



**GEMCare Medicare Plus (HMO)
2012 Formulary
(List of Covered Drugs)**

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

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

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

GEMCare Health Plan is a Federally-Qualified HMO with a Medicare Contract.

To request this material in an alternate format or language, call 1-877-697-2464, 8am – 8pm PST seven days a week. TTY/TDD users should call 1-888-833-9312.

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What is the GEMCare Medicare Plus (HMO) Formulary?

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

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of 8/29/2011.

To get updated information about the drugs covered by GEMCare Medicare Plus (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 Medicare Plus (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 7. 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 90. 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 90. 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 Medicare Plus (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 Medicare Plus (HMO) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from GEMCare Medicare Plus (HMO) before you fill your prescriptions. If you don't get approval, GEMCare Medicare Plus (HMO) may not cover the drug.
- **Quantity Limits:** For certain drugs, GEMCare Medicare Plus (HMO) limits the amount of the drug that GEMCare Medicare Plus (HMO) will cover. For example, GEMCare Medicare Plus (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 Medicare Plus (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 Medicare Plus (HMO) may not cover drug B unless you try Drug A first. If Drug A does not work for you, GEMCare Medicare Plus (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 7. 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 Medicare Plus (HMO) to make an exception to these restrictions or limits. See the section, “How do I request an exception to the GEMCare Medicare Plus (HMO) formulary?” on page 4 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 Medicare Plus (HMO) pays for certain OTC drugs. The following is a listing of these agents:

- OTC omeprazole

GEMCare Medicare Plus (HMO) will provide these OTC drugs at no cost to you. The cost to GEMCare Medicare Plus (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 Medicare Plus (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 Medicare Plus (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 Medicare Plus (HMO).
- You can ask GEMCare Medicare Plus (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 Medicare Plus (HMO) Formulary?

You can ask GEMCare Medicare Plus (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 Medicare Plus (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 Medicare Plus (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 prescriber's or prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber's or prescribing physician's supporting statement.

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

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 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 allow you to refill your prescription until we have provided you with a 91-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

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 Medicare Plus (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about GEMCare Medicare Plus (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 Medicare Plus (HMO) Formulary

The formulary below provides coverage information about some of the drugs covered by GEMCare Medicare Plus (HMO). If you have trouble finding your drug in the list, turn to the Index that begins on page 90.

