



GEMCare Health Plan (HMO)

2010 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.

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What is the GEMCare Health Plan (HMO) Formulary?

A formulary is a list of covered drugs selected by GEMCare Health Plan (HMO) 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. GEMCare Health Plan (HMO) will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a GEMCare Health Plan (HMO) network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

Generally, if you are taking a drug on our 2010 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2010 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 10/09/2009.

To get updated information about the drugs covered by GEMCare Health Plan (HMO), please visit our Web site at www.gemcarehealthplan.com or call Member Services at 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757.

In the event of non-maintenance changes to the formulary throughout the plan year, GEMCare Health Plan (HMO) may make changes via errata sheets mailed to you. Additionally you may visit our website for a link to the errata sheet.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 8. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, **CARDIOVASCULAR AGENTS**. If you know what your drug is used for, look for the category name in the list that begins on page number 91. 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 91. 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?

GEMCare Health Plan (HMO) 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:** GEMCare Health Plan (HMO) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from GEMCare Health Plan (HMO) before you fill your prescriptions. If you don't get approval, GEMCare Health Plan (HMO) may not cover the drug.
- **Quantity Limits:** For certain drugs, GEMCare Health Plan (HMO) limits the amount of the drug that GEMCare Health Plan (HMO) will cover. For example, GEMCare Health Plan (HMO) provides six tablets per month per prescription for Zomig. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, GEMCare Health Plan (HMO) 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, GEMCare Health Plan (HMO) may not cover drug B unless you try Drug A first. If Drug A does not work for you, GEMCare Health Plan (HMO) 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 8. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at www.gemcarehealthplan.com.

You can ask GEMCare Health Plan (HMO) to make an exception to these restrictions or limits. See the section, “How do I request an exception to the GEMCare Health Plan (HMO) formulary?” on page 5 for information about how to request an exception.

What are over-the counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. GEMCare Health Plan (HMO) pays for certain OTC drugs. The following is a listing of these agents:

- OTC Prilosec
- OTC omeprazole

GEMCare Health Plan (HMO) will provide these OTC drugs at no cost to you. The cost to GEMCare Health Plan (HMO) of these OTC drugs will not count toward your total drug costs.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Member Services and confirm that your drug is not covered. If you learn that GEMCare Health Plan (HMO) does not cover your drug, you have two options:

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

You can ask GEMCare Health Plan (HMO) 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, GEMCare Health Plan (HMO) limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limits and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier subject to the tiering exceptions process instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the specialty tier.

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

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your 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 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 ninety (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 thirty (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 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. 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.

Exceptions are available for beneficiaries who have experienced a change in the level of care they are receiving which requires them to transition from one facility or treatment center to another. Examples of situations in which beneficiaries would be eligible for the one-time temporary fill exception when they are outside of the three month effective date into the Part D program are as follows:

- i. For example if a beneficiary was discharged from the hospital and was provided a discharge list of medications based upon the formulary of the hospital.
- ii. Beneficiaries who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert back to their Part D plan formulary
- iii. Beneficiaries who give up Hospice Status to revert back to standard Medicare Part A and B benefits
- iv. Beneficiaries who are discharged from Chronic Psychiatric Hospitals with medication regimens that are highly individualized.

All of these situations would warrant a temporary one-time fill exception irregardless of if the beneficiary is in their first ninety (90) days of program enrollment.

For more information

For more detailed information about your GEMCare Health Plan (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about GEMCare Health Plan (HMO), please call Customer Service at 1-877-697-2464, 8am – 8pm PST seven days a week. TTY/TDD users should call 1-888-833-9312. Or visit www.gemcarehealthplan.com.

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

GEMCare Health Plan (HMO) Formulary

The formulary below provides coverage information about some of the drugs covered by GEMCare Health Plan (HMO). If you have trouble finding your drug in the list, turn to the Index that begins on page 91.

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

The information in the Requirements/Limits column tells you if GEMCare Health Plan (HMO) has any special requirements for coverage of your drug.

Tier Level	Tier Name
1	Preferred Generic
2	Non-Preferred Generic
3	Preferred Brand
4	Non-Preferred Brand
5	Injectable
6	Specialty

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
Opioid Analgesics		
acetaminophen/codeine	1	Quantity Limitation - 400 tablets per 30 days
acetaminophen/codeine	2	Oral solution
acetaminophen/codeine #3	1	Quantity Limitation - 400 tablets per 30 days
acetaminophen/codeine #4	1	Quantity Limitation - 400 tablets per 30 days
ascomp/codeine	2	
AVINZA	4	Step Therapy Protocols Apply; Quantity Limitation - 30 capsules per 30 days
BALACET 325	2	
buprenorphine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		need to be submitted describing the use and setting of drug to make the determination.
butalbital/apap/caffeine/codeine	2	
butorphanol tartrate	2	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Quantity Limitation – 10ml per 30 days
co-gesic	2	Quantity Limitation - 240 tablets per 30 days
DARVON-N	4	
endocet	2	Quantity Limitation - 360 tablets per 30 days
fentanyl	2	Quantity Limitation - 30 patches per 30 days; Transdermal Dosage Formulation
hydrocodone bitartrate/acetaminophen	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
hydrocodone/acetaminophen	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
hydrocodone/acetaminophen-hs	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
hydrocodone/ibuprofen	2	Quantity Limitation - 480 tablets per 30 days
hydromorphone hcl	2	
KADIAN	3	Step Therapy Protocols Apply; Quantity Limitation - 60 capsules per 30 days
levorphanol tartrate	2	
margesic-h	2	Quantity Limitation - 240 capsules per 30 days
meperidine hcl	2	
METHADONE HCL	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
methadone hcl	1	
methadose	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
morphine sulfate	2	
morphine sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
morphine sulfate er	2	
nalbuphine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
oxycodone hcl	2	
oxycodone/acetaminophen	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
oxycodone/apap	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
oxycodone/aspirin	2	Quantity Limitation - 360 tablets per 30 days
oxycodone/ibuprofen	2	
oxycodone-apap	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
OXYCONTIN	3	Quantity Limitation - 120 tablets per 30 days
pentazocine/acetaminophen	2	Quantity Limitation - 180 tablets per 30 days
pentazocine/naloxone hcl	2	
propoxyphene hcl	2	
propoxyphene/acetaminophen	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
propoxyphene-n/acetaminophen	2	Quantity Limitation - Not to exceed 4,000mg of acetaminophen/day
roxicet	2	Quantity Limitation - 360 per 30 days on 325mg, 240 per 30 days on 500mg; 1800ml per 30 days on solution
stagesic	2	Quantity Limitation - 240 capules per 30 days
SUBOXONE	4	
SUBUTEX	4	
tramadol hcl	2	Quantity Limitation - 240 tablets

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		per 30 days
tramadol hydrochloride/acetaminophen	2	Quantity Limitation - 240 tablets per 30 days
trezix	2	
vanacet	2	Quantity Limitation - 240 tablets per 30 days
zerlor	2	
ZYDONE	4	
Nonsteroidal Anti-Inflammatory Drugs		
CELEBREX	4	Step Therapy Protocols Apply; Quantity Limitation - 60 capsules per 30 days
diclofenac potassium	1	
diclofenac sodium	1	
diclofenac sodium ec	1	
diclofenac sodium xr	1	
diflunisal	2	
etodolac	2	
etodolac er	2	
fenoprofen calcium	2	
flurbiprofen	2	
ibuprofen	1	This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
indomethacin	2	
indomethacin er	2	
ketoprofen	2	
ketoprofen er	2	
ketorolac tromethamine	2	Quantity Limitation - 20 tablets per 30 days
ketorolac tromethamine	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
meclofenamate sodium	2	
meloxicam	1	Quantity Limitation - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
nabumetone	2	
naproxen	1	
naproxen dr	1	
naproxen sodium	1	
oxaprozin	2	
piroxicam	2	
sulindac	2	
tolmetin sodium	2	
ANESTHETICS		
Local Anesthetics		
lidocaine hcl	2	Topical Dosage Formulation
lidocaine hcl jelly	1	Topical Dosage Formulation
lidocaine/prilocaine	2	Quantity Limitation - 30 grams per prescription; Topical Dosage Formulation
ANTIBACTERIALS		
Aminoglycosides		
ak-tob	1	
genoptic	2	
gentak	2	
gentamicin sulfate	2	
gentamicin sulfate	2	Topical Dosage Formulation
gentamicin sulfate	5	Injectable dosage Formulation
gentamicin sulfate/0.9% sodium chloride	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
gentamicin sulfate/sodiumchloride	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
gentasol	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
isotonic gentamicin	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kanamycin sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
NEO-FRADIN	4	
neomycin sulfate	2	
paromomycin sulfate	2	
tobramycin sulfate	1	
tobramycin sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
tobrasol	1	
Antibacterials, Other		
ak-poly-bac	2	
baciim	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
bacitracin	2	
bacitracin/neomycin/polymyxin	2	
bacitracin/polymyxin b	2	
CLEOCIN	4	Vaginal Dosage Formulation
clindamycin hcl	2	
clindamycin phosphate	2	Topical Dosage Formulation
clindamycin phosphate	2	Vaginal Dosage Formulation
clindamycin phosphateadd- vantage	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
colistimethate sodium	2	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
CUBICIN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
erythromycin/sulfisoxazole	2	
FURADANTIN	4	
HIPREX	4	
methenamine hippurate	2	
METROGEL	4	Prior Authorization Required; Topical Dosage Formulation
metronidazole	2	
metronidazole	2	Topical Dosage Formulation
metronidazole vaginal	2	Vaginal Dosage Formulation
MONUROL	4	
mupirocin	2	Topical Dosage Formulation
neomycin/polymyxin/gramicidin	2	
nitrofurantoin macrocrystalline	1	
nitrofurantoin monohydrate	1	
NORITATE	4	Topical Dosage Formulation
polycin b	2	
SYNERCID	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
trimethoprim	2	
trimethoprim sulfate/polymyxin b sulfate	2	
TYGACIL	5	Prior Authorization Required;

