

# Abrazo Advantage (HMO)

## 2012 Formulary (List of Covered Drugs)

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

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

This document includes Abrazo Advantage (HMO)'s partial formulary as of August 10, 2011. For a complete, updated formulary, please visit our Web site at <http://www.abrazoadvantage.com> or call (602) 824-3900 or (888) 864-1114 if outside Maricopa County, seven days a week from 8 a.m. to 8 p.m.

TTY/TDD users should call (602) 824-3909 or (800) 489-1472 Monday – Friday 8 a.m. to 5 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays.

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

Abrazo Advantage is a Medicare Advantage organization with a Medicare contract.

To receive material in alternate format or language contact our Member Services Department at the number above.

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 information is available for free in other languages. Please contact our Member Service number at (888) 864-1114 for additional information seven days a week from 8 a.m. to 8 p.m. TTY/TDD (800) 842-4681 to access the Arizona Relay System.

Esta información esta disponible gratuitamente en otros lenguajes. Por favor comuníquese al número para servicio al cliente a (888) 864-1114 para información adicional los 7 días a la semana, 8 a.m. - 8 p.m. Para los de impedimento del habla por favor llame a TTY/TDD (800) 842-4681.

## **What is the Abrazo Advantage Formulary?**

A formulary is a list of covered drugs selected by Abrazo Advantage 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. Abrazo Advantage will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Abrazo Advantage 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 Abrazo Advantage. For a complete listing of all prescription drugs covered by Abrazo Advantage, please visit our Web site at <http://www.abrazoadvantage.com> or call (602) 824-3900 or (888) 864-1114 if outside Maricopa County seven days a week from 8 a.m. to 8 p.m. TTY/TDD users should call (602) 824-3909 or (800) 489-1472 Monday – Friday 8 a.m. to 5 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays.

## **Can the Formulary change?**

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

If we remove drugs from our formulary, or add prior authorization, 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. 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 August 12, 2011. To get updated information about the drugs covered by Abrazo Advantage, please visit our Web site at <http://www.abrazoadvantage.com> or call Member Services at (602) 824-3900 or (888) 864-1114 if outside Maricopa County seven days a week from 8 a.m. to 8 p.m. TTY/TDD users should call (602) 824-3909 or (800) 489-1472 Monday – Friday 8 a.m. to 5 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays.

In the event of mid-year non-maintenance formulary change Abrazo Advantage Health Plan will notify you in writing within 60 days.

## How do I use the Formulary?

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

### ***Medical Condition***

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Medication”. 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 57. 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?

Abrazo Advantage 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***

Abrazo Advantage requires you to get prior authorization for certain drugs. This means that you will need to get approval from Abrazo Advantage before you fill your prescriptions. If you don't get approval, Abrazo Advantage may not cover the drug.

### ***Quantity Limits***

For certain drugs, Abrazo Advantage limits the amount of the drug that Abrazo Advantage will cover. For example, Abrazo Advantage provides 34 tablets per prescription for Vytorin. This may be in addition to a standard one month or three month supply.

### ***Step Therapy***

In some cases, Abrazo Advantage 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, Abrazo Advantage may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Abrazo Advantage 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 <http://www.abrazoadvantage.com>.

You can ask Abrazo Advantage to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Abrazo Advantage formulary?” on this page 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 Abrazo Advantage may cover your drug. You can contact Member Services at (602) 824-3900 or (888) 864-1114 if outside Maricopa County seven days a week from 8 a.m. to 8 p.m. TTY/TDD users should call (602) 824-3909 or (800) 489-1472 Monday – Friday 8 a.m. to 5 p.m. or call

(800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays.

If you learn that Abrazo Advantage does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Abrazo Advantage. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Abrazo Advantage.
- You can ask Abrazo Advantage 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 Abrazo Advantage Formulary?**

You can ask Abrazo Advantage 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, Abrazo Advantage 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 highest tier subject to the tiering exceptions process tier, you can ask us to cover it at a the cost-sharing amount that applies to drugs in the lowest tier subject to the tiering exceptions process 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 tier designated as the high-cost/unique drug tier.”

Generally, Abrazo Advantage 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.

The transition program is designed to ensure continuity of care for new members, existing members who may be subject to formulary changes, and members who experience a level of care change. A level of care change occurs when you are discharged from a hospital or moved to or from a Long Term Care (LTC) facility. The program also allows members in LTC facilities access to a temporary transition supply of drugs.

As a new member in our plan you may be taking drugs that are not on the formulary, or you may be taking a drug that is on the formulary with restrictions or limits. For example, you may need a prior authorization from us before your prescription can be billed. You should talk to your doctor to decide if you should switch to a drug that we cover or request an exception so that we will cover the drug you take. This may also apply to renewing members who experience a change in formulary upon annual benefit renewal.

During this time, for each of your drugs that is not on the formulary or your ability to get your drugs is limited, we will cover a one-time temporary 30-day transition supply (unless you have a prescription written for fewer days) when you go to a network pharmacy.

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan

## **For more information**

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

If you have questions about Abrazo Advantage, please call Member Services at (602) 824-3900 or (888) 864-1114 if outside Maricopa County seven days a week from 8 a.m. to 8 p.m. TTY/TDD users should call (602) 824-3909 or (800) 489-1472 Monday – Friday 8 a.m. to 5 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays.

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](http://www.medicare.gov).

## **Abrazo Advantage (HMO) Formulary**

The abridged formulary below provides coverage information about some of the drugs covered by Abrazo Advantage. If you have trouble finding your drug in the list, turn to the Index that begins on page 57. Remember: This is only a partial list of drugs covered by Abrazo Advantage. If your prescription is not in this partial formulary, please visit our Web site at <http://www.abrazoadvantage.com> or call Member Services at (602) 824-3900 or (888) 864-1114 if outside Maricopa County seven days a week from 8 a.m. to 8 p.m. TTY/TDD users should call (602) 824-3909 or (800) 489-1472 Monday – Friday 8 a.m. to 5 p.m. or call (800) 842-4681 to access the Arizona Relay System after hours, on weekends and holidays for additional help.

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

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

**[LA] – Limited Access**

This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at (602) 824-3900 or toll free at (888) 864-1114 seven days a week from 8 a.m. to 8 p.m. TTY/TDD users should call (602) 824-3909 or (800) 489-1472 toll free Monday – Friday, 8 a.m. to 5 p.m. or for service after hours, weekends or holidays (8 a.m. to 8 p.m.) call (800) 842-4681 to access the Arizona Relay Service.

**[PAR] – Prior Authorization**

Indicates the prescription must be approved by our plan.

**[QLL] – Quantity Level Limits**

Indicates that the quantities dispensed may be limited.

**[ST] – Step Therapy**

Indicates that step therapy may apply.

**[G] – Generic**

Indicates that the drug may be available in a generic form.

**[INJ] – Injectable**

Indicates that the drug is available in injectable form.

***Abrazo Advantage (HMO) has four drug tiers:***

Tier 1 – Preferred Generic Drugs you pay a \$0.00 copay for a one-month (30-day) supply

Tier 2 – Non-Preferred Generic Drugs you pay a \$20.00 copay for a one-month (30-day) supply

Tier 3 – Preferred Brand Drugs you pay a \$40.00 copay for a one-month (30-day) supply

Tier 4 – Specialty Tier Drugs you pay 33% coinsurance for a one-month (30-day) supply

# General Drug Table

## ANESTHETICS

### LOCAL ANESTHETICS

Drug	Generic	Tier	Requirements/ Limits
<i>lidocaine hcl 0.5% vial, -1% vial</i> [INJ]		2	

### TOPICAL ANESTHETICS

Drug	Generic	Tier	Requirements/ Limits
<i>lidocaine hcl jel, -ointment, -solution non-oral</i>		2	
<i>lidocaine hcl viscous</i>		2	
<i>lidocaine-prilocaine</i>		2	
LIDODERM	<i>lidocaine</i>	3	[PAR]

## ANTIINFECTIVES

### AMEBICIDES

Drug	Generic	Tier	Requirements/ Limits
<i>paromomycin sulfate</i>		2	

### AMINOGLYCOSIDES

Drug	Generic	Tier	Requirements/ Limits
<i>amikacin sulfate injection</i> [INJ]		2	
<i>gentamicin 90 mg/ns 100 ml pb, -100 mg/ns 100 ml, -60 mg/ns 50 ml pb, -70 mg/ns 50 ml pb, -80 mg/ns 50 ml pb</i> [INJ]		2	
<i>gentamicin sulfate injection</i> [INJ]		2	
<i>iso gentamicin 100 mg/100 ml, -isoton gentamicin 60 mg/50 ml, -isoton gentamicin 80 mg/50 ml</i> [INJ][G]		2	

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
<i>kanamycin sulfate injection</i> [INJ]		2	
<i>neomycin sulfate tablet</i>		2	
TOBI	<i>tobramycin/sodium chloride</i>	4	[PAR][QLL, 56/28]
<i>tobramycin sulfate in ns</i> [INJ]		2	
<i>tobramycin sulfate injection</i> [INJ]		2	

### **ANTHELMINTICS**

Drug	Generic	Tier	Requirements/ Limits
ALBENZA	<i>albendazole</i>	3	
<i>mebendazole tablet chewable</i>		2	
STROMEKTOL	<i>ivermectin</i>	3	

### **ANTIINFECTIVES SPECIALIZED INDICATIONS**

Drug	Generic	Tier	Requirements/ Limits
DAPSONE TABLET	<i>dapsone</i>	3	
<i>metronidazole capsule, -tablet</i>		2	
<i>metronidazole injection</i> [INJ]		2	

### **ANTIRETROVIRALS AND PROTEASE INH**

Drug	Generic	Tier	Requirements/ Limits
APTIVUS	<i>tipranavir</i>	4	
ATRIPLA	<i>emtricitabine/tenofovir/efavir</i>	4	
COMBIVIR	<i>lamivudine/zidovudine</i>	4	
CRIXIVAN	<i>indinavir</i>	3	
<i>didanosine</i>		2	
EDURANT	<i>rilpivirine hydrochloride</i>	4	

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Drug	Generic	Tier	Requirements/ Limits
EMTRIVA	<i>emtricitabine</i>	3	
EPIVIR	<i>lamivudine</i>	3	
EPZICOM	<i>abacavir sulfate/lamivudine</i>	4	
FUZEON [INJ]	<i>enfuvirtide</i>	4	
INCIVEK	<i>telaprevir</i>	4	
INTELENCE	<i>etravirine</i>	4	
INVIRASE	<i>saquinavir mesylate</i>	4	
ISENTRESS	<i>raltegravir potassium</i>	4	
KALETRA 100-25 MG TABLET	<i>ritonavir/lopinavir</i>	3	
KALETRA SOLUTION, -200-50 MG TABLET	<i>ritonavir/lopinavir</i>	4	
LEXIVA SUSPENSION ORAL	<i>fosamprenavir calcium</i>	3	
LEXIVA TABLET	<i>fosamprenavir calcium</i>	4	
NORVIR	<i>ritonavir</i>	3	
PREZISTA 400 MG TABLET, -600 MG TABLET	<i>darunavir ethanolate</i>	4	
PREZISTA 75 MG TABLET, -150 MG TABLET	<i>darunavir ethanolate</i>	3	
RESCRIPTOR	<i>delavirdine mesylate</i>	3	
RETROVIR INJECTION [INJ]	<i>zidovudine</i>	3	
REYATAZ 100 MG CAPSULE	<i>atazanavir sulfate</i>	3	
REYATAZ 150 MG CAPSULE, -200 MG CAPSULE, -300 MG CAPSULE	<i>atazanavir sulfate</i>	4	
SELZENTRY	<i>maraviroc</i>	4	
<i>stavudine</i>		2	
SUSTIVA	<i>efavirenz</i>	3	
TRIZIVIR	<i>zidovudine/lamivudine/abacavir</i>	4	
TRUVADA	<i>emtricitabine/tenofovir</i>	4	
VICTRELIS	<i>boceprevir</i>	4	[PAR]

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Drug	Generic	Tier	Requirements/ Limits
VIDEX	<i>didanosine</i>	3	
VIRACEPT 625 MG TABLET	<i>nelfinavir mesylate</i>	4	
VIRACEPT POWDER, -250 MG TABLET	<i>nelfinavir mesylate</i>	3	
VIRAMUNE	<i>nevirapine</i>	3	
VIRAMUNE XR	<i>nevirapine</i>	3	
VIREAD	<i>tenofovir disproxil fumarate</i>	4	
ZIAGEN	<i>abacavir sulfate</i>	3	
<i>zidovudine</i>		2	

### ANTITUBERCULOSIS DRUGS

Drug	Generic	Tier	Requirements/ Limits
CAPASTAT SULFATE [INJ]	<i>capreomycin</i>	3	
<i>ethambutol hcl</i>		2	
<i>isonarif</i>		2	
<i>isoniazid injection</i> [INJ]		2	
<i>isoniazid syrup, -tablet</i>		2	
MYCOBUTIN	<i>rifabutin</i>	3	
PASER	<i>aminosalicylic acid</i>	3	
PRIFTIN	<i>rifapentine</i>	3	
<i>pyrazinamide</i>		2	
<i>rifampin capsule</i>		2	
<i>rifampin injection</i> [INJ]		2	
SEROMYCIN	<i>cycloserine</i>	3	
TRECTOR	<i>ethionamide</i>	3	

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## CEPHALOSPORINS

Drug	Generic	Tier	Requirements/ Limits
<i>cefaclor</i>		2	
<i>cefaclor er</i>		2	
<i>cefadroxil</i>		2	
<i>cefazolin 20 gm bulk vial, -500 mg vial, -1 gm vial, -1 gm-d5w bag</i> [INJ]		2	
<i>cefdinir</i>		2	
<i>cefepime hcl</i> [INJ]		2	
<i>cefotaxime sodium</i> [INJ]		2	
<i>cefotetan</i> [INJ]		2	
<i>cefoxitin</i> [INJ]		2	
<i>cefoxitin sodium</i> [INJ]		2	
<i>cefpodoxime proxetil</i>		2	
<i>cefprozil</i>		2	
<i>ceftazidime</i> [INJ]		2	
<i>ceftriaxone</i> [INJ]		2	
<i>cefuroxime axetil</i>		2	
<i>cefuroxime sod 750 mg vial, -sod 1.5 gm vial, -sod 7.5 gm vial</i> [INJ]		2	
<i>cefuroxime tablet</i>		2	
<i>cephalexin</i>		2	
SUPRAX	<i>cefixime</i>	3	

## CHLORAMPHENICOLS

Drug	Generic	Tier	Requirements/ Limits
<i>chloramphenicol sod succinate</i> [INJ]		2	

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## CLINDAMYCINS

Drug	Generic	Tier	Requirements/ Limits
<i>clindamycin hcl capsule</i>		2	
<i>clindamycin phosphate injection [INJ]</i>		2	

## ERYTHROMYCINS

Drug	Generic	Tier	Requirements/ Limits
E.E.S. 200	<i>erythromycin ethylsuccinate</i>	3	
ERYPED 200	<i>erythromycin ethylsuccinate</i>	3	
ERYPED 400	<i>erythromycin ethylsuccinate</i>	3	
ERY-TAB	<i>erythromycin base</i>	3	
ERYTHROCIN LACTOBIONATE [INJ]	<i>erythromycin lactobionate</i>	3	
<i>erythrocin stearate</i>		2	
<i>erythromycin ethylsuccinate tablet</i>		2	
<i>erythromycin tablet</i>		2	

## ORAL ANTIFUNGAL DRUGS

Drug	Generic	Tier	Requirements/ Limits
ANCOBON	<i>flucytosine</i>	4	
<i>clotrimazole troche</i>		2	
<i>fluconazole 150 mg tablet</i>		2	[QLL, 2/7]
<i>fluconazole 50 mg tablet, -100 mg tablet, -200 mg tablet</i>		2	[PAR]
<i>fluconazole suspension</i>		2	
GRIFULVIN V	<i>griseofulvin microsize</i>	3	
<i>griseofulvin suspension oral</i>		2	
GRIS-PEG	<i>griseofulvin ultramicrosize</i>	3	
<i>itraconazole capsule</i>		2	[PAR][QLL, 136/34]