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 Medicare Plus (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 | Specialty |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| ANALGESICS | | |
| Nonsteroidal Anti-Inflammatory Drugs | | |
| ARTHROTEC | 4 | Step therapy protocols apply |
| CELEBREX | 4 | Quantity limit - 60 capsules per 30 days; Step therapy protocols apply |
| <i>diclofenac potassium</i> | 1 | |
| <i>diclofenac sodium</i> | 1 | |
| <i>diclofenac sodium ec</i> | 1 | |
| <i>diclofenac sodium xr</i> | 2 | |
| <i>diflunisal</i> | 2 | |
| <i>etodolac</i> | 2 | |
| <i>fenoprofen calcium</i> | 2 | |
| <i>flurbiprofen</i> | 2 | |
| <i>ibuprofen</i> | 1 | This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| INDOCIN | 4 | Suspension |
| <i>indomethacin</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|------------------|---|
| <i>ketoprofen</i> | 2 | |
| <i>ketorolac tromethamine</i> | 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; Injectable dosage formulation |
| <i>meclufenamate sodium</i> | 2 | |
| <i>meloxicam</i> | 1 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>nabumetone</i> | 2 | |
| <i>naproxen</i> | 1 | |
| <i>naproxen dr</i> | 1 | |
| <i>naproxen sodium</i> | 1 | |
| <i>piroxicam</i> | 1 | |
| <i>sulindac</i> | 2 | |
| <i>tolmetin sodium</i> | 2 | |
| Opioid Analgesics | | |
| <i>acetaminophen/codeine</i> | 1 | Quantity limit - 400 tablets per 30 days |
| <i>ascomp/codeine</i> | 2 | |
| <i>buprenorphine hcl</i> | 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; Injectable dosage formulation |
| <i>buprenorphine hcl</i> | 2 | |
| <i>butalbital/acetaminophen/caffeine/codeine</i> | 2 | Quantity limit - 360 capsules per 30 days |
| <i>butorphanol tartrate</i> | 2 | Quantity limit - 10ml per 30 days |
| <i>co-gesic</i> | 2 | Quantity limit - 240 tablets per 30 days |
| <i>endocet</i> | 2 | Quantity limit - not to exceed 4,000mg of acetaminophen per day |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|----------------------------------|-----------|--|
| <i>fentanyl</i> | 2 | Quantity limit - 30 patches per 30 days; Transdermal dosage formulation |
| <i>fentanyl citrate</i> | 2 | Quantity limit - 120 per 30 days; Prior authorization required |
| <i>hydrocodone/acetaminophen</i> | 2 | Quantity limit - not to exceed 4,000mg of acetaminophen per day |
| <i>hydrocodone/ibuprofen</i> | 2 | Quantity limit - 480 tablets per 30 days |
| <i>hydromorphone hcl</i> | 2 | |
| <i>levorphanol tartrate</i> | 2 | |
| <i>margesic-h</i> | 2 | Quantity limit - 240 capsules per 30 days |
| <i>methadone hcl</i> | 1 | |
| METHADONE HCL | 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; Injectable dosage formulation |
| <i>methadose</i> | 1 | |
| <i>morphine sulfate</i> | 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; Injectable dosage formulation |
| <i>morphine sulfate</i> | 2 | |
| <i>morphine sulfate er</i> | 2 | Quantity limit - 120 tablets per 30 days |
| <i>nalbuphine hcl</i> | 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; Injectable dosage formulation |
| <i>oxycodone hcl</i> | 2 | |
| <i>oxycodone/acetaminophen</i> | 2 | Quantity limit - not to exceed |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| | | 4,000mg of acetaminophen per day |
| <i>oxycodone/aspirin</i> | 2 | Quantity limit - 360 tablets per 30 days |
| <i>oxycodone/ibuprofen</i> | 2 | |
| OXYCONTIN | 4 | Quantity limit - 120 tablets per 30 days |
| <i>stagesic</i> | 2 | Quantity limit - 240 capsules per 30 days |
| SUBOXONE | 4 | Quantity limit - 90 per 30 days |
| <i>tramadol hcl</i> | 1 | Quantity limit - 240 tablets per 30 days |
| <i>tramadol hydrochloride/acetaminophen</i> | 2 | Quantity limit - 240 tablets per 30 days |
| <i>zerlor</i> | 2 | |
| <i>zydone</i> | 2 | |
| ANESTHETICS | | |
| Local Anesthetics | | |
| | | 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; Injectable dosage formulation |
| <i>lidocaine hcl</i> | 2 | |
| <i>lidocaine hcl</i> | 1 | Topical dosage formulation |
| <i>lidocaine/prilocaine</i> | 2 | Topical dosage formulation |
| ANTIBACTERIALS | | |
| Aminoglycosides | | |
| <i>ak-tob</i> | 1 | Ophthalmic dosage formulation |
| <i>gentak</i> | 1 | Ophthalmic dosage 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; Injectable dosage formulation |
| <i>gentamicin sulfata</i> | 2 | |
| <i>gentamicin sulfata</i> | 1 | Topical dosage formulation |
| <i>gentamicin sulfata</i> | 1 | Ophthalmic dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------|-----------|--|
| <i>gentasol</i> | 1 | Ophthalmic dosage formulation |
| <i>isotonic gentamicin</i> | 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; Injectable dosage formulation |
| <i>kanamycin sulfate</i> | 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; Injectable dosage formulation |
| <i>neomycin sulfate</i> | 2 | |
| <i>paromomycin sulfate</i> | 2 | |
| TOBI | 5 | Prior authorization required |
| <i>tobramycin sulfate</i> | 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; Injectable dosage formulation |
| <i>tobramycin sulfate</i> | 2 | Ophthalmic dosage formulation |
| <i>tobrasol</i> | 1 | Ophthalmic dosage formulation |
| Antibacterials, Other | | |
| <i>baciim</i> | 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; Injectable dosage formulation |
| <i>bacitracin</i> | 2 | Ophthalmic dosage formulation |
| <i>bacitracin/polymyxin b</i> | 2 | Ophthalmic dosage formulation |
| CLEOCIN | 4 | Vaginal dosage formulation |
| <i>clindamycin hcl</i> | 2 | |
| <i>clindamycin phosphate</i> | 2 | Vaginal dosage formulation |
| <i>clindamycin phosphate</i> | 2 | This drug may be covered under |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| | | 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; Injectable dosage formulation |
| <i>clindamycin phosphate</i> | 2 | Topical dosage 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; Injectable dosage formulation |
| <i>colistimethate sodium</i> | 2 | |
| <i>erythromycin/sulfisoxazole</i> | 2 | |
| <i>methenamine hippurate</i> | 2 | |
| METROGEL | 4 | Topical dosage formulation |
| <i>metronidazole</i> | 2 | |
| <i>metronidazole</i> | 2 | Topical dosage formulation |
| <i>metronidazole vaginal</i> | 2 | Vaginal dosage formulation |
| MONUROL | 4 | |
| <i>mupirocin</i> | 2 | Topical dosage formulation |
| <i>neomycin/bacitracin/polymyxin</i> | 2 | Ophthalmic dosage formulation |
| <i>neomycin/polymyxin/gramicidan</i> | 2 | Ophthalmic dosage formulation |
| <i>nitrofurantoin macrocrystalline</i> | 2 | |
| <i>nitrofurantoin monohydrate</i> | 2 | |
| NORITATE | 4 | Topical dosage 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; Injectable dosage formulation |
| SYNERCID | 4 | |
| <i>trimethoprim</i> | 2 | |
| <i>trimethoprim sulfate/polymyxin</i> | 2 | Ophthalmic dosage formulation |
| TYGACIL | 4 | Prior authorization required; Injectable dosage formulation |
| VANCOCIN HCL | 5 | Prior authorization required |
| <i>vancomycin hcl</i> | 2 | Prior authorization required; Injectable dosage formulation |
| <i>vandazole</i> | 2 | Vaginal dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|------------------------------------|-----------|--|
| ZYVOX | 5 | Prior authorization required; Injectable dosage formulation |
| ZYVOX | 5 | Quantity limit - 56 tablets per 28 days; Prior authorization required |
| Beta-lactam, Cephalosporins | | |
| <i>cefaclor</i> | 2 | |
| <i>cefaclor er</i> | 2 | |
| <i>cefadroxil</i> | 2 | |
| <i>cefazolin sodium</i> | 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; Injectable dosage formulation |
| <i>cefdinir</i> | 2 | |
| <i>cefepime</i> | 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; Injectable dosage formulation |
| <i>cefoxitin sodium</i> | 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; Injectable dosage formulation |
| <i>cefpodoxime proxetil</i> | 2 | |
| <i>cefprozil</i> | 2 | |
| <i>ceftriaxone sodium</i> | 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; Injectable dosage formulation |
| <i>cefuroxime axetil</i> | 2 | |
| <i>cefuroxime sodium</i> | 2 | This drug may be covered under |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------------|-----------|--|
| | | 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; Injectable dosage formulation |
| <i>cephalexin</i> | 1 | |
| SUPRAX | 4 | |
| Beta-lactam, Other | | |
| AZACTAM | 3 | Prior authorization required; Injectable dosage formulation |
| INVANZ | 4 | Injectable dosage formulation |
| PRIMAXIN I.M. | 4 | Prior authorization required; Injectable dosage formulation |
| PRIMAXIN IV | 4 | Prior authorization required; Injectable dosage formulation |
| Beta-lactam, Penicillins | | |
| <i>amoxicillin</i> | 1 | |
| <i>amoxicillin/clavulanate</i> | 2 | |
| <i>ampicillin</i> | 1 | |
| <i>ampicillin</i> | 1 | |
| <i>ampicillin sodium</i> | 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; Injectable dosage formulation |
| <i>ampicillin-sulbactam</i> | 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; Injectable dosage formulation |
| <i>dicloxacillin sodium</i> | 2 | |
| <i>nafcillin sodium</i> | 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; Injectable dosage formulation |
| <i>penicillin g potassium</i> | 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; Injectable dosage formulation |
| PENICILLIN G POTASSIUM IN DEXTROSE | 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; Injectable dosage formulation |
| <i>penicillin g procaine</i> | 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; Injectable dosage formulation |
| <i>penicillin g sodium</i> | 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; Injectable dosage formulation |
| <i>penicillin v potassium</i> | 1 | |
| <i>piperacillin sodium</i> | 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; Injectable dosage formulation |
| <i>piperacillin sodium/ tazobactam</i> | 2 | Prior authorization required; Injectable dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------------|-----------|--|
| ZOSYN | 4 | Prior authorization required; Injectable dosage formulation |
| Macrolides | | |
| <i>azithromycin</i> | 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; Injectable dosage formulation |
| <i>azithromycin suspension</i> | 2 | Quantity limit - 30ml per 5 days on 100mg; 90ml per 5 days on 200mg |
| <i>azithromycin tablets</i> | 2 | Quantity limit - 6 tablets per prescription |
| <i>clarithromycin</i> | 2 | Quantity limit - 28 tablets per prescription |
| <i>clarithromycin er e.e.s. 400</i> | 2 | Quantity limit - 28 tablets per prescription |
| <i>ery</i> | 1 | Topical dosage formulation |
| <i>ery-tab</i> | 1 | |
| ERYTHROCIN LACTOBIONATE | 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; Injectable dosage formulation |
| <i>erythrocin stearate</i> | 1 | |
| <i>erythromycin</i> | 1 | Topical dosage formulation |
| <i>erythromycin</i> | 1 | Ophthalmic dosage formulation |
| <i>erythromycin base</i> | 1 | |
| <i>romycin</i> | 1 | Ophthalmic dosage formulation |
| ZMAX | 4 | Quantity limit - 60ml per prescription |
| Quinolones | | |
| AVELOX | 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; Injectable dosage |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------------|-----------|--|
| | | formulation |
| AVELOX ABC PACK | 4 | Quantity limit - 14 tablets per prescription |
| CILOXAN | 4 | Ophthalmic dosage formulation |
| <i>ciprofloxacin hcl</i> | 1 | Ophthalmic dosage formulation |
| <i>ciprofloxacin hcl</i> | 1 | |
| FACTIVE | 4 | Quantity limit - 7 tablets per prescription |
| <i>levofloxacin</i> | 2 | Ophthalmic dosage formulation |
| NOROXIN | 4 | |
| <i>ofloxacin</i> | 2 | Ophthalmic dosage formulation |
| <i>ofloxacin</i> | 2 | Otic dosage formulation |
| <i>ofloxacin</i> | 2 | |
| VIGAMOX | 4 | Ophthalmic dosage formulation |
| ZYMAR | 4 | Ophthalmic dosage formulation |
| Sulfonamides | | |
| <i>silver sulfadiazine</i> | 2 | Topical dosage formulation |
| <i>sodium sulfacetamide</i> | 2 | Ophthalmic dosage formulation |
| <i>sodium sulfacetamide</i> | 2 | Topical dosage formulation |
| <i>ssd</i> | 2 | Topical dosage formulation |
| <i>sulfadiazine</i> | 2 | |
| <i>sulfamethoxazole/trimethoprim</i> | 1 | |
| | | 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; Injectable dosage formulation |
| <i>sulfamethoxazole/trimethoprim</i> | 2 | |
| SULFAMYLON | 4 | Topical dosage formulation |
| <i>thermazene</i> | 2 | Topical dosage formulation |
| Tetracyclines | | |
| <i>demeclocycline hcl</i> | 2 | |
| <i>doxycycline hyclate</i> | 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; Injectable dosage formulation |
| <i>doxycycline hyclate</i> | 2 | |
| <i>doxycycline monohydrate</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| <i>minocycline hcl</i> | 1 | |
| <i>tetracycline hcl</i> | 1 | |
| ANTICONVULSANTS | | |
| Anticonvulsants, Other | | |
| BANZEL | 4 | Quantity limit - 240 tablets per 30 days; 2400ml per 30 days on suspension |
| KEPPRA XR | 4 | Quantity limit - 180 tablets per 30 days on 500mg; 120 tablets per 30 days on 750mg |
| <i>levetiracetam</i> | 2 | |
| <i>levetiracetam</i> | 2 | Injectable dosage formulation |
| VIMPAT | 4 | Quantity limit - 1200ml per 30 days; Injectable dosage formulation |
| VIMPAT | 4 | Quantity limit - 60 tablets per 30 days; 1200ml per 30 days on solution |
| Calcium Channel Modifying Agents | | |
| CELONTIN | 4 | |
| <i>ethosuximide</i> | 2 | |
| LYRICA | 4 | |
| <i>zonisamide</i> | 1 | |
| Gamma-aminobutyric Acid (GABA) Augmenting Agents | | |
| <i>divalproex sodium</i> | 2 | |
| <i>gabapentin capsules</i> | 2 | Quantity limit - 360 capsules per 30 days on 100mg and 300mg; 270 capsules per 30 days on 400mg |
| <i>gabapentin solution</i> | 2 | |
| <i>gabapentin tablets</i> | 2 | Quantity limit - 180 tablets per 30 days on 500mg; 120 tablets per 30 days on 750mg |
| GABITRIL | 4 | |
| <i>primidone</i> | 2 | |
| SABRIL | 5 | Quantity limit - 180 per 30 days; This prescription may be available only at certain pharmacies. For more information, call 1-800-546-5677, 24 hours a day, 7 days a week. TTY/TDD users should call 1-866-706-4757. |
| STAVZOR | 4 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| <i>valproate sodium</i> | 2 | Injectable dosage formulation |
| <i>valproic acid</i> | 2 | |
| Glutamate Reducing Agents | | |
| FELBATOL | 4 | |
| LAMICTAL XR | 4 | |
| <i>lamotrigine</i> | 2 | |
| <i>topiramate</i> | 2 | |
| Sodium Channel Inhibitors | | |
| <i>carbamazepine</i> | 1 | |
| <i>carbamazepine er</i> | 2 | |
| DILANTIN | 4 | 30mg |
| DILANTIN INFATABS | 4 | |
| <i>epitol</i> | 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; Injectable dosage formulation |
| <i>fosphenytoin sodium</i> | 2 | |
| <i>oxcarbazepine</i> | 2 | |
| PEGANONE | 4 | |
| <i>phenytoin</i> | 1 | |
| | | 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; Injectable dosage formulation |
| <i>phenytoin sodium</i> | 2 | |
| <i>phenytoin sodium extended release</i> | 1 | |
| ANTIDEMENTIA AGENTS | | |
| Cholinesterase Inhibitors | | |
| <i>donepezil hcl</i> | 2 | Quantity limit - 30 tablets per 30 days |
| EXELON | 4 | Transdermal dosage formulation |
| EXELON | 4 | Solution; Quantity limit - 180ml per 30 days |
| <i>galantamine hydrobromide</i> | 2 | Quantity limit - 180ml per 30 days on solution |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| <i>galantamine hydrobromide er</i> | 2 | Quantity limit - 30 capsules per 30 days |
| <i>rivastigmine tartrate</i> | 2 | Quantity limit - 60 capsules per 30 days |
| Glutamate Pathway Modifiers | | |
| NAMENDA | 3 | Quantity limit - 60 tablets per 30 days; 360ml per 30 days on solution |
| NAMENDA TITRATION PAK | 3 | Quantity limit - 60 tablets per 30 days |
| ANTIDEPRESSANTS | | |
| Antidepressants, Other | | |
| <i>amoxapine</i> | 2 | |
| <i>budeprion sr</i> | 2 | Quantity limit - 60 tablets per 30 days on 100mg; 90 tablets per 30 days on 150mg |
| <i>budeprion xl</i> | 2 | Quantity limit - 30 tablets per 30 days |