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Injectable dosage Formulation
UREX	4	
VANCOCIN HCL	6	Prior Authorization Required
vancomycin hcl	5	Prior Authorization Required; Injectable dosage Formulation
VANCOMYCIN HCL ISO-OSMOTIC DEXTROSE	5	Prior Authorization Required; Injectable dosage Formulation
vandazole	2	
ZYVOX	6	Prior Authorization Required; Injectable dosage Formulation
ZYVOX	6	Prior Authorization Required; Quantity Limitation - 56 tablets per 28 days
Beta-lactam, Cephalosporins		
cefaclor	2	
cefaclor er	2	
cefadroxil	2	
cefazolin sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
cefdinir	2	
cefoxitin sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
cefepodoxime proxetil	2	
cefprozil	2	
ceftriaxone sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
CEFTRIAXONE/DEXTROSE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		need to be submitted describing the use and setting of drug to make the determination.
cefuroxime axetil	2	
cephalexin	1	
MAXIPIME	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
SPECTRACEF	4	
SUPRAX	4	
Beta-lactam, Other		
AZACTAM	3	Prior Authorization Required; Injectable dosage Formulation
AZACTAM IN DEXTROSE	3	Prior Authorization Required; Injectable dosage Formulation
INVANZ	5	Prior Authorization Required; Injectable dosage Formulation
MERREM	5	
PRIMAXIN I.M.	5	Prior Authorization Required; Injectable dosage Formulation
PRIMAXIN IV	5	Prior Authorization Required; Injectable dosage Formulation
Beta-lactam, Penicillins		
amoxicillin	1	
amoxicillin/clavulanate potassium	2	
amoxicillin/potassium clavulanate	2	
amoxil	1	
ampicillin	1	
ampicillin sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ampicillin-sulbactam	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		need to be submitted describing the use and setting of drug to make the determination.
dicloxacillin sodium	2	
nafcillin sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
penicillin g potassium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
PENICILLIN G POTASSIUM INISO-OSMOTIC DEXTROSE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
PENICILLIN G PROCAINE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
PENICILLIN G SODIUM	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
penicillin v potassium	1	
PIPERACILLIN SODIUM	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		the use and setting of drug to make the determination.
trimox	2	
veetids	1	
ZOSYN	5	Prior Authorization Required; Injectable dosage Formulation
Macrolides		
azithromycin	2	Quantity Limitation - 6 tablets per prescription
azithromycin	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
clarithromycin	2	Quantity Limitation - 28 tablets per prescription
clarithromycin er	2	Quantity Limitation - 28 tablets per prescription
e.e.s. 400	1	
ery	1	Topical Dosage Formulation
ery-tab	1	
ERYTHROCIN LACTOBIONATE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
erythrocin stearate	1	
erythromycin	1	
erythromycin	1	Topical Dosage Formulation
erythromycin base	1	
romycin	1	
ZMAX	3	
Quinolones		
AVELOX	4	Quantity Limitation - 14 tablets per prescription
AVELOX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
AVELOX ABC PACK	4	Quantity Limitation - 14 tablets per prescription
CILOXAN	4	
ciprofloxacin er	1	
ciprofloxacin extended-release	1	
ciprofloxacin hcl	1	
FACTIVE	4	Quantity Limitation - 7 tablets per prescription
LEVAQUIN	3	Quantity Limitation - 14 tablets per prescription
LEVAQUIN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
LEVAQUIN PREMIX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
NOROXIN	4	
ofloxacin	2	
QUIXIN	4	
VIGAMOX	4	
ZYMAR	4	
Sulfonamides		
GANTRISIN PEDIATRIC	4	
ocusulf-10	2	
silver sulfadiazine	2	Topical Dosage Formulation
sodium sulfacetamide	2	
sodium sulfacetamide	2	Topical Dosage Formulation
ssd	2	Topical Dosage Formulation
sulfadiazine	2	
sulfamethoxazole/trimethoprim	1	
sulfamethoxazole/trimethoprim	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		the use and setting of drug to make the determination.
sulfamethoxazole/trimethoprim ds	1	
SULFAMYLON	4	Topical Dosage Formulation
sulfatrim	2	
thermazene	2	Topical Dosage Formulation
Tetracyclines		
demeclocycline hcl	2	
doxy-caps	2	
doxycycline hyclate	2	
doxycycline hyclate	5	Injectable dosage Formulation
doxycycline monohydrate	2	
minocycline hcl	2	
tetracycline hcl	1	
ANTICONVULSANTS		
Anticonvulsants, Other		
BANZEL	4	
KEPPRA	3	
KEPPRA	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
KEPPRA XR	4	
levetiracetam	2	
VIMPAT	4	
VIMPAT	5	Injectable dosage Formulation; Quantity Limitation - 1200ml per 30 days
Calcium Channel Modifying Agents		
CELONTIN	4	
ethosuximide	2	
LYRICA	3	
zonisamide	1	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
DEPACON	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		the use and setting of drug to make the determination.
DEPAKOTE SPRINKLES	3	
divalproex sodium	2	
gabapentin	1	Quantity Limitation - 180 tablets per 30 days on 600mg; 120 tablets per 30 days on 800mg; 360 capsules per 30 days on 100mg and 300mg; 270 capsules per 30 days on 400mg
GABITRIL	4	
NEURONTIN	4	
primidone	2	
SABRIL	6	Prior Authorization Required; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757. Limit 180 per 30 days
STAVZOR	4	
valproate sodium	5	Injectable dosage Formulation
valproic acid	1	
Glutamate Reducing Agents		
FELBATOL	4	
LAMICTAL XR	4	Quantity Limitation - 30 tablets per 30 days
lamotrigine	2	
TOPAMAX	4	
TOPAMAX SPRINKLE	4	
Sodium Channel Inhibitors		
carbamazepine	1	
CARBATROL	4	
CEREBYX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
DILANTIN	4	
DILANTIN INFATABS	4	
epitol	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
fosphenytoin sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
oxcarbazepine	2	
PEGANONE	4	
PHENYTEK	4	
phenytoin	1	
phenytoin sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
phenytoin sodium extended	1	
TEGRETOL-XR	4	
TRILEPTAL	4	
ANTIDEMENTIA AGENTS		
Antidementia Agents, Other		
ergoloid mesylates	2	
Cholinesterase Inhibitors		
ARICEPT	3	Quantity Limitation - 30 tablets per 30 days
ARICEPT ODT	3	Quantity Limitation - 30 tablets per 30 days
COGNEX	4	Quantity Limitation - 120 capsules per 30 days
EXELON	3	Transdermal dosage Formulation
EXELON	3	Quantity Limitation - 60 capsules per 30 days; 180ml per 30 days on solution
galantamine hydrobromide	2	
RAZADYNE	4	Oral solution; Quantity Limitation - 180ml per 30 days
Glutamate Pathway Modifiers		
NAMENDA	3	Quantity Limitation - 60 tablets per 30 days; 360ml per 30 days on solution
NAMENDA TITRATION PAK	3	Quantity Limitation - 60 tablets per

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		30 days; 360ml per 30 days on solution
ANTIDEPRESSANTS		
Antidepressants, Other		
amoxapine	2	
budeprion sr	2	
budeprion xl	2	Quantity Limitation - 30 tablets per 30 days
bupropion hcl	2	
bupropion hcl sr	2	
chlordiazepoxide/amitriptyline	2	
maprotiline hcl	2	
mirtazapine	2	Quantity Limitation - 30 tablets per 30 days
mirtazapine odt	2	Quantity Limitation - 30 tablets per 30 days
nefazodone hcl	2	
perphenazine/amitriptyline	2	
trazodone hcl	1	
Monoamine Oxidase Inhibitors		
EMSAM	4	Prior Authorization Required for new starts; Quantity Limitation - 30 patches per 30 days; Transdermal Dosage Formulation
MARPLAN	4	
NARDIL	3	
tranylcypromine sulfate	2	
Serotonin/ Norepinephrine Reuptake Inhibitors		
citalopram hydrobromide	2	This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
CYMBALTA	3	Quantity Limitation - 60 capsules per 30 days on 20mg; 30 capsules per 30 days on 30mg and 60mg
EFFEXOR XR	4	Quantity Limitation - 180 capsules per 30 days on 37.5mg; 90 capsules per 30 days on 75mg; 60 capsules per 30 days on 150mg
fluoxetine hcl	1	
fluvoxamine maleate	2	Quantity Limitation - 45 tablets per

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		30 days on 25mg; 60 tablets per 30 days on 50mg; 90 tablets per 30 days on 100mg
LEXAPRO	4	Quantity Limitation - 30 tablets per 30 days, 620ml per 30 days on 5mg/5ml solution;
LUVOX CR	4	Quantity Limitation - 60 capsules per 30 days
paroxetine hcl	1	Quantity Limitation - 30 tablets per 30 days; 946ml per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
paroxetine hcl	2	10mg; Quantity Limitation - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
paroxetine hcl er	2	
PRISTIQ	4	Quantity Limitation - 30 tablets per 30 days
sertraline hcl	1	Quantity Limitation - 30 per 30 days on 25mg and 50mg, 60 per 30 days on 100mg; 300ml per 30 days on 20mg/ml solution
venlafaxine hcl	2	Quantity Limitation - 90 tablets per 30 days; 150 tablets per 30 days on 75mg; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications..
VENLAFAXINE HCL ER	3	
Tricyclics		
amitriptyline hcl	1	
clomipramine hcl	2	
desipramine hcl	2	
doxepin hcl	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
doxepin hcl	2	Injectable dosage Formulation
imipramine hcl	2	
nortriptyline hcl	1	
nortriptyline hcl	2	Oral solution
protriptyline hcl	2	
SURMONTIL	4	
trimipramine maleate	2	
ANTIDOTES, DETERRENTS, AND TOXICOLOGIC AGENTS		
Antidotes		
ACETADOTE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ANTIZOL	6	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
CUPRIMINE	4	
DEPEN TITRATABS	4	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
EXJADE	6	Prior Authorization Required
sodium polystyrene sulfonate	2	
SYPRINE	4	
Deterrents		
bupropion hcl sr	2	
CAMPRAL	4	
CHANTIX	4	Prior Authorization Required
NICOTROL NS	4	Quantity Limitation - 4 inhalers per 30 days
Toxicologic Agents		
depade	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LEUCOVORIN CALCIUM	4	Prior Authorization Required for new starts
leucovorin calcium	5	Prior Authorization Required for new starts; Injectable dosage Formulation
MESNEX	6	
naloxone hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
naltrexone hcl	2	
ANTIEMETICS		
Antiemetics		
ALOXI	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 5 per prescription.
ANZEMET	4	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 10 per prescription.
ANZEMET	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
chlorpromazine hcl	2	
chlorpromazine hcl	5	Injectable dosage Formulation
diphenhydramine hcl	2	
diphenhydramine hcl	5	Injectable Formulation - This drug may be covered under Medicare