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
<i>ketoconazole tablet</i>		2	
LAMISIL PACKET	<i>terbinafine</i>	3	
NOXAFIL	<i>posaconazole</i>	4	
<i>nystatin suspension oral, -500,000 unit oral tab</i>		2	
SPORANOX SOLUTION	<i>itraconazole</i>	3	
<i>terbinafine hcl</i>		2	[PAR]
VFEND SUSPENSION	<i>voriconazole</i>	4	[PAR]
<i>voriconazole 200 mg tablet</i>		4	[PAR]
<i>voriconazole 50 mg tablet</i>		2	[PAR]

### OTHER ANTIINFECTIVE DRUGS

Drug	Generic	Tier	Requirements/ Limits
ALINIA	<i>nitazoxanide</i>	3	
<i>aztreonam 1 gm vial [INJ]</i>		2	
<i>baciim [INJ]</i>		2	
<i>bacitracin injection [INJ]</i>		2	
CAYSTON	<i>aztreonam lysine</i>	4	[QLL, 84 vials/28][LA]
<i>colistimethate 150 mg vial [INJ]</i>		4	
CUBICIN [INJ]	<i>daptomycin</i>	4	[PAR]
DORIBAX 500 MG VIAL [INJ]	<i>doripenem</i>	4	
INVANZ 1 GM VIAL [INJ]	<i>ertapenem sodium</i>	3	
MEPRON	<i>atovaquone</i>	4	
<i>meropenem [INJ]</i>		2	
<i>polymyxin b sulfate injection [INJ]</i>		2	
PRIMAXIN [INJ]	<i>imipenem/cilastatin sodium</i>	3	
PRIMAXIN I.M. [INJ]	<i>imipenem/cilastatin sodium</i>	3	
SYNERCID [INJ]	<i>quinupristin/dalfopristin</i>	4	

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
TYGACIL [INJ]	<i>tigecycline</i>	3	
VANCOCIN HCL	<i>vancomycin</i>	4	
<i>vancomycin 500 mg a/v vial, -1 gm vial, -10 gm vial</i> [INJ]		2	[PAR]
XIFAXAN 200 MG TABLET	<i>rifaximin</i>	3	
XIFAXAN 550 MG TABLET	<i>rifaximin</i>	4	
ZYVOX INJECTION [INJ]	<i>linezolid</i>	4	
ZYVOX SUSPENSION RECONSTITUTED ORAL, -TABLET	<i>linezolid</i>	4	[PAR]

### OTHER ANTIVIRAL DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>acyclovir capsule, -suspension oral, -tablet</i>		2	
<i>acyclovir sodium</i> [INJ]		2	
<i>amantadine</i>		2	
BARACLUDE SOLUTION	<i>entecavir</i>	3	
BARACLUDE TABLET	<i>entecavir</i>	4	
DENAVIR	<i>penciclovir</i>	3	
EPIVIR HBV	<i>lamivudine</i>	3	
<i>famciclovir 125 mg tablet</i>		2	[QLL, 21/10]
<i>famciclovir 250 mg tablet</i>		2	[QLL, 68/34]
<i>famciclovir 500 mg tablet</i>		2	[QLL, 21/7]
<i>foscarnet sodium</i> [INJ]		2	
<i>ganciclovir 250 mg capsule</i>		2	
<i>ganciclovir 500 mg capsule</i>		4	
<i>ganciclovir sodium</i> [INJ]		2	
HEPSERA	<i>adefovir dipivoxil</i>	4	
RELENZA	<i>zanamivir</i>	3	[QLL, 60 inhalations/180]

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
<i>ribapak</i>		4	
<i>ribasphere 400 mg tablet, -600 mg tablet</i>		4	
<i>ribasphere capsule, -200 mg tablet</i>		2	
<i>ribavirin capsule, -tablet</i>		2	
<i>rimantadine hcl</i>		2	
TAMIFLU 30 MG GELCAP	<i>oseltamivir phosphate</i>	3	[QLL, 84/180]
TAMIFLU 45 MG GELCAP, -75 MG GELCAP	<i>oseltamivir phosphate</i>	3	[QLL, 42/180]
TAMIFLU SUSPENSION	<i>oseltamivir phosphate</i>	3	[QLL, 900 ml/180]
TYZEKA	<i>telbivudine</i>	4	
<i>valacyclovir</i>		2	[QLL, 34/34]
VALCYTE	<i>valganciclovir</i>	4	
VIRAZOLE [INJ]	<i>ribavirin</i>	3	
XERESE	<i>acyclovir/hydrocortisone</i>	3	
ZOVIRAX CREAM, -OINTMENT	<i>acyclovir</i>	3	

#### OTHER MACROLIDES

Drug	Generic	Tier	Requirements/ Limits
<i>azithromycin 100 mg/5 ml susp</i>		2	[QLL, 30 ml/5]
<i>azithromycin 200 mg/5 ml susp</i>		2	[QLL, 90 ml/5]
<i>azithromycin 250 mg tablet</i>		2	[QLL, 8/7]
<i>azithromycin 500 mg tablet</i>		2	[QLL, 4/4]
<i>azithromycin 600 mg tablet</i>		2	
<i>azithromycin injection [INJ]</i>		2	
<i>clarithromycin er</i>		2	
<i>clarithromycin suspension, -tablet</i>		2	

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

## OTHER TOPICAL ANTIFUNGALS

Drug	Generic	Tier	Requirements/ Limits
<i>ciclopirox cream, -gel, -shampoo, -suspension topical</i>		2	
<i>ciclopirox solution non-oral</i>		2	[PAR]
<i>clotrimazole 1% cream, -solution non-oral</i>		2	
<i>clotrimazole af 1% cream</i>		2	
<i>econazole nitrate cream</i>		2	
<i>ketoconazole cream, -shampoo</i>		2	
<i>nyamyc</i>		2	
<i>nystatin cream, -ointment, -100,000 unit/gm powd</i>		2	
<i>nystop</i>		2	
<i>pedi-dri</i>		2	

## PARENTERAL ANTIFUNGALS

Drug	Generic	Tier	Requirements/ Limits
ABELCET [INJ]	<i>amphotericin b lipid complex</i>	4	
AMBISOME [INJ]	<i>amphotericin b liposome</i>	4	
<i>amphotericin b injection</i> [INJ]		2	
CANCIDAS [INJ]	<i>caspofungin acetate</i>	4	
<i>fluconazole in dextrose</i> [INJ]		2	
MYCAMINE [INJ]	<i>micafungin sodium</i>	4	
VFEND IV [INJ]	<i>voriconazole</i>	3	

## PENICILLINS

Drug	Generic	Tier	Requirements/ Limits
<i>amox tr-potassium clavulanate</i>		2	
<i>amoxicillin</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>amoxicillin-clavulanate er</i>		2	
<i>ampicillin sodium</i> [INJ]		2	
<i>ampicillin trihydrate</i>		2	
<i>ampicillin-sulbactam</i> [INJ]		2	
<i>dicloxacillin sodium</i>		2	
<i>nafcillin</i> [INJ]		4	
<i>nafcillin 1 gm vial</i> [INJ]		2	
<i>nafcillin 10 gm bulk vial, -10 gm vial</i> [INJ]		4	
<i>oxacillin 1 gm vial</i> [INJ]		2	
<i>oxacillin 1 gm/ 50 ml inj</i> [INJ]		2	
<i>oxacillin 10 gm vial</i> [INJ]		4	
<i>oxacillin 2 gm/ 50 ml inj</i> [INJ]		4	
<i>penicillin g potassium</i> [INJ]		2	
<i>penicillin g procaine</i> [INJ]		2	
<i>penicillin g sodium</i> [INJ]		2	
<i>penicillin v potassium</i>		2	
<i>piperacillin</i> [INJ]		2	
<i>piperacillin-tazobactam</i> [INJ]		2	

## PLASMODICIDES

Drug	Generic	Tier	Requirements/ Limits
<i>chloroquine phosphate tablet</i>		2	
COARTEM	<i>artemether/lumefantrine</i>	3	
DARAPRIM	<i>pyrimethamine</i>	3	
<i>hydroxychloroquine sulfate tablet</i>		2	
MALARONE	<i>atovaquone/proguanil hcl</i>	3	
<i>mefloquine hcl</i>		2	
PRIMAQUINE	<i>primaquine</i>	3	

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Drug	Generic	Tier	Requirements/ Limits
QUALAQUIN	<i>quinine sulfate</i>	3	

### QUINOLONES

Drug	Generic	Tier	Requirements/ Limits
AVELOX	<i>moxifloxacin</i>	3	
AVELOX ABC PACK	<i>moxifloxacin</i>	3	
AVELOX IV [INJ]	<i>moxifloxacin</i>	3	
<i>ciprofloxacin</i> [INJ]		2	
<i>ciprofloxacin er</i>		2	
<i>ciprofloxacin hcl tablet</i>		2	
<i>ofloxacin tablet</i>		2	

### SULFONAMIDES

Drug	Generic	Tier	Requirements/ Limits
<i>erythromycin-sulfisoxazole</i>		2	
<i>sulfadiazine tablet</i>		2	
<i>sulfamethoxazole-trimethoprim injection</i> [INJ]		2	
<i>sulfamethoxazole-trimethoprim suspension oral, -tablet</i>		2	

### TETRACYCLINES

Drug	Generic	Tier	Requirements/ Limits
<i>demeclocycline hcl</i>		2	
<i>doxycycline</i>		2	
<i>doxycycline hyclate capsule, -capsule enteric coated, -100 mg tab, -tablet enteric coated</i>		2	
<i>doxycycline hyclate injection</i> [INJ]		2	
<i>doxycycline monohydrate</i>		2	

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
<i>minocycline hcl capsule, -tablet, -tablet sustained release 24hr</i>		2	
<i>tetracycline hcl capsule</i>		2	

### TOPICAL ANTIBACTERIAL DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>gentamicin sulfate cream, -0.1% ointment</i>		2	
<i>mupirocin ointment</i>		2	
<i>silver sulfadiazine cream</i>		2	
<i>ssd</i>		2	
SULFAMYLON	<i>mafenide acetate</i>	3	
<i>thermazene</i>		2	

### TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.

Drug	Generic	Tier	Requirements/ Limits
<i>clotrimazole-betamethasone</i>		2	
<i>nystatin-triamcinolone</i>		2	

### URINARY ANTIINFECTIVES

Drug	Generic	Tier	Requirements/ Limits
<i>methenamine hippurate</i>		2	
<i>nitrofurantoin macrocrystal capsule</i>		2	
<i>nitrofurantoin mono-macro</i>		2	
<i>nitrofurantoin suspension oral</i>		2	
PRIMSOL	<i>trimethoprim</i>	3	
<i>trimethoprim tablet</i>		2	

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## VAGINAL ANTIFUNGALS

Drug	Generic	Tier	Requirements/ Limits
<i>miconazole 3 suppository vaginal</i>		2	[QLL, 3/3]
<i>terconazole 0.4% cream</i>		2	[QLL, 45 gm/7]
<i>terconazole 0.8% cream</i>		2	[QLL, 20 gm/3]
<i>terconazole suppository vaginal</i>		2	[QLL, 3/3]

## ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS

### ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS

Drug	Generic	Tier	Requirements/ Limits
AFINITOR	<i>everolimus</i>	4	
ALIMTA [INJ]	<i>pemetrexed disodium</i>	4	
AMEVIVE [INJ]	<i>alefacept</i>	4	[PAR][LA]
<i>amifostine [INJ]</i>		4	
<i>anagrelide hcl</i>		2	
<i>anastrozole tablet</i>		2	
AVASTIN 100 MG/4 ML VIAL [INJ]	<i>bevacizumab</i>	3	
AZASAN	<i>azathioprine</i>	3	[PAR]
<i>azathioprine sodium [INJ]</i>		2	[PAR]
<i>azathioprine tablet</i>		2	[PAR]
<i>bicalutamide</i>		2	
CAMPATH [INJ]	<i>alemtuzumab</i>	4	
CEENU	<i>lomustine</i>	3	
CELLCEPT INJECTION [INJ]	<i>mycophenolate mofetil</i>	3	[PAR]
CELLCEPT SUSPENSION RECONSTITUTED ORAL	<i>mycophenolate mofetil</i>	4	[PAR]
<i>cyclophosphamide tablet</i>		2	[PAR]
<i>cyclosporine capsule, -solution</i>		2	[PAR]

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Drug	Generic	Tier	Requirements/ Limits
<i>cyclosporine injection</i> [INJ]		2	[PAR]
<i>cyclosporine modified</i>		2	[PAR]
DACOGEN [INJ]	<i>decitabine</i>	4	
DEPO-PROVERA 400 MG/ML VIAL [INJ]	<i>medroxyprogesterone</i>	3	
DROXIA	<i>hydroxyurea</i>	3	
ELIGARD [INJ]	<i>leuprolide</i>	3	[PAR]
ELITEK [INJ]	<i>rasburicase</i>	4	
EMCYT	<i>estramustine phosphate sodium</i>	3	
ENBREL [INJ]	<i>etanercept</i>	4	[PAR][QLL, 10/35]
<i>exemestane</i>		2	
FARESTON	<i>toremifene</i>	3	
FASLODEX [INJ]	<i>fulvestrant</i>	4	
<i>flutamide</i>		2	
<i>gengraf</i>		2	[PAR]
GLEEVEC	<i>imatinib mesylate</i>	4	[PAR]
HALAVEN [INJ]	<i>eribulin mesylate</i>	4	
HEXALEN	<i>altretamine</i>	4	
HUMIRA 20 MG/0.4 ML SYRINGE, -40 MG/0.8 ML SYRINGE [INJ]	<i>adalimumab</i>	4	[PAR][QLL, 5 syringes/35]
HUMIRA 40 MG/0.8 ML PEN, -PSORIASIS STARTER PACK [INJ]	<i>adalimumab</i>	4	[PAR][QLL, 6/180]
HUMIRA CROHN'S STARTER PACK [INJ]	<i>adalimumab</i>	4	[PAR][QLL, 6 syringes/180]
<i>hydroxyurea capsule</i>		2	
IRESSA	<i>gefitinib</i>	4	[LA]
<i>leflunomide</i>		2	[QLL, 34/34]
<i>letrozole</i>		2	
<i>leucovorin calcium injection</i> [INJ]		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>leucovorin calcium tablet</i>		2	
LEUKERAN	<i>chlorambucil</i>	3	
LYSODREN	<i>mitotane</i>	3	
MATULANE	<i>procarbazine</i>	4	
MEGACE ES	<i>megestrol</i>	3	
<i>megestrol acetate suspension oral, -tablet</i>		2	
<i>mercaptopurine tablet</i>		2	
<i>mesna</i> [INJ]		2	
MESNEX TABLET	<i>mesna</i>	4	
<i>methotrexate injection</i> [INJ]		2	[PAR]
<i>methotrexate tablet</i>		2	[PAR]
<i>mitoxantrone 25 mg/12.5 ml vl</i> [INJ]		2	[PAR]
<i>mycophenolate mofetil</i>		2	[PAR]
MYFORTIC	<i>mycophenolate sodium</i>	3	[PAR]
NEXAVAR	<i>sorafenib tosylate</i>	4	[LA]
NILANDRON	<i>nilutamide</i>	3	
<i>octreotide acet 200 mcg/ml vl, -acet 500 mcg/ml amp, -1,000 mcg/ml vial</i> [INJ]		4	
<i>octreotide acet 50 mcg/ml amp, -acet 100 mcg/ml amp</i> [INJ]		2	
ORENCIA [INJ]	<i>abatacept/maltose</i>	4	[PAR]
ORTHOCLONE OKT-3 [INJ]	<i>muronab-cd3</i>	3	[PAR]
PROGRAF INJECTION [INJ]	<i>tacrolimus</i>	3	[PAR]
RAPAMUNE 2 MG TABLET	<i>sirolimus</i>	4	[PAR]
RAPAMUNE SOLUTION, -0.5 MG TABLET, -1 MG TABLET	<i>sirolimus</i>	3	[PAR]
REMICADE [INJ]	<i>infliximab</i>	4	[PAR]
REVLIMID	<i>lenalidomide</i>	4	[LA]
RITUXAN [INJ]	<i>rituximab</i>	4	[PAR]