| <i>bupropion hcl</i> | 2 | Quantity limit - 120 tablets per 30 days on 100mg; 180 tablets per 30 days on 75mg |
| <i>bupropion hcl sr</i> | 2 | Quantity limit - 60 tablets per 30 days on 100mg; 90 tablets per 30 days on 150mg; 30 tablets per 30 days on 200mg |
| <i>maprotiline hcl</i> | 2 | |
| <i>mirtazapine</i> | 1 | Quantity limit - 30 tablets per 30 days |
| <i>mirtazapine odt</i> | 2 | Quantity limit - 30 tablets per 30 days |
| <i>nefazodone hcl</i> | 2 | |
| <i>perphenazine/amitriptyline</i> | 2 | |
| <i>trazodone hcl</i> | 1 | |
| VIIBRYD | 4 | Quantity limit - 30 tablets per 30 days |
| Monoamine Oxidase Inhibitors | | |
| EMSAM | 4 | Quantity limit - 30 patches per 30 days; Transdermal dosage formulation |
| MARPLAN | 4 | |
| <i>phenelzine</i> | 2 | |
| <i>tranylcypromine sulfata</i> | 2 | |
| Serotonin/ Norepinephrine Reuptake Inhibitors | | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------|-----------|---|
| <i>citalopram hydrobromide</i> | 1 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| CYMBALTA | 4 | Quantity limit - 60 capsules per 30 days on 20mg; 30 capsules per 30 days on 30mg and 60mg |
| <i>fluoxetine hcl</i> | 1 | Quantity limit - 30 tablets per 30 days on 10mg |
| <i>fluoxetine hcl capsules</i> | 1 | Quantity limit - 30 capsules per 30 days on 10mg; 60 capsules per 30 days on 40mg |
| <i>fluoxetine hcl solution</i> | 1 | |
| <i>fluvoxamine maleate</i> | 2 | Quantity limit - 90 tablets per 30 days on 100mg; 45 tablets per 30 days on 25mg; 60 tablets per 30 days on 50mg |
| LUVOX CR | 4 | Quantity limit - 60 capsules per 30 days |
| <i>paroxetine hcl</i> | 1 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>paroxetine hcl</i> | 2 | Suspension; Quantity limit - 946ml per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>paroxetine hcl er</i> | 2 | Quantity limit - 150 tablets per 30 days; 60 tablets per 30 days on 37.5mg; 90 tablets per 30 days on 25mg; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|---|
| | | version of selected medications. |
| PRISTIQ | 4 | Quantity limit - 30 tablets per 30 days |
| <i>sertraline hcl</i> | 1 | Quantity limit - 60 tablets per 30 days; 300ml per 30 days on solution |
| <i>venlafaxine hcl</i> | 2 | Quantity limit - 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 zero cost share when you select this medication over the brand name version of selected medications. |
| <i>venlafaxine hcl er</i> | 2 | Quantity limit - 60 tablets per 30 days on 150mg; 180 tablets per 30 days on 37.5mg; 90 tablets per 30 days on 75mg; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| VENLAFAXINE HCL ER 225MG | 4 | Quantity limit - 30 tablets per 30 days |
| Tricyclics | | |
| <i>amitriptyline hcl</i> | 1 | |
| <i>clomipramine hcl</i> | 2 | |
| <i>desipramine hcl</i> | 2 | |
| <i>doxepin hcl</i> | 1 | |
| <i>imipramine hcl</i> | 2 | |
| <i>nortriptyline hcl</i> | 1 | |
| <i>nortriptyline hcl</i> | 2 | Suspension |
| <i>protriptyline hcl</i> | 2 | |
| SURMONTIL | 4 | |
| ANTIDOTES, DETERRENTS, AND TOXICOLOGIC AGENTS | | |
| Antidotes | | |
| CUPRIMINE | 4 | |
| DEPEN TITRATABS | 4 | |
| EXJADE | 4 | 125mg; Prior authorization required |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------------|-----------|--|
| EXJADE | 5 | 250mg and 500mg; Prior authorization required |
| <i>sodium polystyrene sulfonate</i> | 2 | |
| SYPRINE | 4 | |
| Deterrents | | |
| <i>buproban</i> | 2 | Quantity limit - 90 tablets per 30 days |
| CAMPRAL | 4 | |
| CHANTIX | 4 | Quantity limit - 60 tablets per 30 days; Prior authorization required |
| NICOTROL NS | 4 | Quantity limit - 40ml per 30 days |
| Toxicologic Agents | | |
| <i>amifostine</i> | 5 | 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; Injectable dosage formulation |
| <i>depade</i> | 2 | |
| <i>leucovorin calcium</i> | 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; Injectable dosage formulation |
| <i>leucovorin calcium</i> | 2 | |
| MESNEX | 4 | |
| <i>naloxone hcl</i> | 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; Injectable dosage formulation |
| <i>naltrexone hcl</i> | 2 | |
| ANTIEMETICS | | |
| Antiemetics | | |
| ALOXI | 4 | Quantity limit - 5 capsules per |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|----------------------------|-----------|--|
| | | prescription; 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. |
| ANZEMET | 4 | Quantity limit - 50ml per prescription; 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. |
| ANZEMET | 4 | Quantity limit - 10 tablets per prescription; 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. |
| <i>chlorpromazine hcl</i> | 2 | Injectable dosage formulation |
| <i>chlorpromazine hcl</i> | 2 | |
| <i>diphenhydramine hcl</i> | 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; Injectable dosage formulation |
| <i>dronabinol</i> | 2 | |
| EMEND | 4 | Quantity limit - 5 capsules per prescription; 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. |
| <i>meclizine hcl</i> | 1 | |
| <i>metoclopramide hcl</i> | 2 | This drug may be covered under Medicare Part B or D depending |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-----------------------------------|-----------|---|
| | | upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination; Injectable dosage formulation |
| <i>metoclopramide hcl</i> | 1 | |
| <i>ondansetron hcl</i> | 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; Injectable dosage formulation |
| <i>ondansetron hcl</i> | 2 | Quantity limit - 10 tablets per prescription; 50ml per prescription on solution; 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. |
| <i>ondansetron odt</i> | 2 | Quantity limit - 10 tablets per prescription; 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. |
| <i>perphenazine</i> | 2 | |
| <i>phenadoz</i> | 2 | Rectal dosage formulation |
| <i>prochlorperazine edisylate</i> | 2 | Injectable dosage formulation |
| <i>prochlorperazine maleate</i> | 2 | |
| <i>promethazine hcl</i> | 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; Injectable dosage formulation |
| <i>promethazine hcl</i> | 2 | Rectal dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------|-----------|--|
| <i>promethegan</i> | 2 | Rectal dosage formulation |
| ANTIFUNGALS | | |
| Antifungals | | |
| ABELCET | 5 | Prior authorization required; Injectable dosage formulation |
| <i>amphotericin b</i> | 2 | Prior authorization required; Injectable dosage formulation |
| ANCOBON | 4 | |
| CANCIDAS | 5 | 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; Injectable dosage formulation |
| <i>ciclopirox</i> | 2 | Topical dosage formulation |
| <i>ciclopirox nail lacquer</i> | 2 | Topical dosage formulation |
| <i>ciclopirox olamine</i> | 2 | Topical dosage formulation |
| <i>clotrimazole</i> | 2 | Topical dosage formulation |
| <i>clotrimazole</i> | 2 | |
| <i>econazole nitrate</i> | 2 | Topical dosage formulation |
| ERAXIS | 4 | Prior authorization required; Injectable dosage formulation |
| EXELDERM | 4 | Topical dosage formulation |
| <i>fluconazole</i> | 2 | Quantity limit - 2 tablets per 7 days on 150mg |
| <i>griseofulvin microsize</i> | 2 | |
| <i>itraconazole</i> | 2 | Prior authorization required |
| <i>ketoconazole</i> | 2 | Topical dosage formulation |
| <i>ketoconazole</i> | 2 | |
| <i>miconazole 3</i> | 2 | Quantity limit - 3 suppositories per 3 days; Vaginal dosage formulation |
| NAFTIN | 4 | Topical dosage formulation |
| NATACYN | 3 | Ophthalmic dosage formulation |
| <i>nystatin</i> | 1 | Topical dosage formulation |
| <i>nystatin</i> | 1 | |
| <i>nystatin/triamcinolone</i> | 1 | Topical dosage formulation |
| <i>nystop</i> | 1 | Topical dosage formulation |
| OXISTAT | 4 | Topical dosage formulation |
| <i>pedi-dri</i> | 1 | Topical dosage formulation |
| <i>terbinafine hcl</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------------------|-----------|--|
| <i>terconazole</i> | 2 | Quantity limit - 45gm per 7 days on 0.4%; 20gm per 3 days on 0.8%; Vaginal dosage formulation |
| <i>terconazole</i> | 2 | Quantity limit - 3 suppositories per 3 days; Vaginal dosage formulation |
| VFEND | 5 | Suspension; Prior authorization required |
| VFEND IV | 4 | Prior authorization required; Injectable dosage formulation |
| <i>voriconazole</i> | 5 | Prior authorization required |
| ANTIGOUT AGENTS | | |
| Antigout Agents | | |
| <i>allopurinol</i> | 1 | |
| COLCRYS | 4 | Quantity limit - 120 tablets per 30 days |
| <i>probenecid</i> | 2 | |
| <i>probenecid/colchicine</i> | 2 | |
| ANTI-INFLAMMATORY AGENTS | | |
| Glucocorticoids | | |
| <i>a-methapred</i> | 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; Injectable dosage formulation |
| CELESTONE | 4 | |
| <i>cortisone acetate</i> | 2 | |
| <i>dexamethasone</i> | 1 | |
| <i>dexamethasone sodium phosphate</i> | 2 | Injectable dosage formulation |
| <i>hydrocortisone</i> | 2 | |
| <i>methylprednisolone</i> | 2 | |
| <i>methylprednisolone acetate</i> | 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; Injectable dosage |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------------|-----------|--|
| | | 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; Injectable dosage formulation |
| <i>methylprednisolone sodium</i> | 2 | |
| <i>prednisolone sodium phosphate</i> | 2 | |
| <i>prednisone intensol</i> | 1 | |
| ANTIMIGRAINE AGENTS | | |
| Abortive | | |
| AXERT | 4 | Quantity limit - 12 tablets per 30 days |
| <i>dihydroergotamine mesylate</i> | 2 | Injectable dosage formulation |
| <i>ergomar</i> | 2 | Quantity limit - 20 tablets per 28 days |
| FROVA | 4 | Quantity limit - 12 tablets per 30 days |
| MAXALT | 4 | Quantity limit - 12 tablets per 30 days |
| MAXALT-MLT | 4 | Quantity limit - 12 tablets per 30 days |
| <i>migergot</i> | 2 | Rectal dosage formulation |
| MIGRANAL | 4 | Quantity limit - 16ml per 30 days |
| <i>naratriptan hcl</i> | 2 | Quantity limit - 9 tablets per 30 days |
| RELPAK | 4 | Quantity limit - 6 tablets per 30 days |
| <i>sumatriptan succinate</i> | 2 | Quantity limit - 6ml per 30 days; Injectable dosage formulation |
| <i>sumatriptan succinate</i> | 2 | Quantity limit - 9 tablets per 30 days |
| ZOMIG | 3 | Quantity limit - 6 tablets per 30 days |
| ZOMIG SPRAY | 3 | Quantity limit - 6ml per 30 days |
| ZOMIG ZMT | 3 | Quantity limit - 6 tablets per 30 days |
| Prophylactic | | |
| <i>divalproex sodium er</i> | 2 | |
| <i>timolol maleate</i> | 1 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|----------------------------------|-----------|--|
| ANTIMYASTHENIC AGENTS | | |
| Parasympathomimetics | | |
| GUANIDINE HCL | 3 | |
| MESTINON | 4 | |
| MESTINON TIMESPAN | 4 | |
| MYTELASE | 4 | |
| <i>pyridostigmine bromide</i> | 2 | |
| ANTIMYCOBACTERIALS | | |
| Antimycobacterials, Other | | |
| <i>dapsone</i> | 2 | |
| MYCOBUTIN | 4 | |
| Antituberculars | | |
| CAPASTAT SULFATE | 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; Injectable dosage formulation |
| <i>ethambutol hcl</i> | 2 | |
| <i>isonarif</i> | 2 | |
| <i>isoniazid</i> | 2 | |
| <i>paser</i> | 2 | |
| PRIFTIN | 4 | |
| <i>pyrazinamide</i> | 2 | |
| <i>rifampin</i> | 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; Injectable dosage formulation |
| <i>rifampin</i> | 2 | |
| RIFATER | 4 | |
| <i>seromycin</i> | 2 | |
| TRECTOR | 4 | |
| ANTINEOPLASTICS | | |
| Alkylating Agents | | |
| CEENU | 4 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------|-----------|--|
| EMCYT | 4 | |
| HEXALEN | 5 | |
| LEUKERAN | 3 | |
| MATULANE | 4 | |
| TREANDA | 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; Injectable dosage formulation |
| ZANOSAR | 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; Injectable dosage formulation |
| Antiangiogenic Agents | | |
| REVLIMID | 5 | This prescription may be available only at certain pharmacies. For more information, call 1-800-546-5677, 24 hours a day, 7 days a week. TTY/TDD users should call 1-866-706-4757. |
| THALOMID | 5 | |
| Antiestrogens/Modifiers | | |
| FARESTON | 4 | |
| <i>tamoxifen citrate</i> | 1 | |
| Antimetabolites | | |
| DACOGEN | 5 | 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; Injectable dosage formulation |
| DROXIA | 4 | |
| <i>hydroxyurea</i> | 2 | |
| <i>mercaptopurine</i> | 2 | |
| TABLOID | 4 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------|-----------|--|
| Antineoplastics, Other | | |
| AFINITOR | 5 | Quantity limit - 60 tablets per 30 days |
| ALIMTA | 5 | 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; Injectable dosage formulation |
| ARRANON | 5 | 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; Injectable dosage formulation |
| <i>bleomycin sulfate</i> | 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; Injectable dosage formulation |
| <i>cyclophosphamide</i> | 2 | |
| DAUNOXOME | 5 | 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; Injectable dosage formulation |
| ELITEK | 5 | 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; Injectable dosage formulation |
| FASLODEX | 5 | Injectable dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------|-----------|--|
| HALAVEN | 5 | 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; Injectable dosage formulation |
| ISTODAX | 5 | 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; Injectable dosage formulation |
| JEVTANA | 5 | 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; Injectable dosage formulation |
| <i>mitoxantrone hcl</i> | 3 | 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; Injectable dosage formulation |
| ONTAK | 5 | 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; Injectable dosage formulation |
| <i>oxaliplatin</i> | 2 | Injectable dosage formulation |
| PROLEUKIN | 5 | Injectable dosage formulation |
| TAXOTERE | 5 | This drug may be covered under Medicare Part B or D depending upon the circumstances. |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| | | Information may need to be submitted describing the use and setting of drug to make the determination; Injectable dosage formulation |
| <i>topotecan hcl</i> | 5 | 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; Injectable dosage formulation |
| TRISENOX | 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; Injectable dosage formulation |
| TYKERB | 5 | |
| VELCADE | 5 | 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; Injectable dosage formulation |
| VIDAZA | 5 | 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; Injectable dosage formulation |
| ZOLINZA | 5 | |
| Aromatase Inhibitors, 3rd Generation | | |
| <i>anastrozole</i> | 2 | Quantity limit - 30 tablets per 30 days |
| <i>exemestane</i> | 2 | |
| <i>letrozole</i> | 2 | Quantity limit - 30 tablets per 30 days |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|------------------------------------|-----------|--|
| Molecular Target Inhibitors | | |
| GLEEVEC | 5 | Quantity limit - 90 tablets per 30 days on 100mg; 60 tablets per 30 days on 400mg |
| IRESSA | 5 | Quantity limit - 30 tablets per 30 days |
| NEXAVAR | 5 | Quantity limit - 120 tablets per 30 days |
| SPRYCEL | 5 | |
| SUTENT | 5 | |
| TARCEVA | 5 | |
| TASIGNA | 5 | |
| VANDETANIB | 5 | Quantity limit - 60 tablets per 30 days on 100mg; 30 tablets per 30 days on 300mg |
| VOTRIENT | 5 | |
| Monoclonal Antibodies | | |
| ARZERRA | 5 | 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; Injectable dosage formulation |
| AVASTIN | 5 | 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; Injectable dosage formulation |
| CAMPATH | 5 | 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; Injectable dosage formulation |
| HERCEPTIN | 5 | This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-----------------------------------|-----------|--|
| | | submitted describing the use and setting of drug to make the determination; Injectable dosage formulation |
| RITUXAN | 5 | 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; Injectable dosage formulation |
| Retinoids | | |
| PANRETIN | 5 | Topical dosage formulation |
| TARGRETIN | 5 | |