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dronabinol	2	
EMEND	4	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit - 5 capsules per prescription.
granisetron hcl	2	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 10 tablets per prescription.
granisol	2	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
hydroxyzine pamoate	2	
meclizine hcl	1	
metoclopramide hcl	1	
metoclopramide hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ondansetron hcl	2	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		determination. Limit 10 tablets or 50ml per prescription.
ondansetron hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ondansetron odt	2	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 10 per prescription.
perphenazine	2	
phenadoz	2	
prochlorperazine edisylate	5	
prochlorperazine maleate	2	
promethazine hcl	1	Tablet
promethazine hcl	2	Syrup and Suppository
promethazine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
promethegan	2	
TRANSDERM-SCOP	4	Transdermal Dosage Formulation; Quantity Limitation 24 per 30 days
trimethobenzamide hcl	1	
trimethobenzamide hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ANTIFUNGALS		
Antifungals		
ABELCET	6	Prior Authorization Required;

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Injectable dosage Formulation
amphotericin b	5	Prior Authorization Required; Injectable dosage Formulation
ANCOBON	4	
CANCIDAS	6	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ciclopirox	2	Topical Dosage Formulation
ciclopirox nail lacquer	2	
ciclopirox olamine	2	Topical Dosage Formulation
clotrimazole	2	
clotrimazole	2	Topical Dosage Formulation
econazole nitrate	2	Topical Dosage Formulation
ERAXIS	5	Prior Authorization Required; Injectable dosage Formulation
EXELDERM	4	Topical Dosage Formulation
fluconazole	1	
griseofulvin microsize	4	
itraconazole	2	
ketoconazole	2	
ketoconazole	2	Topical Dosage Formulation
kuric	2	Topical Dosage Formulation
LAMISIL	3	Quantity Limitation - 30 grams per 30 days; Topical Dosage Formulation
LOPROX	4	Topical Dosage Formulation
LOPROX SHAMPOO	4	Topical Dosage Formulation
miconazole 3	2	Vaginal Dosage Formulation
NAFTIN	4	Topical Dosage Formulation
NATACYN	3	
nystatin	1	
nystatin	1	Topical Dosage Formulation
nystatin/triamcinolone	1	Topical Dosage Formulation
nystop	1	Topical Dosage Formulation
OXISTAT	4	Topical Dosage Formulation
pedi-dri	1	Topical Dosage Formulation
terbinafine hcl	2	
terconazole	2	
VFEND	6	Prior Authorization Required
VFEND IV	6	Prior Authorization Required;

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Injectable dosage Formulation
zazole	2	
ANTIGOUT AGENTS		
Antigout Agents		
allopurinol	1	
COLCRYS	4	
probenecid	2	
probenecid/colchicine	2	
ANTI-INFLAMMATORY AGENTS		
Nonsteroidal Anti-inflammatory Drugs		
ARTHROTEC	4	Step Therapy Protocols Apply
PREVACID NAPRAPAC	4	Step Therapy Protocols Apply; Quantity Limitation - 84 capsules per 30 days
Glucocorticoids		
a-methapred	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
CELESTONE	4	
cortisone acetate	2	
dexamethasone	1	
hydrocortisone	1	
methylprednisolone	2	
methylprednisolone acetate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
methylprednisolone sodium succinate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
prednisolone sodium phosphate	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
prednisone intensol	1	
ANTIMIGRAINE AGENTS		
Abortive		
AMERGE	4	Quantity Limitation - 9 tablets per 30 days
AXERT	4	Quantity Limitation - 12 tablets per 30 days
dihydroergotamine mesylate	5	
ERGOMAR	4	Quantity Limitation - 20 tablet per 28 days
FROVA	4	Quantity Limitation - 12 tablets per 30 days
MAXALT	4	Quantity Limitation - 12 tablets per 30 days
MAXALT-MLT	4	Quantity Limitation - 12 tablets per 30 days
migergot	2	
MIGRANAL	4	Quantity Limitation - 16 ml per 30 days
RELPAK	4	Quantity Limitation - 6 tablets per 30 days
sumatriptan succinate	2	
TREXIMET	3	
ZOMIG	3	Quantity Limitation - 6 tablets per 30 days; 6ml nasal spray per 30 days
ZOMIG ZMT	3	Quantity Limitation - 6 tablets per 30 days
Prophylactic		
divalproex sodium	2	
timolol maleate	1	
ANTIMYASTHENIC AGENTS		
Parasympathomimetics		
GUANIDINE HCL	3	
MESTINON	4	
MESTINON TIMESPAN	4	
MYTELASE	4	
pyridostigmine bromide	2	
ANTIMYCOBACTERIALS		
Antimycobacterials, Other		
DAPSONE	3	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MYCOBUTIN	4	
Antituberculars		
CAPASTAT SULFATE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ethambutol hcl	2	
isonarif	2	
isoniazid	2	
PASER	4	
PRIFTIN	4	
pyrazinamide	2	
RIFAMATE	4	
rifampin	2	
rifampin	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
RIFATER	4	
SEROMYCIN	4	
TRECATOR	4	
ANTINEOPLASTICS		
Alkylating Agents		
CEENU	4	Prior Authorization Required for new starts
EMCYT	4	Prior Authorization Required for new starts
HEXALEN	6	Prior Authorization Required for new starts
LEUKERAN	3	Prior Authorization Required for new starts
MATULANE	4	
ZANOSAR	5	Prior Authorization Required for new starts; Injectable dosage Formulation
Antiangiogenic Agents		
REVLIMID	6	Prior Authorization Required for

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		new starts; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757.
THALOMID	6	Prior Authorization Required for new starts
Antiestrogens/Modifiers		
FARESTON	4	
tamoxifen citrate	2	
Antimetabolites		
DROXIA	4	
hydroxyurea	2	
mercaptopurine	2	
TABLOID	4	Prior Authorization Required for new starts
Antineoplastics, Other		
AFINITOR	6	Quantity Limitation - 60 tablets per 30 days
ARRANON	6	Prior Authorization Required for new starts; Injectable dosage Formulation
bleomycin sulfate	5	Prior Authorization Required for new starts; Injectable dosage Formulation
cyclophosphamide	2	Prior Authorization Required for new starts
ELITEK	6	Prior Authorization Required for new starts; Injectable dosage Formulation
mitoxantrone hcl	6	Prior Authorization Required for new starts; Injectable dosage Formulation
ONTAK	6	Prior Authorization Required for new starts; Injectable dosage Formulation
oxaliplatin	2	
PROLEUKIN	6	Prior Authorization Required for new starts; Injectable dosage Formulation
TRISENOX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TYKERB	6	Prior Authorization Required for new starts
VELCADE	6	Prior Authorization Required for new starts; Injectable dosage Formulation
VIDAZA	6	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ZOLINZA	6	
Aromatase Inhibitors, 3rd Generation		
ARIMIDEX	3	Quantity Limitation - 30 tablets per 30 days
AROMASIN	3	
FEMARA	4	
Molecular Target Inhibitors		
GLEEVEC	6	Prior Authorization Required for new starts - Quantity Limitation - 90 tablets per 30 days on 100mg, 60 tablets per 30 days on 400mg
IRESSA	6	Prior Authorization Required for new starts; Quantity Limitation - 30 tablets per 30 days
NEXAVAR	6	Prior Authorization Required for new starts; Quantity Limitation 120 per 30 days
SPRYCEL	6	Prior Authorization Required for new starts
SUTENT	6	Prior Authorization Required for new starts
TARCEVA	6	Prior Authorization Required for new starts
TASIGNA	6	
Monoclonal Antibodies		
AVASTIN	6	Prior Authorization Required for new starts; Injectable dosage Formulation
CAMPATH	6	Prior Authorization Required for

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		new starts; Injectable dosage Formulation
HERCEPTIN	6	Prior Authorization Required for new starts; Injectable dosage Formulation
MYLOTARG	6	Prior Authorization Required for new starts; Injectable dosage Formulation
RITUXAN	6	Prior Authorization Required for new starts; Injectable dosage Formulation
Retinoids		
PANRETIN	6	Topical Dosage Formulation
TARGRETIN	6	Prior Authorization Required for new starts
TARGRETIN	6	Prior Authorization Required for new starts; Quantity Limitation - 60 grams per prescription; Topical Dosage Formulation
tretinoin	2	Prior Authorization Required for new starts
ANTIPARASITICS		
Anthelmintics		
BILTRICIDE	4	
mebendazole	2	
STROMEKTOL	4	
Antiprotozoals		
ALINIA	4	
chloroquine phosphate	2	
DARAPRIM	4	
FANSIDAR	4	
hydroxychloroquine sulfate	2	
MALARONE	4	
mefloquine hcl	2	
MEPRON	4	Prior Authorization Required
NEUTREXIN	6	Prior Authorization Required; Injectable dosage Formulation
PRIMAQUINE PHOSPHATE	4	
TINDAMAX	4	
Pediculicides/Scabicides		
acticin	2	Topical Dosage Formulation
lindane	2	Topical Dosage Formulation
OVIDE	4	Topical Dosage Formulation

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
permethrin	2	Topical Dosage Formulation
ANTIPARKINSON AGENTS		
Antiparkinson Agents		
amantadine hcl	2	
APOKYN	6	Prior Authorization Required; Injectable dosage Formulation
atamet	2	
AZILECT	4	
benztropine mesylate	1	
bromocriptine mesylate	2	
carbidopa/levodopa	2	
carbidopa/levodopa cr	2	
carbidopa/levodopa odt	2	
carbidopa/levodopa sr	2	
COMTAN	3	Quantity Limitation - 240 tablets per 30 days
LODOSYN	4	
MIRAPEX	3	Quantity Limitation - 90 tablets per 30 days
REQUIP XL	4	
ropinirole hcl	2	
selegiline hcl	2	
STALEVO	4	
TASMAR	4	Quantity Limitation - 90 tablets per 30 days
trihexyphenidyl hcl	1	
ANTIPSYCHOTICS		
Atypicals		
ABILIFY	4	Quantity Limitation - 30 tablets per 30 days; 900ml per 30 days on solution
ABILIFY	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ABILIFY DISCMELT	4	Quantity Limitation - 60 tablets per 30 days
clozapine	2	Quantity Limitation - 120 tablets per 30 days