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Drug	Generic	Tier	Requirements/ Limits
SANDOSTATIN LAR 10 MG KIT, -30 MG KIT [INJ]	<i>octreotide</i>	4	[QLL, 1/28]
SANDOSTATIN LAR 20 MG KIT [INJ]	<i>octreotide</i>	4	[QLL, 2/28]
SIMULECT [INJ]	<i>basiliximab</i>	3	[PAR]
SPRYCEL	<i>dasatinib</i>	4	[PAR]
SUTENT	<i>sunitinib malate</i>	4	
TABLOID	<i>thioguanine</i>	3	
<i>tacrolimus 0.5 mg capsule, -1 mg capsule</i>		2	[PAR]
<i>tacrolimus 5 mg capsule</i>		4	[PAR]
<i>tamoxifen citrate tablet</i>		2	
TARCEVA	<i>erlotinib hcl</i>	4	
TARGRETIN	<i>bexarotene</i>	4	
TASIGNA 200 MG CAPSULE	<i>nilotinib hydrochloride</i>	4	[PAR]
TRELSTAR [INJ]	<i>triptorelin pamoate</i>	4	
<i>tretinoin capsule</i>		4	
TYKERB	<i>lapatinib ditosylate</i>	4	[PAR]
TYSABRI [INJ]	<i>natalizumab</i>	4	[PAR][LA]
VANDETANIB	<i>vandetanib</i>	4	[LA]
VELCADE [INJ]	<i>bortezomib</i>	4	
VIDAZA [INJ]	<i>azacitidine</i>	4	
VOTRIENT	<i>pazopanib</i>	4	
ZOLINZA	<i>vorinostat</i>	4	
ZORTRESS 0.25 MG TABLET	<i>everolimus</i>	3	[PAR]
ZORTRESS 0.5 MG TABLET, -0.75 MG TABLET	<i>everolimus</i>	4	[PAR]
ZYTIGA	<i>abiraterone acetate</i>	4	

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## AUTONOMIC AND CNS MEDICATIONS

### ANALGESICS

Drug	Generic	Tier	Requirements/ Limits
<i>buprenorphine hcl injection</i> [INJ]		2	
<i>butorphanol tartrate injection</i> [INJ]		2	
<i>nalbuphine hcl injection</i> [INJ]		2	
<i>tramadol hcl tablet</i>		2	[QLL, 272/34]
<i>tramadol hcl tablet sustained release 24hr</i>		2	[QLL, 34/34]
<i>tramadol hcl-acetaminophen</i>		2	[QLL, 272/34]

### ANTIDEMENTIA DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>donepezil hcl</i>		2	
EXELON PATCH TRANSDERMAL 24 HOURS, -SOLUTION	<i>rivastigmine tartrate</i>	3	[ST]
<i>galantamine hbr</i>		2	
<i>galantamine hydrobromide</i>		2	
NAMENDA	<i>memantine hcl</i>	3	
<i>rivastigmine</i>		2	

### ANTIMANIA DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>lithium</i>		2	
<i>lithium carbonate capsule, -tablet, -tablet sustained action</i>		1	

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## ANTIPARKINSON ANTICHOLINERGIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>benztropine mesylate injection</i> [INJ]		2	
<i>benztropine mesylate tablet</i>		1	
<i>trihexyphenidyl hcl elixir</i>		2	
<i>trihexyphenidyl hcl tablet</i>		1	

## ANTIPSYCHOTIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
ABILIFY 2 MG TABLET, -5 MG TABLET, -10 MG TABLET, -15 MG TABLET	<i>aripiprazole</i>	3	[QLL, 34/34]
ABILIFY 20 MG TABLET, -30 MG TABLET	<i>aripiprazole</i>	4	[QLL, 34/34]
ABILIFY DISCMELT	<i>aripiprazole</i>	3	[QLL, 68/34]
ABILIFY INJECTION [INJ]	<i>aripiprazole</i>	3	
ABILIFY SOLUTION	<i>aripiprazole</i>	3	
<i>chlorpromazine hcl injection</i> [INJ]		2	
<i>chlorpromazine hcl tablet</i>		2	
<i>clozapine</i>		2	
FANAPT TABLET	<i>iloperidone</i>	3	[QLL, 68/34]
FANAPT TABLET DOSE PACK	<i>iloperidone</i>	3	[QLL, 1/34]
FAZACLO	<i>clozapine</i>	3	
<i>fluphenazine decanoate</i> [INJ]		2	
<i>fluphenazine hcl elixir, -solution, -tablet</i>		2	
<i>fluphenazine hcl injection</i> [INJ]		2	
GEODON CAPSULE	<i>ziprasidone</i>	3	[QLL, 68/34]
GEODON INJECTION [INJ]	<i>ziprasidone</i>	3	
<i>haloperidol decanoate</i> [INJ]		2	
<i>haloperidol lactate injection</i> [INJ]		2	
<i>haloperidol lactate solution</i>		2	

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
<i>haloperidol tablet</i>		1	
INVEGA ER 1.5 MG TABLET, -ER 3 MG TABLET, -ER 9 MG TABLET	<i>paliperidone</i>	3	[QLL, 34/34]
INVEGA ER 6 MG TABLET	<i>paliperidone</i>	3	[QLL, 68/34]
INVEGA SUSTENNA 117 MG PREF SY, -156 MG PREF SY, -234 MG PREF SY [INJ]	<i>paliperidone</i>	4	
INVEGA SUSTENNA 39 MG PREF SYR, -78 MG PREF SYR [INJ]	<i>paliperidone</i>	3	
LATUDA	<i>lurasidone hcl</i>	3	[QLL, 34/34]
<i>loxapine</i>		2	
ORAP	<i>pimozide</i>	3	
<i>perphenazine</i>		2	
RISPERDAL CONSTA 12.5 MG SYR, -25 MG SYR [INJ]	<i>risperidone</i>	3	
RISPERDAL CONSTA 37.5 MG SYR, -50 MG SYR [INJ]	<i>risperidone</i>	4	
<i>risperidone odt</i>		2	[QLL, 68/34]
<i>risperidone solution</i>		2	[QLL, 544 ml/34]
<i>risperidone tablet</i>		2	[QLL, 68/34]
SAPHRIS	<i>asenapine</i>	3	[QLL, 68/34]
SEROQUEL 25 MG TABLET, -50 MG TABLET, -100 MG TABLET, -200 MG TABLET	<i>quetiapine fumarate</i>	3	[QLL, 102/34]
SEROQUEL 300 MG TABLET, -400 MG TABLET	<i>quetiapine fumarate</i>	3	[QLL, 68/34]
SEROQUEL XR 150 MG TABLET, -200 MG TABLET	<i>quetiapine fumarate</i>	3	[QLL, 34/34]
SEROQUEL XR 50 MG TABLET, -300 MG TABLET, -400 MG TABLET	<i>quetiapine fumarate</i>	3	[QLL, 68/34]
<i>thioridazine hcl</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>thiothixene</i>		1	
<i>trifluoperazine hcl</i>		2	
ZYPREXA 15 MG TABLET, -20 MG TABLET	<i>olanzapine</i>	4	[QLL, 34/34]
ZYPREXA 2.5 MG TABLET, -5 MG TABLET, -7.5 MG TABLET, -10 MG TABLET	<i>olanzapine</i>	3	[QLL, 34/34]
ZYPREXA INJECTION [INJ]	<i>olanzapine</i>	3	
ZYPREXA ZYDIS 15 MG TABLET, -20 MG TABLET	<i>olanzapine</i>	4	[QLL, 34/34]
ZYPREXA ZYDIS 5 MG TABLET, -10 MG TABLET	<i>olanzapine</i>	3	[QLL, 34/34]

### ANTIVERTIGO AND ANTIEMETIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
ALOXI [INJ]	<i>palonosetron hcl</i>	4	[QLL, 10/30]
CESAMET	<i>nabilone</i>	4	[PAR][QLL, 30/5]
<i>compro</i>		2	
<i>dronabinol 10 mg capsule</i>		4	[PAR]
<i>dronabinol 2.5 mg capsule, -5 mg capsule</i>		2	[PAR]
EMEND 40 MG CAPSULE, -125 MG CAPSULE	<i>aprepitant</i>	3	[PAR][QLL, 1/1]
EMEND 80 MG CAPSULE	<i>aprepitant</i>	3	[PAR][QLL, 2/2]
EMEND INJECTION [INJ]	<i>aprepitant</i>	3	
EMEND TRIFOLD PACK	<i>aprepitant</i>	3	[PAR][QLL, 3/3]
<i>granisetron hcl injection [INJ]</i>		2	
<i>granisetron hcl tablet</i>		2	[PAR][QLL, 2/1]
<i>granisol</i>		2	[PAR][QLL, 30 ml/3]

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Drug	Generic	Tier	Requirements/ Limits
<i>meclizine hcl tablet</i>		2	
<i>ondansetron hcl 24 mg tablet</i>		2	[PAR][QLL, 1/1]
<i>ondansetron hcl 4 mg tablet, -8 mg tablet</i>		2	[PAR][QLL, 12/5]
<i>ondansetron hcl injection [INJ]</i>		2	
<i>ondansetron hcl solution</i>		2	[PAR][QLL, 150 ml/5]
<i>ondansetron odt</i>		2	[PAR][QLL, 12/5]
<i>phenadoz</i>		2	
<i>prochlorperazine edisylate [INJ]</i>		2	
<i>prochlorperazine maleate suppository rectal</i>		2	
<i>prochlorperazine maleate tablet</i>		1	
<i>promethazine hcl suppository rectal</i>		2	
<i>promethegan</i>		2	
<i>trimethobenzamide hcl capsule</i>		2	
<i>trimethobenzamide hcl injection [INJ]</i>		2	

## ANXIOLYTICS

Drug	Generic	Tier	Requirements/ Limits
<i>bupirone hcl tablet</i>		2	
<i>meprobamate</i>		2	

## CARBAMAZEPINES

Drug	Generic	Tier	Requirements/ Limits
<i>carbamazepine suspension oral</i>		2	
<i>carbamazepine tablet, -tablet chewable</i>		1	
<i>carbamazepine xr</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>epitol</i>		1	
<i>oxcarbazepine</i>		2	
TEGRETOL XR 100 MG TABLET	<i>carbamazepine</i>	3	

## CLASS II NARCOTICS

Drug	Generic	Tier	Requirements/ Limits
<i>codeine sulfate</i>		2	
<i>endocet</i>		2	
<i>endodan</i>		2	
<i>fentanyl</i>		2	
<i>fentanyl citrate injection</i> [INJ]		2	
<i>fentanyl citrate lozenge</i>		4	[PAR][QLL, 120/30]
<i>hydromorphone hcl injection</i> [INJ]		2	
<i>hydromorphone hcl tablet</i>		2	
<i>levorphanol tartrate tablet</i>		2	
<i>meperidine hcl injection</i> [INJ]		2	
<i>methadone hcl injection</i> [INJ]		2	
<i>methadone hcl solution, -tablet</i>		2	
<i>methadose</i>		2	
<i>morphine sulfate injection</i> [INJ]		2	
<i>morphine sulfate solution, -tablet</i>		2	
<i>morphine sulfate tablet sustained action</i>		2	[QLL, 120/30]
OPANA ER 40 MG TABLET	<i>oxymorphone</i>	4	[QLL, 90/30][ST]
OPANA ER 5 MG TABLET, -7.5 MG TABLET, -10 MG TABLET, -15 MG TABLET, -20 MG TABLET, -30 MG TABLET	<i>oxymorphone</i>	3	[QLL, 90/30][ST]
<i>oxycodone concentrate</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>oxycodone hcl</i>		2	
<i>oxycodone hcl-acetaminophen</i>		2	
<i>oxycodone hcl-aspirin</i>		2	
<i>oxycodone hcl-ibuprofen</i>		2	
<i>oxycodone-acetaminophen</i>		2	
<i>oxycodone-aspirin</i>		2	
OXYCONTIN 10 MG TABLET, -15 MG TABLET, -20 MG TABLET, -30 MG TABLET, -40 MG TABLET, -60 MG TABLET	<i>oxycodone</i>	3	[QLL, 90/30][ST]
OXYCONTIN 80 MG TABLET	<i>oxycodone</i>	4	[QLL, 90/30][ST]
<i>oxymorphone hcl</i>		2	
<i>roxicet tablet</i>		2	

### CLASS III NARCOTICS

Drug	Generic	Tier	Requirements/ Limits
<i>acetaminoph-caff-dihydrocodein</i>		2	
<i>acetaminophen-codeine</i>		2	
<i>buprenorphine hcl tablet sublingual</i>		2	
<i>co-gesic</i>		2	
<i>hydrocodone bit-ibuprofen</i>		2	
<i>hydrocodone-acetaminophen</i>		2	
<i>margesic h</i>		2	
<i>reprexain</i>		2	
<i>stagesic</i>		2	
SUBOXONE TABLET SUBLINGUAL	<i>buprenorphine/naloxone</i>	3	[PAR][QLL, 102/34]
<i>zamicet</i>		2	

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## CNS STIMULANT DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>amphetamine salt combo</i>		2	
<i>dexmethylphenidate hcl</i>		2	
<i>dextroamphetamine sulfate</i>		2	
METADATE CD	<i>methylphenidate</i>	3	
<i>metadate er</i>		2	
<i>methamphetamine hcl</i>		2	
<i>methylin er</i>		2	
<i>methylin tablet</i>		2	
<i>methylphenidate hcl solution, -tablet</i>		2	
<i>methylphenidate sr</i>		2	
PROVIGIL	<i>modafinil</i>	3	[PAR]

## DRUGS TO PREVENT AND TREAT HEADACHES

Drug	Generic	Tier	Requirements/ Limits
<i>ascomp with codeine</i>		2	
<i>butalb-caff-acetaminoph-codein</i>		2	
<i>butorphanol tartrate aerosol spray</i>		2	[QLL, 5 ml/3]
<i>dihydroergotamine mesylate injection [INJ]</i>		2	
ERGOMAR	<i>ergotamine</i>	3	
<i>ergotamine-caffeine</i>		2	
FROVA	<i>frovatriptan</i>	3	[QLL, 27/28]
MAXALT	<i>rizatriptan benzoate</i>	3	[QLL, 36/28]
MAXALT MLT	<i>rizatriptan benzoate</i>	3	[QLL, 36/28]
<i>migergot</i>		2	
<i>naratriptan hcl</i>		2	[QLL, 18/28]
<i>sumatriptan 4 mg/0.5 ml vial, -6 mg/0.5 ml vial [INJ]</i>		2	[QLL, 16 ml/28]

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Drug	Generic	Tier	Requirements/ Limits
<i>sumatriptan succinate tablet</i>		2	[QLL, 18/28]
ZOMIG SPRAY NON-AEROSOL	<i>zolmitriptan</i>	3	[QLL, 18 nasal sprayers/28]

### HYDANTOINS

Drug	Generic	Tier	Requirements/ Limits
DILANTIN 30 MG CAPSULE, -TABLET CHEWABLE	<i>phenytoin</i>	3	
<i>fosphenytoin sodium</i> [INJ]		2	
PEGANONE	<i>ethotoin</i>	3	
<i>phenytoin sodium extended</i>		2	
<i>phenytoin sodium injection</i> [INJ]		2	
<i>phenytoin suspension oral</i>		2	

### MAO INHIBITORS

Drug	Generic	Tier	Requirements/ Limits
EMSAM	<i>selegiline</i>	3	
MARPLAN	<i>isocarboxazid</i>	3	
<i>phenelzine sulfate tablet</i>		2	
<i>tranylcypromine sulfate</i>		2	

### OTHER ANTICONVULSANTS

Drug	Generic	Tier	Requirements/ Limits
BANZEL 400 MG TABLET	<i>rufinamide</i>	4	
BANZEL SUSPENSION ORAL, -200 MG TABLET	<i>rufinamide</i>	3	
FELBATOL	<i>felbamate</i>	3	
<i>gabapentin capsule, -tablet</i>		1	

