents		
chlorhexidine gluconate	1	
chlorhexidine gluconate oral rinse	1	
triamcinolone in orabase	1	
Dermatological Agents		
Dermatological Agents		
tretinoin	1	PA
ZYCLARA	2	QL (28 EA per 30 days)
Enzyme Replacement/Modifiers		
Enzyme Replacement/Modifiers		

Drug Name	Drug Tier	Requirements/Limits
CREON	2	
PANCREAZE	2	
Gastrointestinal Agents		
<i>Antispasmodics, Gastrointestinal</i>		
<i>glycopyrrolate tabs</i>	1	
<i>methscopolamine bromide</i>	1	
<i>Gastrointestinal Agents, Other</i>		
<i>loperamide hcl</i>	1	
<i>metoclopramide hcl soln, tabs</i>	1	
<i>Histamine2 (H2) receptor Antagonists</i>		
<i>famotidine susr, tabs</i>	1	
<i>ranitidine hcl caps, syrp, tabs</i>	1	
<i>Irritable Bowel Syndrome Agents</i>		
AMITIZA	3	QL (60 EA per 30 days) PA
LOTRONEX	2	PA
<i>Laxatives</i>		
<i>enulose</i>	1	
<i>peg 3350/electrolytes</i>	1	
<i>Protectants</i>		
<i>misoprostol</i>	1	
<i>sucralfate</i>	1	
<i>Proton Pump Inhibitors</i>		
DEXILANT	2	QL (30 EA per 30 days) ST
<i>lansoprazole</i>	2	
<i>omeprazole</i>	1	
<i>pantoprazole sodium</i>	1	
Genitourinary Agents		
<i>Antispasmodics, Urinary</i>		
ENABLEX TB24 15MG	3	QL (30 EA per 30 days) ST
ENABLEX TB24 7.5MG	3	QL (60 EA per 30 days) ST
<i>oxybutynin chloride</i>	1	
<i>oxybutynin chloride er</i>	1	
VESICARE TABS 10MG	2	QL (30 EA per 30 days) ST
VESICARE TABS 5MG	2	QL (60 EA per 30 days) ST
<i>Benign Prostatic Hypertrophy Agents</i>		
AVODART	3	QL (30 EA per 30 days) ST
<i>doxazosin mesylate</i>	1	
<i>finasteride</i>	1	
<i>tamsulosin hcl</i>	1	
<i>terazosin hcl</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>Genitourinary Agents, Other</i>		
<i>bethanechol chloride</i>	1	
ELMIRON	2	
<i>Phosphate Binders</i>		
FOSRENOL	5	†
REVELA TABS	2	QL (540 EA per 30 days)
REVELA PACK	2	QL (180 EA per 30 days)
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
<i>Glucocorticoids/Mineralocorticoids</i>		
<i>desonide crea, oint</i>	1	
<i>methylprednisolone</i>	1	
<i>prednisone</i>	1	
<i>prednisone intensol</i>	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</i>		
<i>desmopressin acetate tabs</i>	1	
NUTROPIN	5	PA †
NUTROPIN AQ	5	PA †
NUTROPIN AQ NUSPIN 5	5	PA †
NUTROPIN AQ PEN	5	PA †
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
<i>Anabolic Steroids</i>		
<i>oxandrolone</i>	2	PA
<i>Androgens</i>		
ANDRODERM	3	QL (30 EA per 30 days) ST
ANDROGEL	2	QL (300 GM per 30 days)
ANDROGEL PUMP GEL 1.62%	2	QL (150 GM per 30 days)
ANDROGEL PUMP GEL 1.25GM/ACT	2	QL (300 GM per 30 days)
<i>Estrogens</i>		
ENJUVIA	2	PA
<i>estradiol tabs</i>	1	
PREMARIN CREA	2	
PREMPHASE	2	QL (28 EA per 28 days) PA
PREMPRO	2	QL (28 EA per 28 days) PA
VAGIFEM	2	
VIVELLE-DOT PTTW 0.05MG/24HR	2	QL (16 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
VIVELLE-DOT PTTW 0.025MG/24HR, 0.0375MG/24HR, 0.075MG/24HR, 0.1MG/24HR	2	QL (16 EA per 30 days)
Progestins		
<i>megestrol acetate susp</i>	1	PA
<i>megestrol acetate tabs</i>	1	PA
<i>progesterone</i>	1	
Selective Estrogen Receptor Modifying Agents		
EVISTA	2	QL (30 EA per 30 days)