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FAZACLO	4	Quantity Limitation - 270 tablets per 30 days
GEODON	3	Quantity Limitation - 60 capsules per 30 days
GEODON	5	Injectable dosage Formulation
INVEGA	4	Quantity Limitation - 30 tablets per 30 days on 3mg and 9mg, 60 tablets per 30 days on 6mg
RISPERDAL	4	Oral solution; Quantity Limitation - 480ml per 30 days
RISPERDAL CONSTA	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
RISPERDAL M-TAB	4	Quantity Limitation - 60 tablets per 30 days, 120 tablets per 30 days on 4mg
risperidone	2	This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
SAPHRIS	4	Quantity Limitation - 60 tablets per 30 days
SEROQUEL	3	Quantity Limitation - 60 per 30 days on 400mg, 90 per 30 days on 200mg and 300mg, 120 per 30 days on 25mg and 50mg and 100mg
SEROQUEL XR	3	Quantity Limitation - 30 tablets per 30 days on 200mg; 60 tablets per 30 days on 300mg and 400mg
SYMBYAX	4	Quantity Limitation - 30 capsules per 30 days
ZYPREXA	3	Quantity Limitation - 30 tablets per 30 days
ZYPREXA	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		the use and setting of drug to make the determination. Limit 30 per 30 days
ZYPREXA ZYDIS	3	Quantity Limitation - 30 tablets per 30 days
Conventional		
compro	2	
fluphenazine decanoate	5	
fluphenazine hcl	2	
fluphenazine hcl	5	Injectable dosage Formulation
haloperidol	1	
haloperidol decanoate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
haloperidol lactate	5	
loxapine succinate	2	
MOBAN	4	
NAVANE	4	
ORAP	4	
prochlorperazine	2	
thioridazine hcl	2	
thiothixene	1	
thiothixene	2	5mg capsule
trifluoperazine hcl	2	
ANTISPASTICITY AGENTS		
Antispasticity Agents		
baclofen	2	
dantrolene sodium	2	
tizanidine hcl	2	
ANTIVIRALS		
Anti-cytomegalovirus (CMV) Agents		
CYTOVENE	5	
foscarnet sodium	4	
FOSCAVIR	6	
ganciclovir	2	
VALCYTE	6	
VISTIDE	6	
Antihepatitis Agents		

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BARACLUDE	4	Oral solution; Prior Authorization Required; Quantity Limitation - 600ml per 30 days on solution
BARACLUDE	6	Prior Authorization Required; Quantity Limitation - 30 tablets per 30 days
HEPSERA	6	Prior Authorization Required for new starts; Injectable dosage Formulation
ribasphere	2	
ribavirin	2	
TYZEKA	4	Prior Authorization Required for new starts
Antiherpetic Agents		
acyclovir	1	
DENAVIR	4	Quantity Limitation - 1.5 grams per 28 days; Topical Dosage Formulation
famciclovir	2	
trifluridine	2	
VALTREX	3	
ZOVIRAX	4	Quantity Limitation - 10grams per 30 days on cream, 30 grams per 30 days on ointment; Topical Dosage Formulation
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors		
INTELENCE	4	
RESCRIPTOR	4	
SUSTIVA	3	
VIRAMUNE	3	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors		
ATRIPLA	4	
COMBIVIR	3	
didanosine	2	
EMTRIVA	4	
EPIVIR	3	
EPIVIR HBV	3	
EPZICOM	3	
RETROVIR IV INFUSION	5	Injectable dosage Formulation
stavudine	2	
TRIZIVIR	3	
TRUVADA	3	
VIDEX EC	4	
VIDEX PEDIATRIC	4	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIREAD	4	
ZERIT	4	
ZIAGEN	3	
zidovudine	2	
Anti-HIV Agents, Other		
FUZEON	6	
ISENTRESS	6	
SELZENTRY	6	
Anti-HIV Agents, Protease Inhibitors		
APTIVUS	4	Quantity Limitation - 300ml per 30 days on solution
CRIXIVAN	4	
INVIRASE	4	
KALETRA	3	
LEXIVA	3	
NORVIR	4	
PREZISTA	4	
REYATAZ	3	
VIRACEPT	4	
Anti-influenza Agents		
RELENZA DISKHALER	3	
rimantadine hcl	2	
TAMIFLU	3	
ANXIOLYTICS		
Anxiolytics, Other		
bupirone hcl	2	
meprobamate	2	
BIPOLAR AGENTS		
Bipolar Agents		
lithium carbonate	2	
lithium carbonate er	2	
lithium citrate	2	
BLOOD GLUCOSE REGULATORS		
Antidiabetic Agents		
acarbose	2	
ACTOPLUS MET	4	Quantity Limitation - 90 tablets per 30 days
ACTOS	3	Quantity Limitation - 30 tablets per 30 days
AVANDAMET	4	Quantity Limitation - 60 tablets per 30 days

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AVANDARYL	4	Quantity Limitation - 60 tablets per 30 days
AVANDIA	4	Quantity Limitation - 60 tablets per 30 days
BYETTA	5	Quantity Limitation - 1 kit per 30 days; Injectable dosage Formulation
chlorpropamide	2	
glimepiride	1	
glipizide	1	
glipizide er	1	
glipizide xl	1	
glipizide/metformin hcl	1	
glyburide	1	
glyburide micronized	1	
glyburide/metformin hcl	1	
glycron	2	
GLYSET	4	
JANUMET	3	Step Therapy Protocols Apply
JANUVIA	3	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
metformin hcl	1	
metformin hcl er	1	
PRANDIN	4	Quantity Limitation - 240 tablets per 30 days
STARLIX	4	Quantity Limitation - 90 tablets per 30 days
SYMLIN	5	Quantity Limitation - 20ml per 30 days; Injectable dosage Formulation
tolazamide	2	
tolbutamide	2	
Blood Glucose Regulators, Misc		
ALCOHOL PREPS	3	
BD INSULIN SYRINGE	3	
BD ULTRA-FINE ORIGINAL PEN NEEDLES	3	
GAUZE PADS	3	
Glycemic Agents		
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	3	
PROGLYCEM	4	
Insulins		

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
APIDRA	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMALOG	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMALOG MIX 50/50	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMALOG MIX 75/25	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMULIN 50/50	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMULIN 70/30	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMULIN N	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMULIN R	3	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
HUMULIN R U-500 (CONCENTRATED)	3	
LANTUS	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
LEVEMIR	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
NOVOLIN 70/30	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
NOVOLIN N	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
NOVOLIN R	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
NOVOLOG	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
NOVOLOG MIX 70/30	5	Quantity Limitation - 30ml per 30

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		days; Injectable dosage Formulation
RELION 70/30	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
RELION N	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
RELION R	5	Quantity Limitation - 30ml per 30 days; Injectable dosage Formulation
BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS		
Anticoagulants		
ARIXTRA	4	2.5/0.5; Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation - 30 syringes per 30 days
ARIXTRA	6	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation - 30 syringes per 30 days
COUMADIN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
COUMADIN	3	
FRAGMIN	5	2500/0.2, 5000/0.2; Prior Authorization Required; Injectable dosage Formulation
FRAGMIN	6	Prior Authorization Required; Injectable dosage Formulation
heparin sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
HEPARIN SODIUM DCU	5	Injectable Formulation - This drug

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
heparin sodium/d5w	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
heparin sodium/nacl 0.9%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
INNOHEP	5	Prior Authorization Required; Injectable dosage Formulation
jantoven	1	
LOVENOX	4	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation - 28 syringes per 30 days
warfarin sodium	1	
Blood Formation Products		
ARANESP ALBUMIN FREE	4	40mcg; Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation
ARANESP ALBUMIN FREE	5	25mcg; Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation
ARANESP ALBUMIN FREE	6	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation
EPOGEN	5	2000, 3000, 4000 unit strengths only; Quantity Limitation - 12 per 28 days; Prior Authorization Required; Injectable dosage Formulation
EPOGEN	6	10000, 20000, 40000 unit strengths; Prior Authorization