| TARGRETIN | 5 | Quantity limit - 60gm per prescription; Topical dosage formulation |
| <i>tretinoin</i> | 2 | |
| ANTIPARASITICS | | |
| Anthelmintics | | |
| ALBENZA | 4 | |
| BILTRICIDE | 4 | |
| <i>mebendazole</i> | 2 | |
| STROMEKTOL | 4 | |
| Antiprotozoals | | |
| ALINIA | 4 | |
| <i>chloroquine phosphate</i> | 2 | |
| DARAPRIM | 4 | |
| <i>hydroxychloroquine sulfate</i> | 2 | |
| <i>mefloquine hcl</i> | 2 | |
| MEPRON | 4 | Prior authorization required |
| PENTAM 300 | 4 | Prior authorization required; Injectable dosage formulation |
| PRIMAQUINE PHOSPHATE | 4 | |
| Pediculicides/Scabicides | | |
| <i>acticin</i> | 2 | Topical dosage formulation |
| <i>lindane</i> | 2 | Topical dosage formulation |
| <i>malathion</i> | 2 | Topical dosage formulation |
| <i>permethrin</i> | 2 | Topical dosage formulation |
| ANTIPARKINSON AGENTS | | |
| Antiparkinson Agents | | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------|-----------|--|
| <i>amantadine hcl</i> | 2 | |
| APOKYN | 5 | Prior authorization required; Injectable dosage formulation |
| AZILECT | 4 | |
| <i>benztropine mesylate</i> | 1 | |
| <i>bromocriptine mesylate</i> | 2 | |
| <i>carbidopa/levodopa</i> | 2 | |
| <i>carbidopa/levodopa cr</i> | 2 | |
| <i>carbidopa/levodopa odt</i> | 2 | |
| <i>carbidopa/levodopa sr</i> | 2 | |
| COMTAN | 3 | Quantity limit - 240 tablets per 30 days |
| LODOSYN | 4 | |
| <i>pramipexole</i> | 2 | Quantity limit - 90 tablets per 30 days |
| REQUIP XL | 4 | Quantity limit - 60 tablets per 30 days on 12mg; 360 tablets per 30 days on 2mg; 180 tablets per 30 days on 4mg; 90 tablets per 30 days on 8mg |
| <i>ropinirole hcl</i> | 2 | |
| <i>selegiline hcl</i> | 2 | |
| STALEVO | 4 | |
| TASMAR | 4 | |
| <i>trihexyphenidyl hcl</i> | 1 | |
| ANTIPSYCHOTICS | | |
| Atypicals | | |
| ABILIFY | 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; Injectable dosage formulation |
| ABILIFY | 4 | Quantity limit - 30 tablets per 30 days; 900ml per 30 days on solution |
| ABILIFY DISCMELT | 4 | Quantity limit - 60 tablets per 30 days |
| <i>clozapine</i> | 2 | Quantity limit - 120 tablets per 30 days |
| FANAPT | 4 | Quantity limit - 60 tablets per 30 |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|------------------------|-----------|--|
| | | days |
| FANAPT TITRATION PACK | 4 | Quantity limit - 60 tablets per 30 days |
| FAZACLO | 4 | Quantity limit - 270 tablets per 30 days on 100mg, 12.5mg and 25mg; 180 tablets per 30 days on 150mg; 120 tablets per 30 days on 200mg |
| GEODON | 4 | Quantity limit - 60 capsules per 30 days |
| INVEGA | 4 | Quantity limit - 60 tablets per 30 days on 1.5mg and 6mg; 30 tablets per 30 days on 3mg and 9mg |
| INVEGA SUSTENNA | 5 | 117mg, 156mg, and 234mg; Injectable dosage formulation |
| INVEGA SUSTENNA | 4 | 39mg and 78mg; Injectable dosage formulation |
| LATUDA | 4 | Quantity limit - 30 tablets per 30 days |
| RISPERDAL CONSTA | 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; Injectable dosage formulation |
| <i>risperidone</i> | 2 | Quantity limit - 60 tablets per 30 days; 120 tablets per 30 days on 4mg; 480ml per 30 days on solution; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>risperidone odt</i> | 2 | Quantity limit - 60 tablets per 30 days; 120 tablets per 30 days on 4mg; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------|-----------|---|
| SAPHRIS | 4 | Quantity limit - 60 per 30 days |
| SEROQUEL | 4 | Quantity limit - 120 tablets per 30 days on 100mg, 25mg and 50mg; 90 tablets per 30 days on 200mg and 300mg; 60 tablets per 30 days on 400mg |
| SEROQUEL XR | 4 | Quantity limit - 30 tablets per 30 days on 150mg and 200mg; 60 tablets per 30 days on 300mg, 400mg and 50mg |
| SYMBYAX | 4 | Quantity limit - 30 capsules per 30 days |
| ZYPREXA | 4 | Quantity limit - 30ml per 30 days; 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. |
| ZYPREXA | 4 | Quantity limit - 30 tablets per 30 days |
| ZYPREXA ZYDIS | 4 | Quantity limit - 30 tablets per 30 days |
| Conventional | | |
| <i>compro</i> | 2 | Rectal dosage formulation |
| <i>fluphenazine decanoate</i> | 2 | Injectable dosage formulation |
| <i>fluphenazine hcl</i> | 2 | |
| <i>fluphenazine hcl</i> | 2 | Injectable dosage formulation |
| <i>haloperidol</i> | 1 | |
| <i>haloperidol decanoate</i> | 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; Injectable dosage formulation |
| <i>haloperidol lactate</i> | 2 | Injectable dosage formulation |
| <i>loxapine succinate</i> | 2 | |
| ORAP | 4 | |
| <i>prochlorperazine</i> | 2 | Rectal dosage formulation |
| <i>thioridazine hcl</i> | 2 | |
| <i>thiothixene</i> | 1 | |
| <i>trifluoperazine hcl</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| ANTISPASTICITY AGENTS | | |
| Antispasticity Agents | | |
| <i>baclofen</i> | 2 | |
| <i>dantrolene sodium</i> | 2 | |
| <i>tizanidine hcl</i> | 2 | |
| ANTIVIRALS | | |
| Anti-cytomegalovirus (CMV) Agents | | |
| <i>foscarnet sodium</i> | 2 | Injectable dosage formulation |
| <i>ganciclovir</i> | 2 | |
| VALCYTE | 5 | |
| VISTIDE | 5 | Injectable dosage formulation |
| Antihepatitis Agents | | |
| BARACLUDE | 4 | solution; Quantity limit - 600ml per 30 days; Prior authorization required |
| BARACLUDE | 5 | Quantity limit - 30 tablets per 30 days; Prior authorization required |
| HEPSERA | 5 | |
| <i>ribasphere</i> | 2 | |
| <i>ribavirin</i> | 2 | |
| TYZEKA | 4 | |
| Antiherpetic Agents | | |
| <i>acyclovir</i> | 1 | |
| <i>acyclovir sodium</i> | 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; Injectable dosage formulation |
| DENAVIR | 4 | Quantity limit - 1.5gm per 28 days; Topical dosage formulation |
| <i>famciclovir</i> | 2 | Quantity limit - 21 tablets per 10 days on 125mg; 60 tablets per 30 days on 250mg; 21 tablets per 7 days on 500mg |
| <i>trifluridine</i> | 2 | Ophthalmic dosage formulation |
| <i>valacyclovir hcl</i> | 2 | Quantity limit - 30 tablets per 30 days |
| ZOVIRAX | 4 | Quantity limit - 10gm per 30 days on cream; 30gm per 30 days on |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| | | ointment; Topical dosage formulation |
| Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors | | |
| EDURANT | 5 | Quantity limit - 30 tablets per 30 days |
| INTELENCE | 4 | Quantity limit - 120 tablets per 30 days |
| RESCRIPTOR | 4 | |
| SUSTIVA | 3 | |
| VIRAMUNE | 3 | |
| VIRAMUNE XR | 3 | |
| Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors | | |
| ATRIPLA | 4 | |
| COMBIVIR | 3 | |
| <i>didanosine</i> | 2 | |
| EMTRIVA | 4 | |
| EPIVIR | 3 | |
| EPIVIR HBV | 3 | |
| EPZICOM | 4 | |
| RETROVIR IV INFUSION | 4 | Injectable dosage formulation |
| <i>stavudine</i> | 2 | |
| TRIZIVIR | 4 | |
| TRUVADA | 4 | |
| VIDEX | 4 | |
| VIREAD | 4 | |
| ZIAGEN | 3 | |
| <i>zidovudine</i> | 2 | |
| Anti-HIV Agents, Other | | |
| FUZEON | 5 | Injectable dosage formulation |
| ISENTRESS | 5 | |
| SELZENTRY | 5 | |
| Anti-HIV Agents, Protease Inhibitors | | |
| APTIVUS | 4 | Quantity limit - 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 | Quantity limit - 3 inhalers per 180 |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------------|-----------|---|
| | | days |
| <i>rimantadine hcl</i> | 2 | |
| TAMIFLU | 3 | Quantity limit - 84 capsules per 180 days on 30mg; 42 capsules per 30 days on 45mg and 75mg; 900ml per 180 days on suspension |
| ANXIOLYTICS | | |
| Anxiolytics, Other | | |
| <i>bupirone hcl</i> | 2 | |
| <i>meprobamate</i> | 2 | Prior authorization required |
| BIPOLAR AGENTS | | |
| Bipolar Agents | | |
| <i>lithium carbonate</i> | 2 | |
| <i>lithium carbonate er</i> | 2 | |
| LITHIUM CITRATE | 3 | Syrup |
| BLOOD GLUCOSE REGULATORS | | |
| Antidiabetic Agents | | |
| <i>acarbose</i> | 2 | |
| ACTOPLUS MET | 4 | Quantity limit - 90 tablets per 30 days |
| ACTOS | 3 | Quantity limit - 30 tablets per 30 days |
| BYETTA | 4 | Quantity limit - 1 pen per 30 days on 10mcg; 2 pens per 30 days on 5mcg; Injectable dosage formulation |
| <i>glimepiride</i> | 1 | Quantity limit - 60 tablets per 30 days |
| <i>glipizide</i> | 1 | Quantity limit - 120 tablets per 30 days on 10mg; 240 tablets per 30 days on 5mg |
| <i>glipizide er</i> | 1 | Quantity limit - 60 tablets per 30 days on 10mg; 240 tablets per 30 days on 2.5mg; 120 tablets per 30 days on 5mg |
| <i>glipizide/metformin hcl</i> | 1 | Quantity limit - 240 tablets per 30 days on 2.5/250mg; 120 tablets per 30 days on 2.5/500mg and 5/500mg |
| <i>glyburide</i> | 1 | Quantity limit - 480 tablets per 30 days on 1.25mg; 240 tablets per |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------------------|-----------|---|
| | | 30 days on 2.5mg; 120 tablets per 30 days on 5mg |
| <i>glyburide micronized</i> | 1 | Quantity limit - 120 tablets per 30 days on 1.5mg; 60 tablets per 30 days on 3mg; 30 tablets per 30 days on 6mg |
| <i>glyburide/metformin hcl</i> | 1 | Quantity limit - 240 tablets per 30 days on 1.25/250mg; 120 tablets per 30 days on 2.5/250mg and 5/500mg |
| <i>glycron</i> | 1 | Quantity limit - 240 tablets per 30 days on 1.5mg; 120 tablets per 30 days on 3mg; 90 tablets per 30 days on 4.5mg; 60 tablets per 30 days on 6mg |
| GLYSET | 4 | Quantity limit - 90 tablets per 30 days |
| JANUMET | 3 | Quantity limit - 60 tablets per 30 days |
| JANUVIA | 3 | Quantity limit - 30 tablets per 30 days |
| KOMBIGLYZE XR | 3 | Quantity limit - 60 tablets per 30 days |
| <i>metformin hcl</i> | 1 | Quantity limit - 90 tablets per 30 days on 1000mg and 850mg; 150 tablets per 30 days on 500mg |
| <i>metformin hcl er</i> | 1 | Quantity limit - 120 tablets per 30 days on 500mg; 90 tablets per 30 days on 750mg |
| <i>nateglinide</i> | 2 | Quantity limit - 90 tablets per 30 days |
| PRANDIMET | 4 | Quantity limit - 150 tablets per 30 days |
| PRANDIN | 4 | Quantity limit - 240 tablets per 30 days |
| SYMLIN | 4 | Quantity limit - 20ml per 30 days; Injectable dosage formulation |
| SYMLINPEN 60 | 4 | Quantity limit - 10.8ml per 30 days; Injectable dosage formulation |
| Blood Glucose Regulators, Misc | | |
| ALCOHOL PREPS | 2 | |
| GAUZE PADS | 3 | |
| INSULIN NEEDLES | 2 | |
| INSULIN PEN NEEDLES | 2 | |
| INSULIN SYRINGES | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|---|
| Glycemic Agents | | |
| GLUCAGEN | 3 | Quantity limit - 2 kits per prescription; Injectable dosage formulation |
| GLUCAGON EMERGENCY KIT | 3 | Quantity limit - 2 kits per prescription; Injectable dosage formulation |
| PROGLYCEM | 3 | |
| Insulins | | |
| APIDRA | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMALOG | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMALOG MIX 50/50 | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMALOG MIX 75/25 | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMULIN 70/30 | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMULIN N | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMULIN N U-100 PEN | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMULIN R | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| HUMULIN R U-500 | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| LANTUS | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| LEVEMIR | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| NOVOLIN 70/30 | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| NOVOLIN N | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| NOVOLIN R | 2 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| NOVOLOG | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| NOVOLOG MIX 70/30 | 3 | Quantity limit - 30ml per 30 days; Injectable dosage formulation |
| BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS | | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------|-----------|--|
| Anticoagulants | | |
| ARIXTRA | 4 | 2.5/0.5; Quantity limit - 30 syringes per 30 days; Prior authorization required; Injectable dosage formulation |
| ARIXTRA | 5 | Quantity limit - 30 syringes per 30 days; Prior authorization required; Injectable dosage formulation |
| COUMADIN | 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; Injectable dosage formulation |
| COUMADIN | 3 | |
| <i>enoxaparin sodium</i> | 2 | Quantity limit - 28 syringes per 30 days; Injectable dosage formulation |
| FRAGMIN | 5 | 10000/ml, 12500 units, 15000 units, 18000 units, 7500/0.3; Quantity limit - 20ml per 30 days; Prior authorization required; Injectable dosage formulation |
| FRAGMIN | 4 | 2500/0.2, 25000/ml, 5000/0.2; Quantity limit - 20ml per 30 days; Prior authorization required; Injectable dosage formulation |
| <i>heparin sodium</i> | 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; Injectable dosage formulation |
| <i>heparin sodium/d5w</i> | 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; Injectable dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------------|-----------|--|
| HEPARIN SODIUM/NACL 0.45% | 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; Injectable dosage formulation |
| INNOHEP | 4 | Quantity limit - 20ml per 30 days; Prior authorization required; Injectable dosage formulation |
| <i>jantoven</i> | 1 | |
| LOVENOX | 4 | 300/3ml; Quantity limit - 28 syringes per 30 days; Injectable dosage formulation |
| PRADAXA | 4 | Quantity limit - 60 capsules per 30 days |
| <i>warfarin sodium</i> | 1 | |
| Blood Formation Products | | |
| ARANESP ALBUMIN FREE | 4 | 100mcg, 25mcg, 40mcg, 60mcg; Quantity limits apply; Prior authorization required; Injectable dosage formulation |
| ARANESP ALBUMIN FREE | 5 | 150mcg, 200mcg, 300mcg, 500mcg; Quantity limits apply; Prior authorization required; Injectable dosage formulation |
| EPOGEN | 4 | 10000/ml, 20000/ml; Prior authorization required; Injectable dosage formulation |
| EPOGEN | 4 | 2000/ml, 3000/ml, 4000/ml; Quantity limit - 12ml per 28 days; Prior authorization required; Injectable dosage formulation |
| LEUKINE | 4 | Prior authorization required; Injectable dosage formulation |
| METHERGINE | 4 | |
| NEULASTA | 5 | Quantity limit - 2ml per 30 days; Prior authorization required; Injectable dosage formulation |
| NEUMEGA | 5 | Quantity limit - 21ml per 21 days; Prior authorization required; Injectable dosage formulation |
| NEUPOGEN | 5 | Prior authorization required; Injectable dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| PROCRIT | 3 | 10000/ml; Prior authorization required; Injectable dosage formulation |
| PROCRIT | 3 | 2000/ml, 3000/ml, 4000/ml; Quantity limit - 12ml per 28 days; Prior authorization required; Injectable dosage formulation |
| PROCRIT | 5 | 20000/ml, 40000/ml; Prior authorization required; Injectable dosage formulation |
| PROMACTA | 5 | Quantity limit - 90 tablets per 30 days; Prior authorization required |
| Coagulants | | |
| CYKLOKAPRON | 3 | Injectable dosage formulation |
| Platelet Aggregation Inhibitors | | |
| AGGRENOX | 4 | |
| <i>anagrelide hydrochloride</i> | 2 | |
| <i>cilostazol</i> | 2 | |
| EFFIENT | 3 | Quantity limit - 30 tablets per 30 days |
| <i>pentopak</i> | 2 | |
| <i>pentoxifylline er</i> | 2 | |
| PLAVIX | 3 | Quantity limit - 30 tablets per 30 days |
| CARDIOVASCULAR AGENTS | | |
| Alpha-adrenergic Agonists | | |
| | | Quantity limit - 4 patches per 28 days; Transdermal dosage formulation |
| <i>clonidine hcl</i> | 2 | |
| <i>clonidine hcl</i> | 1 | |
| <i>guanabenz acetate</i> | 2 | |
| <i>guanfacine hcl</i> | 2 | |
| <i>methyldopa</i> | 1 | |
| <i>methyldopa/hydrochlorothiazide</i> | 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; Injectable dosage formulation |
| <i>methyldopate hcl</i> | 2 | |
| <i>midodrine hcl</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| Alpha-adrenergic Blocking Agents | | |
| <i>doxazosin mesylate</i> | 1 | Quantity limit - 30 tablets per 30 days; 60 tablets per 30 days on 8mg |
| <i>prazosin hcl</i> | 2 | |
| <i>terazosin hcl</i> | 1 | Quantity limit - 60 capsules per 30 days on 10mg; 30 capsules per 30 days on 1mg, 2mg and 5mg |
| Antiarrhythmics | | |
| <i>acebutolol hcl</i> | 2 | |
| <i>amiodarone hcl</i> | 2 | |
| <i>cartia xt</i> | 2 | |
| <i>diltiazem cd</i> | 2 | |
| <i>diltiazem hcl</i> | 2 | |
| <i>diltiazem hcl er</i> | 2 | |
