



## **GEMCare Medicare Plus (HMO)**

### **Vademécum 2010 (Lista de medicamentos cubiertos)**

**LEA ATENTAMENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE MEDICAMENTOS QUE CUBRE ESTE PLAN.**

**Nota a los miembros existentes:** Este formulario ha sido modificado con respecto al del año pasado. Revíselo para asegurarse de que aún contiene los medicamentos que usted toma.

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## **¿Qué es el Vademécum del Plan de Salud GEMCare?**

Un vademécum es una lista de medicamentos cubiertos, seleccionados por el Plan de Salud GEMCare en conjunto con un equipo de proveedores de salud, que representa los tratamientos recetados considerados una parte necesaria de un programa de tratamiento de calidad. El Plan de Salud GEMCare generalmente cubrirá los medicamentos enumerados en nuestro vademécum, siempre que el medicamento sea necesario, la receta se prepare en una farmacia de la red del Plan de Salud GEMCare y se cumplan otras normas del plan. Para más información sobre cómo hacer preparar sus recetas, revise su Prueba de Cobertura.

## **¿Puede cambiar el vademécum?**

Generalmente, si usted está tomando un medicamento incluido en nuestro vademécum 2010, que estaba cubierto al comienzo del año, no discontinuaremos ni reduciremos la cobertura del medicamento durante el año 2010, excepto cuando se comercialice un nuevo medicamento genérico menos costoso o cuando surja nueva información adversa sobre la seguridad o la eficacia de una droga. Otros tipos de cambios en el vademécum, como quitar un medicamento del vademécum, no afectarán a los miembros que están tomando actualmente esa medicación. Permanecerá disponible al mismo costo para aquellos miembros que estén tomando el medicamento, durante el resto del año de cobertura. Creemos que es importante que tenga un acceso continuo durante el resto del año de cobertura a los medicamentos del vademécum que se encontraban disponibles cuando eligió nuestro plan, excepto en casos en los que puede ahorrar dinero adicional o en los que podemos garantizar su seguridad.

Si quitamos medicamentos de nuestro vademécum o agregamos autorizaciones previas, límites de cantidad o restricciones en tratamientos progresivos sobre un medicamento, o pasamos un medicamento a un nivel más costoso, debemos notificar a los miembros afectados por el cambio, con una anticipación de 60 días como mínimo, antes de que el cambio entre en vigencia, o cuando un miembro solicite el reabastecimiento del medicamento. En ese momento, el miembro recibirá un suministro para 60 días. Si la Administración de Drogas y Alimentos de los Estados Unidos (FDA) considera que uno de los medicamentos en nuestro vademécum es inseguro, o el fabricante del medicamento lo retira del mercado, eliminaremos inmediatamente dicho medicamento de nuestro vademécum y notificaremos a los miembros que lo están tomando. El vademécum adjunto tiene vigencia a partir del 10/09/2009.

Para recibir información actualizada sobre medicamentos cubiertos por el Plan de Salud GEMCare, ingrese a nuestro sitio web: [www.gemcarehealthplan.com](http://www.gemcarehealthplan.com) o llame al Departamento de Servicios para Miembros al 1-800-546-5677, las 24 horas del día, los 7 días de la semana. Los usuarios de TTY (teléfonos de texto) deben llamar al 1-866-706-4757.

## ¿Cómo utilizo el Vademécum?

Existen dos formas de encontrar su medicamento dentro del vademécum:

### Tipo de enfermedad

El vademécum comienza en la página 8. Los medicamentos en este vademécum están agrupados en categorías que dependen del tipo de enfermedad que tratan.

Por ejemplo, los medicamentos usados para tratar una afección cardíaca están enumerados debajo de la categoría AGENTES CARDIOVASCULARES. Si sabe para qué se utiliza el medicamento que está tomando, busque el nombre de la categoría en la lista que comienza en la página número 45. Luego, busque su medicamento debajo del nombre de la categoría.

### Listado alfabético

Si no está seguro de en qué categoría buscar, debe buscar su medicamento en el Índice que comienza en la página 91. El Índice le brinda una lista alfabética de todos los medicamentos incluidos en este documento. El Índice enumera tanto los medicamentos según su marca como los medicamentos genéricos. Busque en el Índice y encuentre su medicamento. Al lado de su medicamento, podrá ver el número de página donde puede encontrar información de cobertura. Vaya a la página indicada en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

## ¿Qué son los medicamentos genéricos?

El Plan de Salud GEMCare cubre medicamentos de marca y medicamentos genéricos. Un medicamento genérico aprobado por la FDA tiene el mismo principio activo que el medicamento de marca. Generalmente, los medicamentos genéricos cuestan menos que los de marca.

## ¿Mi cobertura tiene alguna restricción?

Puede solicitar una lista de medicamentos similares que estén cubiertos por el Plan de Salud GEMCare al Departamento de Servicios para Miembros. Cuando reciba la lista, muéstrelela al médico y solicítele que le recete un medicamento similar, que esté cubierto por el Plan de Salud GEMCare.

Algunos medicamentos cubiertos pueden tener límites o requisitos adicionales sobre la cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** El Plan de Salud GEMCare requiere que usted o su médico obtengan autorización previa para ciertos medicamentos. Esto significa que deberá obtener aprobación del Plan de Salud GEMCare antes de hacer preparar sus

recetas. Si no recibe la aprobación, puede suceder que el Plan de Salud GEMCare no cubra el medicamento.

- **Límites de cantidad:** Para ciertos medicamentos, el Plan de Salud GEMCare limita la cantidad cubierta del medicamento. Por ejemplo, el Plan de Salud GEMCare le otorga seis comprimidos por mes, por receta, de Zomig. Esto puede ser además del suministro estándar de un mes o de tres meses.
- **Tratamiento progresivo:** En algunos casos, el Plan de Salud GEMCare requiere que primero pruebe ciertos medicamentos para tratar su enfermedad antes de cubrir otro medicamento para dicha enfermedad. Por ejemplo, si el Medicamento A y el Medicamento B sirven para el tratamiento de su enfermedad, puede suceder que el Plan de Salud GEMCare no cubra el medicamento B a menos que usted pruebe el Medicamento A primero. Si el Medicamento A no funciona, entonces el Plan de Salud GEMCare cubrirá el medicamento B.

Puede verificar si su medicamento tiene algún límite o requisito adicional en el vademécum que comienza en la página 8.

Puede solicitar al Plan de Salud GEMCare que haga una excepción a estas restricciones o límites. Consulte la sección "¿Cómo solicito una excepción al vademécum del Plan de Salud GEMCare?" en la página 4, para obtener información sobre cómo solicitar una excepción.

### **¿Qué sucede si mi medicamento no está en el Vademécum?**

Si su medicamento no está incluido en este vademécum, primero debe contactar al Departamento de Servicios para Miembros y preguntar si su medicamento está cubierto. Si el Plan de Salud GEMCare no cubre su medicamento, usted tiene dos opciones:

- Puede solicitar una lista de medicamentos similares que estén cubiertos por el Plan de Salud GEMCare al Departamento de Servicios para Miembros. Cuando reciba la lista, muéstresela al médico y solicítele que le recete un medicamento similar, que esté cubierto por el Plan de Salud GEMCare.
- Puede solicitar al Plan de Salud GEMCare que haga una excepción y cubra su medicamento. Consulte a continuación la información sobre cómo solicitar una excepción.

### **¿Cómo solicito una excepción al Vademécum del Plan de Salud GEMCare?**

Puede solicitar al Plan de Salud GEMCare que haga una excepción a las normas de cobertura. Existen varios tipos de excepciones que puede solicitar.

- Puede solicitar que se cubra su medicamento incluso si no está en nuestro vademécum.

- Puede solicitar que no se apliquen las restricciones o límites de cobertura sobre su medicamento. Por ejemplo, para ciertos medicamentos, el Plan de Salud GEMCare limita la cantidad cubierta del medicamento. Si su medicamento posee límites de cantidad, puede solicitar que no se apliquen los límites y se otorgue una cobertura mayor.
- Puede solicitar que se otorgue un nivel mayor de cobertura para su medicamento. Si su medicamento está incluido en nuestro nivel no preferido, puede solicitar que se lo cubra al costo que se aplica a medicamentos en el nivel preferido, sujeto al proceso de excepciones al nivel de cobertura. Esto disminuirá el monto que debe pagar por su medicamento. Tenga en cuenta que si le otorgamos su solicitud para cubrir un medicamento que no está en nuestro vademécum, no podrá solicitar que se brinde un nivel mayor de cobertura para dicho medicamento. Tampoco podrá solicitar que se otorgue un nivel mayor de cobertura para medicamentos que están incluidos en el nivel de especialidad.

Generalmente, el Plan de Salud GEMCare sólo aprueba su pedido de excepción si los medicamentos alternativos incluidos en el vademécum del plan, los medicamentos de menor nivel o las restricciones de uso adicionales no serán tan eficaces en el tratamiento de su enfermedad o le provocarán efectos secundarios adversos.

Debe contactarse con nosotros para solicitar una decisión de cobertura inicial para una excepción de restricciones de uso, nivel o medicamentos en el vademécum. Cuando solicita una excepción de uso, nivel o medicamento en el vademécum, debe presentar una declaración de su médico que respalde la solicitud. Generalmente, debemos tomar la decisión dentro de las 72 horas luego de haber recibido la justificación del médico que le prescribe la receta. Puede solicitar una excepción expeditiva (rápida) si usted o su médico consideran que su salud podría estar en serio peligro si espera las 72 horas de la decisión. Si se concede su solicitud para agilizar la decisión, debemos comunicarle la decisión en un plazo no mayor a 24 horas luego de haber recibido la justificación de su médico.

### **¿Qué hago antes de poder hablar con mi médico acerca de un cambio de medicamento o antes de solicitar una excepción?**

Como miembro nuevo o continuo en nuestro plan, puede suceder que esté tomando medicamentos que no se encuentran en nuestro vademécum. O tal vez, está tomando un medicamento que está en el vademécum, pero que está limitado. Por ejemplo, puede necesitar nuestra autorización previa antes de hacer preparar su receta. Debe hablar con su médico para decidir si debe cambiar a un medicamento adecuado que esté cubierto, o solicitar una excepción al vademécum, de modo que se otorgue cobertura para el medicamento que toma. Durante el tiempo que habla con su doctor para determinar la medida adecuada para usted, podemos cubrir su medicamento en ciertos casos, durante los primeros noventa (90) días en los que es miembro del plan.

Para cada uno de sus medicamentos que no se encuentre en el vademécum, o si existen límites para obtener estos medicamentos, cubriremos un suministro temporal

de treinta (30) días (a menos que tenga una receta por menos días) cuando vaya a una farmacia de la red. Después del suministro inicial de 30 días, ya no abonaremos estos medicamentos, aunque usted haya sido miembro del plan por menos de 90 días.

Si usted es residente de una institución de cuidados a largo plazo, cubriremos un suministro de transición temporal de 31 días (a menos que tenga una receta por menos días). Cubriremos más de un reabastecimiento de estos medicamentos durante los primeros 90 días en que usted sea miembro de nuestro plan. Si usted necesita un medicamento que no se encuentra en nuestro vademécum, o si existen límites para obtenerlo, pero ya pasaron los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia de 31 días de dicho medicamento (a menos que tenga una receta por menos días), mientras solicita una excepción al vademécum.

Las excepciones pueden ser solicitadas por beneficiarios que han experimentado un cambio en el nivel de atención médica que están recibiendo, que les exige pasar de una institución o centro de tratamiento a otro. A continuación, hay ejemplos de situaciones en las cuales los beneficiarios podrían calificar para la excepción única de abastecimiento temporal, cuando se encuentran fuera de los tres meses de la fecha de vigencia en el programa de la Parte D:

- i. Por ejemplo, si un beneficiario fue dado de alta del hospital y se le otorgó una lista de medicamentos según el vademécum del hospital para seguir tomando luego del alta.
- ii. Beneficiarios que terminan su estadía cubierta por la Parte A de Medicare en una institución de enfermería especializada (donde los pagos incluyen todos los cargos de farmacia) y que necesitan regresar a su vademécum del plan de la Parte D.
- iii. Beneficiarios que renuncian al estado de cuidados paliativos para regresar a los beneficios estándar de Medicare Parte A y B.
- iv. Beneficiarios que son dados de alta de hospitales psiquiátricos crónicos con regímenes de medicación que son altamente individualizados.