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Required; Injectable dosage Formulation
LEUKINE	3	Prior Authorization Required; Injectable dosage Formulation
METHERGINE	4	
NEULASTA	6	Prior Authorization Required; Injectable dosage Formulation
NEUMEGA	6	Prior Authorization Required; Injectable dosage Formulation
NEUPOGEN	6	Prior Authorization Required; Injectable dosage Formulation
PROCRIT	4	10000 unit strength; Prior Authorization Required; Injectable dosage Formulation
PROCRIT	5	2000, 3000, 4000 unit strengths only; Quantity Limitation - 12 per 28 days; Prior Authorization Required; Injectable dosage Formulation
PROCRIT	6	20000, 40000 unit strengths; Prior Authorization Required; Injectable dosage Formulation
Coagulants		
CYKLOKAPRON	3	
Platelet Aggregation Inhibitors		
AGGRENOX	4	
anagrelide hydrochloride	2	
cilostazol	2	
dipyridamole	1	
EFFIENT	4	Quantity Limitation - 30 tablets per 30 days
pentopak	2	
pentoxifylline er	2	
pentoxil	2	
PLAVIX	3	Quantity Limitation - 30 tablets per 30 days
ticlopidine hcl	2	
CARDIOVASCULAR AGENTS		
Alpha-adrenergic Agonists		
CATAPRES-TTS	4	Transdermal Dosage Formulation; Quantity Limitation 4 patches per 28 days
clonidine hcl	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
guanabenz acetate	2	
guanfacine hcl	2	
methyldopa	1	
methyldopa/hydrochlorothiazide	2	
methyldopate hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
midodrine hcl	2	
Alpha-adrenergic Blocking Agents		
doxazosin mesylate	1	
prazosin hcl	2	
reserpine	2	
terazosin hcl	1	
Antiarrhythmics		
acebutolol hcl	2	
amiodarone hcl	2	
cartia xt	2	
dilt-cd	2	
diltiazem cd	2	
diltiazem hcl	2	
diltiazem hcl er	2	
dilt-xr	2	
disopyramide phosphate	2	
flecainide acetate	2	
mexiletine hcl	2	
PACERONE	4	
pacerone	2	200mg
PROCAINAMIDE HCL	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
propafenone hcl	2	
propranolol hcl	1	
propranolol hcl	2	Oral solution
propranolol hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
propranolol hcl er	2	
quinidine gluconate cr	2	
quinidine sulfate	2	
quinidine sulfate er	2	
sorine	2	
sotalol hcl	2	
taztia xt	2	
TIKOSYN	4	
verapamil hcl	2	
verapamil hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
verapamil hcl er	2	
Beta-adrenergic Blocking Agents		
atenolol	1	
atenolol/chlorthalidone	1	
betaxolol hcl	2	
bisoprolol fumarate	2	
bisoprolol fumarate/hydrochlorothiazide	2	
CARTROL	4	
carvedilol	2	This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
COREG CR	4	Quantity Limitation - 30 tablets per 30 days
EXFORGE	4	Quantity Limitation - 30 tablets per 30 days
labetalol hcl	2	
labetalol hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		need to be submitted describing the use and setting of drug to make the determination.
LEVATOL	2	
metoprolol succinate er	2	Quantity Limitation - 30 tablets per 30 days; 60 tablets per 30 days on 200mg
metoprolol tartrate	1	
metoprolol tartrate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
metoprolol/hydrochlorothiazide	1	
nadolol	1	
nadolol/bendroflumethiazide	2	
pindolol	1	
propranolol/hydrochlorothiazide	1	
Calcium Channel Blocking Agents		
afeditab cr	2	
amlodipine besylate	1	Quantity Limitation - 30 tablets per 30 days
amlodipine besylate/benazepril hydrochloride	2	Quantity Limitation - 30 capsules per 30 days
felodipine er	2	
isradipine	2	
nicardipine hcl	2	
nifediac cc	2	
nifedical xl	2	
nifedipine	2	
nifedipine er	2	
nimodipine	2	
nisoldipine	2	
Cardiovascular Agents, Others		
digoxin	1	
LANOXIN	3	
LANOXIN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
RANEXA	3	Quantity Limitation - 120 tablets per 30 days
Diuretics		
amiloride hcl	2	
amiloride/hydrochlorothiazide	1	
bumetanide	2	
chlorothiazide	2	
chlorthalidone	2	
eplerenone	2	
furosemide	1	
furosemide	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
hydrochlorothiazide	1	
indapamide	1	
methazolamide	1	
methyclothiazide	2	
metolazone	2	
spironolactone	1	25mg and 50mg
spironolactone	2	100mg
spironolactone/hydrochlorothiazide	2	
toremide	2	
triamterene/hydrochlorothiazide	1	
Dyslipidemics		
ADVICOR	4	Quantity Limitation - 30 tablets per 30 days
CADUET	4	Quantity Limitation - 30 tablets per 30 days
cholestyramine	2	
cholestyramine light	2	
colestipol hcl	2	
CRESTOR	3	Quantity Limitation - 30 tablets per 30 days
fenofibrate	2	
fenofibrate micronized	2	
gemfibrozil	2	
LESCOL	4	Quantity Limitation - 60 capsules per 30 days

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LESCOL XL	4	Quantity Limitation - 30 tablets per 30 days
LIPITOR	3	Quantity Limitation - 30 tablets per 30 days
lovastatin	2	Quantity Limitation - 30 tablets per 30 days on 10mg and 20mg; 60 tablets per 30 days on 40mg
LOVAZA	4	Quantity Limitation - 120 capsules per 30 days
niacor	2	
NIASPAN	3	Quantity Limitation - 60 tablets per 30 days
pravastatin sodium	2	Quantity Limitation - 30 tablets per 30 days; 60 tablets per 30 days on 40mg
prevalite	2	
SIMCOR	3	Quantity Limitation - 60 tablets per 30 days
simvastatin	1	Quantity Limitation - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
TRICOR	3	Quantity Limitation - 30 tablets per 30 days
TRILIPIX	3	
VYTORIN	4	Quantity Limitation - 30 tablets per 30 days
WELCHOL	4	
ZETIA	4	Quantity Limitation - 30 tablets per 30 days
Renin-angiotensin-aldosterone System Inhibitors		
ATACAND	3	Quantity Limitation - 30 tablets per 30 days
ATACAND HCT	3	Quantity Limitation - 30 tablets per 30 days
AVALIDE	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
AVAPRO	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
benazepril hcl	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
benazepril hcl/hydrochlorothiazide	1	
BENICAR	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
BENICAR HCT	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
captopril	1	
captopril/hydrochlorothiazide	1	
COZAAR	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
DIOVAN	3	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
DIOVAN HCT	3	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
enalapril maleate	1	This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
enalapril maleate/hydrochlorothiazide	1	This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
fosinopril sodium	2	
fosinopril sodium/hydrochlorothiazide	2	
HYZAAR	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
lisinopril	1	
lisinopril/hydrochlorothiazide	1	
MICARDIS	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
MICARDIS HCT	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
moexipril hcl	2	
moexipril/hydrochlorothiazide	2	
quinapril hcl	2	
quinapril/hydrochlorothiazide	2	
quinaretic	2	
TARKA	4	Quantity Limitation - 30 tablets per 30 days
TEKTURNA	4	Quantity Limitation - 30 tablets per 30 days; Step Therapy Protocols Apply
TEKTURNA HCT	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
trandolapril	2	
Vasodilators		
BIDIL	4	Prior Authorization Required
hydralazine hcl	2	
hydralazine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
isochron	2	
isosorbide dinitrate	1	
isosorbide dinitrate er	1	
isosorbide mononitrate	1	10mg
isosorbide mononitrate	2	20mg
isosorbide mononitrate er	1	30mg and 120mg
isosorbide mononitrate er	2	20mg and 60mg
minitran	2	Transdermal Dosage Formulation
minoxidil	2	
NITRO-DUR	4	Transdermal Dosage Formulation
nitroglycerin	2	Transdermal Dosage Formulation
nitroglycerin	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
nitroglycerin transdermal	2	Transdermal Dosage Formulation
NITROLINGUAL PUMPSPRAY	4	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NITROSTAT	1	
CENTRAL NERVOUS SYSTEM AGENTS		
Amphetamines, ADHD		
ADDERALL XR	4	Quantity Limitation - 30 capsules per 30 days on 5mg, 10mg, and 15mg; 60 capsules per 30 days on 20mg and 30mg
amphetamine salt combo	2	Quantity Limitation - 90 tablets per 30 days
dextroamphetamine sulfate	2	Quantity Limitation - 180 tablets per 30 days
dextroamphetamine sulfate er	2	Quantity Limitation - 120 capsules per 30 days
Non-amphetamines, ADHD		
CONCERTA	4	Quantity Limitation - 30 tablets per 30 days on 18mg, 27mg, and 54mg; 60 tablets per 30 days on 36mg
dexmethylphenidate hcl	2	Quantity Limitation - 90 tablets per 30 days
METADATE CD	4	Quantity Limitation - 180 capsules per 30 days
metadate er	2	Quantity Limitation - 90 capsules per 30 days
methylin	2	Quantity Limitation - 90 tablets per 30 days
methylin er	2	Quantity Limitation - 90 tablets per 30 days
methylphenidate hcl	2	Quantity Limitation - 90 tablets per 30 days
methylphenidate hcl er	2	Quantity Limitation - 90 tablets per 30 days
RITALIN LA	4	Quantity Limitation - 60 capsules per 30 days
STRATTERA	3	Quantity Limitation - 60 capsules per 30 days
Non-amphetamines, Other		
PROVIGIL	3	Quantity Limitation - 60 tablets per 30 days
RILUTEK	4	Prior Authorization Required
XYREM	4	Prior Authorization Required; This prescription may be available only at certain pharmacies. For more

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757.
DENTAL AND ORAL AGENTS		
Dental and Oral Agents		
APHTHASOL	4	
chlorhexidine gluconateoral rinse	2	
periogard	2	
pilocarpine hcl	2	
pilocarpine hydrochloride	2	
triamcinolone in orabase	2	
DERMATOLOGICAL AGENTS		
Dermatological Agents		
8-MOP	3	Prior Authorization Required
ALDARA	4	Prior Authorization Required for new starts; Topical Dosage Formulation
ammonium lactate	2	Topical Dosage Formulation
avita	2	Topical Dosage Formulation
calcipotriene	2	
clotrimazole/betamethasone dipropionate	2	Topical Dosage Formulation
colocort	2	
CORTIFOAM	4	
DIFFERIN	4	Topical Dosage Formulation; Prior Authorization Required
DOVONEX	4	Topical Dosage Formulation
ELIDEL	3	Prior Authorization Required; Quantity Limitation - 30 grams per prescription; Topical Dosage Formulation
erythromycin/benzoyl peroxide	2	
fluorouracil	2	
fluorouracil	2	Topical Dosage Formulation
hydrocortisone	2	
laclotion	2	Topical Dosage Formulation
lidocaine	2	Topical Dosage Formulation
LIDODERM	4	Quantity Limitation - 90 patches per 30 days; Transdermal Dosage Formulation

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ORACEA	4	
OXSORALEN ULTRA	4	Prior Authorization Required for new starts
podofilox	2	Topical Dosage Formulation
proctocream-hc	2	
proctosol hc	2	
proctozone-hc	2	
PROTOPIC	4	Prior Authorization Required for new starts; Quantity Limitation - 30 grams per prescription; Topical Dosage Formulation
REGRANEX	4	Prior Authorization Required; Quantity Limitation - 15 grams per 30 days; Topical Dosage Formulation
RETIN-A MICRO	4	Topical Dosage Formulation
SANTYL	3	Quantity Limitation -30 grams per prescription; Topical Dosage Formulation
selenium sulfide	2	Topical Dosage Formulation
SOLARAZE	3	Prior Authorization Required; Quantity Limitation - 50 grams per prescription; Topical Dosage Formulation
TAZORAC	4	Topical Dosage Formulation
tretinoin	2	Topical Dosage Formulation
u-cort	1	Topical Dosage Formulation
ENZYME REPLACEMENTS/ MODIFIERS		
Enzyme Replacements/ Modifiers		
ADAGEN	6	Prior Authorization Required; Injectable dosage Formulation
ALDURAZYME	6	Prior Authorization Required; Injectable dosage Formulation
BUPHENYL	4	
CEREDASE	6	Prior Authorization Required; Injectable dosage Formulation
CEREZYME	6	Prior Authorization Required; Injectable dosage Formulation
CREON	3	
CYSTADANE	4	
CYSTAGON	4	
ELAPRASE	6	Prior Authorization Required; Injectable dosage Formulation