| <i>dilt-xr</i> | 2 | |
| <i>disopyramide phosphate</i> | 2 | |
| <i>flecainide acetate</i> | 2 | |
| <i>mexiletine hcl</i> | 2 | |
| MULTAQ | 4 | Quantity limit - 60 tablets per 30 days |
| <i>pacerone</i> | 2 | 100mg and 200mg |
| <i>procainamide hcl</i> | 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; Injectable dosage formulation |
| <i>propafenone hcl</i> | 2 | |
| <i>quinidine gluconate cr</i> | 2 | |
| <i>quinidine sulfate</i> | 2 | |
| <i>quinidine sulfate er</i> | 2 | |
| <i>sorine</i> | 2 | |
| <i>sotalol hcl</i> | 2 | |
| <i>taztia xt</i> | 2 | |
| TIKOSYN | 4 | |
| <i>verapamil hcl</i> | 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; Injectable dosage formulation |
| <i>verapamil hcl</i> | 2 | |
| <i>verapamil hcl er</i> | 2 | |
| Beta-adrenergic Blocking Agents | | |
| <i>atenolol</i> | 1 | |
| <i>atenolol/chlorthalidone</i> | 1 | |
| <i>betaxolol hcl</i> | 2 | |
| <i>bisoprolol fumarate</i> | 2 | |
| <i>bisoprolol fumarate/hydrochlorothiazide</i> | 2 | |
| <i>carvedilol</i> | 1 | Quantity limit - 60 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| COREG CR | 4 | Quantity limit - 30 capsules per 30 days |
| EXFORGE | 4 | Quantity limit - 30 tablets per 30 days |
| <i>labetalol hcl</i> | 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; Injectable dosage formulation |
| <i>labetalol hcl</i> | 2 | |
| LEVATOL | 3 | |
| <i>metoprolol succinate er</i> | 2 | Quantity limit - 30 tablets per 30 days; 60 tablets per 30 days on 200mg |
| <i>metoprolol tartrate</i> | 1 | |
| <i>metoprolol tartrate</i> | 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; Injectable dosage formulation |
| <i>metoprolol/hydrochlorothiazide</i> | 1 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| <i>nadolol</i> | 1 | |
| <i>nadolol/bendroflumethiazide</i> | 2 | |
| <i>pindolol</i> | 1 | |
| <i>propranolol hcl</i> | 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; Injectable dosage formulation |
| <i>propranolol hcl</i> | 1 | |
| <i>propranolol hcl er</i> | 2 | |
| <i>propranolol/hydrochlorothiazide</i> | 1 | |
| Calcium Channel Blocking Agents | | |
| <i>afeditab cr</i> | 2 | |
| <i>amlodipine besylate</i> | 1 | Quantity limit - 30 tablets per 30 days |
| <i>felodipine er</i> | 2 | |
| <i>isradipine</i> | 2 | |
| <i>nicardipine hcl</i> | 2 | |
| <i>nifediac cc</i> | 2 | |
| <i>nifedical xl</i> | 2 | |
| <i>nifedipine er</i> | 2 | |
| <i>nimodipine</i> | 2 | |
| <i>nisoldipine</i> | 2 | |
| Cardiovascular Agents, Others | | |
| <i>digoxin</i> | 2 | Injectable dosage formulation |
| <i>digoxin</i> | 1 | |
| LANOXIN | 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; Injectable dosage formulation |
| RANEXA | 4 | Quantity limit - 120 tablets per 30 days |
| Diuretics | | |
| <i>amiloride hcl</i> | 1 | |
| <i>amiloride/hydrochlorothiazide</i> | 1 | |
| <i>bumetanide</i> | 2 | |
| <i>chlorthiazide</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| <i>chlorthalidone</i> | 2 | |
| <i>eplerenone</i> | 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; Injectable dosage formulation |
| <i>furosemide</i> | 2 | |
| <i>furosemide</i> | 1 | |
| <i>hydrochlorothiazide</i> | 1 | |
| <i>indapamide</i> | 1 | |
| <i>methazolamide</i> | 1 | |
| <i>methyclothiazide</i> | 2 | |
| <i>metolazone</i> | 2 | |
| <i>spironolactone</i> | 1 | |
| <i>spironolactone/ hydrochlorothiazide</i> | 2 | |
| <i>toremide</i> | 2 | |
| <i>triamterene/hydrochlorothiazide</i> | 1 | |
| Dyslipidemics | | |
| ADVICOR | 4 | Quantity limit - 30 tablets per 30 days |
| <i>cholestyramine light</i> | 2 | |
| <i>colestipol hcl</i> | 2 | |
| CRESTOR | 3 | Quantity limit - 30 tablets per 30 days |
| <i>fenofibrate</i> | 2 | Quantity limit - 30 tablets per 30 days |
| <i>fenofibrate micronized</i> | 2 | Quantity limit - 30 capsules per 30 days |
| <i>gemfibrozil</i> | 2 | |
| LESCOL | 4 | Quantity limit - 60 capsules per 30 days |
| LESCOL XL | 4 | Quantity limit - 60 tablets per 30 days |
| <i>lovastatin</i> | 2 | Quantity limit - 30 tablets per 30 days; 60 tablets per 30 days on 40mg |
| LOVAZA | 4 | |
| <i>niacor</i> | 2 | |
| NIASPAN | 4 | Quantity limit - 60 tablets per 30 days |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|---|
| <i>pravastatin sodium</i> | 2 | Quantity limit - 30 tablets per 30 days; 60 tablets per 30 days on 40mg |
| <i>prevalite</i> | 2 | |
| SIMCOR | 4 | Quantity limit - 60 tablets per 30 days |
| <i>simvastatin</i> | 1 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| TRILIPIX | 4 | Quantity limit - 30 capsules per 30 days |
| VYTORIN | 4 | Quantity limit - 30 tablets per 30 days |
| WELCHOL | 4 | |
| ZETIA | 4 | Quantity limit - 30 tablets per 30 days |
| Renin-angiotensin-aldosterone System Inhibitors | | |
| ATACAND | 3 | Quantity limit - 30 tablets per 30 days |
| ATACAND HCT | 3 | Quantity limit - 30 tablets per 30 days |
| <i>benazepril hcl</i> | 1 | |
| <i>benazepril hcl/hydrochlorothiazide</i> | 1 | |
| BENICAR | 4 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| BENICAR HCT | 4 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| <i>captopril</i> | 1 | |
| <i>captopril/hydrochlorothiazide</i> | 1 | |
| DIOVAN | 3 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| DIOVAN HCT | 3 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| <i>enalapril maleate</i> | 1 | |
| <i>enalapril maleate/hydrochlorothiazide</i> | 1 | |
| <i>fosinopril sodium</i> | 2 | |
| <i>fosinopril sodium/hydrochlorothiazide</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|---|
| <i>lisinopril</i> | 1 | |
| <i>lisinopril/hydrochlorothiazide</i> | 1 | |
| <i>losartan potassium</i> | 1 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>losartan potassium/hydrochlorothiazide</i> | 1 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>moexipril hcl</i> | 2 | |
| <i>moexipril/hydrochlorothiazide</i> | 2 | |
| <i>quinapril hcl</i> | 2 | |
| <i>quinapril/hydrochlorothiazide</i> | 2 | |
| TEKTURNA | 4 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| TEKTURNA HCT | 4 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| <i>trandolapril</i> | 2 | |
| VALTURNA | 4 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| Vasodilators | | |
| BIDIL | 4 | Prior authorization required |
| <i>hydralazine hcl</i> | 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; Injectable dosage formulation |
| <i>hydralazine hcl</i> | 2 | |
| <i>isochron</i> | 2 | |
| <i>isosorbide dinitrate</i> | 1 | |
| <i>isosorbide dinitrate er</i> | 1 | |
| <i>isosorbide mononitrate</i> | 1 | |
| <i>isosorbide mononitrate er</i> | 1 | |
| LETAIRIS | 5 | Prior authorization required; This prescription may be available only |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| | | at certain pharmacies. For more information, call 1-800-546-5677, 24 hours a day, 7 days a week. TTY/TDD users should call 1-866-706-4757. |
| <i>minitran</i> | 2 | Transdermal dosage formulation |
| <i>minoxidil</i> | 2 | |
| NITRO-DUR | 4 | Transdermal dosage formulation |
| <i>nitroglycerin</i> | 2 | Transdermal dosage formulation |
| <i>nitroglycerin</i> | 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; Injectable dosage formulation |
| <i>nitroglycerin transdermal</i> | 2 | Transdermal dosage formulation |
| NITROLINGUAL PUMPSPRAY | 4 | |
| NITROSTAT | 3 | |
| CENTRAL NERVOUS SYSTEM AGENTS | | |
| Amphetamines, ADHD | | |
| <i>amphetamine/ dextroamphetamine</i> | 2 | Prior authorization required |
| <i>dextroamphetamine sulfate</i> | 2 | |
| Non-amphetamines, ADHD | | |
| <i>methylin</i> | 2 | Prior authorization required |
| <i>methylin er</i> | 2 | Prior authorization required |
| <i>methylphenidate hcl</i> | 2 | Prior authorization required |
| <i>methylphenidate hcl sr</i> | 2 | Prior authorization required |
| STRATTERA | 3 | Quantity limit - 60 capsules per 30 days |
| Non-amphetamines, Other | | |
| PROVIGIL | 3 | Quantity limit - 60 tablets per 30 days |
| RILUTEK | 4 | Prior authorization required |
| XENAZINE | 5 | Prior authorization required |
| XYREM | 4 | Prior authorization required; This prescription may be available only at certain pharmacies. For more information, call 1-800-546-5677, 24 hours a day, 7 days a week. TTY/TDD users should call 1-866- |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------------|-----------|---|
| | | 706-4757. |
| DENTAL AND ORAL AGENTS | | |
| Dental and Oral Agents | | |
| <i>chlorhexidine gluconate</i> | 2 | |
| <i>lidocaine viscous</i> | 1 | |
| <i>periogard</i> | 2 | |
| <i>pilocarpine hcl</i> | 2 | |
| <i>pilocarpine hydrochloride</i> | 2 | |
| <i>triamcinolone in orabase</i> | 2 | |
| DERMATOLOGICAL AGENTS | | |
| Dermatological Agents | | |
| 8-MOP | 3 | Prior authorization required |
| <i>adapalene</i> | 2 | Prior authorization required; Topical dosage formulation |
| <i>ammonium lactate</i> | 2 | Topical dosage formulation |
| <i>avita</i> | 2 | Topical dosage formulation |
| <i>calcipotriene</i> | 2 | Topical dosage formulation |
| <i>clindamycin/benzoyl peroxide</i> | 1 | Topical dosage formulation |
| <i>clotrimazole/betamethasone</i> | 2 | Topical dosage formulation |
| <i>colocort</i> | 2 | Rectal dosage formulation |
| DIFFERIN | 4 | Prior authorization required; Topical dosage formulation |
| ELIDEL | 4 | Quantity limit - 30gm per prescription; Prior authorization required; Topical dosage formulation |
| <i>erythromycin/benzoyl peroxide</i> | 2 | Topical dosage formulation |
| <i>fluorouracil</i> | 2 | Topical dosage formulation |
| <i>hydrocortisone</i> | 1 | Rectal dosage formulation |
| <i>imiquimod</i> | 2 | Topical dosage formulation |
| <i>laclotion</i> | 2 | Topical dosage formulation |
| <i>lidocaine</i> | 1 | Topical dosage formulation |
| LIDODERM | 4 | Quantity limit - 90 patches per 30 days; Topical dosage formulation |
| ORACEA | 4 | |
| OXSORALEN ULTRA | 4 | Prior authorization required for new starts only |
| <i>podofilox</i> | 2 | Topical dosage formulation |
| <i>proctocream-hc</i> | 2 | Rectal dosage formulation |
| <i>proctosol hc</i> | 2 | Rectal dosage formulation |
| <i>proctozone-hc</i> | 2 | Rectal dosage formulation |
| PROTOPIC | 4 | Quantity limit - 30gm per |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------------------|-----------|--|
| | | prescription; Prior authorization required for new starts only; Topical dosage formulation |
| REGRANEX | 4 | Quantity limit - 15gm per 30 days; Prior authorization required; Topical dosage formulation |
| RETIN-A MICROGEL | 4 | Topical dosage formulation |
| SANTYL | 3 | Quantity limit - 30gm per prescription; Topical dosage formulation |
| <i>selenium sulfide</i> | 2 | Topical dosage formulation |
| SOLARAZE | 4 | Quantity limit - 50gm per prescription; Prior authorization required; Transdermal dosage formulation |
| TAZORAC | 4 | Topical dosage formulation |
| <i>tretinoin</i> | 2 | Topical dosage formulation |
| <i>u-cort</i> | 1 | Topical dosage formulation |
| ENZYME REPLACEMENTS/ MODIFIERS | | |
| Enzyme Replacements/ Modifiers | | |
| ADAGEN | 5 | Prior authorization required; Injectable dosage formulation |
| ALDURAZYME | 5 | Prior authorization required; Injectable dosage formulation |
| BUPHENYL | 4 | |
| CEREDASE | 5 | Prior authorization required; Injectable dosage formulation |
| CEREZYME | 5 | Prior authorization required; Injectable dosage formulation |
| CREON | 4 | |
| CYSTADANE | 4 | |
| CYSTAGON | 4 | |
| ELAPRASE | 5 | Prior authorization required; Injectable dosage formulation |
| FABRAZYME | 5 | Prior authorization required; Injectable dosage formulation |
| KUVAN | 5 | Prior authorization required |
| <i>levocarnitine</i> | 2 | |
| MYOZYME | 5 | Prior authorization required; Injectable dosage formulation |
| NAGLAZYME | 5 | Prior authorization required; Injectable dosage formulation |
| ORFADIN | 5 | Prior authorization required |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| PANCREAZE | 4 | |
| ZAVESCA | 4 | |
| ZENPEP | 4 | |
| GASTROINTESTINAL AGENTS | | |
| Antispasmodics, Gastrointestinal | | |
| | | 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; Injectable dosage formulation |
| <i>atropine sulfate</i> | 2 | |
| CANTIL | 4 | |
| <i>dicyclomine hcl</i> | 1 | |
| <i>glycopyrrolate</i> | 2 | |
| <i>methscopolamine bromide</i> | 2 | |
| Gastrointestinal Agents, Other | | |
| <i>constulose</i> | 2 | |
| <i>enulose</i> | 2 | |
| GASTROCROM | 4 | |
| HELIDAC | 4 | |
| <i>lactulose</i> | 2 | |
| <i>loperamide hcl</i> | 2 | |
| RELISTOR | 4 | Prior authorization required; Injectable dosage formulation |
| <i>trilyte</i> | 2 | |
| <i>ursodiol</i> | 2 | |
| Histamine2 (H2) Blocking Agents | | |
| | | 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; Injectable dosage formulation |
| <i>famotidine</i> | 2 | |
| <i>famotidine</i> | 1 | |
| | | 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 |
| <i>famotidine premixed</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| | | setting of drug to make the determination; Injectable dosage formulation |
| <i>nizatidine</i> | 2 | |
| <i>ranitidine hcl</i> | 1 | |
| <i>ranitidine hcl</i> | 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; Injectable dosage formulation |
| Irritable Bowel Syndrome Agents | | |
| LOTRONEX | 3 | Quantity limit - 60 tablets per 30 days; Prior authorization required |
| Protectants | | |
| <i>misoprostol</i> | 2 | |
| <i>sucralfate</i> | 2 | |
| Proton Pump Inhibitors | | |
| <i>lansoprazole</i> | 2 | Quantity limit - 30 capsules per 30 days |
| NEXIUM | 4 | Quantity limit - 30 per 30 days; Step therapy protocols apply |
| NEXIUM I.V. | 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; Injectable dosage formulation |
| <i>omeprazole</i> | 1 | Quantity limit - 60 capsules per 30 days on 10mg and 20mg; 30 capsules per 30 days on 40mg; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>pantoprazole sodium</i> | 1 | Quantity limit - 30 tablets per 30 days |
| PROTONIX | 4 | This drug may be covered under Medicare Part B or D depending |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| | | upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination; Injectable dosage formulation |
| GENITOURINARY AGENTS | | |
| Antispasmodics, Urinary | | |
| <i>bethanechol chloride</i> | 2 | |
| ENABLEX | 4 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| <i>flavoxate hcl</i> | 2 | |
| <i>oxybutynin chloride</i> | 1 | |
| <i>oxybutynin chloride er</i> | 2 | Quantity limit - 90 tablets per 30 days on 10mg; 60 tablets per 30 days on 15mg; 180 tablets per 30 days on 5mg |
| OXYTROL | 4 | Quantity limit - 8 patches per 28 days; Transdermal dosage formulation |
| TOVIAZ | 3 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| <i>tropium chloride</i> | 2 | Quantity limit - 60 tablets per 30 days |
| Benign Prostatic Hypertrophy Agents | | |
| AVODART | 4 | Quantity limit - 30 capsules per 30 days |
| <i>finasteride</i> | 2 | Quantity limit - 30 tablets per 30 days |
| JALYN | 4 | Quantity limit - 30 capsules per 30 days |
| <i>tamsulosin hcl</i> | 1 | Quantity limit - 60 capsules per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| Genitourinary Agents, Other | | |
| <i>neomycin/polymyxin b sulfate</i> | 2 | |
| <i>sodium chloride 0.9%</i> | 2 | |
| <i>sterile water irrigation</i> | 2 | |
| Phosphate Binders | | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|---|
| <i>calcium acetate</i> | 2 | |
| RENAGEL | 4 | |
| RENVELA | 4 | |
| HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (Adrenal) | | |
| Glucocorticoids-Mineralocorticoids | | |
| <i>ala cort</i> | 2 | Topical dosage formulation |
| <i>alclometasone dipropionate</i> | 2 | Topical dosage formulation |
| <i>amcinonide</i> | 2 | Topical dosage formulation |
| <i>augmented betamethasone</i> | 2 | Topical dosage formulation |
| <i>betamethasone dipropionate</i> | 1 | Topical dosage formulation |
| <i>betamethasone valerate</i> | 1 | Topical dosage formulation |
| <i>clobetasol propionate</i> | 2 | Topical dosage formulation |
| <i>clobetasol propionate e</i> | 2 | Topical dosage formulation |