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Drug	Generic	Tier	Requirements/ Limits
<i>gabapentin solution</i>		2	
GABITRIL	<i>tiagabine</i>	3	
<i>lamotrigine</i>		2	
<i>levetiracetam injection [INJ]</i>		2	
<i>levetiracetam solution, -tablet</i>		2	
LYRICA	<i>pregabalin</i>	3	[ST]
<i>primidone tablet</i>		2	
SABRIL	<i>vigabatrin</i>	4	[LA]
<i>topiramate capsule sprinkle, -tablet</i>		2	[PAR]
VIMPAT INJECTION [INJ]	<i>lacosamide</i>	3	
VIMPAT SOLUTION, -TABLET	<i>lacosamide</i>	3	[PAR]
<i>zonisamide</i>		2	[PAR]

#### OTHER ANTIDEPRESSANTS

Drug	Generic	Tier	Requirements/ Limits
<i>budeprion sr</i>		2	[QLL, 68/34]
<i>budeprion xl</i>		2	[QLL, 34/34]
<i>bupropion hcl sr</i>		2	[QLL, 68/34]
<i>bupropion hcl tablet</i>		2	
CYMBALTA 20 MG CAPSULE, -60 MG CAPSULE	<i>duloxetine</i>	3	[QLL, 68/34][ST]
CYMBALTA 30 MG CAPSULE	<i>duloxetine</i>	3	[QLL, 34/34][ST]
<i>maprotiline hcl</i>		2	
<i>mirtazapine</i>		2	
<i>nefazodone hcl</i>		2	
<i>perphenazine-amitriptyline</i>		2	
PRISTIQ	<i>desvenlafaxine succinate</i>	3	[QLL, 34/34][ST]

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Drug	Generic	Tier	Requirements/ Limits
SAVELLA TABLET	<i>milnacipran hcl</i>	3	[QLL, 68/34][ST]
SAVELLA TABLET DOSE PACK	<i>milnacipran hcl</i>	3	[QLL, 1/34][ST]
<i>trazodone hcl tablet</i>		1	
<i>venlafaxine hcl</i>		2	[QLL, 102/34]
<i>venlafaxine hcl er 37.5 mg cap, -150 mg cap</i>		2	[QLL, 34/34]
<i>venlafaxine hcl er 75 mg cap</i>		2	[QLL, 102/34]

#### **OTHER ANTIPARKINSON DRUGS**

Drug	Generic	Tier	Requirements/ Limits
APOKYN [INJ]	<i>apomorphine hcl</i>	4	[LA]
AZILECT	<i>rasagiline mesylate</i>	3	
<i>bromocriptine mesylate capsule, -tablet</i>		2	
<i>carbidopa-levodopa</i>		2	
COMTAN	<i>entacapone</i>	3	
LODOSYN	<i>carbidopa</i>	3	
<i>pramipexole dihydrochloride</i>		2	
<i>ropinirole hcl</i>		2	
<i>selegiline hcl capsule, -tablet</i>		2	
STALEVO 100	<i>carbidopa/levodopa/entacap</i>	3	
STALEVO 125	<i>carbidopa/levodopa/entacap</i>	3	
STALEVO 150	<i>carbidopa/levodopa/entacap</i>	3	
STALEVO 200	<i>carbidopa/levodopa/entacap</i>	3	
STALEVO 50	<i>carbidopa/levodopa/entacap</i>	3	
STALEVO 75	<i>carbidopa/levodopa/entacap</i>	3	
TASMAR	<i>tolcapone</i>	4	

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## OTHER CNS/AUTONOMIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
ANTABUSE 250 MG TABLET [G]	<i>disulfiram</i>	3	
ANTABUSE 500 MG TABLET	<i>disulfiram</i>	3	
<i>atropine sulfate injection</i> [INJ]		2	
<i>depade</i>		2	
<i>guanidine hcl</i>		2	
MESTINON SYRUP, -TABLET SUSTAINED ACTION	<i>pyridostigmine</i>	3	
<i>naloxone hcl injection</i> [INJ]		2	
<i>naltrexone hcl tablet</i>		2	
NUEDEXTA	<i>dextromethorphan/quinidine</i>	3	[PAR]
<i>pyridostigmine bromide</i>		2	
STRATTERA	<i>atomoxetine</i>	3	[ST]
XENAZINE	<i>tetrabenazine</i>	4	[PAR][LA]
XYREM	<i>sodium oxybate</i>	4	[LA]

## SECONDARY AMINES

Drug	Generic	Tier	Requirements/ Limits
<i>amoxapine</i>		2	
<i>desipramine hcl tablet</i>		2	
<i>nortriptyline hcl capsule, -solution</i>		2	
<i>protriptyline hcl</i>		2	

## SEDATIVE/HYPNOTIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
ROZEREM	<i>ramelteon</i>	3	[QLL, 34/34][ST]
<i>zaleplon 10 mg capsule</i>		2	[QLL, 68/34]

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Drug	Generic	Tier	Requirements/ Limits
<i>zaleplon 5 mg capsule</i>		2	[QLL, 34/34]
<i>zolpidem tartrate</i>		2	[QLL, 34/34]

### SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Drug	Generic	Tier	Requirements/ Limits
<i>citalopram</i>		2	
<i>citalopram hbr</i>		1	[QLL, 34/34]
<i>fluoxetine dr</i>		2	[QLL, 5/34]
<i>fluoxetine hcl 10 mg capsule, -10 mg tablet</i>		2	[QLL, 34/34]
<i>fluoxetine hcl 20 mg capsule, -solution, -20 mg tablet</i>		2	
<i>fluoxetine hcl 40 mg capsule</i>		2	[QLL, 68/34]
<i>fluvoxamine maleate 100 mg tab</i>		2	[QLL, 102/34]
<i>fluvoxamine maleate 25 mg tab</i>		2	[QLL, 34/34]
<i>fluvoxamine maleate 50 mg tab</i>		2	[QLL, 68/34]
<i>paroxetine hcl 10 mg tablet, -40 mg tablet</i>		1	[QLL, 34/34]
<i>paroxetine hcl 20 mg tablet, -30 mg tablet</i>		1	[QLL, 68/34]
<i>paroxetine hcl suspension oral</i>		2	
<i>paroxetine hcl tablet sustained release 24hr</i>		2	[QLL, 68/34]
<i>rapiflux</i>		2	
<i>selfemra 10 mg capsule</i>		2	[QLL, 35/14]
<i>selfemra 20 mg capsule</i>		2	[QLL, 140/14]
<i>sertraline hcl 25 mg tablet</i>		1	[QLL, 34/34]
<i>sertraline hcl 50 mg tablet, -100 mg tablet</i>		1	[QLL, 68/34]
<i>sertraline hcl solution</i>		2	
VIIBRYD	<i>vilazodone hydrochloride</i>	3	[QLL, 34/34][ST]

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## SMOKING CESSATION PRODUCTS

Drug	Generic	Tier	Requirements/ Limits
<i>buproban</i>		2	
CHANTIX	<i>varenicline tartrate</i>	3	
NICOTROL	<i>nicotine inhaler</i>	3	
NICOTROL NS	<i>nicotine ns</i>	3	

## SUCCINIMIDES

Drug	Generic	Tier	Requirements/ Limits
CELONTIN	<i>methsuximide</i>	3	
<i>ethosuximide capsule, -syrup</i>		2	

## TERTIARY AMINES

Drug	Generic	Tier	Requirements/ Limits
<i>amitriptyline hcl tablet</i>		2	
<i>clomipramine hcl capsule</i>		2	
<i>doxepin hcl capsule, -solution</i>		2	
<i>imipramine hcl tablet</i>		2	
<i>imipramine pamoate</i>		2	
SURMONTIL	<i>trimipramine</i>	3	

## VALPROIC ACID AND DERIVATIVES

Drug	Generic	Tier	Requirements/ Limits
<i>divalproex sodium</i>		2	
<i>divalproex sodium er</i>		2	
<i>valproate sodium injection [INJ]</i>		2	
<i>valproic acid capsule, -syrup</i>		2	

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## CARDIOVASCULAR MEDICATIONS

### AMIODARONES

Drug	Generic	Tier	Requirements/ Limits
<i>amiodarone hcl injection</i> [INJ]		2	
<i>amiodarone hcl tablet</i>		2	
<i>pacerone 200 mg tablet</i>		2	

### ANGIOTENSIN CONVERTING ENZYME INHIBITORS

Drug	Generic	Tier	Requirements/ Limits
<i>benazepril hcl</i>		1	
<i>captopril tablet</i>		1	
<i>enalapril maleate tablet</i>		1	
<i>fosinopril sodium</i>		2	
<i>lisinopril tablet</i>		1	
<i>moexipril hcl</i>		2	
<i>perindopril erbumine</i>		2	
<i>quinapril hcl</i>		1	
<i>ramipril</i>		1	
<i>trandolapril</i>		2	

### ANGIOTENSIN II RECEPTOR ANTAGONISTS

Drug	Generic	Tier	Requirements/ Limits
DIOVAN	<i>valsartan</i>	3	[ST]
<i>losartan potassium</i>		2	
MICARDIS	<i>telmisartan</i>	3	[ST]

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## ANTIDYSRHYTHMIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>flecainide acetate</i>		2	
<i>mexiletine hcl capsule</i>		2	
<i>procainamide hcl injection</i> [INJ]		2	
<i>propafenone hcl</i>		2	
<i>quinidine gluconate injection</i> [INJ]		2	
<i>quinidine gluconate tablet sustained action</i>		2	
<i>quinidine sulfate tablet, -tablet sustained action</i>		2	

## BETA-ADRENERGIC ANTAGONIST DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>acebutolol hcl capsule</i>		2	
<i>atenolol tablet</i>		1	
<i>betaxolol hcl tablet</i>		2	
<i>bisoprolol fumarate</i>		2	
<i>carvedilol</i>		1	
<i>labetalol hcl injection</i> [INJ]		2	
<i>labetalol hcl tablet</i>		2	
<i>metoprolol succinate</i>		2	
<i>metoprolol tartrate injection</i> [INJ]		2	
<i>metoprolol tartrate tablet</i>		1	
<i>nadolol tablet</i>		1	
<i>pindolol</i>		2	
<i>propranolol hcl capsule sustained action, - tablet</i>		1	
<i>propranolol hcl injection</i> [INJ]		2	
<i>propranolol hcl solution</i>		2	
<i>timolol maleate tablet</i>		1	

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## CALCIUM ANTAGONISTS

Drug	Generic	Tier	Requirements/ Limits
<i>afeditab cr</i>		2	
<i>amlodipine besylate tablet</i>		1	
<i>cartia xt</i>		2	
<i>dilt-cd</i>		2	
<i>diltiazem 24hr er</i>		2	
<i>diltiazem er</i>		2	
<i>diltiazem hcl injection [INJ]</i>		2	
<i>diltiazem hcl tablet</i>		1	
<i>dilt-xr</i>		2	
<i>diltzac er</i>		2	
<i>felodipine er</i>		2	
<i>isradipine</i>		2	
<i>matzim la</i>		2	
<i>nicardipine hcl capsule</i>		2	
<i>nicardipine hcl injection [INJ]</i>		2	
<i>nifediac cc</i>		2	
<i>nifedical xl</i>		2	
<i>nifedipine er</i>		2	
<i>nimodipine</i>		2	
<i>nisoldipine</i>		2	
<i>taztia xt</i>		2	
<i>verapamil er</i>		1	
<i>verapamil er pm</i>		2	
<i>verapamil hcl injection [INJ]</i>		2	
<i>verapamil hcl tablet, -tablet sustained action</i>		1	

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**CARDIAC GLYCOSIDES**

Drug	Generic	Tier	Requirements/ Limits
<i>digoxin injection</i> [INJ]		2	
<i>digoxin solution</i>		2	
<i>digoxin tablet</i>		1	

**CENTRALLY ACTING ANTIHYPERTENSIVES**

Drug	Generic	Tier	Requirements/ Limits
<i>clonidine</i>		2	[QLL, 5/35]
<i>clonidine hcl tablet</i>		1	
<i>guanabenz acetate tablet</i>		2	
<i>guanfacine hcl</i>		1	
<i>methyldopa</i>		1	
<i>methyldopate hcl</i> [INJ]		2	

**DRUGS FOR PHEOCHROMOCYTOMA**

Drug	Generic	Tier	Requirements/ Limits
DEMSER	<i>metirosine</i>	3	
DIBENZYLINE	<i>phenoxybenzamine</i>	3	

**ENDOTHELIN RECPTR ANTAGONIST**

Drug	Generic	Tier	Requirements/ Limits
LETAIRIS	<i>ambrisentan</i>	4	[PAR][LA]
TRACLEER	<i>bosentan</i>	4	[PAR][LA]

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## HMG-COA REDUCTASE INHIBITORS

Drug	Generic	Tier	Requirements/ Limits
ADVICOR 500 MG-20 MG TABLET	<i>lovastatin/niacin</i>	3	[QLL, 34/34]
ADVICOR 750 MG-20 MG TABLET, -1,000 MG-20 MG TABLET, -1,000 MG-40 MG TABLET	<i>lovastatin/niacin</i>	3	[QLL, 68/34]
CRESTOR 10 MG TABLET, -20 MG TABLET, -40 MG TABLET	<i>rosuvastatin calcium</i>	3	[QLL, 34/34]
CRESTOR 5 MG TABLET	<i>rosuvastatin calcium</i>	3	[QLL, 34/34][ST]
<i>lovastatin 10 mg tablet</i>		1	[QLL, 34/34]
<i>lovastatin 20 mg tablet, -40 mg tablet</i>		1	[QLL, 68/34]
<i>pravastatin sodium</i>		1	[QLL, 34/34]
SIMCOR 500-20 MG TABLET, -500-40 MG TABLET, -1,000-40 MG TABLET	<i>niacin/simvastatin</i>	3	[QLL, 34/34]
SIMCOR 750-20 MG TABLET, -1,000-20 MG TABLET	<i>niacin/simvastatin</i>	3	[QLL, 68/34]
<i>simvastatin</i>		1	[QLL, 34/34]
VYTORIN 10-10 MG TABLET	<i>ezetimibe/simvastatin</i>	3	[QLL, 34/34][ST]
VYTORIN 10-20 MG TABLET, -10-40 MG TABLET, -10-80 MG TABLET	<i>ezetimibe/simvastatin</i>	3	[QLL, 34/34]

## HYPOLIPOPROTEINEMICS

Drug	Generic	Tier	Requirements/ Limits
<i>cholestyramine light</i>		2	
<i>colestipol hcl</i>		2	
<i>fenofibrate</i>		2	
<i>gemfibrozil tablet</i>		2	
LIPOFEN	<i>fenofibrate</i>	3	[ST]
LOVAZA	<i>omega-3 acid ethyl esters</i>	3	

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Drug	Generic	Tier	Requirements/ Limits
NIASPAN	<i>niacin</i>	3	
<i>prevalite</i>		2	
WELCHOL	<i>colesevelam</i>	3	[ST]
ZETIA	<i>ezetimibe</i>	3	[ST]

### LOOP DIURETICS

Drug	Generic	Tier	Requirements/ Limits
<i>bumetanide injection</i> [INJ]		2	
<i>bumetanide tablet</i>		2	
<i>furosemide injection</i> [INJ]		2	
<i>furosemide solution</i>		2	
<i>furosemide tablet</i>		1	
<i>toremide injection</i> [INJ]		2	
<i>toremide tablet</i>		2	

### NITRATES

Drug	Generic	Tier	Requirements/ Limits
<i>isosorbide dinitrate</i>		2	
<i>isosorbide mononitrate</i>		1	
<i>nitro-bid</i>		2	
<i>nitroglycerin injection</i> [INJ]		2	
<i>nitroglycerin patch</i>		2	
NITROSTAT	<i>nitroglycerin</i>	3	

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## OTHER ANTIARRHYTHMICS

Drug	Generic	Tier	Requirements/ Limits
<i>sorine</i>		2	
<i>sotalol</i>		2	
TIKOSYN	<i>dofetilide</i>	3	