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FABRAZYME	6	Prior Authorization Required; Injectable dosage Formulation
levocarnitine	2	
LIPRAM	4	
LIPRAM-PN	4	
LIPRAM-UL	4	
MYOZYME	6	Prior Authorization Required; Injectable dosage Formulation
NAGLAZYME	6	Prior Authorization Required; Injectable dosage Formulation
ORFADIN	6	Prior Authorization Required
PANCREASE MT	3	
PANCRECARB MS	4	
PANCRELIPASE	3	
PANCRELIPASE MST	3	
PANCRON	4	
SUCRAID	4	
ULTRASE	4	
ULTRASE MT	4	
VIKASE	3	
ZAVESCA	4	

GASTROINTESTINAL AGENTS

Antispasmodics, Gastrointestinal

atropine sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
CANTIL	4	
dicyclomine hcl	1	
dicyclomine hcl	2	Oral solution
glycopyrrolate	2	
methscopolamine bromide	2	
propantheline bromide	2	

Gastrointestinal Agents, Other

colyte	2	
constulose	2	
diphenoxylate/atropine	2	
enulose	2	
GASTROCROM	4	
generlac	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HELIDAC	4	
lactulose	2	
lonox	2	
loperamide hcl	2	
MOTOFEN	4	
NULYTELY	3	
peg 3350/electrolytes	2	
trilyte	2	
URSO	4	
URSO FORTE	4	
ursodiol	2	
Histamine2 (H2) Blocking Agents		
cimetidine	2	
cimetidine hcl	2	
famotidine	2	
famotidine	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
famotidine premixed	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
nizatidine	2	
ranitidine hcl	1	
ranitidine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
Irritable Bowel Syndrome Agents		
LOTRONEX	3	Quantity Limitation - 60 tablets per 30 days
Protectants		
misoprostol	2	
sucralfate	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Proton Pump Inhibitors		
ACIPHEX	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
NEXIUM	3	Step Therapy Protocols Apply; Quantity Limitation - 30 capsules per 30 days
NEXIUM I.V.	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
omeprazole	1	Quantity Limitation - 60 capsules per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
PREVACID	4	Step Therapy Protocols Apply; Quantity Limitation - 30 capsules per 30 days
PREVACID SOLUTAB	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
PREVPAC	4	Quantity Limitation - 1 pack per 30 days
PROTONIX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
GENITOURINARY AGENTS		
Antispasmodics, Urinary		
bethanechol chloride	2	
DETROL	3	Quantity Limitation - 60 tablets per 30 days
DETROL LA	3	Quantity Limitation - 30 capsules per 30 days

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ENABLEX	4	Quantity Limitation - 30 tablets per 30 days
flavoxate hcl	2	
oxybutynin chloride	1	
oxybutynin chloride	2	Oral syrup
oxybutynin chloride er	2	Quantity Limitation - 180 tablets per 30 days on 5mg; 90 tablets per 30 days on 10mg; 60 tablets per 30 days on 15mg
OXYTROL	4	Transdermal Dosage Formulation
SANCTURA	4	Quantity Limitation - 60 tablets per 30 days
SANCTURA XR	4	Quantity Limitation - 30 capsules per 30 days
TOVIAZ	3	
VESICARE	3	Quantity Limitation - 30 tablets per 30 days
Benign Prostatic Hypertrophy Agents		
AVODART	3	Quantity Limitation - 30 capsules per 30 days
finasteride	2	Quantity Limitation - 30 tablets per 30 days
FLOMAX	3	Quantity Limitation - 60 capsules per 30 days
UROXATRAL	4	Quantity Limitation - 30 tablets per 30 days
Genitourinary Agents, Other		
neomycin/polymyxin b sulfates	2	
sodium chloride 0.9%	2	
sterile water irrigation	2	
THIOLA	3	
Phosphate Binders		
calcium acetate	2	
FOSRENOL	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (Adrenal)		
Glucocorticoids-Mineralocorticoids		
ala-cort	2	Topical Dosage Formulation
alclometasone dipropionate	2	Topical Dosage Formulation
amcinonide	2	Topical Dosage Formulation
augmented betamethasone dipropionate	2	Topical Dosage Formulation
betamethasone dipropionate	1	Topical Dosage Formulation;

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		cream and ointment
betamethasone dipropionate	2	Topical Dosage Formulation; gel
betamethasone valerate	1	Topical Dosage Formulation
beta-val	1	Topical Dosage Formulation
CAPEX	4	Topical Dosage Formulation
clobetasol propionate	2	Topical Dosage Formulation
clobetasol propionate e	2	Topical Dosage Formulation
cormax	2	Topical Dosage Formulation
del-beta	2	Topical Dosage Formulation
DERMA-SMOOTH/FS BODY OIL	4	Topical Dosage Formulation
desonide	2	Topical Dosage Formulation
desoximetasone	2	Topical Dosage Formulation
diflorasone diacetate	2	Topical Dosage Formulation
fludrocortisone acetate	2	
fluocinolone acetonide	2	Topical Dosage Formulation
fluocinonide	2	Topical Dosage Formulation
fluocinonide emollient base	2	Topical Dosage Formulation
fluticasone propionate	2	Topical Dosage Formulation
halobetasol propionate	2	Topical Dosage Formulation
HALOG	4	Topical Dosage Formulation
hydrocortisone	1	Topical Dosage Formulation
hydrocortisone butyrate	1	Topical Dosage Formulation
hydrocortisone butyrate	2	Enema
hydrocortisone in absorbbase	1	Topical Dosage Formulation
hydrocortisone valerate	2	Topical Dosage Formulation
isovate	2	Topical Dosage Formulation
lokara	2	Topical Dosage Formulation
mometasone furoate	2	Topical Dosage Formulation
OLUX-E	4	Topical Dosage Formulation
prednicarbate	2	Topical Dosage Formulation
procto-pak	2	Topical Dosage Formulation
triamcinolone acetonide	1	Topical Dosage Formulation
triamcinolone acetonide in absorbbase	1	Topical Dosage Formulation
triderm	2	Topical Dosage Formulation
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
desmopressin acetate	2	
desmopressin acetate	5	Injectable Formulation - This drug may be covered under Medicare

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
GENOTROPIN	6	Prior Authorization Required; Injectable dosage Formulation
GENOTROPIN MINIQUICK	5	Prior Authorization Required; Injectable dosage Formulation
HUMATROPE	6	Prior Authorization Required; Injectable dosage Formulation
HUMATROPE COMBO PACK	6	Prior Authorization Required; Injectable dosage Formulation
INCRELEX	5	Prior Authorization Required; Injectable dosage Formulation
NORDITROPIN NORDIFLEX PEN	6	Prior Authorization Required; Injectable dosage Formulation
NUTROPIN	6	Prior Authorization Required; Injectable dosage Formulation
NUTROPIN AQ	6	Prior Authorization Required; Injectable dosage Formulation
SAIZEN	6	Prior Authorization Required; Injectable dosage Formulation
SAIZEN CLICK.EASY	6	Prior Authorization Required; Injectable dosage Formulation
SEROSTIM	6	Prior Authorization Required; Injectable dosage Formulation
STIMATE	4	
ZORBTIVE	6	Prior Authorization Required; Injectable dosage Formulation
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)		
Anabolic Steroids		
ANADROL-50	4	
oxandrolone	2	
Androgens		
ANDRODERM	4	Transdermal Dosage Formulation; Quantity Limitation 30 patches per 30 days
ANDROGEL	4	Quantity Limitation - 300 grams per 30 days; Topical Dosage Formulation
ANDROID	4	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
androxy	2	
danazol	2	
STRIANT	4	Prior Authorization Required
TESTIM	4	Topical Dosage Formulation
testosterone enanthate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TESTRED	4	
Estrogens		
ACTIVELLA	3	
ALORA	3	Transdermal Dosage Formulation
apri	2	
aranelle	2	
aviane	2	
balziva	2	
CENESTIN	3	
cesia	2	
cryselle-28	2	
enpresse-28	2	
ESTRACE	4	Vaginal Dosage Formulation
ESTRADERM	4	Transdermal Dosage Formulation
estradiol	2	
estradiol	2	Transdermal Dosage Formulation
estradiol/norethindrone acetate	2	
ESTRASORB	4	
ESTRING	4	Vaginal Dosage Formulation; Quantity Limitation - 1 per 90 days
estropipate	2	
FEMHRT 1/5	4	
FEMHRT LOW DOSE	4	
gynodiol	2	
junel	2	
junel fe	2	
kariva	2	
kelnor 1/35	2	
leena	2	
lessina-28	2	
levora 0.15/30-28	2	
low-ogestrel	2	
lutera	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MENEST	3	
microgestin	2	
microgestin fe	2	
mononessa	2	
necon	2	
nortrel	2	
NUVARING	4	Vaginal Dosage Formulation
ocella	2	
ogestrel	2	
ORTHO EVRA	4	Transdermal Dosage Formulation
ortho-est	2	
portia-28	2	
PREFEST	3	
PREMARIN	3	
PREMARIN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
PREMARIN W/APPLICATOR	3	Vaginal Dosage Formulation
PREMPHASE	3	
PREMPRO	3	
previfem	2	
quasense	2	
reclipsen	2	
solia	2	
sprintec 28	2	
sronyx	2	
tri-legest fe	2	
trinessa	2	
tri-previfem	2	
tri-sprintec	2	
trivora-28	2	
VAGIFEM	4	Vaginal Dosage Formulation
velivet	2	
VIVELLE-DOT	4	Transdermal Dosage Formulation
zovia	2	
Progestins		
camila	2	
CRINONE	4	Vaginal Dosage Formulation
errin	2	
jolivette	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
medroxyprogesterone acetate	2	
medroxyprogesterone acetate	5	Injectable dosage Formulation
MEGACE ES	4	Prior Authorization Required for new starts
megestrol acetate	2	Prior Authorization Required for new starts
nora-be	2	
norethindrone acetate	2	
PLAN B	4	
PROCHIEVE	4	Vaginal Dosage Formulation
PROMETRIUM	4	
Selective Estrogen Receptor Modifying Agents		
EVISTA	3	Quantity Limitation - 30 tablets per 30 days
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
CYTOMEL	4	
levothroid	1	
levothyroxine sodium	1	
SYNTHROID	3	
THYROLAR	3	
unithroid	2	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	3	
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)		
Hormonal Agents, Suppressant (Parathyroid)		
SENSIPAR	3	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
Hormonal Agents, Suppressant (Pituitary)		
cabergoline	2	
leuprolide acetate	5	Prior Authorization Required for new starts; Injectable dosage Formulation
octreotide acetate	4	50mcg/ml; Prior Authorization Required; Injectable dosage Formulation