| DERMA-SMOOTH/FS BODY OIL | 4 | Topical dosage formulation |
| <i>desonide</i> | 2 | Topical dosage formulation |
| <i>desoximetasone</i> | 2 | Topical dosage formulation |
| <i>diflorasone diacetate</i> | 2 | Topical dosage formulation |
| <i>fludrocortisone acetate</i> | 2 | |
| <i>fluocinolone acetonide</i> | 2 | Topical dosage formulation |
| <i>fluocinonide</i> | 2 | Topical dosage formulation |
| <i>fluocinonide emollient base</i> | 2 | Topical dosage formulation |
| <i>fluticasone propionate</i> | 2 | Topical dosage formulation |
| <i>halobetasol propionate</i> | 2 | Topical dosage formulation |
| HALOG | 4 | Topical dosage formulation |
| <i>hydrocortisone</i> | 1 | Topical dosage formulation |
| <i>hydrocortisone butyrate</i> | 1 | Topical dosage formulation |
| <i>hydrocortisone valerate</i> | 2 | Topical dosage formulation |
| <i>lokara</i> | 2 | Topical dosage formulation |
| <i>mometasone furoate</i> | 2 | Topical dosage formulation |
| <i>prednicarbate</i> | 2 | Topical dosage formulation |
| <i>procto-pak</i> | 2 | Rectal dosage formulation |
| <i>triamcinolone acetonide</i> | 1 | Topical dosage formulation |
| <i>triderm</i> | 2 | Topical dosage formulation |
| HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY) | | |
| Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary) | | |
| <i>desmopressin acetate</i> | 2 | This drug may be covered under Medicare Part B or D depending |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| | | upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination; Injectable dosage formulation |
| <i>desmopressin acetate</i> | 2 | |
| GENOTROPIN | 5 | Prior authorization required; Injectable dosage formulation |
| GENOTROPIN MINIQUICK | 4 | Prior authorization required; Injectable dosage formulation |
| HUMATROPE | 5 | 12mg and 24mg; Prior authorization required; Injectable dosage formulation |
| HUMATROPE | 4 | 6mg; Prior authorization required; Injectable dosage formulation |
| HUMATROPE COMBO PACK | 5 | Prior authorization required; Injectable dosage formulation |
| INCRELEX | 4 | Prior authorization required; Injectable dosage formulation |
| NORDITROPIN NORDIFLEX PEN | 5 | Prior authorization required; Injectable dosage formulation |
| NUTROPIN | 5 | Prior authorization required; Injectable dosage formulation |
| SAIZEN | 5 | Prior authorization required; Injectable dosage formulation |
| SAIZEN CLICK.EASY | 5 | Prior authorization required; Injectable dosage formulation |
| SEROSTIM | 5 | Prior authorization required; Injectable dosage formulation |
| SOMATULINE DEPOT | 5 | Prior authorization required; Injectable dosage formulation |
| ZORBTIVE | 5 | Prior authorization required; Injectable dosage formulation |
| HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS) | | |
| Anabolic Steroids | | |
| ANADROL-50 | 4 | |
| <i>oxandrolone</i> | 2 | |
| Androgens | | |
| ANDRODERM | 4 | Quantity limit - 30 patches per 30 days; Transdermal dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------|-----------|--|
| ANDROGEL | 4 | Quantity limit - 300gm per 30 days; Transdermal dosage formulation |
| <i>androxy</i> | 2 | |
| <i>danazol</i> | 2 | |
| STRIANT | 4 | Prior authorization required |
| TESTIM | 4 | Transdermal dosage formulation |
| <i>testosterone enanthate</i> | 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; Injectable dosage formulation |
| Estrogens | | |
| ACTIVELLA | 3 | 0.5-0.1 |
| ALORA | 4 | Quantity limit - 8 patches per 28 days; Transdermal dosage formulation |
| <i>apri</i> | 2 | |
| <i>aranelle</i> | 2 | |
| <i>aviane</i> | 2 | |
| <i>balziva</i> | 2 | |
| <i>cesia</i> | 2 | |
| <i>cryselle-28</i> | 2 | |
| <i>enpresse-28</i> | 2 | |
| ESTRACE | 4 | Vaginal dosage formulation |
| ESTRADERM | 4 | Quantity limit - 8 patches per 28 days; Transdermal dosage formulation |
| <i>estradiol</i> | 2 | Quantity limit - 4 patches per 28 days; Transdermal dosage formulation |
| <i>estradiol</i> | 1 | |
| <i>estradiol/norethindrone</i> | 2 | |
| ESTRING | 4 | Quantity limit - 1 ring per 90 days; Vaginal dosage formulation |
| <i>estropipate</i> | 3 | |
| FEMHRT LOW DOSE | 4 | |
| <i>jinteli</i> | 2 | |
| <i>junel 1.5/30</i> | 2 | |
| <i>junel 1/20</i> | 2 | |
| <i>junel fe 1.5/30</i> | 2 | |
| <i>junel fe 1/20</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|------------------------------|-----------|--|
| <i>kariva</i> | 2 | |
| <i>kelnor 1/35</i> | 2 | |
| <i>leena</i> | 2 | |
| <i>lessina-28</i> | 2 | |
| <i>levora 0.15/30-28</i> | 2 | |
| <i>low-ogestrel</i> | 2 | |
| <i>lutera</i> | 2 | |
| <i>menest</i> | 3 | |
| <i>microgestin 1.5/30</i> | 2 | |
| <i>microgestin 1/20</i> | 2 | |
| <i>microgestin fe</i> | 2 | |
| <i>microgestin fe 1.5/30</i> | 2 | |
| <i>mononessa</i> | 2 | |
| <i>necon 0.5/35-28</i> | 2 | |
| <i>necon 1/35-28</i> | 2 | |
| <i>necon 10/11-28</i> | 2 | |
| <i>necon 7/7/7</i> | 2 | |
| <i>nortrel 0.5/35 (28)</i> | 2 | |
| <i>nortrel 1/35 (21)</i> | 2 | |
| <i>nortrel 1/35 (28)</i> | 2 | |
| <i>nortrel 7/7/7</i> | 2 | |
| NUVARING | 4 | Vaginal dosage formulation |
| <i>ocella</i> | 2 | |
| <i>ogestrel</i> | 2 | |
| ORTHO EVRA | 4 | Transdermal dosage formulation |
| <i>ortho-est</i> | 3 | |
| <i>portia-28</i> | 2 | |
| PREFEST | 3 | |
| | | 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; Injectable dosage formulation |
| PREMARIN | 4 | |
| PREMARIN | 3 | |
| PREMARIN W/APPLICATOR | 3 | Vaginal dosage formulation |
| PREMPHASE | 3 | |
| PREMPRO | 3 | |
| <i>previfem</i> | 2 | |
| <i>quasense</i> | 2 | |
| <i>reclipsen</i> | 2 | |
| <i>solia</i> | 2 | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|---|
| <i>sprintec 28</i> | 2 | |
| <i>sronyx</i> | 2 | |
| <i>tri-legest fe</i> | 2 | |
| <i>trinessa</i> | 2 | |
| <i>tri-previfem</i> | 2 | |
| <i>tri-sprintec</i> | 2 | |
| <i>trivora-28</i> | 2 | |
| VAGIFEM | 4 | Vaginal dosage formulation |
| <i>velivet</i> | 2 | |
| VIVELLE-DOT | 4 | Quantity limit - 8 patches per 28 days; Transdermal dosage formulation |
| <i>zovia 1/35e</i> | 2 | |
| <i>zovia 1/50e</i> | 2 | |
| Progestins | | |
| <i>camila</i> | 2 | |
| CRINONE | 4 | Vaginal dosage formulation |
| <i>errin</i> | 2 | |
| <i>jolivette</i> | 2 | |
| <i>medroxyprogesterone acetate</i> | 2 | Quantity limit - 1 injection per 90 days; Injectable dosage formulation |
| <i>medroxyprogesterone acetate</i> | 2 | |
| MEGACE ES | 4 | Suspension |
| <i>megestrol acetate</i> | 2 | |
| <i>nora-be</i> | 2 | |
| <i>norethindrone acetate</i> | 2 | |
| PROMETRIUM | 4 | |
| Selective Estrogen Receptor Modifying Agents | | |
| EVISTA | 3 | Quantity limit - 30 tablets per 30 days |
| HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID) | | |
| Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid) | | |
| <i>levothroid</i> | 1 | |
| <i>levothyroxine sodium</i> | 1 | |
| <i>liothyronine sodium</i> | 2 | |
| SYNTHROID | 3 | |
| THYROLAR | 3 | |
| HORMONAL AGENTS, SUPPRESSANT (ADRENAL) | | |
| Hormonal Agents, Suppressant (Adrenal) | | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| LYSODREN | 3 | |
| HORMONAL AGENTS, SUPPRESSANT (PARATHYROID) | | |
| Hormonal Agents, Suppressant (Parathyroid) | | |
| SENSIPAR | 3 | |
| HORMONAL AGENTS, SUPPRESSANT (PITUITARY) | | |
| Hormonal Agents, Suppressant (Pituitary) | | |
| <i>cabergoline</i> | 2 | |
| <i>leuprolide acetate</i> | 2 | Injectable dosage formulation |
| LUPRON DEPOT | 4 | Injectable dosage formulation |
| <i>octreotide acetate</i> | 5 | 1000mcg and 500mcg; Prior authorization required; Injectable dosage formulation |
| <i>octreotide acetate</i> | 4 | 100mcg and 200mcg; Prior authorization required; Injectable dosage formulation |
| <i>octreotide acetate</i> | 2 | 50mcg/ml; Prior authorization required; Injectable dosage formulation |
| SANDOSTATIN LAR DEPOT | 5 | 10mg and 30mg; Quantity limit - 1 kit per 28 days; Prior authorization required; Injectable dosage formulation |
| SANDOSTATIN LAR DEPOT | 5 | 20mg; Quantity limit - 2 kits per 28 days; Prior authorization required; Injectable dosage formulation |
| SOMAVERT | 5 | Prior authorization required; Injectable dosage formulation |
| SYNAREL | 5 | Prior authorization required |
| TRELSTAR DEPOT MIXJECT | 5 | Injectable dosage formulation |
| TRELSTAR LA MIXJECT | 5 | Injectable dosage formulation |
| HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS) | | |
| Antiandrogens | | |
| <i>bicalutamide</i> | 2 | Quantity limit - 30 tablets per 30 days |
| <i>flutamide</i> | 2 | |
| NILANDRON | 4 | |
| ZYTIGA | 5 | Quantity limit - 120 tablets per 30 days |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| HORMONAL AGENTS, SUPPRESSANTS (THYROID) | | |
| Antithyroid Agents | | |
| <i>methimazole</i> | 2 | |
| <i>propylthiouracil</i> | 2 | |
| IMMUNOLOGICAL AGENTS | | |
| Immune Suppressants | | |
| ARCALYST | 5 | Prior authorization required; Injectable dosage formulation |
| <i>azasan</i> | 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. |
| <i>azathioprine</i> | 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. |
| CELLCEPT | 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. |
| CELLCEPT INTRAVENOUS | 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; Injectable dosage formulation |
| <i>cyclosporine</i> | 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. |
| <i>cyclosporine</i> | 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; Injectable dosage formulation |
| <i>cyclosporine modified</i> | 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. |
| ENBREL | 5 | Quantity limit - 8ml per 28 days on 25/0.5ml and 50mg/ml; 16ml per 28 days on 25mg; Prior authorization required; Injectable dosage formulation |
| HUMIRA | 5 | Quantity limit - 8ml per 28 days; Prior authorization required; Injectable dosage formulation |
| HUMIRA PEN-CROHNS DISEASE | 5 | Quantity limit - 8ml per 28 days; Injectable dosage formulation |
| <i>methotrexate</i> | 2 | |
| <i>methotrexate sodium</i> | 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; Injectable dosage formulation |
| <i>mycophenolate mofetil</i> | 1 | 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 | This drug may be covered under Medicare Part B or D depending upon the circumstances. |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-----------------|-----------|--|
| | | Information may need to be submitted describing the use and setting of drug to make the determination. |
| NEORAL | 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. |
| ORENCIA | 5 | Prior authorization required; Injectable dosage formulation |
| ORTHOCLONE OKT3 | 5 | Injectable dosage formulation |
| PROGRAF | 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. |
| PROGRAF | 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; Injectable dosage formulation |
| RAPAMUNE | 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. |
| REMICADE | 5 | Prior authorization required; Injectable dosage formulation |
| SANDIMMUNE | 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. |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-----------------------------------|-----------|---|
| SANDIMMUNE | 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; Injectable dosage formulation |
| SIMPONI | 5 | Prior authorization required; Step therapy protocols apply; Injectable dosage formulation |
| SIMULECT | 5 | 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; Injectable dosage formulation |
| <i>tacrolimus</i> | 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. |
| ZORTRESS | 4 | 0.25mg; Quantity limit - 60 tablets per 30 days; 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. |
| ZORTRESS | 5 | 0.5mg and 0.75mg; Quantity limit - 60 tablets per 30 days; 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. |
| Immunizing Agents, Passive | | |
| CARIMUNE NANOFILTERED | 5 | Prior authorization required; Injectable dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------|-----------|--|
| GAMASTAN S/D | 3 | Prior authorization required; Injectable dosage formulation |
| GAMMAGARD LIQUID | 5 | Prior authorization required; Injectable dosage formulation |
| VIVAGLOBIN | 5 | Prior authorization required; Injectable dosage formulation |
| Immunomodulators | | |
| ACTIMMUNE | 5 | 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; Injectable dosage formulation |
| AVONEX | 5 | Quantity limit - 1 kit per 28 days; Prior authorization required; Injectable dosage formulation |
| BETASERON | 5 | Quantity limit - 15ml per 30 days; Prior authorization required; Injectable dosage formulation |
| COPAXONE | 5 | Quantity limit - 1 kit per 30 days; Prior authorization required; Injectable dosage formulation |
| INFERGEN | 5 | Prior authorization required; Injectable dosage formulation |
| INTRON-A | 5 | 10MU pen and 5MU pen; Injectable dosage formulation |
| INTRON-A | 4 | 18MU and 3MU pen; Injectable dosage formulation |
| INTRON-A W/DILUENT | 4 | Injectable dosage formulation |
| KINERET | 5 | Prior authorization required; Injectable dosage formulation |
| <i>leflunomide</i> | 2 | Quantity limit - 30 tablets per 30 days |
| PEGASYS | 5 | Quantity limit - 1 kit per 28 days; Prior authorization required; Injectable dosage formulation |
| PEG-INTRON | 5 | Quantity limit - 1 kit per 28 days; Prior authorization required; Injectable dosage formulation |
| PEG-INTRON REDIPEN | 5 | Quantity limit - 1 kit per 28 days; Prior authorization required; Injectable dosage formulation |
| REBIF | 5 | Quantity limit - 12ml per 30 days; |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------|-----------|--|
| | | Prior authorization required; Injectable dosage formulation |
| REBIF TITRATION PACK | 5 | Quantity limit - 6ml per 30 days; Prior authorization required; Injectable dosage formulation |
| RIDAURA | 4 | |
| TYSABRI | 5 | Prior authorization required; This prescription may be available only at certain pharmacies. For more information, call 1-800-546-5677, 24 hours a day, 7 days a week. TTY/TDD users should call 1-866-706-4757; Injectable dosage formulation |
| Vaccines | | |
| ACTHIB | 4 | Injectable dosage formulation |
| ADACEL | 4 | Injectable dosage formulation |
| BOOSTRIX | 4 | Injectable dosage formulation |
| CERVARIX | 4 | Injectable dosage formulation |
| COMVAX | 4 | Injectable dosage formulation |
| DAPTACEL | 4 | Injectable dosage formulation |
| DECAVAC | 4 | Injectable dosage formulation |
| DIPHTHERIA/TETANUS TOXOID | 3 | Injectable dosage formulation |
| ENGERIX-B | 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; Injectable dosage formulation |
| GARDASIL | 4 | Prior authorization required; Injectable dosage formulation |
| HAVRIX | 4 | Injectable dosage formulation |
| IMOVAX RABIES | 4 | Injectable dosage formulation |
| INFANRIX | 4 | Injectable dosage formulation |
| IPOL INACTIVATED IPV | 4 | Injectable dosage formulation |
| IXIARO | 4 | Injectable dosage formulation |
| JE-VAX | 4 | Injectable dosage formulation |
| MENACTRA | 4 | Injectable dosage formulation |
| MENOMUNE-A/C/Y/W-135 | 4 | Injectable dosage formulation |
| MENVEO | 4 | Injectable dosage formulation |
| M-M-R II W/DILUENT | 4 | Injectable dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---------------------------|-----------|---|
| PEDVAX HIB | 4 | Injectable dosage formulation |
| PROQUAD | 4 | Injectable dosage formulation |
| RABAVERT | 4 | Injectable dosage formulation |
| RECOMBIVAX HB | 4 | Prior authorization required for new starts only; Injectable dosage formulation |
| ROTATEQ | 4 | |
| TETANUS TOXOID ADSORBED | 3 | Injectable dosage formulation |
| TETANUS/DIPHThERIA TOXOID | 3 | Injectable dosage formulation |
| TRIPEDIA | 3 | Injectable dosage formulation |
| TWINRIX | 3 | Injectable dosage formulation |
| TYPHIM VI | 3 | Injectable dosage formulation |
| VAQTA | 3 | Injectable dosage formulation |
| VARIVAX | 4 | Injectable dosage formulation |
| YF-VAX | 4 | Injectable dosage formulation |
| ZOSTAVAX | 4 | Prior authorization required; Injectable dosage formulation |