## OTHER ANTIHYPERTENSIVES

Drug	Generic	Tier	Requirements/ Limits
<i>amlodipine besylate-benazepril</i>		2	
AMTURNIDE	<i>aliskiren/amlodipine/hctz</i>	3	[ST]
<i>atenolol-chlorthalidone</i>		1	
<i>benazepril-hydrochlorothiazide</i>		1	
<i>bisoprolol-hydrochlorothiazide</i>		1	
<i>captopril-hydrochlorothiazide</i>		1	
DIOVAN HCT	<i>hctz/valsartan</i>	3	[ST]
<i>enalapril-hydrochlorothiazide</i>		1	
EXFORGE	<i>amlodipine/valsartan</i>	3	[ST]
EXFORGE HCT	<i>amlodipine/valsartan/hctz</i>	3	[ST]
<i>fosinopril-hydrochlorothiazide</i>		2	
<i>lisinopril-hydrochlorothiazide</i>		1	
<i>losartan-hydrochlorothiazide</i>		2	
<i>methyldopa-hydrochlorothiazide</i>		2	
<i>metoprolol-hydrochlorothiazide</i>		2	
MICARDIS HCT	<i>telmisartan/hctz</i>	3	[ST]
<i>moexipril-hydrochlorothiazide</i>		2	
<i>nadolol-bendroflumethiazide</i>		2	
<i>propranolol-hydrochlorothiazid</i>		1	
<i>quinapril-hydrochlorothiazide</i>		2	
<i>reserpine tablet</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
TEKAMLO	<i>aliskiren/amlodipine</i>	3	[ST]
TEKTURNA	<i>aliskiren hemifumarate</i>	3	[ST]
TEKTURNA HCT	<i>aliskiren/hydrochlorothiazid</i>	3	[ST]
TWYNSTA	<i>telmisartan/amlodipine</i>	3	[ST]

#### OTHER CARDIOVASCULAR DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>midodrine hcl</i>		2	
<i>pentopak</i>		2	
<i>pentoxifylline tablet sustained action</i>		2	
RANEXA	<i>ranolazine</i>	3	

#### OTHER VASODILATING DRUGS

Drug	Generic	Tier	Requirements/ Limits
ADCIRCA	<i>adcirca (tadalafil)</i>	4	[PAR][QLL, 68/34]
REMODULIN [INJ]	<i>treprostinil sodium</i>	4	[PAR][LA]
REVATIO INJECTION [INJ]	<i>revatio (sildenafil citrate)</i>	4	
REVATIO TABLET	<i>revatio (sildenafil citrate)</i>	4	[PAR][QLL, 102/34]

#### POTASSIUM SPARING DIURETICS

Drug	Generic	Tier	Requirements/ Limits
<i>amiloride hcl tablet</i>		2	
<i>amiloride-hydrochlorothiazide</i>		1	
<i>eplerenone</i>		2	
<i>spironolactone tablet</i>		1	
<i>spironolactone-hctz</i>		1	

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Drug	Generic	Tier	Requirements/ Limits
<i>triamterene-hctz</i>		1	
<i>triamterene-hydrochlorothiazid</i>		1	

### THIAZIDE AND RELATED DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>chlorothiazide</i>		2	
<i>chlorothiazide sodium</i> [INJ]		4	
<i>chlorthalidone</i>		1	
<i>hydrochlorothiazide capsule, -tablet</i>		1	
<i>indapamide</i>		1	
<i>methyclothiazide</i>		2	
<i>metolazone</i>		2	

### VASODILATOR ANTIHYPERTENSIVES

Drug	Generic	Tier	Requirements/ Limits
<i>doxazosin mesylate 1 mg tab, -2 mg tab, -4 mg tab</i>		1	[QLL, 34/34]
<i>doxazosin mesylate 8 mg tab</i>		1	[QLL, 68/34]
<i>hydralazine hcl injection</i> [INJ]		2	
<i>hydralazine hcl tablet</i>		2	
<i>minoxidil tablet</i>		2	
<i>prazosin hcl</i>		1	
<i>terazosin 1 mg capsule, -2 mg capsule, -5 mg capsule</i>		1	[QLL, 34/34]
<i>terazosin 10 mg capsule</i>		1	[QLL, 68/34]

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## DERMATOLOGICAL MEDICATIONS

### ANTIACNE DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>adapalene</i>		2	[PAR]
<i>clindamycin phosphate foam, -gel, -lotion, -solution non-oral, -swab medicated</i>		2	
<i>clindamycin-benzoyl peroxide</i>		2	
<i>ery</i>		2	
<i>erythromycin gel, -solution non-oral</i>		2	
<i>erythromycin-benzoyl peroxide</i>		2	
<i>metronidazole cream, -gel, -lotion</i>		2	
<i>tretinoin 0.025% cream, -0.05% cream, -0.1% cream, -gel</i>		2	[PAR]

### ANTIPRURITIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>hydroxyzine hcl injection</i> [INJ]		2	
<i>hydroxyzine hcl syrup, -tablet</i>		2	[PAR]
<i>hydroxyzine pamoate capsule</i>		2	[PAR]

### ANTIPSORIASIS AND ANTIECZEMA DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>calcipotriene</i>		2	
DOVONEX CREAM	<i>calcipotriene</i>	3	
<i>selenium sulfide 2.5% lotion</i>		2	
SORIATANE	<i>acitretin</i>	4	
<i>sulfacetamide sodium suspension topical</i>		2	
TAZORAC	<i>tazarotene</i>	3	[PAR]

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**KERATOLYTIC DRUGS**

Drug	Generic	Tier	Requirements/ Limits
<i>podofilox</i>		2	

**ORAL DERMATOLOGICAL DRUGS**

Drug	Generic	Tier	Requirements/ Limits
8-MOP	<i>methoxsalen</i>	4	
<i>amnesteem</i>		2	
<i>claravis</i>		2	
OXSORALEN-ULTRA	<i>methoxsalen</i>	4	
<i>sotret</i>		2	

**SCABICIDES**

Drug	Generic	Tier	Requirements/ Limits
<i>acticin</i>		2	
EURAX	<i>crotamiton</i>	3	
LINDANE	<i>benzene hexachloride gamma</i>	3	
<i>malathion</i>		2	
<i>permethrin cream</i>		2	

**TOPICAL CORTICOSTEROID DRUGS**

Drug	Generic	Tier	Requirements/ Limits
<i>alclometasone dipropionate</i>		2	
<i>amcinonide</i>		2	
<i>betamethasone dipropionate cream, -lotion, - ointment</i>		2	
<i>betamethasone valerate cream, -lotion, - ointment</i>		2	
<i>clobetasol emollient</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>clobetasol propionate gel, -ointment, -solution non-oral</i>		2	
<i>desonide cream, -lotion, -ointment</i>		2	
<i>desoximetasone cream, -gel, -ointment</i>		2	
<i>diflorasone diacetate</i>		2	
<i>fluocinolone acetonide cream, -ointment, -solution non-oral</i>		2	
<i>fluocinonide emollient</i>		2	
<i>fluocinonide gel, -ointment, -solution non-oral</i>		2	
<i>fluticasone propionate cream, -ointment</i>		2	
<i>halobetasol propionate</i>		2	
<i>hydrocortisone 1% cream, -2.5% cream, -2.5% lotion, -1% absorbate, -1% ointment, -2.5% ointment</i>		2	
<i>hydrocortisone acetate</i>		2	
<i>hydrocortisone butyrate</i>		2	
<i>hydrocortisone plus 1% cream, —aloe 1% cream, -1% oint</i>		2	
<i>hydrocortisone valerate</i>		2	
<i>mometasone furoate cream, -ointment, -solution non-oral</i>		2	
<i>prednicarbate</i>		2	
<i>triamcinolone acetonide cream, -lotion, -ointment</i>		2	
<i>triderm</i>		2	

### TOPICAL DERMATOLOGICAL DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>ammonium lactate cream, -lotion</i>		2	
ELIDEL	<i>pimecrolimus</i>	3	[ST]

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Drug	Generic	Tier	Requirements/ Limits
FLUOROPLEX	<i>fluorouracil</i>	3	
<i>fluorouracil cream, -solution non-oral</i>		2	
<i>imiquimod cream</i>		2	
OXSORALEN	<i>methoxsalen</i>	3	
PANRETIN	<i>alitretinoin</i>	4	
PROTOPIC	<i>tacrolimus</i>	3	[ST]
REGRANEX	<i>becaplermin</i>	3	[PAR][QLL, 30 gm/34]
SANTYL	<i>collagenase</i>	3	
SOLARAZE	<i>diclofenac sodium</i>	3	[PAR]
ZONALON	<i>doxepin</i>	3	
ZYCLARA	<i>imiquimod</i>	3	

## DIAGNOSTIC AND MISCELLANEOUS MEDICATIONS

### DIAGNOSTIC PRODUCTS

Drug	Generic	Tier	Requirements/ Limits
CHEMET	<i>succimer</i>	3	
EXJADE 125 MG TABLET	<i>deferasirox</i>	3	[LA]
EXJADE 250 MG TABLET, -500 MG TABLET	<i>deferasirox</i>	4	[LA]

### MISCELLANEOUS DRUGS

Drug	Generic	Tier	Requirements/ Limits
ADAGEN [INJ]	<i>pegademase bovine</i>	4	[LA]
AMPYRA	<i>dalfampridine</i>	4	[PAR][LA]
BUPHENYL	<i>sodium phenylbutyrate</i>	4	
COPAXONE [INJ]	<i>glatiramer acetate</i>	4	[PAR][QLL, 30 ml/30]

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Drug	Generic	Tier	Requirements/ Limits
CYKLOKAPRON [INJ]	<i>tranexamic acid</i>	3	
<i>ergoloid mesylates tablet</i>		2	
<i>fomepizole [INJ]</i>		2	
GILENYA	<i>fingolimod hydrochloride</i>	4	[PAR]
ORFADIN	<i>nitisinone</i>	4	[LA]
THALOMID	<i>thalidomide</i>	4	

## EAR-NOSE-THROAT MEDICATIONS

### DRUGS AFFECTING THE EAR

Drug	Generic	Tier	Requirements/ Limits
<i>acetazol hc</i>		2	
<i>acetic acid solution non-oral</i>		2	
<i>acetic acid-hydrocortisone</i>		2	
CIPRODEX	<i>ciprofloxacin/dexameth</i>	3	
<i>cortomycin</i>		2	
DERMOTIC	<i>fluocinolone acetonide</i>	3	
<i>neomycin-polymixin-hc ear susp, -ear susp</i>		2	
<i>neomycin-polymyxin-hydrocort</i>		2	
<i>ofloxacin 0.3% ear drops</i>		2	

### DRUGS AFFECTING THE NOSE

Drug	Generic	Tier	Requirements/ Limits
<i>azelastine hcl aerosol spray w/pump</i>		2	[QLL, 60 ml/34]
<i>flunisolide 0.025% spray</i>		2	[QLL, 75 ml/34]
<i>fluticasone propionate nasal inhaled steroids</i>		2	[QLL, 32 gm/34]
<i>ipratropium 0.03% spray</i>		2	[QLL, 60 ml/34]

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
<i>ipratropium 0.06% spray</i>		2	[QLL, 30 ml/34]
TYZINE	<i>tetrahydrozoline</i>	3	

### DRUGS AFFECTING THE THROAT AND MOUTH

Drug	Generic	Tier	Requirements/ Limits
<i>chlorhexidine gluconate mouthwash</i>		2	
<i>doxycycline hyclate 20 mg tab</i>		2	
<i>periogard</i>		2	
<i>pilocarpine hcl tablet</i>		2	
<i>triamcinolone acetonide paste</i>		2	

## ENDOCRINE MEDICATIONS

### ANTITHYROID DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>methimazole tablet</i>		2	
<i>propylthiouracil</i>		1	

### GLUCOCORTICOID DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>a-methapred [INJ]</i>		2	
<i>cortisone acetate tablet</i>		2	
<i>dexamethasone elixir</i>		2	
<i>dexamethasone intensol</i>		2	
<i>dexamethasone sodium phosphate injection [INJ]</i>		2	
<i>dexamethasone tablet</i>		1	
<i>hydrocortisone tablet</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>methylprednisolone acetate injection [INJ]</i>		2	
<i>methylprednisolone sod succ [INJ]</i>		2	
<i>methylprednisolone tablet, -tablet dose pack</i>		1	
<i>prednisolone sodium phosphate solution</i>		2	
<i>prednisolone solution oral</i>		2	
<i>prednisone intensol</i>		2	
<i>prednisone solution</i>		2	
<i>prednisone tablet</i>		1	
<i>veripred 20</i>		2	

### GLUCOSE ELEVATING DRUGS

Drug	Generic	Tier	Requirements/ Limits
GLUCAGEN [INJ]	<i>glucagon, human recombinant</i>	3	
GLUCAGON EMERGENCY KIT [INJ]	<i>glucagon, human recombinant</i>	3	
PROGLYCEM	<i>diazoxide</i>	3	

### HYPOGLYCEMIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
BYETTA 10 MCG DOSE PEN INJ [INJ]	<i>exenatide</i>	3	[PAR][QLL, 5 ml/34]
BYETTA 5 MCG DOSE PEN INJ [INJ]	<i>exenatide</i>	3	[PAR][QLL, 2 ml/34]
SYMLIN [INJ]	<i>pramlintide acetate</i>	3	[PAR][QLL, 35 ml/34]
SYMLINPEN 120 [INJ]	<i>pramlintide acetate</i>	3	[PAR][QLL, 22 ml/34]
SYMLINPEN 60 [INJ]	<i>pramlintide acetate</i>	3	[PAR][QLL, 12 pens/34]

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**INSULIN**

Drug	Generic	Tier	Requirements/ Limits
LANTUS 100 UNITS/ML VIAL [INJ]		3	
LEVEMIR 100 UNITS/ML VIAL [INJ]		3	
NOVOLIN 70-30 [INJ]		3	
NOVOLIN N 100 UNITS/ML VIAL [INJ]		3	
NOVOLIN R [INJ]		3	
NOVOLOG [INJ]		3	
NOVOLOG MIX 70-30 [INJ]		3	

**MINERALOCORTICOID DRUGS**

Drug	Generic	Tier	Requirements/ Limits
<i>fludrocortisone acetate tablet</i>		2	

**ORAL HYPOGLYCEMICS AND COMBOS**

Drug	Generic	Tier	Requirements/ Limits
<i>acarbose</i>		2	
ACTOPLUS MET	<i>pioglitazone hcl/metformin hc</i>	3	[QLL, 102/34][ST]
ACTOPLUS MET XR 15-1,000 MG TB	<i>pioglitazone hcl/metformin hc</i>	3	[QLL, 68/34][ST]
ACTOPLUS MET XR 30-1,000 MG TB	<i>pioglitazone hcl/metformin hc</i>	3	[QLL, 34/34][ST]
ACTOS	<i>pioglitazone hcl</i>	3	[QLL, 34/34][ST]
AVANDAMET	<i>rosiglitazone/metformin hcl</i>	3	[QLL, 68/34][ST]
AVANDARYL	<i>rosiglitazone maleate/glimepir</i>	3	[QLL, 34/34][ST]
AVANDIA 2 MG TABLET, -4 MG TABLET	<i>rosiglitazone maleate</i>	3	[QLL, 68/34][ST]

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Drug	Generic	Tier	Requirements/ Limits
AVANDIA 8 MG TABLET	<i>rosiglitazone maleate</i>	3	[QLL, 34/34][ST]
DUETACT	<i>pioglitazone/glimepiride</i>	3	[QLL, 34/34][ST]
<i>glimepiride</i>		1	
<i>glipizide er</i>		2	
<i>glipizide tablet</i>		1	
<i>glipizide-metformin</i>		2	
<i>glyburide</i>		1	
<i>glyburide micronized</i>		2	
<i>glyburide-metformin hcl</i>		2	
<i>glycron</i>		2	
JANUMET	<i>sitagliptin phos/metformin hcl</i>	3	[QLL, 68/34]
JANUVIA	<i>sitagliptin phosphate</i>	3	[QLL, 34/34]
KOMBIGLYZE XR 2.5-1,000 MG TAB	<i>saxagliptin hcl/metformin hcl</i>	3	[QLL, 68/34]
KOMBIGLYZE XR 5-1,000 MG TAB, -5-500 MG TABLET	<i>saxagliptin hcl/metformin hcl</i>	3	[QLL, 34/34]
<i>metformin hcl</i>		1	
<i>metformin hcl er</i>		1	
<i>nateglinide</i>		2	
ONGLYZA	<i>saxagliptin hydrochloride</i>	3	[QLL, 34/34]
RIOMET	<i>metformin</i>	3	
<i>tolazamide</i>		2	
<i>tolbutamide</i>		2	