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
octreotide acetate	6	Prior Authorization Required; Injectable dosage Formulation
SANDOSTATIN LAR DEPOT	6	Prior Authorization Required; Injectable dosage Formulation
SOMAVERT	6	Prior Authorization Required; Injectable dosage Formulation
SYNAREL	6	Prior Authorization Required
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)		
Antiandrogens		
CASODEX	3	Quantity Limitation - 30 tablets per 30 days
flutamide	2	
NILANDRON	4	
HORMONAL AGENTS, SUPPRESSANTS (THYROID)		
Antithyroid Agents		
methimazole	2	
propylthiouracil	2	
IMMUNOLOGICAL AGENTS		
Immune Suppressants		
AZASAN	4	Prior Authorization Required for new starts
azathioprine	2	Prior Authorization Required for new starts
CELLCEPT	4	Prior Authorization Required for new starts
CELLCEPT INTRAVENOUS	5	Prior Authorization Required for new starts; Injectable dosage Formulation
cyclosporine	2	Prior Authorization Required for new starts
cyclosporine	5	Prior Authorization Required for new starts; Injectable dosage Formulation
cyclosporine modified	2	Prior Authorization Required for new starts
ENBREL	6	Prior Authorization Required - Quantity Limitation - 16ml per 28 days on 25mg; 8ml per 30 days on 50mg; Injectable dosage

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Formulation
ENBREL SURECLICK	6	Prior Authorization Required - Quantity Limitation - 16ml per 28 days on 25mg; 8ml per 30 days on 50mg; Injectable dosage Formulation
gengraf	2	Prior Authorization Required for new starts
HUMIRA	6	Prior Authorization Required - Quantity Limitation - 8 per 28 days; Injectable dosage Formulation
HUMIRA PEN-CROHNS DISEASESTARTER	6	
methotrexate	2	
methotrexate sodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
MYFORTIC	4	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
NEORAL	3	Prior Authorization Required for new starts
ORENCIA	6	Prior Authorization Required; Injectable dosage Formulation
ORTHOCLONE OKT3	6	Prior Authorization Required for new starts; Injectable dosage Formulation
PROGRAF	4	0.5mg and 1mg capsule; Prior Authorization Required for new starts
PROGRAF	5	Prior Authorization Required for new starts; Injectable dosage Formulation
PROGRAF	6	5mg capsule; Prior Authorization Required for new starts
RAPAMUNE	4	Prior Authorization Required for new starts

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REMICADE	6	Prior Authorization Required; Injectable dosage Formulation
SANDIMMUNE	3	Prior Authorization Required for new starts
SANDIMMUNE	5	Prior Authorization Required for new starts; Injectable dosage Formulation
SIMPONI	6	Step Therapy Protocols Apply; Prior Authorization Required
SIMULECT	6	Prior Authorization Required for new starts; Injectable dosage Formulation
ZENAPAX	6	Prior Authorization Required for new starts; Injectable dosage Formulation
Immunizing Agents, Passive		
carimune nanofiltered	6	Prior Authorization Required; Injectable dosage Formulation
flebogamma	6	Prior Authorization Required; Injectable dosage Formulation
gamastan s/d	4	Prior Authorization Required; Injectable dosage Formulation
gammagard liquid	6	Prior Authorization Required; Injectable dosage Formulation
octagam	6	Prior Authorization Required; Injectable dosage Formulation
polygam s/d	3	Prior Authorization Required; Injectable dosage Formulation
VIVAGLOBIN	6	Prior Authorization Required; Injectable dosage Formulation
Immunomodulators		
ACTIMMUNE	6	Prior Authorization Required for new starts; Injectable dosage Formulation
ALFERON N	6	Prior Authorization Required for new starts; Injectable dosage Formulation
AVONEX	6	Prior Authorization Required; Quantity Limitation - 1 kit per 28 days; Injectable dosage Formulation
BETASERON	6	Prior Authorization Required; Injectable dosage Formulation
COPAXONE	6	Prior Authorization Required - Quantity Limitation - 1 kit per 30

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		days; Injectable dosage Formulation
INFERGEN	6	Prior Authorization Required; Injectable dosage Formulation
INTRON-A	5	3MU Pen; Prior Authorization Required for new starts; Injectable dosage Formulation
INTRON-A	6	18MU, 5MU Pen, 10MU Pen; Prior Authorization Required for new starts; Injectable dosage Formulation
INTRON-A W/DILUENT	4	10MU; Prior Authorization Required for new starts; Injectable dosage Formulation
KINERET	6	Prior Authorization Required; Injectable dosage Formulation
leflunomide	2	
PEGASYS	6	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation - 1 kit per 28 days
PEG-INTRON	6	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation - 4 syringes per 28 days
PEG-INTRON REDIPEN	6	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation - 4 syringes per 28 days
REBIF	6	Prior Authorization Required - Quantity Limitation - 12ml per 30 days; Injectable dosage Formulation
REBIF TITRATION PACK	6	Prior Authorization Required - Quantity Limitation - 6ml per 30 days; Injectable dosage Formulation
RIDAURA	4	
TYSABRI	6	Prior Authorization Required; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Vaccines		
ACTHIB	5	
ADACEL	5	
ATTENUVAX	5	
BOOSTRIX	5	
COMVAX	5	
DAPTACEL	5	
decavac	5	
DIPHThERIA/TETANUS TOXOIDPEDIATRIC	5	
ENGERIX-B	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
GARDASIL	5	Prior Authorization Required; Injectable dosage Formulation
HAVRIX	5	
IMOVAX RABIES (H.D.C.V.)	5	
INFANRIX	5	
IPOL INACTIVATED IPV	5	
JE-VAX	5	
MENACTRA	5	
MENOMUNE-A/C/Y/W-135	5	
MERUVAX II W/DILUENT 10 DOSE	5	
M-M-R II W/DILUENT 10 DOSE	5	
PEDIARIX	5	
pedvax hib	5	
PROQUAD	5	
RABAVERT	5	
RECOMBIVAX HB	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
RECOMBIVAX HB	5	Prior Authorization Required for new starts
ROTATEQ	5	
TETANUS TOXOID	3	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ADSORBED		
TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT	5	
TRIHIBIT	5	
TRIPEDIA	5	
TWINRIX	5	
TYPHIM VI	5	
VAQTA	5	
VARIVAX	5	
VIVOTIF BERNA	5	
YF-VAX	5	Injectable dosage Formulation
ZOSTAVAX	5	Prior Authorization Required; Injectable dosage Formulation

INFLAMMATORY BOWEL DISEASE AGENTS

Glucocorticoids

ENTOCORT EC	3	
prednisone	1	

Salicylates

ASACOL	3	
balsalazide disodium	2	
CANASA	4	
DIPENTUM	4	
mesalamine	2	
PENTASA	4	

Sulfonamides

sulfasalazine	2	
sulfazine	2	
sulfazine ec	2	

METABOLIC BONE DISEASE AGENTS

Metabolic Bone Disease Agents

ACTONEL	4	Quantity Limitation - 30 per 30 days on 5mg; 5 per 30 days on 35mg and 30mg; 2 per 28 days on 75mg; Step Therapy Protocols Apply
ACTONEL WITH CALCIUM	4	Quantity Limitation - 28 tablets per 30 days
alendronate sodium	1	Quantity Limitation - 240 per 30 days on 5mg; 120 per 30 days on 10mg; 30 per 30 days on 40mg; 5 per 30 days on 35mg and 70mg; This prescription drug is part of

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
BONIVA	4	Quantity Limitation - 30 per 30 days on 2.5mg; 1 per 30 days on 150mg; Step Therapy Protocols Apply
BONIVA	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Step Therapy Protocols Apply; Limit 1 per 30 days
calcitonin-salmon	2	
CALCITRIOL	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
calcitriol	2	
DIDRONEL	4	
etidronate disodium	2	
FORTEO	6	Prior Authorization Required; Injectable dosage Formulation
FORTICAL	3	
HECTOROL	4	
HECTOROL	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
MIACALCIN	3	
pamidronate disodium	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		need to be submitted describing the use and setting of drug to make the determination.
SKELID	4	
ZEMPLAR	3	Prior Authorization Required
ZEMPLAR	5	Prior Authorization Required; Injectable dosage Formulation
ZOMETA	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.