Todas estas situaciones garantizarían una excepción única de abastecimiento temporal, independientemente de si el beneficiario está en los primeros noventa (90) días de inscripción del programa.

### **Para más información**

Para obtener información más detallada sobre la cobertura de medicamentos recetados del Plan de Salud GEMCare, revise su Prueba de Cobertura y otros materiales del plan.

Si tiene preguntas sobre el Plan de Salud GEMCare, llame al Servicio de Atención al Cliente al 1877-697-2464, de 8 a. m. a 8 p. m. PST, los 7 días de la semana. Los usuarios de teléfonos de texto (TTY/TDD) deben llamar al 1-888-833-9312 ó ingresar a [www.gemcarehealthplan.com](http://www.gemcarehealthplan.com).

Si tiene preguntas generales sobre la cobertura de medicamentos recetados de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de teléfonos de texto (TTY/TDD) deben llamar al 1-877-486-2048 ó ingresar a [www.medicare.gov](http://www.medicare.gov).

## Vademécum del Plan de Salud GEMCare

El siguiente vademécum le brinda información de cobertura sobre algunos de los medicamentos cubiertos por el Plan de Salud GEMCare. Si no encuentra su medicamento en la lista, consulte el Índice que comienza en la página 91.

La primera columna de la tabla indica el nombre del medicamento. Los nombres de medicamentos de marca están todos en mayúsculas (por ej. L1PITOR) y los medicamentos genéricos están enumerados en itálica minúscula (por ej. *lisinopril*).

La información en la columna de Requisitos/Límites le indica si el Plan de Salud GEMCare posee algún requisito especial para la cobertura de su medicamento.

Nivel	Nombre
1	Genérico preferida
2	Genérico
3	Marca preferida
4	Marca
5	Inyectable
6	De especialidad

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<b>ANALGESICS</b>		
<b>Opioid Analgesics</b>		
acetaminophen/codeine	1	Quantity Limitation - 400 tablets per 30 days
acetaminophen/codeine	2	Oral solution
acetaminophen/codeine #3	1	Quantity Limitation - 400 tablets per 30 days
acetaminophen/codeine #4	1	Quantity Limitation - 400 tablets per 30 days
ascomp/codeine	2	
AVINZA	4	Step Therapy Protocols Apply; Quantity Limitation - 30 capsules per 30 days
BALACET 325	2	
buprenorphine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
butalbital/apap/caffeine/codeine	2	

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nabumetone	2	
naproxen	1	
naproxen dr	1	
naproxen sodium	1	
oxaprozin	2	
piroxicam	2	
sulindac	2	
tolmetin sodium	2	
<b>ANESTHETICS</b>		
<b>Local Anesthetics</b>		
lidocaine hcl	2	Topical Dosage Formulation
lidocaine hcl jelly	1	Topical Dosage Formulation
lidocaine/prilocaine	2	Quantity Limitation - 30 grams per prescription; Topical Dosage Formulation
<b>ANTIBACTERIALS</b>		
<b>Aminoglycosides</b>		
ak-tob	1	
genoptic	2	
gentak	2	
gentamicin sulfate	2	
gentamicin sulfate	2	Topical Dosage Formulation
gentamicin sulfate	5	Injectable dosage Formulation
gentamicin sulfate/0.9% sodium chloride	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
gentamicin sulfate/sodiumchloride	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
gentasol	2	
isotonic gentamicin	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
colistimethate sodium	2	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
CUBICIN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
erythromycin/sulfisoxazole	2	
FURADANTIN	4	
HIPREX	4	
methenamine hippurate	2	
METROGEL	4	Prior Authorization Required; Topical Dosage Formulation
metronidazole	2	
metronidazole	2	Topical Dosage Formulation
metronidazole vaginal	2	Vaginal Dosage Formulation
MONUROL	4	
mupirocin	2	Topical Dosage Formulation
neomycin/polymyxin/gramicidin	2	
nitrofurantoin macrocrystalline	1	
nitrofurantoin monohydrate	1	
NORITATE	4	Topical Dosage Formulation
polycin b	2	
SYNERCID	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
trimethoprim	2	
trimethoprim sulfate/polymyxin b sulfate	2	
TYGACIL	5	Prior Authorization Required; Injectable dosage Formulation
UREX	4	
VANCOCIN HCL	6	Prior Authorization Required

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

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

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

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

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

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<b>Antidepressants, Other</b>		
amoxapine	2	
budeprion sr	2	
budeprion xl	2	Quantity Limitation - 30 tablets per 30 days
bupropion hcl	2	
bupropion hcl sr	2	
chlordiazepoxide/amitriptyline	2	
maprotiline hcl	2	
mirtazapine	2	Quantity Limitation - 30 tablets per 30 days
mirtazapine odt	2	Quantity Limitation - 30 tablets per 30 days
nefazodone hcl	2	
perphenazine/amitriptyline	2	
trazodone hcl	1	
<b>Monoamine Oxidase Inhibitors</b>		
EMSAM	4	Prior Authorization Required for new starts; Quantity Limitation - 30 patches per 30 days; Transdermal Dosage Formulation
MARPLAN	4	
NARDIL	3	
tranylcypromine sulfate	2	
<b>Serotonin/ Norepinephrine Reuptake Inhibitors</b>		
citalopram hydrobromide	2	This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication over the brand name version of selected medications.
CYMBALTA	3	Quantity Limitation - 60 capsules per 30 days on 20mg; 30 capsules per 30 days on 30mg and 60mg
EFFEXOR XR	4	Quantity Limitation - 180 capsules per 30 days on 37.5mg; 90 capsules per 30 days on 75mg; 60 capsules per 30 days on 150mg
fluoxetine hcl	1	
fluvoxamine maleate	2	Quantity Limitation - 45 tablets per 30 days on 25mg; 60 tablets per 30 days on 50mg; 90 tablets per 30 days on 100mg
LEXAPRO	4	Quantity Limitation - 30 tablets per

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Formulation
MESNEX	6	
naloxone hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
naltrexone hcl	2	
<b>ANTIEMETICS</b>		
<b>Antiemetics</b>		
ALOXI	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 5 per prescription.
ANZEMET	4	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 10 per prescription.
ANZEMET	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
chlorpromazine hcl	2	
chlorpromazine hcl	5	Injectable dosage Formulation
diphenhydramine hcl	2	
diphenhydramine hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
dronabinol	2	
EMEND	4	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit - 5 capsules per prescription.
granisetron hcl	2	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 10 tablets per prescription.
granisol	2	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
hydroxyzine pamoate	2	
meclizine hcl	1	
metoclopramide hcl	1	
metoclopramide hcl	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ondansetron hcl	2	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. Limit 10 tablets or 50ml per prescription.
ondansetron hcl	5	Injectable Formulation - This drug may be covered under Medicare

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AMERGE	4	Quantity Limitation - 9 tablets per 30 days
AXERT	4	Quantity Limitation - 12 tablets per 30 days
dihydroergotamine mesylate	5	
ERGOMAR	4	Quantity Limitation - 20 tablet per 28 days
FROVA	4	Quantity Limitation - 12 tablets per 30 days
MAXALT	4	Quantity Limitation - 12 tablets per 30 days
MAXALT-MLT	4	Quantity Limitation - 12 tablets per 30 days
migergot	2	
MIGRANAL	4	Quantity Limitation - 16 ml per 30 days
RELPAK	4	Quantity Limitation - 6 tablets per 30 days
sumatriptan succinate	2	
TREXIMET	3	
ZOMIG	3	Quantity Limitation - 6 tablets per 30 days; 6ml nasal spray per 30 days
ZOMIG ZMT	3	Quantity Limitation - 6 tablets per 30 days
<b>Prophylactic</b>		
divalproex sodium	2	
timolol maleate	1	
<b>ANTIMYASTHENIC AGENTS</b>		
<b>Parasympathomimetics</b>		
GUANIDINE HCL	3	
MESTINON	4	
MESTINON TIMESPAN	4	
MYTELASE	4	
pyridostigmine bromide	2	
<b>ANTIMYCOBACTERIALS</b>		
<b>Antimycobacterials, Other</b>		
DAPSONE	3	
MYCOBUTIN	4	
<b>Antituberculars</b>		
CAPASTAT SULFATE	5	Injectable Formulation - This drug may be covered under Medicare

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ethambutol hcl	2	
isonarif	2	
isoniazid	2	
PASER	4	
PRIFTIN	4	
pyrazinamide	2	
RIFAMATE	4	
rifampin	2	
rifampin	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
RIFATER	4	
SEROMYCIN	4	
TRECTOR	4	
<b>ANTINEOPLASTICS</b>		
<b>Alkylating Agents</b>		
CEENU	4	Prior Authorization Required for new starts
EMCYT	4	Prior Authorization Required for new starts
HEXALEN	6	Prior Authorization Required for new starts
LEUKERAN	3	Prior Authorization Required for new starts
MATULANE	4	
ZANOSAR	5	Prior Authorization Required for new starts; Injectable dosage Formulation
<b>Antiangiogenic Agents</b>		
REVLIMID	6	Prior Authorization Required for new starts; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		day, seven days a week. TTY/TDD users should call 1-866-706-4757.
THALOMID	6	Prior Authorization Required for new starts
<b>Antiestrogens/Modifiers</b>		
FARESTON	4	
tamoxifen citrate	2	
<b>Antimetabolites</b>		
DROXIA	4	
hydroxyurea	2	
mercaptopurine	2	
TABLOID	4	Prior Authorization Required for new starts
<b>Antineoplastics, Other</b>		
AFINITOR	6	Quantity Limitation - 60 tablets per 30 days
ARRANON	6	Prior Authorization Required for new starts; Injectable dosage Formulation
bleomycin sulfate	5	Prior Authorization Required for new starts; Injectable dosage Formulation
cyclophosphamide	2	Prior Authorization Required for new starts
ELITEK	6	Prior Authorization Required for new starts; Injectable dosage Formulation
mitoxantrone hcl	6	Prior Authorization Required for new starts; Injectable dosage Formulation
ONTAK	6	Prior Authorization Required for new starts; Injectable dosage Formulation
oxaliplatin	2	
PROLEUKIN	6	Prior Authorization Required for new starts; Injectable dosage Formulation
TRISENOX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amantadine hcl	2	
APOKYN	6	Prior Authorization Required; Injectable dosage Formulation
atamet	2	
AZILECT	4	
benztropine mesylate	1	
bromocriptine mesylate	2	
carbidopa/levodopa	2	
carbidopa/levodopa cr	2	
carbidopa/levodopa odt	2	
carbidopa/levodopa sr	2	
COMTAN	3	Quantity Limitation - 240 tablets per 30 days
LODOSYN	4	
MIRAPEX	3	Quantity Limitation - 90 tablets per 30 days
REQUIP XL	4	
ropinirole hcl	2	
selegiline hcl	2	
STALEVO	4	
TASMAR	4	Quantity Limitation - 90 tablets per 30 days
trihexyphenidyl hcl	1	
<b>ANTIPSYCHOTICS</b>		
<b>Atypicals</b>		
ABILIFY	4	Quantity Limitation - 30 tablets per 30 days; 900ml per 30 days on solution
ABILIFY	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
ABILIFY DISCMELT	4	Quantity Limitation - 60 tablets per 30 days
clozapine	2	Quantity Limitation - 120 tablets per 30 days
FAZACLO	4	Quantity Limitation - 270 tablets per 30 days
GEODON	3	Quantity Limitation - 60 capsules per 30 days

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		30 days
<b>Conventional</b>		
compro	2	
fluphenazine decanoate	5	
fluphenazine hcl	2	
fluphenazine hcl	5	Injectable dosage Formulation
haloperidol	1	
haloperidol decanoate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
haloperidol lactate	5	
loxapine succinate	2	
MOBAN	4	
NAVANE	4	
ORAP	4	
prochlorperazine	2	
thioridazine hcl	2	
thiothixene	1	
thiothixene	2	5mg capsule
trifluoperazine hcl	2	
<b>ANTISPASTICITY AGENTS</b>		
<b>Antispasticity Agents</b>		
baclofen	2	
dantrolene sodium	2	
tizanidine hcl	2	
<b>ANTIVIRALS</b>		
<b>Anti-cytomegalovirus (CMV) Agents</b>		
CYTOVENE	5	
foscarnet sodium	4	
FOSCAVIR	6	
ganciclovir	2	
VALCYTE	6	
VISTIDE	6	
<b>Antihepatitis Agents</b>		
BARACLUDE	4	Oral solution; Prior Authorization Required; Quantity Limitation - 600ml per 30 days on solution
BARACLUDE	6	Prior Authorization Required;