#### OTHER ENDOCRINE DRUGS

Drug	Generic	Tier	Requirements/ Limits
ALDURAZYME [INJ]	<i>laronidase</i>	4	[LA]
<i>alendronate sodium 35 mg tab, -70 mg tab</i>		1	[QLL, 5/35]

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Drug	Generic	Tier	Requirements/ Limits
<i>alendronate sodium 5 mg tablet, -10 mg tab, -40 mg tab</i>		1	[QLL, 34/34]
BONIVA TABLET	<i>ibandronate</i>	3	[QLL, 1/30][ST]
<i>cabergoline</i>		2	[QLL, 20/34]
<i>calcitonin-salmon</i>		2	
CEREZYME [INJ]	<i>imiglucerase</i>	4	[LA]
<i>desmopressin acetate aerosol spray w/pump, -solution, -tablet</i>		2	
<i>desmopressin acetate injection [INJ]</i>		2	
ELAPRASE [INJ]	<i>idursulfase</i>	4	[LA]
<i>etidronate disodium</i>		2	
EVISTA	<i>raloxifene</i>	3	
FABRAZYME [INJ]	<i>agalsidase</i>	4	[LA]
FORTEO [INJ]	<i>teriparatide</i>	4	[PAR][QLL, 1 pens/28]
<i>fortical</i>		2	
KUVAN	<i>sapropterin dihydrochloride</i>	4	[LA]
MIACALCIN INJECTION [INJ]	<i>calcitonin</i>	3	[PAR]
MYOZYME [INJ]	<i>alglucosidase alfa</i>	4	[LA]
NAGLAZYME [INJ]	<i>galsulfase</i>	4	[LA]
<i>pamidronate disodium [INJ]</i>		2	[PAR]
RECLAST [INJ]	<i>zoledronic acid</i>	3	[PAR]
SAMSCA	<i>tolvaptan</i>	4	[PAR][QLL, 68/34]
SENSIPAR 30 MG TABLET	<i>cinacalcet hcl</i>	3	
SENSIPAR 60 MG TABLET, -90 MG TABLET	<i>cinacalcet hcl</i>	4	
SOMAVERT [INJ]	<i>pegvisomant</i>	4	[LA]
VPRIV [INJ]	<i>velaglucerase alfa</i>	4	

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Drug	Generic	Tier	Requirements/ Limits
XGEVA [INJ]	<i>denosumab</i>	4	
ZAVESCA	<i>miglustat</i>	4	[LA]
ZOMETA [INJ]	<i>zoledronic acid</i>	4	

### THYROID SUPPLEMENTS

Drug	Generic	Tier	Requirements/ Limits
<i>levothroid</i>		1	
<i>levothyroxine sodium tablet</i>		1	
<i>levoxyl</i>		1	
<i>liothyronine sodium injection</i> [INJ]		2	
<i>liothyronine sodium tablet</i>		2	
THYROLAR-1	<i>liotrix</i>	3	
THYROLAR-1/4	<i>liotrix</i>	3	
THYROLAR-2	<i>liotrix</i>	3	
THYROLAR-3	<i>liotrix</i>	3	
<i>unithroid</i>		1	

## GASTROINTESTINAL MEDICATIONS

### ANTIDIARRHEAL DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>diphenoxylate-atropine</i>		2	
<i>loperamide capsule</i>		2	

### ANTISPASMODICS/DRUGS AFFECT GI MOTILITY

Drug	Generic	Tier	Requirements/ Limits
<i>glycopyrrolate injection</i> [INJ]		2	
<i>glycopyrrolate tablet</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>metoclopramide hcl injection</i> [INJ]		2	
<i>metoclopramide hcl solution oral</i>		2	
<i>metoclopramide hcl tablet</i>		1	

### ANTIULCER DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>cimetidine injection</i> [INJ]		2	
<i>cimetidine solution, -tablet</i>		2	
<i>famotidine 20 mg tablet, -40 mg tablet</i>		1	
<i>famotidine injection</i> [INJ]		2	
<i>famotidine suspension oral</i>		2	
<i>nizatidine</i>		2	
<i>ranitidine hcl capsule, -150 mg tablet, -300 mg tablet</i>		1	
<i>ranitidine hcl injection</i> [INJ]		2	
<i>ranitidine hcl syrup</i>		2	

### IRRITABLE BOWEL DRUGS

Drug	Generic	Tier	Requirements/ Limits
AMITIZA	<i>lubiprostone</i>	3	
LOTRONEX	<i>alosetron</i>	4	

### OTHER ANTIULCER DRUGS

Drug	Generic	Tier	Requirements/ Limits
CARAFATE SUSPENSION ORAL	<i>sucralfate</i>	3	
<i>misoprostol</i>		2	
<i>sucralfate tablet</i>		2	

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## OTHER GI DRUGS

Drug	Generic	Tier	Requirements/ Limits
APRISO	<i>mesalamine</i>	3	
<i>balsalazide disodium</i>		2	
CANASA	<i>mesalamine</i>	3	
CORTIFOAM	<i>hydrocortisone acetate</i>	3	
CREON	<i>amylase/lipase/protease</i>	3	
ENTOCORT EC [G]	<i>budesonide</i>	4	
<i>gavilyte-c</i>		2	
<i>gavilyte-g</i>		2	
<i>gavilyte-n</i>		2	
<i>hydrocortisone enema</i>		2	
<i>mesalamine</i>		2	
PANCRELIPASE 5,000	<i>amylase/lipase/protease</i>	3	
PENTASA	<i>mesalamine</i>	3	
<i>polyethylene glycol 3350</i>		2	
<i>polyethylene glycol 3350 packet</i>		2	
<i>procto-pak</i>		2	
<i>proctosol-hc</i>		2	
<i>proctozone-hc</i>		2	
RELISTOR [INJ]	<i>methylnaltrexone bromide</i>	3	
<i>sulfasalazine tablet</i>		2	
<i>sulfazine ec</i>		2	
<i>trilyte with flavor packets</i>		2	
<i>ursodiol capsule, -tablet</i>		2	
VISICOL	<i>sodium phosphate/na biphos</i>	3	
ZENPEP	<i>amylase/lipase/protease</i>	3	

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## PROTON PUMP INHIBITORS

Drug	Generic	Tier	Requirements/ Limits
<i>lansoprazole dr 15 mg capsule, -odt 15 mg tablet</i>		2	[QLL, 34/34]
<i>lansoprazole dr 30 mg capsule, -odt 30 mg tablet</i>		2	
NEXIUM DR 20 MG CAPSULE, -DR 10 MG PACKET, -DR 20 MG PACKET	<i>esomeprazole mag trihyd</i>	3	[QLL, 34/34][ST]
NEXIUM DR 40 MG CAPSULE, -DR 40 MG PACKET	<i>esomeprazole mag trihyd</i>	3	[ST]
NEXIUM I.V. [INJ]	<i>esomeprazole mag trihyd</i>	3	
<i>omeprazole dr 10 mg capsule, -dr 20 mg capsule</i>		2	[QLL, 34/34]
<i>omeprazole dr 40 mg capsule</i>		2	
<i>omeprazole-bicarb 20-1,100 cap</i>		2	[QLL, 34/34]
<i>omeprazole-bicarb 40-1,100 cap</i>		2	
<i>pantoprazole sod dr 20 mg tab</i>		2	[QLL, 34/34]
<i>pantoprazole sod dr 40 mg tab</i>		2	

## IMMUNOLOGICALS AND VACCINES GROWTH HORMONES AND RELATED DRUGS

Drug	Generic	Tier	Requirements/ Limits
EGRIFTA [INJ]	<i>tesamorelin acetate</i>	4	[PAR]
OMNITROPE 5 MG/1.5 ML CRTG, -10 MG/1.5 ML CRTG [INJ]	<i>somatropin</i>	3	[PAR]
OMNITROPE 5.8 MG VIAL [INJ]	<i>somatropin</i>	4	[PAR]
TEV-TROPIN [INJ]	<i>somatropin</i>	3	[PAR]

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## IMMUNOLOGICALS AND VACCINES

Drug	Generic	Tier	Requirements/ Limits
ACTHIB [INJ]	<i>haemophilus b-tet toxoid</i>	3	
ADACEL [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
ATGAM [INJ]	<i>lymphocyte immune globulin</i>	4	[PAR]
BOOSTRIX [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
CARIMUNE NF NANOFILTERED [INJ]	<i>immune globulin - iv</i>	4	[PAR]
CERVARIX [INJ]	<i>human papillomav vacc bival/pf</i>	3	
COMVAX [INJ]	<i>hepatitis b/haemophilus b vacc</i>	3	
DAPTACEL [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
DIPHThERIA-TETANUS TOXOID [INJ]	<i>tetanus,diphtheria toxoid</i>	3	
ENGERIX-B 10 MCG/0.5 ML PED VL, -10 MCG/0.5 ML SYRN, -20 MCG/ML SYRINGE [INJ]	<i>hepatitis b virus vaccine</i>	3	
GAMASTAN S-D [INJ]	<i>immune globulin - im</i>	3	
GAMUNEX [INJ]	<i>immune globulin - iv</i>	4	[PAR]
GARDASIL [INJ]	<i>human papillomavirus vacc</i>	3	
HAVRIX [INJ]	<i>hepatatis a virus vaccine</i>	3	
HIZENTRA 1 GRAM/5 ML VIAL [INJ]	<i>immune globulin- sq</i>	3	[PAR]
IMOVAX RABIES VACCINE [INJ]	<i>rabies vaccine,human diploid</i>	3	
INFANRIX [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
IPOLE [INJ]	<i>poliomyelitis vac,killed</i>	3	
IXIARO [INJ]	<i>japanese encephalitis vaccine</i>	3	
JE-VAX [INJ]	<i>japanese encephalitis vaccine</i>	3	
KEPIVANCE [INJ]	<i>palifermin</i>	4	[LA]
MENACTRA [INJ]	<i>meningococcal vac a,c,y,w-135</i>	3	
MENOMUNE-A-C-Y-W-135 [INJ]	<i>meningococcal vac a,c,y,w-135</i>	3	
MENVEO A-C-Y-W-135-DIP	<i>mening vac a,c,y,w-135 dip</i>	3	
M-M-R II VACCINE [INJ]	<i>measles,mumps&amp;rubella vaccine</i>	3	
MOZOBIL [INJ]	<i>plerixafor</i>	4	

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Drug	Generic	Tier	Requirements/ Limits
PEDVAXHIB [INJ]	<i>haemophilus b vaccine</i>	3	
PRIVIGEN [INJ]	<i>immune globulin - iv</i>	4	[PAR]
PROCRIT 2,000 UNITS/ML VIAL, -3,000 UNITS/ML VIAL, -4,000 UNITS/ML VIAL, -10,000 UNITS/ML VIAL [INJ]	<i>epoetin alfa</i>	3	[PAR]
PROCRIT 20,000 UNITS/ML VIAL, -40,000 UNITS/ML VIAL [INJ]	<i>epoetin alfa</i>	4	[PAR]
PROQUAD [INJ]	<i>measles,mumps,rub,varicella</i>	3	
RABAVERT [INJ]	<i>rabies vac,pf chick-emb cell</i>	3	
RECOMBIVAX HB [INJ]	<i>hepatitis b virus vaccine</i>	3	
ROTATEQ	<i>rotavirus vac, live pentav</i>	3	
TETANUS DIPHTHERIA TOXOIDS [INJ]	<i>tetanus,diphtheria toxoid</i>	3	
<i>tetanus toxoid adsorbed</i> [INJ]		2	
TETANUS-DIPHTERIA-DECAVAC [INJ]	<i>tetanus,diphtheria toxoid</i>	3	
TRIPEDIA [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
TWINRIX [INJ]	<i>hep b vir recomb/hep a vir</i>	3	
TYPHIM VI [INJ]	<i>typhoid vaccine</i>	3	
VAQTA [INJ]	<i>hepatatis a virus vaccine</i>	3	
VARIVAX VACCINE [INJ]	<i>varicella virus vaccine live</i>	3	
YF-VAX [INJ]	<i>yellow fever vaccine</i>	3	
ZOSTAVAX [INJ]	<i>varicella vacc/pf</i>	3	

### INSULIN LIKE GROWTH FACTORS-1

Drug	Generic	Tier	Requirements/ Limits
ACTHIB [INJ]	<i>haemophilus b-tet toxoid</i>	3	
ADACEL [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
ATGAM [INJ]	<i>lymphocyte immune globulin</i>	4	[PAR]
BOOSTRIX [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
CARIMUNE NF NANOFILTERED [INJ]	<i>immune globulin - iv</i>	4	[PAR]

**LEGEND:** [LA] – Limited Access, [PAR] – Prior Authorization, [QLL] – Quantity Level Limits, [ST] – Step Therapy, [G] – Indicates that the drug may be available in a generic form. [INJ] – Indicates that the drug is available in injectable form. All the drugs listed above with the exception of the ones that have a [LA] in the Requirements/Limits column are available through mail-order.

Drug	Generic	Tier	Requirements/ Limits
CERVARIX [INJ]	<i>human papillomav vacc bival/pf</i>	3	
COMVAX [INJ]	<i>hepatitis b/haemophilus b vacc</i>	3	
DAPTACEL [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
DIPHThERIA-TETANUS TOXOID [INJ]	<i>tetanus,diphtheria toxoid</i>	3	
ENGERIX-B 10 MCG/0.5 ML PED VL, -10 MCG/0.5 ML SYRN, -20 MCG/ML SYRINGE [INJ]	<i>hepatitis b virus vaccine</i>	3	
GAMASTAN S-D [INJ]	<i>immune globulin - im</i>	3	
GAMUNEX [INJ]	<i>immune globulin - iv</i>	4	[PAR]
GARDASIL [INJ]	<i>human papillomavirus vacc</i>	3	
HAVRIX [INJ]	<i>hepatatis a virus vaccine</i>	3	
HIZENTRA 1 GRAM/5 ML VIAL [INJ]	<i>immune globulin- sq</i>	3	[PAR]
IMOVAX RABIES VACCINE [INJ]	<i>rabies vaccine,human diploid</i>	3	
INFANRIX [INJ]	<i>diphther,pertuss,tetanus vac</i>	3	
IPOLE [INJ]	<i>poliomyelitis vac,killed</i>	3	
IXIARO [INJ]	<i>japanese encephalitis vaccine</i>	3	
JE-VAX [INJ]	<i>japanese encephalitis vaccine</i>	3	
KEPIVANCE [INJ]	<i>palifermin</i>	4	[LA]
MENACTRA [INJ]	<i>meningococcal vac a,c,y,w-135</i>	3	
MENOMUNE-A-C-Y-W-135 [INJ]	<i>meningococcal vac a,c,y,w-135</i>	3	
MENVEO A-C-Y-W-135-DIP	<i>mening vac a,c,y,w-135 dip</i>	3	
M-M-R II VACCINE [INJ]	<i>measles,mumps&amp;rubella vaccine</i>	3	
MOZOBIL [INJ]	<i>plerixafor</i>	4	
PEDVAXHIB [INJ]	<i>haemophilus b vaccine</i>	3	
PRIVIGEN [INJ]	<i>immune globulin - iv</i>	4	[PAR]
INCRELEX [INJ]	<i>mecasermin</i>	4	[LA]