OPHTHALMIC AGENTS

Ophthalmic Agents, Other		
ak-con	1	
bac/poly/neomy/hc	2	
BLEPHAMIDE	4	
BLEPHAMIDE S.O.P.	4	
dexasporin	2	
LACRISERT	3	
naphazoline hcl	1	
neomycin/polymyxin/dexamethasone	2	
neomycin/polymyxin/hydrocortisone	2	
parcaine	2	
poly-dex	2	
POLY-PRED	4	
PRED-G	4	
PRED-G S.O.P.	4	
proparacaine hcl	2	
RESTASIS	4	Prior Authorization Required
sulfacetamide sodium/prednisolone sodium phosphate	2	
TOBRADEX	4	
tobramycin/dexamethasone	2	
Ophthalmic Anti-allergy Agents		
ALAMAST	4	
ALOCRIAL	4	
ALOMIDE	4	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cromolyn sodium	2	
OPTIVAR	3	
PATANOL	3	
Ophthalmic Antiglaucoma Agents		
acetazolamide	1	
acetazolamide	2	500mg capsule
ALPHAGAN P	4	
AZOPT	3	
betaxolol hcl	2	
BETIMOL	4	
BETOPTIC-S	4	
brimonidine tartrate	2	
carteolol hcl	2	
dipivefrin hcl	1	
dorzolamide hcl	2	
dorzolamide hcl/timolol maleate	2	
IOPIDINE	4	
levobunolol hcl	2	
metipranolol	2	
mydral	2	
PHOSPHOLINE IODIDE	4	
PILOPINE HS	4	
timolol maleate	1	
tropicacyl	2	
tropicamide	2	
Ophthalmic Anti-inflammatories		
ACULAR	4	
ACULAR LS	4	
ALREX	4	
dexamethasone sodium phosphate	2	
diclofenac sodium	2	
FLAREX	4	
fluorometholone	2	
fluor-op	2	
flurbiprofen sodium	2	
FML	4	
FML FORTE	4	
LOTEMAX	4	
MAXIDEX	4	
NEVANAC	4	
PRED MILD	4	
prednisolone acetate	2	
prednisolone sodium phosphate	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VEXOL	4	
Ophthalmic Prostaglandins and Prostanamide Analogs		
LUMIGAN	4	Quantity Limitation - 7.5ml per 30 days
TRAVATAN Z	4	Quantity Limitation - 5ml per 30 days
XALATAN	3	Quantity Limitation - 5ml per 30 days
OTIC AGENTS		
Otic Agents		
acetazol hc	2	
acetic acid	1	
acetic acid/aluminum acetate	2	
acetic acid/hydrocortisone	2	
borofair	2	
CIPRO HC	3	
CIPRODEX	4	
COLY-MYCIN S	4	
cortomycin	2	
DERMOTIC	3	
neomycin/polymyxin/hc	2	
neomycin/polymyxin/hydrocortisone	2	
RESPIRATORY TRACT AGENTS		
Antihistamines		
ASTELIN	4	Quantity Limitation - 1 inhaler per 30 days
carbinoxamine maleate	2	
cetirizine hcl	2	
clemastine fumarate	2	
cyproheptadine hcl	2	
dexchlorpheniramine maleate	2	
fexofenadine hcl	2	Quantity Limitation - 60 tablets per 30 days on 30mg and 60mg; 30 tablets per 30 days on 180mg
hydroxyzine hcl	2	
hydroxyzine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
palgic	2	
Anti-inflammatories, Inhaled Corticosteroids		
AEROBID-M	4	Quantity Limitation - 3 inhalers per 30 days
ASMANEX 120 METERED DOSES	4	Quantity Limitation - 2 inhalers per 30 days
ASMANEX 14 METERED DOSES	4	Quantity Limitation - 4 inhalers per 30 days
ASMANEX 30 METERED DOSES	4	Quantity Limitation - 2 inhalers per 30 days
ASMANEX 60 METERED DOSES	4	Quantity Limitation - 2 inhalers per 30 days
AZMACORT	4	Quantity Limitation - 2 inhalers per 30 days
BECONASE AQ	4	Quantity Limitation - 2 inhalers per 30 days
FLOVENT HFA	3	Quantity Limitation - 2 inhalers per 30 days
flunisolide	1	Quantity Limitation - 1 inhaler per 30 days
fluticasone propionate	1	Quantity Limitation - 1 inhaler per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
NASACORT AQ	4	Quantity Limitation - 2 inhalers per 30 days
NASONEX	4	Quantity Limitation - 1 inhaler per 30 days
PULMICORT FLEXHALER	3	Quantity Limitation - 2 inhalers per 30 days
QVAR	4	Quantity Limitation - 3 inhalers per 30 days
RHINOCORT AQUA	3	Quantity Limitation - 2 inhalers per 30 days
VERAMYST	3	
Antileukotrienes		
ACCOLATE	3	Quantity Limitation - 60 tablets per 30 days
SINGULAIR	4	Quantity Limitation - 30 tablets per 30 days

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZYFLO CR	4	Quantity Limitation - 120 tablets per 30 days
Bronchodilators, Anticholinergic		
ATROVENT HFA	3	Quantity Limitation - 2 inhalers per 30 days
ipratropium bromide	1	Quantity Limitation - 30ml per 30 days
SPIRIVA HANDIHALER	3	Quantity Limitation - 1 handihaler per 30 days
Bronchodilators, Phosphodiesterase 2 Inhibitors (Xanthines)		
aminophylline	1	200mg
aminophylline	2	100mg
aminophylline	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
theochron	2	
theophylline cr	2	
theophylline er	2	
Bronchodilators, Sympathomimetic		
ADVAIR DISKUS	3	Quantity Limitation - 1 inhaler per 30 days
ADVAIR HFA	3	Quantity Limitation - 1 inhaler per 30 days
albuterol sulfate	2	
albuterol sulfate	2	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
albuterol sulfate er	2	
COMBIVENT	3	Quantity Limitation - 2 inhalers per 30 days
epinephrine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EPIPEN 2-PAK	5	
EPIPEN-JR 2-PAK	5	
FORADIL AEROLIZER	4	Quantity Limitation - 1 inhaler per 30 days
metaproterenol sulfate	2	
PROAIR HFA	4	Quantity Limitation - 2 inhalers per 30 days
PROVENTIL HFA	4	Quantity Limitation - 2 inhalers per 30 days
SEREVENT DISKUS	3	Quantity Limitation - 1 inhaler per 30 days
SYMBICORT	4	
terbutaline sulfate	2	
terbutaline sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TWINJECT	5	
VENTOLIN HFA	3	Quantity Limitation - 2 inhalers per 30 days
vospire er	2	
XOPENEX HFA	3	Quantity Limitation - 2 inhalers per 30 days
Pulmonary Antihypertensives		
ADCIRCA	6	Prior Authorization Required
REVATIO	6	Prior Authorization Required
TRACLEER	6	Prior Authorization Required; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757.
Respiratory Tract Agents, Other		
ALLEGRA-D	4	Quantity Limitation - 60 tablets per 30 days on 12hr tablets; 30 tablets per 30 days on 24hr tablets
ARALAST	6	Prior Authorization Required for new starts; Injectable dosage Formulation
CLARINEX-D	4	Quantity Limitation - 60 tablets per

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		30 days on 12hr tablet; 30 tablets per 30 days on 24hr tablet
PROLASTIN	6	
promethazine vc	2	
TYZINE	3	
TYZINE PEDIATRIC NASAL DROPS	3	
VENTAVIS	6	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
XOLAIR	6	Prior Authorization Required; Injectible dosage Formulation
ZEMAIRA	5	Prior Authorization Required; Injectible dosage Formulation
SEDATIVES/ HYPNOTICS		
Sedatives/Hypnotics		
AMBIEN CR	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
ROZEREM	4	Step Therapy Protocols Apply; Quantity Limitation - 30 tablets per 30 days
zaleplon	2	
zolpidem tartrate	1	Quantity Limitation - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
SKELETAL MUSCLE RELAXANTS		
Skeletal Muscle Relaxants		
carisoprodol	3	
carisoprodol/aspirin	2	
carisoprodol/aspirin/codeine	2	
chlorzoxazone	2	
cyclobenzaprine hcl	1	This prescription drug is part of the Free First Fill Program and will

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		be provided at a zero cost share when you select this medication over the brand name version of selected medications.
methocarbamol	2	
MYOBLOC	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
orphenadrine citrate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
orphenadrine citrate er	2	
orphenadrine compound ds	2	
orphenadrine/asa/caffeine	2	
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES		
Electrolytes/Minerals		
AMINOSYN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN 7%/ELECTROLYTES	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
aminosyn 8.5%/electrolytes	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 3.5/DEXTROSE25%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 4.25/DEXTROSE10%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 4.25/DEXTROSE20%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 4.25/DEXTROSE25%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 5/DEXTROSE 25	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
aminosyn ii 8.5%/electrolytes	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II M 3.5%/DEXTROSE 5%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN M	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN-HBC	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
aminosyn-hf	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN-PF	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN-PF 7%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
DEXTROSE 10%/NACL 0.45%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 5%/electrolyte #48 viaflex	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 10%/nacl 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 10%flex container	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 2.5%/sodium chloride 0.45%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 5%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
dextrose 5%/nacl 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 5%/nacl 0.225%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 5%/nacl 0.33%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 5%/nacl 0.45%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
dextrose 5%/nacl 0.9%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
DEXTROSE 5%/POTASSIUM CHLORIDE 0.075%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ed k+10	1	
freamine iii	5	Injectable Formulation - This drug

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
FREAMINE III 3%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
intralipid	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kaon-cl-10	1	
kcl 0.075%/d5w/nacl 0.45%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
KCL 0.15%/D10W/NACL 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
KCL 0.15%/D5W/LR	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.15%/d5w/nacl 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.15%/d5w/nacl 0.225%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.224%/d5w/nacl 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
KCL 0.3%/D5W/LR IV LAC RING	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.3%/d5w/nacl 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.3%/d5w/nacl 0.45%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
KCL 0.3%/D5W/NACL 0.9%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
klor-con	1	
lactated ringers viaflex	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
magnesium sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.075%/d5w/nacl 0.225%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.15%/d5w	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
POTASSIUM CHLORIDE 0.15%/NACL 0.45% VIAFLEX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride	5	Injectable Formulation - This drug

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
0.15%d5w/nacl 0.33%		may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.15%d5w/nacl 0.45% viaflex	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.15%nacl 0.9%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.22%d5w/nacl 0.45%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.224%/d5w	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
POTASSIUM CHLORIDE 0.224%D5W/NACL 0.33%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.3%/d5w	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		need to be submitted describing the use and setting of drug to make the determination.
POTASSIUM CHLORIDE 0.3%/NAACL 0.9%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride cr	2	
potassium chloride er	2	
potassium citrate extended-release	2	
sodium bicarbonate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
sodium chloride	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
sodium chloride 0.45% viaflex	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
tpn electrolytes ftv	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TRAVASOL	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TRAVASOL 2.75%/DEXTROSE 10%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TRAVASOL 2.75%/DEXTROSE 5%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
travasol 3.5%/electrolytes	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TRAVASOL 8.5%/DEXTROSE 10%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TRAVASOL 8.5%/DEXTROSE 20%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TRAVASOL 8.5%/DEXTROSE 50%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
travasol 8.5%/electrolytes	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TROPHAMINE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
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Therapeutic Classes are also listed in Bold

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