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

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

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		the use and setting of drug to make the determination.
heparin sodium/d5w	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
heparin sodium/nacl 0.9%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
INNOHEP	5	Prior Authorization Required; Injectable dosage Formulation
jantoven	1	
LOVENOX	4	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation - 28 syringes per 30 days
warfarin sodium	1	
<b>Blood Formation Products</b>		
ARANESP ALBUMIN FREE	4	40mcg; Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation
ARANESP ALBUMIN FREE	5	25mcg; Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation
ARANESP ALBUMIN FREE	6	Prior Authorization Required; Injectable dosage Formulation; Quantity Limitation
EPOGEN	5	2000, 3000, 4000 unit strengths only; Quantity Limitation - 12 per 28 days; Prior Authorization Required; Injectable dosage Formulation
EPOGEN	6	10000, 20000, 40000 unit strengths; Prior Authorization Required; Injectable dosage Formulation
LEUKINE	3	Prior Authorization Required; Injectable dosage Formulation

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
metoprolol succinate er	2	Quantity Limitation - 30 tablets per 30 days; 60 tablets per 30 days on 200mg
metoprolol tartrate	1	
metoprolol tartrate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
metoprolol/hydrochlorothiazide	1	
nadolol	1	
nadolol/bendroflumethiazide	2	
pindolol	1	
propranolol/hydrochlorothiazide	1	
<b>Calcium Channel Blocking Agents</b>		
afeditab cr	2	
amlodipine besylate	1	Quantity Limitation - 30 tablets per 30 days
amlodipine besylate/benazepril hydrochloride	2	Quantity Limitation - 30 capsules per 30 days
felodipine er	2	
isradipine	2	
nicardipine hcl	2	
nifediac cc	2	
nifedical xl	2	
nifedipine	2	
nifedipine er	2	
nimodipine	2	
nisoldipine	2	
<b>Cardiovascular Agents, Others</b>		
digoxin	1	
LANOXIN	3	
LANOXIN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
RANEXA	3	Quantity Limitation - 120 tablets per 30 days
<b>Diuretics</b>		

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

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ADDERALL XR	4	Quantity Limitation - 30 capsules per 30 days on 5mg, 10mg, and 15mg; 60 capsules per 30 days on 20mg and 30mg
amphetamine salt combo	2	Quantity Limitation - 90 tablets per 30 days
dextroamphetamine sulfate	2	Quantity Limitation - 180 tablets per 30 days
dextroamphetamine sulfate er	2	Quantity Limitation - 120 capsules per 30 days
<b>Non-amphetamines, ADHD</b>		
CONCERTA	4	Quantity Limitation - 30 tablets per 30 days on 18mg, 27mg, and 54mg; 60 tablets per 30 days on 36mg
dexmethylphenidate hcl	2	Quantity Limitation - 90 tablets per 30 days
METADATE CD	4	Quantity Limitation - 180 capsules per 30 days
metadate er	2	Quantity Limitation - 90 capsules per 30 days
methylin	2	Quantity Limitation - 90 tablets per 30 days
methylin er	2	Quantity Limitation - 90 tablets per 30 days
methylphenidate hcl	2	Quantity Limitation - 90 tablets per 30 days
methylphenidate hcl er	2	Quantity Limitation - 90 tablets per 30 days
RITALIN LA	4	Quantity Limitation - 60 capsules per 30 days
STRATTERA	3	Quantity Limitation - 60 capsules per 30 days
<b>Non-amphetamines, Other</b>		
PROVIGIL	3	Quantity Limitation - 60 tablets per 30 days
RILUTEK	4	Prior Authorization Required
XYREM	4	Prior Authorization Required; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<b>DENTAL AND ORAL AGENTS</b>		
<b>Dental and Oral Agents</b>		
APHTHASOL	4	
chlorhexidine gluconateoral rinse	2	
periogard	2	
pilocarpine hcl	2	
pilocarpine hydrochloride	2	
triamcinolone in orabase	2	
<b>DERMATOLOGICAL AGENTS</b>		
<b>Dermatological Agents</b>		
8-MOP	3	Prior Authorization Required
ALDARA	4	Prior Authorization Required for new starts; Topical Dosage Formulation
ammonium lactate	2	Topical Dosage Formulation
avita	2	Topical Dosage Formulation
calcipotriene	2	
clotrimazole/betamethasone dipropionate	2	Topical Dosage Formulation
colocort	2	
CORTIFOAM	4	
DIFFERIN	4	Topical Dosage Formulation; Prior Authorization Required
DOVONEX	4	Topical Dosage Formulation
ELIDEL	3	Prior Authorization Required; Quantity Limitation - 30 grams per prescription; Topical Dosage Formulation
erythromycin/benzoyl peroxide	2	
fluorouracil	2	
fluorouracil	2	Topical Dosage Formulation
hydrocortisone	2	
laclotion	2	Topical Dosage Formulation
lidocaine	2	Topical Dosage Formulation
LIDODERM	4	Quantity Limitation - 90 patches per 30 days; Transdermal Dosage Formulation
ORACEA	4	
OXSORALEN ULTRA	4	Prior Authorization Required for new starts
podofilox	2	Topical Dosage Formulation

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LIPRAM-PN	4	
LIPRAM-UL	4	
MYOZYME	6	Prior Authorization Required; Injectable dosage Formulation
NAGLAZYME	6	Prior Authorization Required; Injectable dosage Formulation
ORFADIN	6	Prior Authorization Required
PANCREASE MT	3	
PANCRECARB MS	4	
PANCRELIPASE	3	
PANCRELIPASE MST	3	
PANCRON	4	
SUCRAID	4	
ULTRASE	4	
ULTRASE MT	4	
VIOKASE	3	
ZAVESCA	4	
<b>GASTROINTESTINAL AGENTS</b>		
<b>Antispasmodics, Gastrointestinal</b>		
atropine sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
CANTIL	4	
dicyclomine hcl	1	
dicyclomine hcl	2	Oral solution
glycopyrrolate	2	
methscopolamine bromide	2	
propantheline bromide	2	
<b>Gastrointestinal Agents, Other</b>		
colyte	2	
constulose	2	
diphenoxylate/atropine	2	
enulose	2	
GASTROCROM	4	
generlac	2	
HELIDAC	4	
lactulose	2	
lonox	2	
loperamide hcl	2	

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

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

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

<b>DRUG NAME</b>	<b>DRUG TIER</b>	<b>REQUIREMENTS/LIMITS</b>
CAPEX	4	Topical Dosage Formulation
clobetasol propionate	2	Topical Dosage Formulation
clobetasol propionate e	2	Topical Dosage Formulation
cormax	2	Topical Dosage Formulation
del-beta	2	Topical Dosage Formulation
DERMA-SMOOTH/FS BODY OIL	4	Topical Dosage Formulation
desonide	2	Topical Dosage Formulation
desoximetasone	2	Topical Dosage Formulation
diflorasone diacetate	2	Topical Dosage Formulation
fludrocortisone acetate	2	
fluocinolone acetonide	2	Topical Dosage Formulation
fluocinonide	2	Topical Dosage Formulation
fluocinonide emollient base	2	Topical Dosage Formulation
fluticasone propionate	2	Topical Dosage Formulation
halobetasol propionate	2	Topical Dosage Formulation
HALOG	4	Topical Dosage Formulation
hydrocortisone	1	Topical Dosage Formulation
hydrocortisone butyrate	1	Topical Dosage Formulation
hydrocortisone butyrate	2	Enema
hydrocortisone in absorbbase	1	Topical Dosage Formulation
hydrocortisone valerate	2	Topical Dosage Formulation
isovate	2	Topical Dosage Formulation
lokara	2	Topical Dosage Formulation
mometasone furoate	2	Topical Dosage Formulation
OLUX-E	4	Topical Dosage Formulation
prednicarbate	2	Topical Dosage Formulation
procto-pak	2	Topical Dosage Formulation
triamcinolone acetonide	1	Topical Dosage Formulation
triamcinolone acetonide in absorbbase	1	Topical Dosage Formulation
triderm	2	Topical Dosage Formulation
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</b>		
desmopressin acetate	2	
desmopressin acetate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		make the determination.
GENOTROPIN	6	Prior Authorization Required; Injectable dosage Formulation
GENOTROPIN MINIQUICK	5	Prior Authorization Required; Injectable dosage Formulation
HUMATROPE	6	Prior Authorization Required; Injectable dosage Formulation
HUMATROPE COMBO PACK	6	Prior Authorization Required; Injectable dosage Formulation
INCRELEX	5	Prior Authorization Required; Injectable dosage Formulation
NORDITROPIN NORDIFLEX PEN	6	Prior Authorization Required; Injectable dosage Formulation
NUTROPIN	6	Prior Authorization Required; Injectable dosage Formulation
NUTROPIN AQ	6	Prior Authorization Required; Injectable dosage Formulation
SAIZEN	6	Prior Authorization Required; Injectable dosage Formulation
SAIZEN CLICK.EASY	6	Prior Authorization Required; Injectable dosage Formulation
SEROSTIM	6	Prior Authorization Required; Injectable dosage Formulation
STIMATE	4	
ZORBTIVE	6	Prior Authorization Required; Injectable dosage Formulation
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)</b>		
<b>Anabolic Steroids</b>		
ANADROL-50	4	
oxandrolone	2	
<b>Androgens</b>		
ANDRODERM	4	Transdermal Dosage Formulation; Quantity Limitation 30 patches per 30 days
ANDROGEL	4	Quantity Limitation - 300 grams per 30 days; Topical Dosage Formulation
ANDROID	4	
androxy	2	
danazol	2	
STRIANT	4	Prior Authorization Required

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		new starts
megestrol acetate	2	Prior Authorization Required for new starts
nora-be	2	
norethindrone acetate	2	
PLAN B	4	
PROCHIEVE	4	Vaginal Dosage Formulation
PROMETRIUM	4	
<b>Selective Estrogen Receptor Modifying Agents</b>		
EVISTA	3	Quantity Limitation - 30 tablets per 30 days
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)</b>		
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</b>		
CYTOMEL	4	
levothroid	1	
levothyroxine sodium	1	
SYNTHROID	3	
THYROLAR	3	
unithroid	2	
<b>HORMONAL AGENTS, SUPPRESSANT (ADRENAL)</b>		
<b>Hormonal Agents, Suppressant (Adrenal)</b>		
LYSODREN	3	
<b>HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)</b>		
<b>Hormonal Agents, Suppressant (Parathyroid)</b>		
SENSIPAR	3	
<b>HORMONAL AGENTS, SUPPRESSANT (PITUITARY)</b>		
<b>Hormonal Agents, Suppressant (Pituitary)</b>		
cabergoline	2	
leuprolide acetate	5	Prior Authorization Required for new starts; Injectable dosage Formulation
octreotide acetate	4	50mcg/ml; Prior Authorization Required; Injectable dosage Formulation
octreotide acetate	6	Prior Authorization Required; Injectable dosage Formulation
SANDOSTATIN LAR DEPOT	6	Prior Authorization Required;

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

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

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

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

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

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

## INFLAMMATORY BOWEL DISEASE AGENTS

### Glucocorticoids

ENTOCORT EC	3	
prednisone	1	

### Salicylates

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

### Sulfonamides

sulfasalazine	2	
sulfazine	2	
sulfazine ec	2	

## METABOLIC BONE DISEASE AGENTS

### Metabolic Bone Disease Agents

ACTONEL	4	Quantity Limitation - 30 per 30 days on 5mg; 5 per 30 days on 35mg and 30mg; 2 per 28 days on 75mg; Step Therapy Protocols Apply
ACTONEL WITH CALCIUM	4	Quantity Limitation - 28 tablets per 30 days
alendronate sodium	1	Quantity Limitation - 240 per 30 days on 5mg; 120 per 30 days on 10mg; 30 per 30 days on 40mg; 5 per 30 days on 35mg and 70mg; This prescription drug is part of the Free First Fill Program and will be provided at a zero cost share when you select this medication