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## INTERFERONS

Drug	Generic	Tier	Requirements/ Limits
ACTIMMUNE [INJ]	<i>interferon gamma-1b, recomb.</i>	4	[LA]
AVONEX [INJ]	<i>interferon beta-1a</i>	4	[PAR][QLL, 4 kits/28]
AVONEX ADMINISTRATION PACK [INJ]	<i>interferon beta-1a</i>	4	[PAR][QLL, 4 kits/28]
BETASERON [INJ]	<i>interferon beta-1b</i>	4	[PAR][QLL, 15/30]
INFERGEN [INJ]	<i>interferon alfacon-1</i>	4	
INTRON A 3 MILLION UNIT/ML PEN, -6 MILLION UNIT/ML VL, -10 MILLION UNITS VIAL [INJ]	<i>interferon alfa-2b , recomb.</i>	3	
INTRON A 5 MILLION UNIT/ML PEN, -10 MILLION UNIT PEN [INJ]	<i>interferon alfa-2b , recomb.</i>	4	
PEGASYS 180 MCG/0.5 ML CONV.PK [INJ]	<i>peginterferon alfa-2a</i>	4	[PAR][QLL, 4 syringes/28]
PEGASYS 180 MCG/ML VIAL [INJ]	<i>peginterferon alfa-2a</i>	4	[PAR][QLL, 4 vials/28]
PEGINTRON 50 MCG KIT [INJ]	<i>peginterferon alfa-2b</i>	4	[PAR][QLL, 5 kits/34]
PEGINTRON 80 MCG KIT, -120 MCG KIT, -150 MCG KIT [INJ]	<i>peginterferon alfa-2b</i>	4	[PAR][QLL, 5/34]
PEGINTRON REDIPEN [INJ]	<i>peginterferon alfa-2b</i>	4	[PAR][QLL, 5 pens/34]
REBIF 22 MCG/0.5 ML SYRINGE, -44 MCG/0.5 ML SYRINGE [INJ]	<i>interferon beta-1a/albumin</i>	4	[PAR][QLL, 8 syringes/35]
REBIF TITRATION PACK [INJ]	<i>interferon beta-1a/albumin</i>	4	[PAR][QLL, 12 syringes/28]

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## INTERLEUKIN RECPTR ANTAGONIST

Drug	Generic	Tier	Requirements/ Limits
ACTEMRA 200 MG/10 ML VIAL [INJ]	<i>tocilizumab</i>	4	[PAR]
ARCALYST [INJ]	<i>rilonacept</i>	4	[PAR][LA]
KINERET [INJ]	<i>anakinra</i>	4	[PAR]

## INTERLEUKINS

Drug	Generic	Tier	Requirements/ Limits
NEUMEGA [INJ]	<i>oprelvekin</i>	4	[QLL, 21 vials/21]
PROLEUKIN [INJ]	<i>aldesleukin</i>	4	

## MYELOID STIMULANTS

Drug	Generic	Tier	Requirements/ Limits
LEUKINE [INJ]	<i>sargramostim</i>	4	
NEULASTA [INJ]	<i>pegfilgrastim</i>	4	[PAR][QLL, 2 syringes/30]
NEUPOGEN [INJ]	<i>filgrastim</i>	4	[PAR]

## THROMBOPOIETIC AGENTS

Drug	Generic	Tier	Requirements/ Limits
PROMACTA	<i>eltrombopag olamine</i>	4	[PAR][LA]

## MEDICAL (MISCELLANEOUS) SUPPLIES

### DIABETIC SUPPLIES

Drug	Generic	Tier	Requirements/ Limits
ALCOHOL SWABS		3	
BD PEN NEEDLE ORIG 29GX1/2		3	

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Drug	Generic	Tier	Requirements/ Limits
CURAD GAUZE PADS	<i>misc supp (dress,tape,gauze)</i>	3	
INSULIN SYRINGE		3	
NOVOFINE 32		3	
NOVOFINE AUTOCOVER		3	

## MUSCULOSKELETAL MEDICATIONS

### CNS MUSCLE RELAXANTS

Drug	Generic	Tier	Requirements/ Limits
<i>chlorzoxazone</i>		2	[PAR]
<i>metaxalone</i>		2	[PAR]
<i>methocarbamol tablet</i>		2	[PAR]
<i>orphenadrine citrate injection</i> [INJ]		2	
<i>orphenadrine citrate tablet sustained action</i>		2	[PAR]
<i>orphenadrine compound</i>		2	[PAR]
<i>orphenadrine compound forte</i>		2	[PAR]
RILUTEK	<i>riluzole</i>	4	

### DIRECT MUSCLE RELAXANTS

Drug	Generic	Tier	Requirements/ Limits
<i>baclofen tablet</i>		2	
<i>dantrolene sodium capsule</i>		2	
<i>tizanidine hcl tablet</i>		2	

### DRUGS TO PREVENT AND TREAT GOUT

Drug	Generic	Tier	Requirements/ Limits
<i>allopurinol sodium</i> [INJ]		2	
<i>allopurinol tablet</i>		1	

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Drug	Generic	Tier	Requirements/ Limits
COLCRYS	<i>colchicine</i>	3	
<i>probenecid</i>		2	
<i>probenecid-colchicine</i>		2	
ULORIC	<i>febuxostat</i>	3	[ST]

### NON-STEROIDAL ANTIINFLAMMATORY AGENTS

Drug	Generic	Tier	Requirements/ Limits
CELEBREX	<i>celecoxib</i>	3	[ST]
<i>diclofenac potassium</i>		2	
<i>diclofenac sodium tablet enteric coated, -tablet sustained release 24hr</i>		2	
<i>etodolac</i>		2	
<i>fenoprofen calcium</i>		2	
<i>flurbiprofen tablet</i>		2	
<i>ibuprofen 100 mg/5 ml sus</i>		2	
<i>ibuprofen 100 mg/5 ml susp</i>		2	
<i>ibuprofen 400 mg tablet, -600 mg tablet, -800 mg tablet</i>		1	
<i>indomethacin capsule, -capsule sustained action</i>		2	
<i>ketoprofen capsule, -capsule 24hr sustained release pellets</i>		2	
<i>ketorolac tromethamine injection [INJ]</i>		2	
<i>ketorolac tromethamine tablet</i>		2	[QLL, 20/5]
<i>meclofenamate sodium capsule</i>		2	
<i>mefenamic acid capsule</i>		2	
<i>meloxicam 15 mg tablet</i>		1	
<i>meloxicam 7.5 mg tablet</i>		1	[QLL, 34/34]
<i>meloxicam suspension oral</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>nabumetone</i>		2	
<i>naproxen sodium 275 mg tab, -550 mg tab</i>		2	
<i>naproxen suspension oral</i>		2	
<i>naproxen tablet, -tablet enteric coated</i>		1	
<i>oxaprozin</i>		2	
<i>piroxicam capsule</i>		2	
<i>sulindac tablet</i>		2	
<i>tolmetin sodium</i>		2	

### **OTHER DRUGS FOR ARTHRITIS**

Drug	Generic	Tier	Requirements/ Limits
CUPRIMINE	<i>penicillamine</i>	3	
RIDAURA	<i>auranofin</i>	3	
SYPRINE	<i>trientine</i>	4	

### **SALICYLATES AND RELATED DRUGS**

Drug	Generic	Tier	Requirements/ Limits
<i>diflunisal</i>		2	

## **NUTRITION, BLOOD MODIFIERS, ELECTROLYTES**

### **ANTIPLATELET DRUGS**

Drug	Generic	Tier	Requirements/ Limits
AGGRENOX	<i>aspirin/dipyridamole</i>	3	
<i>cilostazol</i>		2	
<i>dipyridamole tablet</i>		2	
EFFIENT	<i>prasugrel</i>	3	
PLAVIX	<i>clopidogrel</i>	3	

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**BLOOD DETOXICANTS**

Drug	Generic	Tier	Requirements/ Limits
<i>constulose</i>		2	
<i>enulose</i>		2	
<i>lactulose</i>		2	
RENVELA	<i>sevelamer carbonate</i>	3	

**ELECTROLYTES, IRRIGATING SOLUTIONS, ETC.**

Drug	Generic	Tier	Requirements/ Limits
AMINOSYN [INJ]	<i>amino acids</i>	3	
AMINOSYN II [INJ]	<i>amino acids</i>	3	
AMINOSYN II 3.5% M-DEXTROSE 5% [INJ]	<i>amino acids</i>	3	
AMINOSYN II 3.5%-DEXTROSE 25% [INJ]	<i>amino acids</i>	3	
AMINOSYN II 3.5%-DEXTROSE 5% [INJ]	<i>amino acids</i>	3	
AMINOSYN II 4.25%-DEXTROSE 25% [INJ]	<i>amino acids</i>	3	
AMINOSYN II 5% IN 25% DEXTROSE [INJ]	<i>amino acids</i>	3	
AMINOSYN II IN DEXTROSE [INJ]	<i>amino acids</i>	3	
AMINOSYN II WITH LYTES-CA-DW [INJ]	<i>amino acids</i>	3	
AMINOSYN M [INJ]	<i>amino acids</i>	3	
AMINOSYN-HBC [INJ]	<i>amino acids</i>	3	
AMINOSYN-HF [INJ]	<i>amino acids</i>	3	
AMINOSYN-PF [INJ]	<i>amino acids</i>	3	
AMMONIUM CHLORIDE INJECTION [INJ]	<i>ammonium chloride</i>	3	
CLINIMIX [INJ]	<i>amino acids</i>	3	
CLINIMIX E [INJ]	<i>amino acids</i>	3	
CLINISOL [INJ]	<i>amino acids</i>	3	
CYSTAGON	<i>cysteamine</i>	3	[LA]
<i>d5w-kcl 30 meq/l iv solution</i> [INJ]		2	
<i>dextrose 10%-1/4ns</i> [INJ]		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>dextrose 10%-1/4ns-kcl</i> [INJ]		2	
<i>dextrose 5%-1/2ns-kcl</i> [INJ]		2	
<i>dextrose 5%-1/3ns-kcl</i> [INJ]		2	
<i>dextrose 5%-1/4ns-kcl</i> [INJ]		2	
<i>dextrose 5%-electrolyte #48</i> [INJ]		2	
<i>dextrose 5%-ns-kcl</i> [INJ]		2	
<i>dextrose in water</i> [INJ]		2	
<i>dextrose with sodium chloride</i> [INJ]		2	
FREAMINE III [INJ]	<i>amino acids</i>	3	
HEPATAMINE [INJ]	<i>amino acids</i>	3	
HEPATASOL [INJ]	<i>amino acids</i>	3	
IONOSOL B WITH DEXTROSE 5% [INJ]	<i>electrolyte solutions</i>	3	
IONOSOL MB-DEXTROSE 5% [INJ]	<i>electrolyte solutions</i>	3	
IONOSOL T-DEXTROSE 5% [INJ]	<i>electrolyte solutions</i>	3	
ISOLYTE H WITH DEXTROSE [INJ]	<i>dextrose/electrolytes</i>	3	
ISOLYTE M WITH DEXTROSE [INJ]	<i>dextrose/electrolytes</i>	3	
ISOLYTE P WITH DEXTROSE [INJ]	<i>dextrose/electrolytes</i>	3	
ISOLYTE S [INJ]	<i>electrolyte solutions</i>	3	
ISOLYTE S WITH DEXTROSE [INJ]	<i>dextrose/electrolytes</i>	3	
<i>lactated ringers injection</i> [INJ]		2	
<i>magnesium sulfate injection</i> [INJ]		2	
MAGNESIUM SULFATE-D5W [INJ]	<i>magnesium sulfate/d5w</i>	3	
NEPHRAMINE [INJ]	<i>amino acids</i>	3	
NORMOSOL-M AND DEXTROSE [INJ]	<i>dextrose/electrolytes</i>	3	
NORMOSOL-R AND DEXTROSE [INJ]	<i>electrolyte solutions</i>	3	
NORMOSOL-R PH 7.4 [INJ]	<i>electrolyte solutions</i>	3	
PLASMA-LYTE 148 [INJ]	<i>electrolyte solutions</i>	3	
PLASMA-LYTE 148 IN DEXTROSE [INJ]	<i>electrolyte solutions</i>	3	

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Drug	Generic	Tier	Requirements/ Limits
PLASMA-LYTE 56 IN DEXTROSE [INJ]	<i>d5w/electrolyte-56 solution</i>	3	
PLASMA-LYTE A PH 7.4 [INJ]	<i>electrolyte solutions</i>	3	
<i>potassium chl-normal saline</i> [INJ]		2	
<i>potassium chloride-nacl</i> [INJ]		2	
PREMASOL [INJ]	<i>amino acids</i>	3	
PROCALAMINE [INJ]	<i>aa 3%/electrolyte-tpn/glycerin</i>	3	
<i>ringers injection</i> [INJ]		2	
<i>saline 0.45% soln-excel con, -0.45% soln, - saline 0.9% soln-excel cont, -0.9% soln, -0.9% solution, -cl 2.5 meq/ml vial, -3% iv soln, -5% iv soln</i> [INJ]		2	
<i>sodium bicarbonate injection</i> [INJ]		2	
<i>sodium chloride solution</i>		2	
<i>sodium lactate injection</i> [INJ]		2	
TRAVASOL 10% SOLN VIAFLEX [INJ]	<i>amino acids</i>	3	
TROPHAMINE [INJ]	<i>amino acids</i>	3	

### FLUORIDE PRODUCTS

Drug	Generic	Tier	Requirements/ Limits
<i>sodium fluoride tablet</i>		2	

### INJECTABLE ANTICOAGULANTS

Drug	Generic	Tier	Requirements/ Limits
ARIXTRA 2.5 MG SYRINGE [INJ]	<i>fondaparinux sodium</i>	3	
ARIXTRA 5 MG SYRINGE, -7.5 MG SYRINGE, -10 MG SYRINGE [INJ]	<i>fondaparinux sodium</i>	4	
<i>enoxaparin 120 mg/0.8 ml syr, -150 mg/ml syr</i> [INJ]		4	

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Drug	Generic	Tier	Requirements/ Limits
<i>enoxaparin 30 mg/0.3 ml syr, -40 mg/0.4 ml syr, -60 mg/0.6 ml syr, -80 mg/0.8 ml syr, -100 mg/ml syr [INJ]</i>		2	
<i>heparin sod 1,000 unit/ml vial, -sod 2,000 unit/ml vial, -sod 5,000 unit/ml vial, -sod 10,000 unit/ml vl, -sod 20,000 unit/ml vl [INJ]</i>		2	[PAR]
<i>heparin sodium in 0.45% nacl [INJ]</i>		2	[PAR]
<i>heparin sodium in 5% dextrose [INJ]</i>		2	[PAR]
<i>heparin sodium-ns [INJ]</i>		2	[PAR]

### ORAL ANTICOAGULANTS, VITAMIN K

Drug	Generic	Tier	Requirements/ Limits
<i>jantoven</i>		1	
PRADAXA	<i>dabigatran etexilate mesylate</i>	3	[PAR]
<i>warfarin sodium tablet</i>		1	

### POTASSIUM REMOVING RESINS

Drug	Generic	Tier	Requirements/ Limits
<i>sodium polystyrene sulfonate</i>		2	

### POTASSIUM SUPPLEMENTS

Drug	Generic	Tier	Requirements/ Limits
<i>d5w-kcl 20 meq/l iv solution, -kcl 20 meq in d5w solution, -d5w-kcl 40 meq/l iv solution, -kcl 40 meq in d5w solution [INJ]</i>		2	
<i>klor-con 10</i>		1	
<i>klor-con 8</i>		1	
<i>klor-con m15</i>		2	
<i>klor-con m20</i>		1	

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Drug	Generic	Tier	Requirements/ Limits
<i>potassium chloride capsule sustained action, - tablet sust.releaseparticles/crystals</i>		1	
<i>potassium chloride in d5lr</i> [INJ]		2	
<i>potassium chloride injection</i> [INJ]		2	
<i>potassium chloride solution</i>		2	

### **THERAPEUTIC VITAMINS AND MINERALS**

Drug	Generic	Tier	Requirements/ Limits
<i>calcitriol capsule, -solution</i>		2	[PAR]
<i>calcitriol injection</i> [INJ]		2	[PAR]
<i>calcium acetate</i>		2	
<i>eliphos</i>		2	
<i>levocarnitine injection</i> [INJ]		2	[PAR]
<i>levocarnitine solution, -tablet</i>		2	[PAR]
ZEMPLAR CAPSULE	<i>paricalcitol</i>	3	[PAR]
ZEMPLAR INJECTION [INJ]	<i>paricalcitol</i>	3	[PAR]