INFLAMMATORY BOWEL DISEASE AGENTS

Glucocorticoids

| | | |
|-------------------|---|--|
| ENTOCORT EC | 4 | |
| <i>prednisone</i> | 1 | |

Salicylates

| | | |
|-----------------------------|---|---------------------------|
| ASACOL | 4 | |
| <i>balsalazide disodium</i> | 2 | |
| CANASA | 4 | Rectal dosage formulation |
| DIPENTUM | 4 | |
| <i>mesalamine</i> | 2 | Rectal dosage formulation |
| PENTASA | 4 | |

Sulfonamides

| | | |
|----------------------|---|--|
| <i>sulfasalazine</i> | 2 | |
| <i>sulfazine ec</i> | 2 | |

METABOLIC BONE DISEASE AGENTS

Metabolic Bone Disease Agents

| | | |
|---------------------------|---|---|
| ACTONEL | 4 | Quantity limit - 5 tablets per 30 days; 30 tablets per 30 days on 5mg; Step therapy protocols apply |
| <i>alendronate sodium</i> | 1 | 10mg; Quantity limit - 120 tablets per 30 days |
| <i>alendronate sodium</i> | 1 | 35mg; Quantity limit - 5 tablets per 30 days |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-----------------------------|-----------|---|
| <i>alendronate sodium</i> | 1 | 40mg; Quantity limit - 30 tablets per 30 days |
| <i>alendronate sodium</i> | 1 | 5mg; Quantity limit - 240 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>alendronate sodium</i> | 1 | 70mg; Quantity limit - 5 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>calcitonin-salmon</i> | 2 | |
| <i>calcitriol</i> | 2 | |
| <i>calcitriol</i> | 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; Injectable dosage formulation |
| <i>etidronate disodium</i> | 2 | |
| FORTEO | 5 | Prior authorization required; Injectable dosage formulation |
| HECTOROL | 4 | |
| HECTOROL | 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; Injectable dosage formulation |
| <i>pamidronate disodium</i> | 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; Injectable dosage formulation |
| SKELID | 4 | |
| ZEMPLAR | 4 | Prior authorization required |
| ZEMPLAR | 4 | Prior authorization required; Injectable dosage formulation |
| ZOMETA | 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; Injectable dosage formulation |