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

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

## OPHTHALMIC AGENTS

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<b>Ophthalmic Antiglaucoma Agents</b>		
acetazolamide	1	
acetazolamide	2	500mg capsule
ALPHAGAN P	4	
AZOPT	3	
betaxolol hcl	2	
BETIMOL	4	
BETOPTIC-S	4	
brimonidine tartrate	2	
carteolol hcl	2	
dipivefrin hcl	1	
dorzolamide hcl	2	
dorzolamide hcl/timolol maleate	2	
IOPIDINE	4	
levobunolol hcl	2	
metipranolol	2	
mydral	2	
PHOSPHOLINE IODIDE	4	
PILOPINE HS	4	
timolol maleate	1	
tropicacyl	2	
tropicamide	2	
<b>Ophthalmic Anti-inflammatories</b>		
ACULAR	4	
ACULAR LS	4	
ALREX	4	
dexamethasone sodium phosphate	2	
diclofenac sodium	2	
FLAREX	4	
fluorometholone	2	
fluor-op	2	
flurbiprofen sodium	2	
FML	4	
FML FORTE	4	
LOTEMAX	4	
MAXIDEX	4	
NEVANAC	4	
PRED MILD	4	
prednisolone acetate	2	
prednisolone sodium phosphate	2	
VEXOL	4	
<b>Ophthalmic Prostaglandins and Prostamide Analogs</b>		
LUMIGAN	4	Quantity Limitation - 7.5ml per 30

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

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

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

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

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

<b>DRUG NAME</b>	<b>DRUG TIER</b>	<b>REQUIREMENTS/LIMITS</b>
methocarbamol	2	
MYOBLOC	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
orphenadrine citrate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
orphenadrine citrate er	2	
orphenadrine compound ds	2	
orphenadrine/asa/caffeine	2	
<b>THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES</b>		
<b>Electrolytes/Minerals</b>		
AMINOSYN	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN 7%/ELECTROLYTES	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
aminosyn 8.5%/electrolytes	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II	5	Injectable Formulation - This drug

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 3.5/DEXTROSE25%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 4.25/DEXTROSE10%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 4.25/DEXTROSE20%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 4.25/DEXTROSE25%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
AMINOSYN II 5/DEXTROSE 25	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
aminosyn ii 8.5%/electrolytes	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may

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

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
kcl 0.15%/d5w/nacl 0.225%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.224%/d5w/nacl 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
KCL 0.3%/D5W/LR IV LAC RING	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.3%/d5w/nacl 0.2%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
kcl 0.3%/d5w/nacl 0.45%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
KCL 0.3%/D5W/NACL 0.9%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
klor-con	1	
lactated ringers viaflex	5	Injectable Formulation - This drug may be covered under Medicare

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
magnesium sulfate	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.075%/d5w/nacl 0.225%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.15%/d5w	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
POTASSIUM CHLORIDE 0.15%/NACL 0.45% VIAFLEX	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
potassium chloride 0.15%d5w/nacl 0.33%	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
		circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
TROPHAMINE	5	Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.
<b>Vitamins</b>		
PRENATABS OBN	2	
sodium fluoride	2	

## Index of Drugs

### Therapeutic Classes and Categories

Therapeutic Categories are listed in Bold

Therapeutic Classes are also listed in Bold

8-MOP .....	54	AGGRENEX .....	45
ABELCET .....	28	ak-con .....	72
ABILIFY .....	36	ak-poly-bac.....	13
ABILIFY DISCMELT .....	36	ak-tob .....	12
<b>Abortive</b> .....	30	ala-cort .....	59
acarbose .....	40	ALAMAST .....	72
ACCOLATE.....	75	albuterol sulfate.....	76
acebutolol hcl .....	46	albuterol sulfate er.....	76
ACETADOTE .....	25	alclometasone dipropionate .....	59
acetaminophen/codeine .....	8	ALCOHOL PREPS.....	41
acetaminophen/codeine #3 .....	8	ALDARA.....	54
acetaminophen/codeine #4 .....	8	ALDURAZYME.....	55
acetasol hc.....	74	alendronate sodium.....	70
acetazolamide .....	73	ALFERON N.....	67
acetic acid .....	74	ALINIA.....	35
acetic acid/aluminum acetate.....	74	<b>Alkylating Agents</b> .....	32
acetic acid/hydrocortisone.....	74	ALLEGRA-D.....	77
ACIPHEX .....	57	allopurinol.....	30
ACTHIB .....	68	ALOCRIl.....	72
acticin .....	35	ALOMIDE .....	72
ACTIMMUNE .....	67	ALORA .....	62
ACTIVELLA.....	62	ALOXI.....	26
ACTONEL .....	70	<b>Alpha-adrenergic Agonists</b> .....	45
ACTONEL WITH CALCIUM .....	70	<b>Alpha-adrenergic Blocking Agents</b> .....	46
ACTOPLUS MET .....	40	ALPHAGAN P .....	73
ACTOS.....	40	ALREX .....	73
ACULAR.....	73	amantadine hcl.....	36
ACULAR LS .....	73	AMBIEN CR .....	78
acyclovir .....	39	amcinonide.....	59
ADACEL.....	68	AMERGE.....	31
ADAGEN .....	55	a-methapred.....	30
ADCIRCA .....	77	amiloride hcl .....	49
ADDERALL XR .....	53	amiloride/hydrochlorothiazide.....	49
ADVAIR DISKUS .....	76	<b>Aminoglycosides</b> .....	12
ADVAIR HFA.....	76	aminophylline .....	76
ADVICOR.....	49	AMINOSYN .....	79, 80, 81
AEROBID-M.....	75	AMINOSYN 7%/ELECTROLYTES.....	79
afeditab cr .....	48	aminosyn 8.5%/electrolytes.....	79
AFINITOR .....	33	AMINOSYN II .....	79, 80, 81

AMINOSYN II 3.5/DEXTROSE25% ...	80
AMINOSYN II 4.25/DEXTROSE10% .	80
AMINOSYN II 4.25/DEXTROSE20% .	80
AMINOSYN II 4.25/DEXTROSE25% .	80
AMINOSYN II 5/DEXTROSE 25 .....	80
aminosyn ii 8.5%/electrolytes .....	80
AMINOSYN II M 3.5%/DEXTROSE 5%	
.....	81
AMINOSYN M .....	81
AMINOSYN-HBC .....	81
aminosyn-hf.....	81
AMINOSYN-PF .....	81
AMINOSYN-PF 7% .....	81
amiodarone hcl.....	46
amitriptyline hcl .....	24
amlodipine besylate.....	48
amlodipine besylate/benazepril	
hydrochloride .....	48
ammonium lactate .....	54
amoxapine.....	23
amoxicillin.....	16
amoxicillin/clavulanate potassium .....	16
amoxicillin/potassium clavulanate .....	16
amoxil.....	16
amphetamine salt combo .....	53
<b>Amphetamines, ADHD</b> .....	52
amphotericin b.....	28
ampicillin .....	16
ampicillin sodium.....	16
ampicillin-sulbactam.....	16
<b>Anabolic Steroids</b> .....	61
ANADROL-50.....	61
anagrelide hydrochloride.....	45
<b>ANALGESICS</b> .....	8
ANCOBON .....	28
ANDRODERM.....	61
ANDROGEL .....	61
<b>Androgens</b> .....	61
ANDROID.....	61
androxy .....	61
<b>ANESTHETICS</b> .....	12
<b>Anthelmintics</b> .....	35
<b>Antiandrogens</b> .....	65
<b>Antiangiogenic Agents</b> .....	32
<b>Antiarrhythmics</b> .....	46
<b>ANTIBACTERIALS</b> .....	12

<b>Antibacterials, Other</b> .....	13
<b>Anticoagulants</b> .....	43
<b>ANTICONVULSANTS</b> .....	20
<b>Anticonvulsants, Other</b> .....	20
<b>Anti-cytomegalovirus (CMV) Agents</b>	
.....	38
<b>ANTIDEMENTIA AGENTS</b> .....	22
<b>Antidementia Agents, Other</b> .....	22
<b>ANTIDEPRESSANTS</b> .....	22
<b>Antidepressants, Other</b> .....	23
<b>Antidiabetic Agents</b> .....	40
<b>Antidotes</b> .....	25
<b>ANTIDOTES, DETERRENTS, AND</b>	
<b>TOXICOLOGIC AGENTS</b> .....	25
<b>Antiemetics</b> .....	26
<b>ANTIEMETICS</b> .....	26
<b>Antiestrogens/Modifiers</b> .....	33
<b>Antifungals</b> .....	28
<b>ANTIFUNGALS</b> .....	28
<b>Antigout Agents</b> .....	30
<b>ANTIGOUT AGENTS</b> .....	29
<b>Antihepatitis Agents</b> .....	38
<b>Antiherpetic Agents</b> .....	39
<b>Antihistamines</b> .....	74
<b>Anti-HIV Agents, Non-nucleoside</b>	
<b>Reverse Transcriptase Inhibitors</b>	39
<b>Anti-HIV Agents, Nucleoside and</b>	
<b>Nucleotide Reverse Transcriptase</b>	
<b>Inhibitors</b> .....	39
<b>Anti-HIV Agents, Other</b> .....	40
<b>Anti-HIV Agents, Protease Inhibitors</b>	
.....	40
<b>Anti-inflammatories, Inhaled</b>	
<b>Corticosteroids</b> .....	74
<b>ANTI-INFLAMMATORY AGENTS</b> .....	30
<b>Anti-influenza Agents</b> .....	40
<b>Antileukotrienes</b> .....	75
<b>Antimetabolites</b> .....	33
<b>ANTIMIGRAINE AGENTS</b> .....	30
<b>ANTIMYASTHENIC AGENTS</b> .....	31
<b>ANTIMYCOBACTERIALS</b> .....	31
<b>Antimycobacterials, Other</b> .....	31
<b>ANTINEOPLASTICS</b> .....	32
<b>Antineoplastics, Other</b> .....	33
<b>ANTIPARASITICS</b> .....	35
<b>Antiparkinson Agents</b> .....	35

<b>ANTIPARKINSON AGENTS</b> .....	35	ATTENUVAX.....	69
Antiprotozoals .....	35	<b>Atypicals</b> .....	36
<b>ANTIPSYCHOTICS</b> .....	36	augmented betamethasone dipropionate	59
Antispasmodics, Gastrointestinal ..	56	.....	59
Antispasmodics, Urinary .....	58	AVALIDE .....	50
Antispasticity Agents.....	38	AVANDAMET .....	40
<b>ANTISPASTICITY AGENTS</b> .....	38	AVANDARYL .....	40
Antithyroid Agents.....	65	AVANDIA .....	40
Antituberculars.....	31	AVAPRO .....	50
<b>ANTIVIRALS</b> .....	38	AVASTIN.....	34
ANTIZOL .....	25	AVELOX.....	18
<b>ANXIOLYTICS</b> .....	40	AVELOX ABC PACK.....	18
Anxiolytics, Other.....	40	aviane.....	62
ANZEMET .....	26	AVINZA .....	8
APHTHASOL .....	54	avita.....	54
APIDRA.....	41	AVODART .....	59
APOKYN .....	36	AVONEX .....	67
apri.....	62	AXERT .....	31
APTIVUS.....	40	AZACTAM .....	16
ARALAST .....	77	AZACTAM IN DEXTROSE .....	16
aranelle .....	62	AZASAN.....	65
ARANESP ALBUMIN FREE.....	44	azathioprine.....	65
ARICEPT.....	22	AZILECT .....	36
ARICEPT ODT .....	22	azithromycin .....	18
ARIMIDEX.....	34	AZMACORT .....	75
ARIXTRA.....	43	AZOPT .....	73
AROMASIN .....	34	bac/poly/neomy/hc .....	72
<b>Aromatase Inhibitors, 3rd Generation</b>		baciim.....	13
.....	34	bacitracin.....	13
ARRANON .....	33	bacitracin/neomycin/polymyxin.....	13
ARTHROTEC.....	30	bacitracin/polymyxin b .....	13
ASACOL.....	70	baclofen.....	38
ascomp/codeine .....	8	BALACET 325.....	8
ASMANEX 120 METERED DOSES... 75		balsalazide disodium .....	70
ASMANEX 14 METERED DOSES.... 75		balziva .....	62
ASMANEX 30 METERED DOSES.... 75		BANZEL .....	20
ASMANEX 60 METERED DOSES.... 75		BARACLUDE .....	38
ASTELIN .....	74	BD INSULIN SYRINGE .....	41
ATACAND .....	50	BD ULTRA-FINE ORIGINAL PEN	
ATACAND HCT.....	50	NEEDLES.....	41
atamet .....	36	BECONASE AQ .....	75
atenolol.....	47	benazepril hcl .....	50
atenolol/chlorthalidone .....	47	benazepril hcl/hydrochlorothiazide ....	50
ATRIPLA .....	39	BENICAR .....	50, 51
atropine sulfate.....	56	BENICAR HCT .....	51
ATROVENT HFA .....	75		