### **VITAMINS AND MINERALS AND RELATED PRODUCTS**

Drug	Generic	Tier	Requirements/ Limits
INTRALIPID 30% IV FAT EMUL [INJ][G]	<i>fat emulsions</i>	3	
LIPOSYN II [INJ]	<i>fat emulsions</i>	3	
<i>liposyn iii</i> [INJ]		2	

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## OBSTETRICAL AND GYNECOLOGICAL MEDICATIONS

### ANDROGEN DRUGS

Drug	Generic	Tier	Requirements/ Limits
ANADROL-50	<i>oxymetholone</i>	4	[PAR]
ANDROXY	<i>fluoxymesterone</i>	3	
<i>danazol capsule</i>		2	
FORTESTA	<i>testosterone</i>	3	[PAR]
METHITEST	<i>methyltestosterone</i>	3	
<i>oxandrolone tablet</i>		2	[PAR]
<i>testosterone cypionate injection</i> [INJ]		2	
<i>testosterone enanthate</i> [INJ]		2	

### CONTRACEPTIVES

Drug	Generic	Tier	Requirements/ Limits
<i>apri</i>		2	
<i>aranelle</i>		2	
<i>aviane</i>		2	
<i>balziva</i>		2	
<i>cesia</i>		2	
<i>cryselle</i>		2	
<i>cyclafem</i>		2	
<i>enpresse</i>		2	
<i>gianvi</i>		2	
<i>junel</i>		2	
<i>junel fe</i>		2	
<i>kariva</i>		2	
<i>kelnor 1-35</i>		2	
<i>leena</i>		2	
<i>lessina</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>levora-28</i>		2	
<i>low-ogestrel</i>		2	
<i>lutra</i>		2	
<i>microgestin</i>		2	
<i>microgestin fe</i>		2	
<i>mononessa</i>		2	
<i>necon</i>		2	
<i>next choice</i>		2	[QLL, 2/1]
<i>nortrel</i>		2	
<i>ocella</i>		2	
<i>ogestrel</i>		2	
<i>portia</i>		2	
<i>previfem</i>		2	
<i>quasense</i>		2	
<i>reclipsen</i>		2	
<i>solia</i>		2	
<i>sprintec</i>		2	
<i>sronyx</i>		2	
<i>tri-legest fe</i>		2	
<i>trinessa</i>		2	
<i>tri-previfem</i>		2	
<i>tri-sprintec</i>		2	
<i>trivora-28</i>		2	
<i>velivet</i>		2	
<i>zeosa</i>		2	
<i>zovia 1-35e</i>		2	
<i>zovia 1-50e</i>		2	

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## ESTROGEN DRUGS

Drug	Generic	Tier	Requirements/ Limits
ESTRACE CREAM WITH APPLICATOR	<i>estradiol</i>	3	
<i>estradiol patch transdermal weekly</i>		2	[QLL, 5/35]
<i>estradiol tablet</i>		2	
<i>estradiol valerate injection</i> [INJ]		2	
<i>estropipate</i>		2	
MENEST	<i>estrogens, esterified</i>	3	
PREMARIN CREAM WITH APPLICATOR	<i>estrogens, conjugated</i>	3	
VAGIFEM	<i>estradiol</i>	3	

## ESTROGEN/PROGESTIN COMBINATIONS

Drug	Generic	Tier	Requirements/ Limits
<i>estradiol-norethindrone acetat</i>		2	
<i>jinteli</i>		2	
PREMPHASE	<i>estrogen/medroxyprogesterone</i>	3	
PREMPRO	<i>estrogen/medroxyprogesterone</i>	3	

## OB/GYN TOPICAL ANTIINFECTIVES

Drug	Generic	Tier	Requirements/ Limits
<i>clindamycin phosphate cream with applicator</i>		2	
<i>metronidazole gel with applicator</i>		2	
<i>vandazole</i>		2	

## OXYTOCICS

Drug	Generic	Tier	Requirements/ Limits
METHERGINE TABLET [G]	<i>methylergonovine</i>	3	

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**PRENATAL VITAMINS**

Drug	Generic	Tier	Requirements/ Limits
<i>prenatabs obn</i>		2	

**PROGESTIN DRUGS**

Drug	Generic	Tier	Requirements/ Limits
<i>camila</i>		2	
<i>errin</i>		2	
<i>jolivette</i>		2	
<i>medroxyprogesterone acetate injection</i> [INJ]		2	[QLL, 1 ml/90]
<i>medroxyprogesterone acetate tablet</i>		2	
<i>nora-be</i>		2	
<i>norethindrone acetate tablet</i>		2	
PROMETRIUM	<i>progesterone</i>	3	

**SPECIALIZED OB/GYN DRUGS**

Drug	Generic	Tier	Requirements/ Limits
<i>chorionic gonadotropin injection</i> [INJ]		2	[PAR][QLL, 3/34]
<i>leuprolide acetate injection</i> [INJ]		2	
LUPRON DEPOT 3.75 MG KIT, -11.25 MG 3MO KIT, -22.5 MG 3MO KIT, —4 MONTH KIT [INJ]	<i>leuprolide</i>	3	[PAR]
LUPRON DEPOT 7.5 MG KIT [INJ]	<i>leuprolide</i>	4	[PAR]
LUPRON DEPOT-PED [INJ]	<i>leuprolide</i>	4	[PAR]
<i>novarel</i> [INJ]		2	[PAR]
SYNAREL	<i>nafarelin</i>	4	

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## OPHTHALMIC MEDICATIONS

### ANTIGLAUCOMA DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>acetazolamide capsule sustained action, -tablet</i>		2	
<i>acetazolamide sodium [INJ]</i>		2	
ALPHAGAN P 0.1% DROPS	<i>brimonidine tartrate</i>	3	
<i>apraclonidine hcl</i>		2	
<i>betaxolol hcl drops</i>		2	
<i>brimonidine tartrate</i>		1	
<i>carteolol hcl</i>		1	
COMBIGAN	<i>brimonidine tartrate/timolol</i>	3	[ST]
<i>dorzolamide hcl</i>		2	
<i>dorzolamide-timolol</i>		2	
<i>latanoprost</i>		2	
<i>levobunolol hcl</i>		1	
<i>methazolamide tablet</i>		2	
<i>metipranolol</i>		2	
PHOSPHOLINE IODIDE	<i>echothiophate iodide</i>	3	
<i>timolol maleate drops, -gel-forming solution</i>		1	
TRAVATAN Z	<i>travoprost</i>	3	

### OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS

Drug	Generic	Tier	Requirements/ Limits
<i>neomycin-bacitracin-poly-hc</i>		2	
<i>neomycin-poly-hc eye drops</i>		2	
<i>neomycin-polymyxin-dexameth</i>		1	
<i>poly-dex</i>		1	
<i>sulfacetamide-prednisolone</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>tobramycin-dexamethasone</i>		2	
ZYLET	<i>tobramycin/lotepred etab</i>	3	

### OPHTHALMIC CORTICOSTEROID DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>dexamethasone sodium phosphate drops</i>		2	
<i>fluorometholone suspension drops</i>		2	
FML S.O.P.	<i>fluorometholone</i>	3	
PRED MILD	<i>prednisolone acetate</i>	3	
<i>prednisolone acetate suspension drops</i>		2	
<i>prednisolone sodium phosphate drops</i>		2	

### OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>aktob</i>		1	
AZASITE	<i>azithromycin</i>	3	
<i>bacitracin 500 unit/gm ointmnt</i>		2	
<i>bacitracin-polymyxin eye oint</i>		2	
<i>ciprofloxacin hcl drops</i>		2	
<i>erythromycin ointment</i>		1	
<i>gentak</i>		1	
<i>gentamicin sulfate drops</i>		1	
<i>gentasol</i>		1	
<i>levofloxacin drops</i>		2	
MOXEZA	<i>moxifloxacin</i>	3	
<i>neomycin-bacitracin-polymyxin</i>		2	
<i>neomycin-polymyxin-gramicidin</i>		2	

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Drug	Generic	Tier	Requirements/ Limits
<i>ofloxacin 0.3% eye drops</i>		2	
<i>polymyxin b sul-trimethoprim</i>		1	
<i>romycin</i>		1	
<i>sulfacetamide sodium drops</i>		1	
<i>tobramycin sulfate drops</i>		1	
<i>tobrasol</i>		1	
VIGAMOX	<i>moxifloxacin</i>	3	

### OTHER OPHTHALMIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>ak-con</i>		2	
<i>azelastine hcl drops</i>		2	
BOTOX [INJ]	<i>botulinum toxin a</i>	3	[PAR]
<i>bromfenac sodium</i>		2	
<i>cromolyn sodium drops</i>		2	
<i>diclofenac sodium drops</i>		2	
<i>epinastine hcl</i>		2	
<i>flurbiprofen sodium</i>		2	
<i>ketorolac tromethamine drops</i>		2	
NATACYN	<i>natamycin</i>	3	
<i>parcaine</i>		2	
<i>proparacaine hcl drops</i>		2	
RESTASIS	<i>cyclosporine</i>	3	[QLL, 60 vials/30]
<i>trifluridine</i>		2	
<i>tropicamide drops</i>		2	
ZIRGAN	<i>ganciclovir</i>	3	

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## RESPIRATORY MEDICATIONS

### ANTIHISTAMINES

Drug	Generic	Tier	Requirements/ Limits
<i>carbinoxamine maleate</i>		2	
<i>cetirizine hcl 1 mg/1 ml soln, -1 mg/ml soln, -5 mg/5 ml syrup</i>		2	
<i>cetirizine hcl 1 mg/ml syrup</i>		2	
<i>clemastine fumarate syrup, -fum 2.68 mg tab</i>		2	
<i>cyproheptadine hcl syrup, -tablet</i>		2	[PAR]
<i>dexchlorpheniramine maleate</i>		2	[PAR]
<i>diphenhydramine 50 mg capsule, -elixir</i>		2	[PAR]
<i>diphenhydramine hcl injection [INJ]</i>		2	
<i>fexofenadine hcl 180 mg tablet</i>		2	[QLL, 34/34]
<i>fexofenadine hcl 30 mg tablet, -60 mg tablet</i>		2	[QLL, 68/34]
<i>levocetirizine dihydrochloride</i>		2	[QLL, 34/34]
<i>palgic</i>		2	
<i>promethazine hcl injection [INJ]</i>		2	
<i>promethazine hcl syrup, -tablet</i>		2	[PAR]

### BETA-2 ADRENERGIC DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>albuterol sulfate nebs, -solution non-oral, -vial nebulizer</i>		2	[PAR]
<i>albuterol sulfate syrup, -tablet, -tablet sustained release 12hr</i>		2	
FORADIL	<i>formoterol fumarate</i>	3	[QLL, 120/34]
<i>metaproterenol sulfate syrup, -tablet</i>		2	
PROAIR HFA	<i>albuterol</i>	3	[QLL, 26 gm/34]
PROVENTIL HFA	<i>albuterol</i>	3	[QLL, 20 gm/34]

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Drug	Generic	Tier	Requirements/ Limits
SEREVENT DISKUS	<i>salmeterol</i>	3	[QLL, 120 doses/34]
<i>terbutaline sulfate injection</i> [INJ]		2	
<i>terbutaline sulfate tablet</i>		2	

### LEUKOTRIENE MODIFIERS

Drug	Generic	Tier	Requirements/ Limits
SINGULAIR	<i>montelukast sodium</i>	3	
<i>zafirlukast</i>		2	
ZYFLO CR	<i>zileuton</i>	3	

### METHYL XANTHINE DRUGS

Drug	Generic	Tier	Requirements/ Limits
<i>aminophylline injection</i> [INJ]		2	
<i>aminophylline tablet</i>		2	
<i>theochron</i>		2	
<i>theophylline</i>		2	
<i>theophylline anhydrous tablet sustained release 12hr</i>		2	

### OTHER DRUGS FOR ASTHMA

Drug	Generic	Tier	Requirements/ Limits
ADVAIR DISKUS	<i>salmeterol/fluticasone</i>	3	[PAR][QLL, 120 doses/30]
ADVAIR HFA	<i>salmeterol/fluticasone</i>	3	[PAR][QLL, 24 gm/34]
ASMANEX TWISTHALER 110 MCG #30, - TWISTHALER 110 MCG #7, -TWISTHALER 220 MCG #30	<i>mometasone</i>	3	[QLL, 60 doses/30]

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Drug	Generic	Tier	Requirements/ Limits
ASMANEX TWISTHALER 220 MCG #14	<i>mometasone</i>	3	[QLL, 14 doses/14]
ASMANEX TWISTHALER 220 MCG #60	<i>mometasone</i>	3	[QLL, 120 doses/30]
ASMANEX TWISTHALR 220 MCG #120	<i>mometasone</i>	3	[QLL, 240 doses/30]
ATROVENT HFA	<i>ipratropium</i>	3	[QLL, 26 gm/34]
COMBIVENT	<i>albuterol sulfate/ipratropium</i>	3	[QLL, 44 gm/34]
<i>cromolyn sodium ampul for nebulization</i>		2	[PAR]
<i>epinephrine 0.1 mg/ml syringe [INJ]</i>		2	
EPINEPHRINE 0.15 MG AUTO-INJCT, -0.3 MG AUTO-INJECT [INJ]	<i>epinephrine hcl</i>	3	[QLL, 4/2]
EPIPEN [INJ]	<i>epinephrine hcl</i>	3	[QLL, 4 pens/2]
EPIPEN JR [INJ]	<i>epinephrine hcl</i>	3	[QLL, 4 pens/2]
GASTROCROM	<i>cromolyn</i>	3	
<i>ipratropium bromide solution non-oral</i>		2	[PAR]
QVAR	<i>beclomethasone</i>	3	[QLL, 22 gm/34]
SPIRIVA	<i>tiotropium bromide</i>	3	[QLL, 60 capsules/30]
SYMBICORT	<i>budesonide/formoterol fum</i>	3	[PAR][QLL, 20 gm/34]
XOLAIR [INJ]	<i>omalizumab</i>	4	[PAR][QLL, 6 vials/28][LA]

### OTHER RESPIRATORY DRUGS

Drug	Generic	Tier	Requirements/ Limits
ARALAST NP [INJ]	<i>alpha-1-proteinase inhibitor</i>	4	[PAR][LA]
PROLASTIN [INJ]	<i>alpha-1-proteinase inhibitor</i>	4	[PAR][LA]
PROLASTIN C [INJ]	<i>alpha-1-proteinase inhibitor</i>	4	[PAR][LA]
PULMOZYME	<i>deoxyribonuclease</i>	4	[PAR]

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## UROLOGICAL MEDICATIONS

### ANTICHOLINERGIC ANTISPASMODICS

Drug	Generic	Tier	Requirements/ Limits
ENABLEX	<i>darifenacin hydrobromide</i>	3	[ST]
<i>flavoxate hcl</i>		2	
<i>oxybutynin chloride syrup, -tablet</i>		2	
<i>oxybutynin cl er 10 mg tablet, -cl er 15 mg tablet</i>		2	
<i>oxybutynin cl er 5 mg tablet</i>		2	[QLL, 34/34]
SANCTURA XR	<i>trospium chloride</i>	3	[ST]
<i>trospium chloride</i>		2	

### CHOLINERGIC STIMULANTS

Drug	Generic	Tier	Requirements/ Limits
<i>bethanechol chloride tablet</i>		2	

### OTHER GENITOURINARY PRODUCTS

Drug	Generic	Tier	Requirements/ Limits
CYSTADANE	<i>betaine hcl</i>	3	
ELMIRON	<i>pentosan polysulfate sodium</i>	3	
<i>finasteride</i>		2	
<i>neomycin-polymyxin b [INJ]</i>		2	
<i>potassium citrate TABLET SUSTAINED ACTION</i>		2	
<i>tamsulosin hcl</i>		2	

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