**Hormonal Agents, Stimulant/
Replacement/Modifying (Thyroid)**

**Hormonal Agents, Stimulant/
Replacement/Modifying (Thyroid)**

<i>levothyroxine sodium</i>	1	
<i>levoxyl</i>	1	
SYNTHROID	3	

Hormonal Agents, Suppressant (Adrenal)

Hormonal Agents, Suppressant (Adrenal)

LYSODREN	2	
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Hormonal Agents, Suppressant (Parathyroid)

Hormonal Agents, Suppressant (Parathyroid)		
<i>Suppressant (Parathyroid)</i>		
SENSIPAR TABS 30MG	2	PA
SENSIPAR TABS 60MG, 90MG	5	PA †

Hormonal Agents, Suppressant (Pituitary)

Hormonal Agents, Suppressant (Pituitary)

<i>cabergoline</i>	2	QL (16 EA per 30 days)
<i>octreotide acetate</i>	4	PA †

**Hormonal Agents, Suppressant (Sex
Hormones/Modifiers)**

Antiandrogens		
<i>bicalutamide</i>	1	
NILANDRON	2	

Hormonal Agents, Suppressant (Thyroid)

Antithyroid Agents		
<i>methimazole</i>	1	
<i>propylthiouracil</i>	1	

Immunological Agents

Immune Suppressants		
ENBREL	5	PA †
HUMIRA	5	PA †
HUMIRA PEN	5	PA †
HUMIRA PEN-CROHNS DISEASESTARTER	5	PA †

Drug Name	Drug Tier	Requirements/Limits
<i>methotrexate</i>	1	
MYFORTIC	2	PA
Immunizing Agents, Passive		
GAMMAGARD S/D	5	PA †
PRIVIGEN	5	PA †
Immunomodulators		
AVONEX	5	QL (4 EA per 28 days) †
REBIF	5	QL (12 ML per 30 days) †
REBIF TITRATION PACK	5	QL (4.2 ML per 28 days) †

Vaccines

RECOMBIVAX HB	4	B/D †
ZOSTAVAX	4	†

Inflammatory Bowel Disease Agents

Aminosalicylates		
APRISO	2	QL (120 EA per 30 days)
ASACOL	2	QL (360 EA per 30 days)
ASACOL HD	2	QL (180 EA per 30 days)

Glucocorticoids

<i>methylprednisolone</i>	1	
<i>millipred tabs</i>	1	

Sulfonamides

<i>sulfasalazine</i>	1	
<i>sulfazine</i>	1	
<i>sulfazine ec</i>	1	

Metabolic Bone Disease Agents

Metabolic Bone Disease Agents

<i>alendronate sodium tabs</i> 10mg, 40mg, 5mg	1	QL (30 EA per 30 days)
<i>alendronate sodium tabs</i> 35mg, 70mg	1	QL (4 EA per 28 days)
HECTOROL CAPS	2	
HECTOROL INJ	4	B/D †
ZEMPLAR CAPS	2	
ZEMPLAR INJ	4	B/D †

Miscellaneous Therapeutic Agents

Miscellaneous Therapeutic Agents

BD INSULIN SYRINGE	2	
SAFETYGLIDE/1ML/29G X 1/2"		
BD INSULIN SYRINGE	2	
ULTRAFINE/0.3ML/31G X 5/16"		