**Benign Prostatic Hypertrophy Agents**

..... 59

benztropine mesylate ..... 36

**Beta-adrenergic Blocking Agents**... 47**Beta-lactam, Cephalosporins** ..... 15**Beta-lactam, Other** ..... 16**Beta-lactam, Penicillins** ..... 16

betamethasone dipropionate ..... 59

betamethasone valerate ..... 59

BETASERON ..... 67

beta-val ..... 59

betaxolol hcl ..... 47, 73

bethanechol chloride ..... 58

BETIMOL ..... 73

BETOPTIC-S ..... 73

BIDIL ..... 52

BILTRICIDE ..... 35

**Bipolar Agents**..... 40**BIPOLAR AGENTS** ..... 40

bisoprolol fumarate ..... 47

bisoprolol fumarate/hydrochlorothiazide

..... 47

bleomycin sulfate ..... 33

BLEPHAMIDE ..... 72

BLEPHAMIDE S.O.P ..... 72

**Blood Formation Products** ..... 44**BLOOD GLUCOSE REGULATORS**.. 40**Blood Glucose Regulators, Misc** .... 41**BLOOD PRODUCTS/MODIFIERS/****VOLUME EXPANDERS** ..... 43

BONIVA ..... 71

BOOSTRIX ..... 69

borofair ..... 74

brimonidine tartrate ..... 73

bromocriptine mesylate ..... 36

**Bronchodilators, Anticholinergic**... 75**Bronchodilators, Phosphodiesterase****2 Inhibitors (Xanthines)**..... 76**Bronchodilators, Sympathomimetic**

..... 76

budeprion sr ..... 23

budeprion xl ..... 23

bumetanide ..... 49

BUPHENYL ..... 55

buprenorphine hcl ..... 8

bupropion hcl ..... 23, 25

bupropion hcl sr ..... 23, 25

buspirone hcl ..... 40

butalbital/apap/caffeine/codeine ..... 8

butorphanol tartrate ..... 9

BYETTA ..... 41

cabergoline ..... 64

CADUET ..... 49

calcipotriene ..... 54

calcitonin-salmon ..... 71

calcitriol ..... 71

CALCITRIOL ..... 71

calcium acetate ..... 59

**Calcium Channel Blocking Agents** 48**Calcium Channel Modifying Agents** 20

camila ..... 63

CAMPATH ..... 34

CAMPRAL ..... 25

CANASA ..... 70

CANCIDAS ..... 29

CANTIL ..... 56

CAPASTAT SULFATE ..... 31

CAPEX ..... 60

captopril ..... 51

captopril/hydrochlorothiazide ..... 51

carbamazepine ..... 21

CARBATROL ..... 21

carbidopa/levodopa ..... 36

carbidopa/levodopa cr ..... 36

carbidopa/levodopa odt ..... 36

carbidopa/levodopa sr ..... 36

carbinoxamine maleate ..... 74

**CARDIOVASCULAR AGENTS** ..... 45**Cardiovascular Agents, Other** ..... 48**Cardiovascular Agents, Others** ..... 48

carimune nanofiltered ..... 67

carisoprodol ..... 78

carisoprodol/aspirin ..... 78

carisoprodol/aspirin/codeine ..... 78

carteolol hcl ..... 73

cartia xt ..... 46

CARTROL ..... 47

carvedilol ..... 47

CASODEX ..... 65

CATAPRES-TTS ..... 45

CEENU ..... 32

cefaclor ..... 15

cefaclor er .....	15	ciprofloxacin extended-release.....	19
cefadroxil.....	15	ciprofloxacin hcl.....	19
cefazolin sodium .....	15	citalopram hydrobromide.....	23
cefdinir.....	15	CLARINEX-D .....	77
cefoxitin sodium .....	15	clarithromycin .....	18
cefpodoxime proxetil .....	15	clarithromycin er .....	18
cefprozil.....	15	clemastine fumarate .....	74
ceftriaxone sodium .....	15	CLEOCIN .....	13
CEFTRIAZONE/DEXTROSE .....	15	clindamycin hcl.....	13
cefuroxime axetil .....	16	clindamycin phosphate.....	13
CELEBREX .....	11	clindamycin phosphateadd-vantage...	13
CELESTONE .....	30	clobetasol propionate .....	60
CELLCEPT.....	65	clobetasol propionate e .....	60
CELLCEPT INTRAVENOUS.....	65	clomipramine hcl .....	24
CELONTIN .....	20	clonidine hcl .....	45
CENESTIN .....	62	clotrimazole .....	29, 54
<b>CENTRAL NERVOUS SYSTEM</b>		clotrimazole/betamethasone	
<b>AGENTS</b> .....	52	dipropionate.....	54
cephalexin .....	16	clozapine .....	36
CEREBYX .....	21	<b>Coagulants</b> .....	45
CEREDASE .....	55	co-gesic.....	9
CEREZYME .....	55	COGNEX.....	22
cesia.....	62	COLCRYST .....	30
cetirizine hcl .....	74	colestipol hcl.....	49
CHANTIX .....	25	colistimethate sodium.....	14
chlordiazepoxide/amitriptyline .....	23	colocort.....	54
chlorhexidine gluconateoral rinse.....	54	COLY-MYCIN S .....	74
chloroquine phosphate .....	35	colyte.....	56
chlorothiazide .....	49	COMBIVENT .....	76
chlorpromazine hcl .....	26	COMBIVIR .....	39
chlorpropamide .....	41	compro .....	38
chlorthalidone.....	49	COMTAN.....	36
chlorzoxazone .....	78	COMVAX.....	69
cholestyramine .....	49	CONCERTA .....	53
cholestyramine light.....	49	constulose .....	56
<b>Cholinesterase Inhibitors</b> .....	22	<b>Conventional</b> .....	38
ciclopirox .....	29	COPAXONE .....	67
ciclopirox nail lacquer .....	29	COREG CR.....	47
ciclopirox olamine.....	29	cormax .....	60
cilostazol .....	45	CORTIFOAM.....	54
CILOXAN .....	19	cortisone acetate .....	30
cimetidine .....	57	cortomycin.....	74
cimetidine hcl .....	57	COUMADIN.....	43
CIPRO HC.....	74	COZAAR .....	51
CIPRODEX .....	74	CREON .....	55
ciprofloxacin er .....	19	CRESTOR.....	49

CRINONE.....	63	dexasporin.....	72
CRIXIVAN .....	40	dexchlorpheniramine maleate .....	74
cromolyn sodium .....	72	dexmethylphenidate hcl.....	53
cryselle-28.....	62	dextroamphetamine sulfate .....	53
CUBICIN .....	14	dextroamphetamine sulfate er.....	53
CUPRIMINE .....	25	DEXTROSE 10%/NACL 0.45%.....	82
cyclobenzaprine hcl.....	78	dextrose 5%/electrolyte #48 viaflex ...	82
cyclophosphamide .....	33	dextrose 10%/nacl 0.2%.....	82
cyclosporine .....	65	dextrose 10%flex container .....	82
cyclosporine modified.....	65	dextrose 2.5%/sodium chloride 0.45%82	
CYKLOKAPRON.....	45	dextrose 5% .....	82, 83
CYMBALTA.....	23	dextrose 5%/nacl 0.2%.....	82
cyproheptadine hcl .....	74	dextrose 5%/nacl 0.225%.....	83
CYSTADANE .....	55	dextrose 5%/nacl 0.33%.....	83
CYSTAGON .....	55	dextrose 5%/nacl 0.45%.....	83
CYTOMEL.....	64	dextrose 5%/nacl 0.9%.....	83
CYTOVENE .....	38	DEXTROSE 5%/POTASSIUM	
danazol.....	61	CHLORIDE 0.075%.....	83
dantrolene sodium.....	38	diclofenac potassium.....	11
DAPSONE.....	31	diclofenac sodium .....	11, 73
DAPTACEL .....	69	diclofenac sodium ec.....	11
DARAPRIM .....	35	diclofenac sodium xr.....	11
DARVON-N .....	9	dicloxacillin sodium.....	17
decavac.....	69	dicyclomine hcl.....	56
del-beta .....	60	didanosine.....	39
demeclocycline hcl .....	20	DIDRONEL.....	71
DENAVIR .....	39	DIFFERIN.....	54
<b>Dental and Oral Agents.....</b>	<b>54</b>	diflorasone diacetate .....	60
<b>DENTAL AND ORAL AGENTS .....</b>	<b>54</b>	diflunisal .....	11
DEPACON .....	20	digoxin.....	48
depade .....	25	dihydroergotamine mesylate .....	31
DEPAKOTE SPRINKLES.....	20	DILANTIN.....	21
DEPEN TITRATABS .....	25	DILANTIN INFATABS .....	21
DERMA-SMOOTHIE/FS BODY OIL... 60		dilt-cd.....	46
<b>Dermatological Agents .....</b>	<b>54</b>	diltiazem cd .....	46
<b>DERMATOLOGICAL AGENTS .....</b>	<b>54</b>	diltiazem hcl .....	46
DERMOTIC .....	74	diltiazem hcl er .....	46
desipramine hcl .....	24	dilt-xr .....	46
desmopressin acetate .....	60	DIOVAN .....	51
desonide.....	60	DIOVAN HCT .....	51
desoximetasone .....	60	DIPENTUM .....	70
<b>Deterrents .....</b>	<b>25</b>	diphenhydramine hcl .....	26
DETROL.....	58	diphenoxylate/atropine .....	56
DETROL LA .....	58	DIPHThERIA/TETANUS	
dexamethasone.....	30, 73	TOXOIDPEDIATRIC.....	69
dexamethasone sodium phosphate ... 73		dipivefrin hcl .....	73

dipyridamole .....	45	EPIVIR HBV .....	39
disopyramide phosphate .....	46	eplerenone .....	49
<b>Diuretics</b> .....	48	EPOGEN .....	44
divalproex sodium .....	21, 31	EPZICOM .....	39
dorzolamide hcl .....	73	ERAXIS .....	29
dorzolamide hcl/timolol maleate .....	73	ergoloid mesylates .....	22
DOVONEX .....	54	ERGOMAR .....	31
doxazosin mesylate .....	46	errin .....	63
doxepin hcl .....	24	ery .....	18
doxy-caps .....	20	ery-tab .....	18
doxycycline hyclate .....	20	ERYTHROCIN LACTOBIONATE .....	18
doxycycline monohydrate .....	20	erythrocin stearate .....	18
dronabinol .....	27	erythromycin .....	14, 18, 54
DROXIA .....	33	erythromycin base .....	18
<b>Dyslipidemics</b> .....	49	erythromycin/benzoyl peroxide .....	54
e.e.s. 400 .....	18	erythromycin/sulfisoxazole .....	14
econazole nitrate .....	29	ESTRACE .....	62
ed k+10 .....	83	ESTRADERM .....	62
EFFEXOR XR .....	23	estradiol .....	62
EFFIENT .....	45	estradiol/norethindrone acetate .....	62
ELAPRASE .....	55	ESTRASORB .....	62
<b>Electrolytes/Minerals</b> .....	79	ESTRING .....	62
ELIDEL .....	54	<b>Estrogens</b> .....	62
ELITEK .....	33	estropipate .....	62
EMCYT .....	32	ethambutol hcl .....	32
EMEND .....	27	ethosuximide .....	20
EMSAM .....	23	etidronate disodium .....	71
EMTRIVA .....	39	etodolac .....	11
ENABLEX .....	58	etodolac er .....	11
enalapril maleate .....	51	EVISTA .....	64
enalapril maleate/hydrochlorothiazide .....	51	EXELDERM .....	29
ENBREL .....	65	EXELON .....	22
ENBREL SURECLICK .....	65	EXFORGE .....	47
endocet .....	9	EXJADE .....	25
ENGERIX-B .....	69	FABRAZYME .....	55
enpresse-28 .....	62	FACTIVE .....	19
ENTOCORT EC .....	70	famciclovir .....	39
enulose .....	56	famotidine .....	57
<b>Enzyme Replacements/ Modifiers</b> .....	55	famotidine premixed .....	57
<b>ENZYME REPLACEMENTS/</b>		FANSIDAR .....	35
<b>MODIFIERS</b> .....	55	FARESTON .....	33
epinephrine hcl .....	76	FAZACLO .....	36
EIPEN 2-PAK .....	76	FELBATOL .....	21
EIPEN-JR 2-PAK .....	76	felodipine er .....	48
epitol .....	21	FEMARA .....	34
EPIVIR .....	39	FEMHRT 1/5 .....	62