OPHTHALMIC AGENTS

| Ophthalmic Agents, Other | | |
|---|---|--|
| <i>ak-con</i> | 1 | Ophthalmic dosage formulation |
| BLEPHAMIDE | 4 | Ophthalmic dosage formulation |
| <i>blephamide s.o.p.</i> | 4 | Ophthalmic dosage formulation |
| LACRISERT | 3 | Ophthalmic dosage formulation |
| <i>neomycin/polymyxin/bacitracin</i> | 2 | Ophthalmic dosage formulation |
| <i>neomycin/polymyxin/bacitracin/hydrocortisone</i> | 2 | Ophthalmic dosage formulation |
| <i>neomycin/polymyxin/dexamethasone</i> | 2 | Ophthalmic dosage formulation |
| <i>neomycin/polymyxin/hydrocortisone</i> | 2 | Ophthalmic dosage formulation |
| <i>parcaine</i> | 2 | Ophthalmic dosage formulation |
| <i>poly-dex</i> | 2 | Ophthalmic dosage formulation |
| POLY-PRED | 4 | Ophthalmic dosage formulation |
| PRED-G | 4 | Ophthalmic dosage formulation |
| PRED-G S.O.P. | 4 | Ophthalmic dosage formulation |
| <i>proparacaine hcl</i> | 2 | Ophthalmic dosage formulation |
| RESTASIS | 4 | Quantity limit - 1 pack per 30 days; Prior authorization required; Ophthalmic dosage formulation |
| <i>sulfacetamide sodium/prednisolone</i> | 2 | Ophthalmic dosage formulation |
| <i>tobramycin/dexamethasone</i> | 2 | Ophthalmic dosage formulation |
| Ophthalmic Anti-allergy Agents | | |
| ALAMAST | 4 | Ophthalmic dosage formulation |
| ALOCRIAL | 4 | Ophthalmic dosage formulation |
| ALOMIDE | 4 | Ophthalmic dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|-------------------------------------|
| <i>azelastine hcl</i> | 2 | Ophthalmic dosage formulation |
| <i>cromolyn sodium</i> | 2 | Ophthalmic dosage formulation |
| <i>epinastine</i> | 2 | |
| PATANOL | 3 | Ophthalmic dosage formulation |
| Ophthalmic Antiglaucoma Agents | | |
| <i>acetazolamide</i> | 1 | |
| ALPHAGAN P | 4 | 0.1%; Ophthalmic dosage formulation |
| <i>apraclonidine</i> | 2 | Ophthalmic dosage formulation |
| AZOPT | 3 | Ophthalmic dosage formulation |
| <i>betaxolol hcl</i> | 2 | Ophthalmic dosage formulation |
| BETIMOL | 4 | Ophthalmic dosage formulation |
| BETOPTIC-S | 4 | Ophthalmic dosage formulation |
| <i>brimonidine tartrate</i> | 1 | Ophthalmic dosage formulation |
| <i>carteolol hcl</i> | 2 | Ophthalmic dosage formulation |
| <i>dorzolamide hcl</i> | 2 | Ophthalmic dosage formulation |
| <i>dorzolamide hcl/timolol</i> | 2 | Ophthalmic dosage formulation |
| IOPIDINE | 4 | Ophthalmic dosage formulation |
| <i>levobunolol hcl</i> | 2 | Ophthalmic dosage formulation |
| <i>metipranolol</i> | 2 | Ophthalmic dosage formulation |
| PHOSPHOLINE IODIDE | 4 | Ophthalmic dosage formulation |
| PILOPINE HS | 4 | Ophthalmic dosage formulation |
| <i>timolol maleate</i> | 1 | Ophthalmic dosage formulation |
| <i>tropicamide</i> | 2 | Ophthalmic dosage formulation |
| Ophthalmic Anti-inflammatories | | |
| ALREX | 4 | Ophthalmic dosage formulation |
| <i>dexamethasone sodium phosphate</i> | 2 | Ophthalmic dosage formulation |
| <i>diclofenac sodium</i> | 2 | Ophthalmic dosage formulation |
| FLAREX | 4 | Ophthalmic dosage formulation |
| <i>fluorometholone</i> | 2 | Ophthalmic dosage formulation |
| <i>flurbiprofen sodium</i> | 2 | Ophthalmic dosage formulation |
| FML | 4 | Ophthalmic dosage formulation |
| FML FORTE | 4 | Ophthalmic dosage formulation |
| <i>ketorolac tromethamine</i> | 2 | Ophthalmic dosage formulation |
| LOTEMAX | 4 | Ophthalmic dosage formulation |
| MAXIDEX | 4 | Ophthalmic dosage formulation |
| NEVANAC | 4 | Ophthalmic dosage formulation |
| PRED MILD | 4 | Ophthalmic dosage formulation |
| <i>prednisolone acetate</i> | 2 | Ophthalmic dosage formulation |
| <i>prednisolone sodium phosphate</i> | 2 | Ophthalmic dosage formulation |
| VEXOL | 4 | Ophthalmic dosage formulation |
| Ophthalmic Prostaglandins and Prostanamide Analogs | | |
| <i>latanaprost</i> | 2 | Quantity limit - 5ml per 30 days; |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| | | Ophthalmic dosage formulation |
| LUMIGAN | 4 | Quantity limit - 7.5ml per 30 days; Ophthalmic dosage formulation |
| OTIC AGENTS | | |
| Otic Agents | | |
| <i>acetazol hc</i> | 2 | Otic dosage formulation |
| <i>acetic acid</i> | 2 | Otic dosage formulation |
| <i>acetic acid/hydrocortisone</i> | 2 | Otic dosage formulation |
| CIPRO HC | 3 | Otic dosage formulation |
| CIPRODEX | 4 | Otic dosage formulation |
| COLY-MYCIN S | 4 | Otic dosage formulation |
| <i>cortomycin</i> | 2 | Otic dosage formulation |
| DERMOTIC | 3 | Otic dosage formulation |
| <i>neomycin/polymyxin/hc</i> | 2 | Otic dosage formulation |
| RESPIRATORY TRACT AGENTS | | |
| Antihistamines | | |
| <i>azelastine hcl</i> | 2 | Quantity limit - 30ml per 30 days |
| <i>carbinoxamine maleate</i> | 2 | |
| <i>clemastine fumarate</i> | 2 | |
| <i>fexofenadine hcl</i> | 2 | Quantity limit - 30 tablets per 30 days on 180mg; 60 tablets per 30 days on 30mg and 60mg |
| <i>hydroxyzine hcl</i> | 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; Injectable dosage formulation |
| <i>hydroxyzine hcl</i> | 2 | Injectable dosage formulation |
| Anti-inflammatories, Inhaled Corticosteroids | | |
| ASMANEX 120 METERED DOSES | 4 | Quantity limit - 2 inhalers per 30 days |
| ASMANEX 14 METERED DOSES | 4 | Quantity limit - 4 inhalers per 30 days |
| ASMANEX 30 METERED DOSES | 4 | Quantity limit - 2 inhalers per 30 days |
| ASMANEX 60 METERED DOSES | 4 | Quantity limit - 2 inhalers per 30 days |
| BECONASE AQ | 4 | Quantity limit - 2 inhalers per 30 days |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| FLOVENT HFA | 3 | Quantity limit - 2 inhalers per 30 days |
| <i>flunisolide</i> | 1 | Quantity limit - 1 inhaler per 30 days |
| <i>fluticasone propionate</i> | 1 | Quantity limit - 1 inhaler per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| NASONEX | 4 | Quantity limit - 2 inhalers per 30 days |
| PULMICORT FLEXHALER | 3 | Quantity limit - 2 inhalers per 30 days |
| QVAR | 3 | Quantity limit - 3 inhalers per 30 days |
| RHINOCORT AQUA | 3 | Quantity limit - 2 inhalers per 30 days |
| VERAMYST | 3 | Quantity limit - 20ml per 30 days |
| Antileukotrienes | | |
| SINGULAIR | 3 | Quantity limit - 30 per 30 days |
| <i>zafirlukast</i> | 2 | Quantity limit - 60 tablets per 30 days |
| ZYFLO CR | 4 | Quantity limit - 120 tablets per 30 days |
| Bronchodilators, Anticholinergic | | |
| ATROVENT HFA | 3 | Quantity limit - 2 inhalers per 30 days |
| <i>ipratropium bromide</i> | 1 | Quantity limit - 30ml per 30 days |
| SPIRIVA HANDIHALER | 3 | Quantity limit - 90 capsules per 30 days |
| Bronchodilators, Phosphodiesterase 2 Inhibitors (Xanthines) | | |
| <i>aminophylline</i> | 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; Injectable dosage formulation |
| <i>aminophylline</i> | 1 | |
| <i>theochron</i> | 2 | |
| <i>theophylline er</i> | 2 | |
| Bronchodilators, Sympathomimetic | | |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------|-----------|--|
| ADVAIR DISKUS | 3 | Quantity limit - 1 inhaler per 30 days |
| ADVAIR HFA | 3 | Quantity limit - 1 inhaler per 30 days |
| <i>albuterol sulfate</i> | 2 | |
| <i>albuterol sulfate er</i> | 2 | |
| COMBIVENT | 3 | Quantity limit - 2 inhalers per 30 days |
| DULERA | 4 | Quantity limit - 1 inhaler per 30 days |
| <i>epinephrine hcl</i> | 2 | Injectable dosage formulation |
| EPIPEN 2-PAK | 4 | Quantity limit - 1 pack per prescription; Injectable dosage formulation |
| EPIPEN-JR 2-PAK | 4 | Quantity limit - 1 pack per prescription; Injectable dosage formulation |
| FORADIL AEROLIZER | 3 | Quantity limit - 60 capsules per 30 days |
| <i>metaproterenol sulfate</i> | 2 | |
| PROAIR HFA | 3 | Quantity limit - 2 inhalers per 30 days |
| PROVENTIL HFA | 3 | Quantity limit - 2 inhalers per 30 days |
| SEREVENT DISKUS | 3 | Quantity limit - 1 inhaler per 30 days |
| SYMBICORT | 4 | Quantity limit - 1 inhaler per 30 days |
| <i>terbutaline sulfate</i> | 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; Injectable dosage formulation |
| <i>terbutaline sulfate</i> | 2 | |
| TWINJECT | 4 | Quantity limit - 2 packs per 2 days; Injectable dosage formulation |
| VENTOLIN HFA | 3 | Quantity limit - 2 inhalers per 30 days |
| <i>vospire er</i> | 2 | |
| XOPENEX HFA | 3 | Quantity limit - 2 inhalers per 30 days |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--|-----------|--|
| Mast Cell Stabilizers | | |
| <i>cromolyn sodium</i> | 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. |
| Pulmonary Antihypertensives | | |
| ADCIRCA | 5 | Quantity limit - 60 tablets per 30 days; Prior authorization required |
| REVATIO | 5 | Quantity limit - 90 tablets per 30 days; Prior authorization required |
| TRACLEER | 5 | Prior authorization required; This prescription may be available only at certain pharmacies. For more information, call 1-800-546-5677, 24 hours a day, 7 days a week. TTY/TDD users should call 1-866-706-4757. |
| Respiratory Tract Agents, Other | | |
| <i>acetylcysteine</i> | 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. |
| ARALAST NP | 5 | Prior authorization required for new starts only; Injectable dosage formulation |
| CLARINEX-D 12 HOUR | 4 | Quantity limit - 60 tablets per 30 days |
| CLARINEX-D 24 HOUR | 4 | Quantity limit - 30 tablets per 30 days |
| PROLASTIN | 5 | Injectable dosage formulation |
| PULMOZYME | 5 | Prior authorization required |
| <i>tyzine</i> | 2 | |
| <i>tyzine pediatric nasal</i> | 2 | |
| VENTAVIS | 5 | 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. |
| XOLAIR | 5 | Prior authorization required; Injectable dosage formulation |
| ZEMAIRA | 4 | Prior authorization required; Injectable dosage formulation |
| SEDATIVES/ HYPNOTICS | | |
| Sedatives/Hypnotics | | |
| ROZEREM | 4 | Quantity limit - 30 tablets per 30 days; Step therapy protocols apply |
| <i>zaleplon</i> | 2 | Quantity limit - 60 capsules per 30 days on 10mg; 30 capsules per 30 days on 5mg |
| <i>zolpidem tartrate</i> | 1 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| <i>zolpidem tartrate er</i> | 2 | Quantity limit - 30 tablets per 30 days; This prescription drug is part of the Free First Fill Program and will be provided at zero cost share when you select this medication over the brand name version of selected medications. |
| SKELETAL MUSCLE RELAXANTS | | |
| Skeletal Muscle Relaxants | | |
| <i>cyclobenzaprine hcl</i> | 2 | |
| <i>orphenadrine citrate</i> | 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; Injectable dosage formulation |
| THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES | | |
| Electrolytes/Minerals | | |
| AMINOSYN | 4 | This drug may be covered under |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|----------------------------------|-----------|--|
| | | 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; Injectable dosage formulation |
| <i>aminosyn 8.5%/electrolyte</i> | 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; Injectable dosage formulation |
| AMINOSYN II | 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; Injectable dosage formulation |
| AMINOSYN II 3.5/DEXTROSE | 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; Injectable dosage formulation |
| AMINOSYN II 4.25/DEXTROSE | 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; Injectable dosage formulation |
| AMINOSYN II 5/DEXTROSE 25 | 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 |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------------|-----------|--|
| | | determination; Injectable dosage formulation |
| <i>aminosyn ii 8.5%/electrolytes</i> | 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; Injectable dosage formulation |
| AMINOSYN II M 3.5%/DEXTROSE | 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; Injectable dosage formulation |
| AMINOSYN M | 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; Injectable dosage formulation |
| AMINOSYN-HBC | 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; Injectable dosage formulation |
| <i>aminosyn-hf</i> | 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; Injectable dosage formulation |
| AMINOSYN-PF | 4 | This drug may be covered under Medicare Part B or D depending upon the circumstances. |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-------------------------------|-----------|--|
| | | Information may need to be submitted describing the use and setting of drug to make the determination; Injectable dosage formulation |
| AMINOSYN-PF 7% | 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; Injectable dosage formulation |
| DEXTROSE 10%/NACL 0.45% | 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; Injectable dosage formulation |
| DEXTROSE 5% | 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; Injectable dosage formulation |
| <i>dextrose 10%</i> | 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; Injectable dosage formulation |
| <i>dextrose 10%/nacl 0.2%</i> | 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; Injectable dosage formulation |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------------|-----------|--|
| <i>dextrose 2.5%/sodium chloride</i> | 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; Injectable dosage formulation |
| <i>dextrose 5%</i> | 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; Injectable dosage formulation |
| <i>dextrose 5%/nacl 0.2%</i> | 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; Injectable dosage formulation |
| DEXTROSE 5%/NAACL 0.225% | 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; Injectable dosage formulation |
| <i>dextrose 5%/nacl 0.33%</i> | 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; Injectable dosage formulation |
| <i>dextrose 5%/nacl 0.45%</i> | 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 |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|----------------------------------|-----------|--|
| | | setting of drug to make the determination; Injectable dosage formulation |
| <i>dextrose 5%/nacl 0.9%</i> | 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; Injectable dosage formulation |
| DEXTROSE 5%/POTASSIUM CHLORIDE | 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; Injectable dosage formulation |
| <i>ed k+10</i> | 1 | |
| FREAMINE III | 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; Injectable dosage formulation |
| FREAMINE III 3% | 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; Injectable dosage formulation |
| <i>intralipid</i> | 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; Injectable dosage formulation |
| <i>kcl 0.075%/d5w/nacl 0.45%</i> | 2 | This drug may be covered under |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|--------------------------------|-----------|--|
| | | 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; Injectable dosage formulation |
| KCL 0.15%/D10W/NACL 0.2% | 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; Injectable dosage formulation |
| <i>kcl 0.15%/d5w/lr</i> | 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; Injectable dosage formulation |
| <i>kcl 0.15%/d5w/nacl 0.2%</i> | 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; Injectable dosage formulation |
| KCL 0.15%/D5W/NACL 0.225% | 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; Injectable dosage formulation |
| <i>kcl 0.3%/d5w/lr</i> | 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; Injectable dosage formulation |
| <i>kcl 0.3%/d5w/nacl 0.2%</i> | 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; Injectable dosage formulation |
| <i>kcl 0.3%/d5w/nacl 0.45%</i> | 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; Injectable dosage formulation |
| <i>kcl 0.3%/d5w/nacl 0.9%</i> | 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; Injectable dosage formulation |
| <i>klor-con</i> | 1 | |
| <i>lactated ringers</i> | 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; Injectable dosage formulation |
| MAGNESIUM SULFATE | 4 | 40mg/ml and 80mg/ml; 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; Injectable dosage formulation |
| <i>magnesium sulfate</i> | 2 | 50%; This drug may be covered under Medicare Part B or D |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|----------------------------------|-----------|--|
| | | depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination; Injectable dosage formulation |
| <i>potassium chloride</i> | 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; Injectable dosage formulation |
| <i>potassium chloride 0.075%</i> | 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; Injectable dosage formulation |
| <i>potassium chloride 0.15%</i> | 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; Injectable dosage formulation |
| <i>potassium chloride 0.15%</i> | 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; Injectable dosage formulation |
| <i>potassium chloride 0.15%</i> | 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; Injectable dosage |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|---|-----------|--|
| | | formulation |
| <i>potassium chloride 0.15%/</i> | 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; Injectable dosage formulation |
| <i>potassium chloride 0.22%</i> | 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; Injectable dosage formulation |
| <i>potassium chloride 0.224%</i> | 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; Injectable dosage formulation |
| POTASSIUM CHLORIDE 0.224% | 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; Injectable dosage formulation |
| <i>potassium chloride 0.3%</i> | 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; Injectable dosage formulation |
| <i>potassium chloride er</i> | 1 | |
| <i>potassium citrate extended release</i> | 2 | |
| <i>sodium bicarbonate</i> | 2 | This drug may be covered under |

| DRUG NAME | DRUG TIER | REQUIREMENTS/LIMITS |
|-----------------------------|-----------|--|
| | | 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; Injectable dosage formulation |
| <i>sodium chloride</i> | 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; Injectable dosage formulation |
| <i>tpn electrolytes ftv</i> | 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; Injectable dosage formulation |
| TRAVASOL | 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; Injectable dosage formulation |
| TROPHAMINE | 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; Injectable dosage formulation |
| Vitamins | | |
| <i>prenatabs obn</i> | 2 | |
| <i>sodium fluoride</i> | 2 | |

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Therapeutic Classes are also listed in Bold

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