Drug Name	Drug Tier	Requirements/Limits
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	2	
BD PEN NEEDLE/ULTRAFINE/29 G X 12.7MM	2	
<i>levocarnitine tabs</i>	1	
Ophthalmic Agents		
<i>Ophthalmic Prostaglandin and Prostanoid Analogs</i>		
<i>latanoprost</i>	1	
LUMIGAN SOLN 0.01%	2	QL (2.5 ML per 30 days)
LUMIGAN SOLN 0.03%	2	QL (7.5 ML per 30 days)
TRAVATAN Z	2	QL (5 ML per 30 days)
<i>Ophthalmic Agents, Other</i>		
<i>atropine sulfate</i>	1	
RESTASIS	2	QL (64 EA per 30 days)
<i>Ophthalmic Anti-allergy Agents</i>		
BEPREVE	3	
LASTACAFT	3	QL (3 ML per 30 days)
PATADAY	2	
<i>Ophthalmic Anti-inflammatories</i>		
ALREX	2	
LOTEMAX SUSP <i>prednisolone acetate</i>	2 1	
ZYLET	2	
<i>Ophthalmic Antiglaucoma Agents</i>		
<i>acetazolamide er</i>	1	
ALPHAGAN P	2	
AZOPT	2	
BETIMOL	2	
<i>dorzolamide hcl/timolol maleate</i>	1	
Otic Agents		
<i>Otic Agents</i>		
COLY-MYCIN S	2	
<i>neomycin/polymyxin/hydroc ortisone</i>	1	
Respiratory Tract Agents		
<i>Anti-inflammatories, Inhaled Corticosteroids</i>		
ADVAIR DISKUS	2	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ADVAIR HFA	2	QL (12 GM per 30 days)
ASMANEX 120 METERED DOSES	2	QL (0.24 EA per 30 days)
ASMANEX 14 METERED DOSES	2	QL (0.24 EA per 30 days)
ASMANEX 30 METERED DOSES AEPB 110MCG/INH	2	QL (0.14 EA per 30 days)
ASMANEX 30 METERED DOSES AEPB 220MCG/INH	2	QL (0.24 EA per 30 days)
ASMANEX 60 METERED DOSES	2	QL (0.48 EA per 30 days)
ASMANEX 7 METERED DOSES	2	QL (0.54 EA per 30 days)
FLOVENT DISKUS AEPB 250MCG/BLIST	2	QL (240 EA per 30 days)
FLOVENT DISKUS AEPB 100MCG/BLIST, 50MCG/BLIST	2	QL (60 EA per 30 days)
FLOVENT HFA AERO 44MCG/ACT	2	QL (22 GM per 30 days)
FLOVENT HFA AERO 110MCG/ACT, 220MCG/ACT	2	QL (24 GM per 30 days)
<i>fluticasone propionate nasal soln</i>	1	QL (16 GM per 30 days)
NASONEX	2	QL (34 GM per 30 days)
PULMICORT FLEXHALER	2	QL (2 EA per 30 days)
QVAR AERS 80MCG/ACT	2	QL (21.9 GM per 30 days)
QVAR AERS 40MCG/ACT	2	QL (36.5 GM per 30 days)
SYMBICORT AERO 160MCG/ACT; 4.5MCG/ACT	3	QL (10.2 GM per 30 days)
SYMBICORT AERO 80MCG/ACT; 4.5MCG/ACT	3	QL (6.9 GM per 30 days)
<i>Antihistamines</i>		
ASTEPRO	2	QL (30 ML per 25 days)
<i>azelastine hcl</i>	1	QL (30 ML per 30 days)
<i>Antileukotrienes</i>		