FEMHRT LOW DOSE .....	62
fenofibrate .....	49
fenofibrate micronized .....	49
fenoprofen calcium .....	11
fentanyl.....	9
fexofenadine hcl .....	74
finasteride.....	59
FLAREX .....	73
flavoxate hcl .....	58
flebogamma .....	67
flecainide acetate .....	46
FLOMAX .....	59
FLOVENT HFA .....	75
fluconazole .....	29
fludrocortisone acetate .....	60
flunisolide .....	75
fluocinolone acetonide.....	60
fluocinonide .....	60
fluocinonide emollient base .....	60
fluorometholone .....	73
fluor-op .....	73
fluorouracil.....	54
fluoxetine hcl .....	23
fluphenazine decanoate .....	38
fluphenazine hcl .....	38
flurbiprofen .....	11, 73
flurbiprofen sodium.....	73
flutamide.....	65
fluticasone propionate .....	60, 75
fluvoxamine maleate .....	23
FML .....	73
FML FORTE .....	73
FORADIL AEROLIZER .....	76
FORTEO .....	71
FORTICAL .....	71
foscarnet sodium .....	38
FOSCAVIR .....	38
fosinopril sodium .....	51
fosinopril sodium/hydrochlorothiazide .....	51
fosphenytoin sodium .....	21
FOSRENOL .....	59
FRAGMIN.....	43
freamine iii .....	83
FREAMINE III 3%.....	84
FROVA.....	31
FURADANTIN .....	14

furosemide .....	49
FUZEON .....	40
gabapentin .....	21
GABITRIL.....	21
galantamine hydrobromide.....	22
gamastan s/d.....	67
<b>Gamma-aminobutyric Acid (GABA)</b>	
<b>Augmenting Agents</b> .....	20
gammagard liquid.....	67
ganciclovir .....	38
GANTRISIN PEDIATRIC.....	19
GARDASIL .....	69
GASTROCROM .....	56
<b>GASTROINTESTINAL AGENTS</b> .....	56
<b>Gastrointestinal Agents, Other</b> .....	56
GAUZE PADS .....	41
gemfibrozil .....	49
generlac .....	56
gengraf .....	66
<b>GENITOURINARY AGENTS</b> .....	58
<b>Genitourinary Agents, Other</b> .....	59
genoptic.....	12
GENOTROPIN .....	61
GENOTROPIN MINIQUICK .....	61
gentak .....	12
gentamicin sulfate .....	12
gentamicin sulfate/0.9% sodium chloride .....	12
gentamicin sulfate/sodiumchloride ....	12
gentalol.....	12
GEODON .....	36, 37
GLEEVEC .....	34
glimepiride .....	41
glipizide .....	41
glipizide er .....	41
glipizide xl.....	41
glipizide/metformin hcl.....	41
GLUCAGEN HYPOKIT .....	41
GLUCAGON EMERGENCY KIT .....	41
<b>Glucocorticoids</b> .....	30, 59, 70
<b>Glucocorticoids- XE</b>	
<b>"Glucocorticoids"</b>	
<b>Mineralocorticoids</b> .....	59
<b>Glutamate Pathway Modifiers</b> .....	22
<b>Glutamate Reducing Agents</b> .....	21
glyburide.....	41

glyburide micronized .....	41
glyburide/metformin hcl .....	41
<b>Glycemic Agents</b> .....	41
glycopyrrolate .....	56
glycron.....	41
GLYSET .....	41
granisetron hcl.....	27
granisol.....	27
griseofulvin microsize .....	29
guanabenz acetate.....	45
guanfacine hcl .....	45
GUANIDINE HCL .....	31
gynodiol.....	62
halobetasol propionate .....	60
HALOG.....	60
haloperidol.....	38
haloperidol decanoate .....	38
haloperidol lactate .....	38
HAVRIX.....	69
HECTOROL .....	71
HELIDAC.....	56
heparin sodium.....	43, 44
HEPARIN SODIUM DCU .....	43
heparin sodium/d5w .....	44
heparin sodium/nacl 0.9% .....	44
HEPSERA .....	39
HERCEPTIN .....	34
HEXALEN .....	32
HIPREX.....	14
<b>Histamine2 (H2) Blocking Agents</b> ...	57
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (Adrenal)</b> .....	59
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)</b> .....	60
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)</b> .....	61
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)</b> .....	64
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</b> .....	60

<b>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</b> .....	64
<b>Hormonal Agents, Suppressant (Adrenal)</b> .....	64
<b>HORMONAL AGENTS, SUPPRESSANT (ADRENAL)</b> .....	64
<b>Hormonal Agents, Suppressant (Parathyroid)</b> .....	64
<b>HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)</b> 64	
<b>Hormonal Agents, Suppressant (Pituitary)</b> .....	64
<b>HORMONAL AGENTS, SUPPRESSANT (PITUITARY)</b> .....	64
<b>HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)</b> .....	65
<b>HORMONAL AGENTS, SUPPRESSANTS (THYROID)</b> .....	65
HUMALOG .....	41, 42
HUMALOG MIX 50/50.....	42
HUMALOG MIX 75/25.....	42
HUMATROPE .....	61
HUMATROPE COMBO PACK.....	61
HUMIRA .....	66
HUMIRA PEN-CROHNS DISEASESTARTER .....	66
HUMULIN 50/50 .....	42
HUMULIN 70/30 .....	42
HUMULIN N .....	42
HUMULIN R .....	42
HUMULIN R U-500 (CONCENTRATED) .....	42
hydralazine hcl .....	52
hydrochlorothiazide .....	49
hydrocodone bitartrate/acetaminophen	9
hydrocodone/acetaminophen .....	9
hydrocodone/acetaminophen-hs .....	9
hydrocodone/ibuprofen.....	9
hydrocortisone.....	30, 54, 60
hydrocortisone butyrate.....	60
hydrocortisone in absorbase .....	60
hydrocortisone valerate.....	60
hydromorphone hcl.....	9
hydroxychloroquine sulfate.....	35

hydroxyurea .....	33	JANUMET .....	41
hydroxyzine hcl .....	74	JANUVIA .....	41
hydroxyzine pamoate .....	27	JE-VAX.....	69
HYZAAR.....	51	jolivette .....	63
ibuprofen .....	11	junel.....	62
imipramine hcl .....	24	junel fe.....	62
<b>Immune Suppressants</b> .....	65	KADIAN.....	9
<b>Immunizing Agents, Passive</b> .....	67	KALETRA.....	40
<b>IMMUNOLOGICAL AGENTS</b> .....	65	kanamycin sulfate.....	13
<b>Immunomodulators</b> .....	67	kaon-cl-10 .....	84
IMOVAX RABIES (H.D.C.V.).....	69	kariva.....	62
INCRELEX .....	61	kcl 0.075%/d5w/nacl 0.45% .....	84
indapamide.....	49	KCL 0.15%/D10W/NACL 0.2% .....	84
indomethacin .....	11	KCL 0.15%/D5W/LR.....	84
indomethacin er.....	11	kcl 0.15%/d5w/nacl 0.2% .....	84
INFANRIX .....	69	kcl 0.15%/d5w/nacl 0.225% .....	85
INFERGEN.....	67	kcl 0.224%/d5w/nacl 0.2% .....	85
<b>INFLAMMATORY BOWEL DISEASE</b>		KCL 0.3%/D5W/LR IV LAC RING .....	85
<b>AGENTS</b> .....	70	kcl 0.3%/d5w/nacl 0.2% .....	85
INNOHEP .....	44	kcl 0.3%/d5w/nacl 0.45% .....	85
<b>Insulins</b> .....	41	KCL 0.3%/D5W/NACL 0.9% .....	85
INTELENCE .....	39	kelnor 1/35 .....	62
intralipid.....	84	KEPPRA.....	20
INTRON-A.....	68	KEPPRA XR.....	20
INTRON-A W/DILUENT .....	68	ketoconazole .....	29
INVANZ .....	16	ketoprofen .....	11
INVEGA.....	37	ketoprofen er .....	11
INVIRASE .....	40	ketorolac tromethamine.....	11
IOPIDINE .....	73	KINERET.....	68
IPOL INACTIVATED IPV.....	69	klor-con .....	85
ipratropium bromide .....	76	kuric.....	29
IRESSA .....	34	labetalol hcl .....	47
<b>Irritable Bowel Syndrome Agents</b> ...	57	laclotion .....	54
ISENTRESS.....	40	LACRISERT .....	72
isochron.....	52	lactated ringers viaflex.....	85
isonarif.....	32	lactulose .....	56
isoniazid .....	32	LAMICTAL XR.....	21
isosorbide dinitrate .....	52	LAMISIL .....	29
isosorbide dinitrate er .....	52	lamotrigine.....	21
isosorbide mononitrate .....	52	LANOXIN .....	48
isosorbide mononitrate er.....	52	LANTUS .....	42
isotonic gentamicin.....	12	leena .....	62
isovate.....	60	leflunomide.....	68
isradipine.....	48	LESCOL .....	49
itraconazole.....	29	LESCOL XL.....	49
jantoven.....	44	lessina-28.....	62

leucovorin calcium.....	25	loxapine succinate.....	38
LEUCOVORIN CALCIUM .....	25	LUMIGAN.....	73
LEUKERAN.....	32	lutea .....	62
LEUKINE .....	44	LUVOX CR.....	24
leuprolide acetate.....	64	LYRICA .....	20
LEVAQUIN .....	19	LYSODREN .....	64
LEVAQUIN PREMIX .....	19	<b>Macrolides</b> .....	18
LEVATOL.....	47	magnesium sulfate.....	86
LEVEMIR .....	42	MALARONE .....	35
levetiracetam.....	20	maprotiline hcl.....	23
levobunolol hcl .....	73	margesic-h .....	9
levocarnitine .....	55	MARPLAN.....	23
levora 0.15/30-28 .....	62	MATULANE.....	32
levorphanol tartrate .....	9	MAXALT .....	31
levothroid.....	64	MAXALT-MLT .....	31
levothyroxine sodium.....	64	MAXIDEX .....	73
LEXAPRO .....	23	MAXIPIME.....	16
LEXIVA.....	40	mebendazole.....	35
lidocaine .....	12, 54	meclizine hcl.....	27
lidocaine hcl .....	12	meclofenamate sodium .....	11
lidocaine hcl jelly .....	12	medroxyprogesterone acetate.....	63
lidocaine/prilocaine.....	12	mefloquine hcl .....	35
LIDODERM .....	54	MEGACE ES.....	63
lindane.....	35	megestrol acetate.....	64
LIPITOR .....	49	meloxicam .....	11
LIPRAM.....	55	MENACTRA .....	69
LIPRAM-PN.....	56	MENEST .....	62
LIPRAM-UL .....	56	MENOMUNE-A/C/Y/W-135.....	69
lisinopril .....	51	meperidine hcl.....	9
lisinopril/hydrochlorothiazide .....	51	meprobamate .....	40
lithium carbonate.....	40	MEPRON .....	35
lithium carbonate er.....	40	mercaptapurine .....	33
lithium citrate.....	40	MERREM .....	16
<b>Local Anesthetics</b> .....	12	MERUVAX II W/DILUENT 10 DOSE..	69
LODOSYN.....	36	mesalamine.....	70
lokara .....	60	MESNEX .....	26
lonox.....	56	MESTINON .....	31
loperamide hcl.....	56	MESTINON TIMESPAN .....	31
LOPROX .....	29	<b>Metabolic Bone Disease Agents</b> .....	70
LOPROX SHAMPOO .....	29	<b>METABOLIC BONE DISEASE</b>	
LOTEMAX .....	73	<b>AGENTS</b> .....	70
LOTRONEX .....	57	METADATE CD .....	53
lovastatin .....	50	metadate er .....	53
LOVAZA .....	50	metaproterenol sulfate.....	77
LOVENOX.....	44	metformin hcl.....	41
low-ogestrel.....	62	metformin hcl er .....	41

methadone hcl.....	9	mirtazapine odt.....	23
METHADONE HCL .....	9	misoprostol.....	57
methadose .....	9	mitoxantrone hcl.....	33
methazolamide.....	49	M-M-R II W/DILUENT 10 DOSE .....	69
methenamine hippurate.....	14	MOBAN.....	38
METHERGINE .....	45	moexipril hcl .....	51
methimazole.....	65	moexipril/hydrochlorothiazide.....	51
methocarbamol .....	79	<b>Molecular Target Inhibitors</b> .....	34
methotrexate .....	66	mometasone furoate .....	60
methotrexate sodium.....	66	<b>Monoamine Oxidase Inhibitors</b> .....	23
methscopolamine bromide .....	56	<b>Monoclonal Antibodies</b> .....	34
methyclothiazide .....	49	mononessa.....	63
methyl dopa.....	45	MONUROL.....	14
methyl dopa/hydrochlorothiazide.....	45	morphine sulfate.....	9, 10
methyl dopate hcl .....	46	morphine sulfate er.....	10
methylin.....	53	MOTOFEN .....	57
methylin er.....	53	mupirocin.....	14
methylphenidate hcl .....	53	MYCOBUTIN.....	31
methylphenidate hcl er .....	53	mydral .....	73
methylprednisolone .....	30	MYFORTIC .....	66
methylprednisolone acetate .....	30	MYLOTARG .....	35
methylprednisolone sodium succinate	30	MYOBLOC .....	79
metipranolol.....	73	MYOZYME .....	56
metoclopramide hcl .....	27	MYTELASE .....	31
metolazone.....	49	nabumetone .....	12
metoprolol succinate er .....	48	nadolol.....	48
metoprolol tartrate .....	48	nadolol/bendroflumethiazide .....	48
metoprolol/hydrochlorothiazide .....	48	nafcillin sodium.....	17
METROGEL.....	14	NAFTIN .....	29
metronidazole.....	14	NAGLAZYME .....	56
metronidazole vaginal .....	14	nalbuphine hcl .....	10
mexiletine hcl .....	46	naloxone hcl.....	26
MIACALCIN.....	71	naltrexone hcl.....	26
MICARDIS.....	51	NAMENDA .....	22
MICARDIS HCT .....	51	NAMENDA TITRATION PAK .....	22
miconazole 3.....	29	naphazoline hcl .....	72
microgestin.....	62	naproxen .....	12
microgestin fe.....	62	naproxen dr .....	12
midodrine hcl.....	46	naproxen sodium.....	12
migergot .....	31	NARDIL .....	23
MIGRANAL .....	31	NASACORT AQ .....	75
minitran .....	52	NASONEX.....	75
minocycline hcl.....	20	NATACYN .....	29
minoxidil .....	52	NAVANE .....	38
MIRAPEX.....	36	necon .....	63
mirtazapine.....	23	nefazodone hcl.....	23

NEO-FRADIN.....	13	NORITATE .....	14
neomycin sulfate .....	13	NOROXIN .....	19
neomycin/polymyxin b sulfates.....	59	nortrel .....	63
neomycin/polymyxin/dexamethasone.	72	nortriptyline hcl .....	24
neomycin/polymyxin/gramicidin.....	14	NORVIR .....	40
neomycin/polymyxin/hc .....	74	NOVOLIN 70/30 .....	42
neomycin/polymyxin/hydrocortisone..	72,	NOVOLIN N .....	42
74		NOVOLIN R .....	42
NEORAL .....	66	NOVOLOG .....	42
NEULASTA .....	45	NOVOLOG MIX 70/30.....	42
NEUMEGA .....	45	NULYTELY.....	57
NEUPOGEN.....	45	NUTROPIN .....	61
NEURONTIN.....	21	NUTROPIN AQ .....	61
NEUTREXIN .....	35	NUVARING .....	63
NEVANAC .....	73	nystatin.....	29
NEXAVAR .....	34	nystatin/triamcinolone.....	29
NEXIUM .....	58	nystop.....	29
NEXIUM I.V. ....	58	ocella.....	63
niacor .....	50	octagam .....	67
NIASPAN .....	50	octreotide acetate.....	64
nicardipine hcl .....	48	ocusulf-10.....	19
NICOTROL NS.....	25	ofloxacin .....	19
nifediac cc .....	48	ogestrel .....	63
nifedical xl .....	48	OLUX-E.....	60
nifedipine.....	48	omeprazole .....	58
nifedipine er.....	48	ondansetron hcl.....	27
NILANDRON.....	65	ondansetron odt .....	28
nimodipine.....	48	ONTAK.....	33
nisoldipine .....	48	<b>OPHTHALMIC AGENTS .....</b>	<b>72</b>
NITRO-DUR .....	52	<b>Ophthalmic Agents, Other .....</b>	<b>72</b>
nitrofurantoin macrocrystalline .....	14	<b>Ophthalmic Anti-allergy Agents.....</b>	<b>72</b>
nitrofurantoin monohydrate .....	14	<b>Ophthalmic Antiglaucoma Agents..</b>	<b>73</b>
nitroglycerin.....	52	<b>Ophthalmic Anti-inflammatories .....</b>	<b>73</b>
nitroglycerin transdermal.....	52	<b>Ophthalmic Prostaglandins and</b>	
NITROLINGUAL PUMPSPRAY .....	52	<b>Prostamide Analogs .....</b>	<b>73</b>
NITROSTAT .....	52	<b>Opioid Analgesics .....</b>	<b>8</b>
nizatidine .....	57	OPTIVAR .....	72
<b>Non-amphetamines, ADHD.....</b>	<b>53</b>	ORACEA .....	54
<b>Non-amphetamines, Other .....</b>	<b>53</b>	ORAP .....	38
<b>Nonsteriodal Anti-Inflammatory</b>		ORENCIA.....	66
<b>Drugs .....</b>	<b>11</b>	ORFADIN .....	56
<b>Nonsteroidal Anti-inflammatory</b>		orphenadrine citrate .....	79
<b>Drugs .....</b>	<b>30</b>	orphenadrine citrate er .....	79
nora-be.....	64	orphenadrine compound ds.....	79
NORDITROPIN NORDIFLEX PEN ....	61	orphenadrine/asa/caffeine.....	79
norethindrone acetate .....	64	ORTHO EVRA .....	63

ORTHOCLONE OKT3.....	66	PEG-INTRON REDIPEN.....	68
ortho-est.....	63	penicillin g potassium .....	17
<b>Otic Agents</b> .....	74	PENICILLIN G POTASSIUM INISO-	
<b>OTIC AGENTS</b> .....	74	OSMOTIC DEXTROSE .....	17
OVIDE .....	35	PENICILLIN G PROCAINE .....	17
oxaliplatin .....	33	PENICILLIN G SODIUM.....	17
oxandrolone .....	61	penicillin v potassium .....	17
oxaprozin.....	12	PENTASA .....	70
oxcarbazepine.....	22	pentazocine/acetaminophen .....	10
OXISTAT.....	29	pentazocine/naloxone hcl.....	10
OXSORALEN ULTRA .....	54	pentopak .....	45
oxybutynin chloride.....	58, 59	pentoxifylline er .....	45
oxybutynin chloride er .....	59	pentoxil.....	45
oxycodone hcl .....	10	periogard .....	54
oxycodone/acetaminophen .....	10	permethrin .....	35
oxycodone/apap .....	10	perphenazine .....	23, 28
oxycodone/aspirin .....	10	perphenazine/amitriptyline .....	23
oxycodone/ibuprofen .....	10	phenadoz .....	28
oxycodone-apap.....	10	PHENYTEK.....	22
OXYCONTIN.....	10	phenytoin.....	22
OXYTROL .....	59	phenytoin sodium .....	22
pacerone .....	46	phenytoin sodium extended .....	22
PACERONE .....	46	<b>Phosphate Binders</b> .....	59
palgic.....	74	PHOSPHOLINE IODIDE .....	73
pamidronate disodium.....	71	pilocarpine hcl .....	54
PANCREASE MT .....	56	pilocarpine hydrochloride .....	54
PANCRECARB MS .....	56	PILOPINE HS.....	73
PANCRELIPASE.....	56	pindolol.....	48
PANCRELIPASE MST .....	56	PIPERACILLIN SODIUM.....	17
PANCRON .....	56	piroxicam.....	12
PANRETIN .....	35	PLAN B .....	64
<b>Parasympathomimetics</b> .....	31	<b>Platelet Aggregation Inhibitors</b> .....	45
parcaine .....	72	PLAVIX.....	45
paromomycin sulfate .....	13	podofilox.....	54
paroxetine hcl.....	24	polycin b.....	14
paroxetine hcl er.....	24	poly-dex.....	72
PASER .....	32	polygam s/d.....	67
PATANOL .....	72	POLY-PRED .....	72
PEDIARIX .....	69	portia-28 .....	63
<b>Pediculicides/Scabicides</b> .....	35	potassium chloride .....	86, 87, 88
pedi-dri .....	29	potassium chloride 0.075%/d5w/nacl	
pedvax hib.....	69	0.225% .....	86
peg 3350/electrolytes .....	57	potassium chloride 0.15%/d5w.....	86
PEGANONE .....	22	POTASSIUM CHLORIDE 0.15%/NACL	
PEGASYS .....	68	0.45% VIAFLEX.....	86
PEG-INTRON.....	68		

potassium chloride 0.15%d5w/nacl 0.33% .....	86	PROAIR HFA .....	77
potassium chloride 0.15%d5w/nacl 0.45% viaflex .....	87	probenecid .....	30
potassium chloride 0.15%nacl 0.9% ..	87	probenecid/colchicine.....	30
potassium chloride 0.22%d5w/nacl 0.45% .....	87	PROCAINAMIDE HCL .....	46
potassium chloride 0.224%/d5w.....	87	PROCHIEVE .....	64
<b>POTASSIUM CHLORIDE</b>		prochlorperazine .....	28, 38
0.224%D5W/NACL 0.33%.....	87	prochlorperazine edisylate .....	28
potassium chloride 0.3%/d5w.....	87	prochlorperazine maleate.....	28
<b>POTASSIUM CHLORIDE 0.3%/NACL</b>		PROCRIT .....	45
0.9% .....	87	proctocream-hc .....	55
potassium chloride cr .....	88	procto-pak .....	60
potassium chloride er .....	88	proctosol hc.....	55
potassium citrate extended-release...	88	proctozone-hc .....	55
PRANDIN .....	41	<b>Progestins</b> .....	63
pravastatin sodium .....	50	PROGLYCEM .....	41
prazosin hcl .....	46	PROGRAF .....	66
PRED MILD.....	73	PROLASTIN.....	77
PRED-G .....	72	PROLEUKIN .....	33
PRED-G S.O.P.....	72	promethazine hcl.....	28
prednicarbate .....	60	promethazine vc.....	77
prednisolone acetate .....	73	promethegan .....	28
prednisolone sodium phosphate ..	30, 73	PROMETRIUM.....	64
prednisone .....	30, 70	propafenone hcl .....	46
prednisone intensol .....	30	propantheline bromide.....	56
PREFEST.....	63	proparacaine hcl.....	72
PREMARIN .....	63	<b>Prophylactic</b> .....	31
PREMARIN W/APPLICATOR .....	63	propoxyphene hcl.....	10
PREMPHASE.....	63	propoxyphene/acetaminophen .....	10
PREMPRO .....	63	propoxyphene-n/acetaminophen .....	10
PRENATABS OBN.....	90	propranolol hcl.....	46, 47
PREVACID.....	30, 58	propranolol hcl er .....	47
PREVACID NAPRAPAC .....	30	propranolol/hydrochlorothiazide .....	48
PREVACID SOLUTAB .....	58	propylthiouracil .....	65
prevalite.....	50	PROQUAD .....	69
previfem .....	63	<b>Protectants</b> .....	57
PREVPAC .....	58	<b>Proton Pump Inhibitors</b> .....	57
PREZISTA.....	40	PROTONIX .....	58
PRIFTIN .....	32	PROTOPIC .....	55
PRIMAQUINE PHOSPHATE .....	35	protriptyline hcl .....	25
PRIMAXIN I.M.....	16	PROVENTIL HFA.....	77
PRIMAXIN IV .....	16	PROVIGIL .....	53
primidone .....	21	PULMICORT FLEXHALER .....	75
PRISTIQ.....	24	<b>Pulmonary Antihypertensives</b> .....	77
		pyrazinamide.....	32
		pyridostigmine bromide .....	31
		quasense.....	63