Drug Name	Drug Tier	Requirements/Limits
SINGULAIR	2	QL (30 EA per 30 days)
<i>zafirlukast</i>	1	
Bronchodilators, Anticholinergic		
<i>ipratropium bromide soln 0.03%</i>	1	QL (30 ML per 28 days)
<i>ipratropium bromide soln 0.06%</i>	1	QL (45 ML per 28 days)
SPIRIVA HANDIHALER	2	QL (30 EA per 30 days)
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)		
ELIXOPHYLLIN	3	
<i>theophylline cr</i>	1	
<i>theophylline er</i>	1	
Bronchodilators, Sympathomimetic		
PROAIR HFA	2	QL (17 GM per 30 days)
SEREVENT DISKUS	2	QL (60 EA per 30 days)
VENTOLIN HFA	2	QL (36 GM per 30 days)
Mast Cell Stabilizers		
<i>cromolyn sodium</i>	1	QL (240 ML per 30 days) B/D
Pulmonary Antihypertensives		
ADCIRCA	5	PA †
REVATIO TABS	5	QL (90 EA per 30 days) PA †
Respiratory Tract Agents, Other		
<i>acetylcysteine</i>	1	B/D
TYZINE	2	
TYZINE PEDIATRIC	2	
NASAL DROPS		
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
<i>carisoprodol tabs 250mg</i>	1	QL (120 EA per 30 days) PA
<i>orphenadrine citrate er</i>	1	PA

Drug Name	Drug Tier	Requirements/Limits
Sleep Disorder Agents		
GABA Receptor Modulators		
<i>temazepam caps 7.5mg</i>	1	QL (120 EA per 30 days)
<i>temazepam caps 22.5mg, 30mg</i>	1	QL (30 EA per 30 days)
<i>temazepam caps 15mg</i>	1	QL (60 EA per 30 days)
<i>zolpidem tartrate er tbcr 12.5mg</i>	1	QL (30 EA per 30 days) ST
<i>zolpidem tartrate er tbcr 6.25mg</i>	1	QL (60 EA per 30 days) ST
<i>zolpidem tartrate tabs 10mg</i>	1	QL (30 EA per 30 days)
<i>zolpidem tartrate tabs 5mg</i>	1	QL (60 EA per 30 days)
Sleep Disorders, Other		
NUVIGIL TABS 150MG, 250MG	2	QL (30 EA per 30 days) PA
NUVIGIL TABS 50MG	2	QL (60 EA per 30 days) PA
SILENOR	3	QL (30 EA per 30 days)
Therapeutic Nutrients/Minerals/Electrolytes		
Electrolyte/Mineral Modifiers		
CUPRIMINE	2	
<i>sodium polystyrene sulfonate</i>	2	
Electrolyte/Mineral Replacement		
<i>calcium acetate</i>	1	
<i>klor-con m10</i>	1	
<i>potassium chloride er cpcr</i>	1	
<i>potassium chloride er tbcr 20meq</i>	1	
Vitamins		
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<i>prenatabs obn</i>	1	

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<i>acetazolamide er</i>	10	<i>atropine sulfate</i>	10
<i>acetylcysteine</i>	11	AVODART	8
ACTOS	5	AVONEX	9
<i>acyclovir</i>	5	<i>azelastine hcl</i>	10
ADCIRCA	11	AZILECT	4
ADVAIR DISKUS	10	<i>azithromycin</i>	2
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AFINITOR	4	<i>baclofen</i>	4
AGGRENOLX	6	BARACLUDGE	5
<i>alendronate sodium</i>	9	BD INSULIN SYRINGE	9
<i>allopurinol</i>	3	SAFETYGLIDE/1ML/29G X 1/2"	
ALPHAGAN P	10	BD INSULIN SYRINGE	9
ALREX	10	ULTRAFINE/0.3ML/31G X 5/16"	
<i>amantadine hcl</i>	5	BD INSULIN SYRINGE	10
<i>amiodarone hcl</i>	6	ULTRAFINE/0.5ML/30G X 1/2"	
AMITIZA	8	BD INSULIN SYRINGE	10
<i>amitriptyline hcl</i>	3	ULTRAFINE/1ML/31G X 5/16"	
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