quinapril hcl .....	51	RILUTEK .....	53
quinapril/hydrochlorothiazide.....	51	rimantadine hcl.....	40
quinaretic.....	52	RISPERDAL.....	37
quinidine gluconate cr .....	47	RISPERDAL CONSTA.....	37
quinidine sulfate .....	47	RISPERDAL M-TAB.....	37
quinidine sulfate er .....	47	risperidone .....	37
<b>Quinolones</b> .....	18	RITALIN LA.....	53
QUIXIN.....	19	RITUXAN .....	35
QVAR.....	75	romycin.....	18
RABAVERT .....	69	ropinirole hcl.....	36
RANEXA .....	48	ROTATEQ.....	69
ranitidine hcl.....	57	roxacet.....	10
RAPAMUNE.....	66	ROZEREM .....	78
RAZADYNE.....	22	SABRIL .....	21
REBIF.....	68	SAIZEN .....	61
REBIF TITRATION PACK.....	68	SAIZEN CLICK.EASY .....	61
reclipsen.....	63	<b>Salicylates</b> .....	70
RECOMBIVAX HB .....	69	SANCTURA .....	59
REGRANEX.....	55	SANCTURA XR .....	59
RELENZA DISKHALER .....	40	SANDIMMUNE.....	66, 67
RELION 70/30.....	42	SANDOSTATIN LAR DEPOT .....	64
RELION N .....	43	SANTYL .....	55
RELION R .....	43	SAPHRIS .....	37
RELPAK.....	31	<b>SEDATIVES/ HYPNOTICS</b> .....	78
REMICADE .....	66	<b>Sedatives/Hypnotics</b> .....	78
<b>Renin-angiotensin-aldosterone</b>		<b>Selective Estrogen Receptor</b>	
<b>System Inhibitors</b> .....	50	<b>Modifying Agents</b> .....	64
REQUIP XL.....	36	selegiline hcl.....	36
RESCRIPTOR.....	39	selenium sulfide .....	55
reserpine .....	46	SELZENTRY .....	40
<b>RESPIRATORY TRACT AGENTS</b> ....	74	SENSIPAR .....	64
<b>Respiratory Tract Agents, Other</b> ....	77	SEREVENT DISKUS.....	77
RESTASIS .....	72	SEROMYCIN .....	32
RETIN-A MICRO .....	55	SEROQUEL .....	37
<b>Retinoids</b> .....	35	SEROQUEL XR .....	37
RETROVIR IV INFUSION .....	39	SEROSTIM .....	61
REVATIO .....	77	<b>Serotonin/ Norepinephrine Reuptake</b>	
REVLIMID .....	32	<b>Inhibitors</b> .....	23
REYATAZ.....	40	sertraline hcl.....	24
RHINOCORT AQUA .....	75	silver sulfadiazine.....	19
ribasphere .....	39	SIMCOR.....	50
ribavirin.....	39	SIMPONI .....	67
RIDAURA.....	68	SIMULECT .....	67
RIFAMATE .....	32	simvastatin .....	50
rifampin .....	32	SINGULAIR.....	75
RIFATER.....	32	<b>Skeletal Muscle Relaxants</b> .....	78

<b>SKELETAL MUSCLE RELAXANTS</b> .	78	sulfazine ec .....	70
SKELID .....	72	<b>Sulfonamides</b> .....	19, 70
sodium bicarbonate .....	88	sulindac .....	12
<b>Sodium Channel Inhibitors</b> .....	21	sumatriptan succinate .....	31
sodium chloride .....	59, 88	SUPRAX .....	16
sodium chloride 0.9% .....	59	SURMONTIL .....	25
sodium chloride 0.45% viaflex .....	88	SUSTIVA .....	39
sodium fluoride .....	90	SUTENT .....	34
sodium polystyrene sulfonate .....	25	SYMBICORT .....	77
sodium sulfacetamide.....	19	SYMBYAX .....	37
SOLARAZE .....	55	SYMLIN.....	41
solia .....	63	SYNAREL .....	65
SOMAVERT .....	65	SYNERCID.....	14
sorine .....	47	SYNTHROID .....	64
sotalol hcl .....	47	SYPRINE .....	25
SPECTRACEF .....	16	TABLOID .....	33
SPIRIVA HANDIHALER .....	76	TAMIFLU .....	40
spironolactone .....	49	tamoxifen citrate .....	33
spironolactone/hydrochlorothiazide ...	49	TARCEVA .....	34
sprintec 28.....	63	TARGRETIN .....	35
SPRYCEL .....	34	TARKA .....	52
sronyx.....	63	TASIGNA .....	34
ssd.....	19	TASMAR .....	36
stagesic .....	10	TAZORAC .....	55
STALEVO.....	36	tazia xt.....	47
STARLIX .....	41	TEGRETOL-XR.....	22
stavudine .....	39	TEKTURNA.....	52
STAVZOR .....	21	TEKTURNA HCT.....	52
sterile water irrigation .....	59	terazosin hcl .....	46
STIMATE.....	61	terbinafine hcl.....	29
STRATTERA.....	53	terbutaline sulfate .....	77
STRIANT.....	61	terconazole.....	29
STROMECTOL .....	35	TESTIM .....	62
SUBOXONE .....	10	testosterone enanthate.....	62
SUBUTEX .....	10	TESTRED .....	62
SUCRAID .....	56	TETANUS TOXOID ADSORBED.....	69
sucralfate.....	57	TETANUS/DIPHThERIA TOXOIDS- ADSORBED ADULT .....	69
sulfacetamide sodium/prednisolone sodium phosphate .....	72	tetracycline hcl .....	20
sulfadiazine .....	19	<b>Tetracyclines</b> .....	20
sulfamethoxazole/trimethoprim .....	19	THALOMID.....	33
sulfamethoxazole/trimethoprim ds.....	19	theochron .....	76
SULFAMYLON .....	20	theophylline cr .....	76
sulfasalazine .....	70	theophylline er.....	76
sulfatrim.....	20		
sulfazine .....	70		

<b>THERAPEUTIC</b>	
<b>NUTRIENTS/MINERALS/ELECTROLYTES</b>	
thermazene	20
THIOLA	59
thioridazine hcl	38
thiothixene	38
THYROLAR	64
ticlopidine hcl	45
TIKOSYN	47
timolol maleate	31, 73
TINDAMAX	35
tizanidine hcl	38
TOBRADEX	72
tobramycin sulfate	13
tobramycin/dexamethasone	72
tobrasol	13
tolazamide	41
tolbutamide	41
tolmetin sodium	12
TOPAMAX	21
TOPAMAX SPRINKLE	21
torsemide	49
TOVIAZ	59
<b>Toxicologic Agents</b>	25
tpn electrolytes ftv	88
TRACLEER	77
tramadol hcl	10
tramadol hydrochloride/acetaminophen	10
trandolapril	52
TRANSDERM-SCOP	28
tranylcypramine sulfate	23
TRAVASOL	88, 89
TRAVASOL 2.75%/DEXTROSE 10%	89
TRAVASOL 2.75%/DEXTROSE 5%	89
travasol 3.5%/electrolytes	89
TRAVASOL 8.5%/DEXTROSE 10%	89
TRAVASOL 8.5%/DEXTROSE 20%	89
TRAVASOL 8.5%/DEXTROSE 50%	89
travasol 8.5%/electrolytes	89
TRAVATAN Z	74
trazodone hcl	23
TRECATOR	32
tretinoin	35, 55
TREXIMET	31
trezix	10
triamcinolone acetonide	60
triamcinolone acetonide in absorbase	60
triamcinolone in orabase	54
triamterene/hydrochlorothiazide	49
TRICOR	50
<b>Tricyclics</b>	24
triderm	60
trifluoperazine hcl	38
trifluridine	39
trihexyphenidyl hcl	36
TRIHIBIT	70
tri-legest fe	63
TRILEPTAL	22
TRILIPIX	50
trilyte	57
trimethobenzamide hcl	28
trimethoprim	14
trimethoprim sulfate/polymyxin b sulfate	14
trimipramine maleate	25
trimox	17
trinessa	63
TRIPEDIA	70
tri-previfem	63
TRISENOX	33
tri-sprintec	63
trivora-28	63
TRIZIVIR	39
TROPHAMINE	90
tropicacyl	73
tropicamide	73
TRUVADA	39
TWINJECT	77
TWINRIX	70
TYGACIL	14
TYKERB	34
TYPHIM VI	70
TYSABRI	68
TYZEKA	39
TYZINE	78
TYZINE PEDIATRIC NASAL DROPS	78
u-cort	55
ULTRASE	56
ULTRASE MT	56
unithroid	64

UREX .....	14	<b>Vitamins</b> .....	90
UROXATRAL .....	59	VIVAGLOBIN .....	67
URSO .....	57	VIVELLE-DOT .....	63
URSO FORTE .....	57	VIVOTIF BERNA .....	70
ursodiol .....	57	vospire er .....	77
<b>Vaccines</b> .....	68	VYTORIN .....	50
VAGIFEM .....	63	warfarin sodium .....	44
VALCYTE .....	38	WELCHOL .....	50
valproate sodium .....	21	XALATAN .....	74
valproic acid .....	21	XOLAIR .....	78
VALTREX .....	39	XOPENEX HFA .....	77
vanacet .....	11	XYREM .....	53
VANCOCIN HCL .....	14	YF-VAX .....	70
vancomycin hcl .....	15	zaleplon .....	78
VANCOMYCIN HCL ISO-OSMOTIC DEXTROSE .....	15	ZANOSAR .....	32
vandazole .....	15	ZAVESCA .....	56
VAQTA .....	70	zazole .....	29
VARIVAX .....	70	ZEMAIRA .....	78
<b>Vasodilators</b> .....	52	ZEMPLAR .....	72
veetids .....	18	ZENAPAX .....	67
VELCADE .....	34	ZERIT .....	39
velivet .....	63	zerlor .....	11
venlafaxine hcl .....	24	ZETIA .....	50
VENLAFAXINE HCL ER .....	24	ZIAGEN .....	39
VENTAVIS .....	78	zidovudine .....	39
VENTOLIN HFA .....	77	ZMAX .....	18
VERAMYST .....	75	ZOLINZA .....	34
verapamil hcl .....	47	zolpidem tartrate .....	78
verapamil hcl er .....	47	ZOMETA .....	72
VESICARE .....	59	ZOMIG .....	31
VEXOL .....	73	ZOMIG ZMT .....	31
VFEND .....	29	zonisamide .....	20
VFEND IV .....	29	ZORBTIVE .....	61
VIDAZA .....	34	ZOSTAVAX .....	70
VIDEX EC .....	39	ZOSYN .....	18
VIDEX PEDIATRIC .....	39	zovia .....	63
VIGAMOX .....	19	ZOVIRAX .....	39
VIMPAT .....	20	ZYDONE .....	11
VIOKASE .....	56	ZYFLO CR .....	75
VIRACEPT .....	40	ZYMAR .....	19
VIRAMUNE .....	39	ZYPREXA .....	37
VIREAD .....	39	ZYPREXA ZYDIS .....	37
VISTIDE .....	38	ZYVOX .....	15