



AAA0 Vantage Zero (HMO-POS) 2012 Abridged Formulary

(List of Covered Drugs)

Current as of April 1, 2012

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

Note to existing members:

This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. This document includes Vantage Medicare Advantage's partial formulary as of January 1, 2012. For a complete updated formulary, please visit our web site at www.vhp-medicare.com or call (888) 823-1910, 8 a.m. – 8 p.m., seven days a week from October 15, 2011 through February 14, 2012. After February 14, 2012, Member Services may be reached from 8 a.m. – 8 p.m., Monday – Friday. TTY users should call (866) 524-5144.

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

Vantage Health Plan is a health plan with a Medicare contract. This document may be available in an alternate format such as a digital document. Please call Member Services at the phone numbers above to request the alternate format.

Vantage Medicare Advantage Premium (HMO-POS) Plan

2012 Abridged Formulary

What is the Vantage Medicare Advantage Formulary?

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

This document is a partial formulary and includes only some of the drugs covered by Vantage Medicare Advantage. For a complete listing of all prescription drugs covered by Vantage Medicare Advantage, please visit our website at www.vhp-medicare.com or call (888) 823-1910, 8 a.m. – 8 p.m., and seven days a week from October 15, 2011, through February 14, 2012. After February 14, 2012, Member Services may be reached from 8 a.m. – 8 p.m. Monday – Friday. TTY users should call (866) 524-5144.

Can the Formulary change?

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

If we remove drugs from our formulary, or add prior authorization, quantity limits, and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of the date printed on the cover. To get updated information about the drugs covered by Vantage Medicare Advantage, please visit our website at www.vhp-medicare.com or call (888) 823-1910, 8 a.m. – 8 p.m., and seven days a week from October 15, 2011, through February 14, 2012. After February 14, 2012, Member Services may be reached from 8 a.m. – 8 p.m. Monday – Friday. TTY users should call (866) 524-5144.

In the event of mid-year non-maintenance formulary changes that are approved by CMS, Vantage Medicare Advantage will update the printed and web-based versions of the formulary. The updated version of the

printed formulary will be available upon request, and the changes will be included in notices to members using the affected drug(s) no less than 60 days prior to the effective date of the change. The mid-year non-maintenance formulary changes will also be made to the CatalystRx searchable online formulary accessed via www.vhp-medicare.com/drugs/Drug_search.asp.

How do I use the Formulary?

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

Medical Condition The formulary begins on page 8. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list that begins on page 6. Then look under the category name for your drug.

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

What are generic drugs?

Vantage Medicare Advantage covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Vantage Medicare Advantage requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Vantage Medicare Advantage before you fill your prescriptions. If you do not get approval, Vantage Medicare Advantage may not cover the drug.
- **Quantity Limits:** For certain drugs, Vantage Medicare Advantage limits the amount of the drug that Vantage Medicare Advantage will cover. For example, Vantage Medicare Advantage provides 30 or 90 tablets per prescription for Lipitor. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Vantage Medicare Advantage requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Vantage Medicare Advantage may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Vantage Medicare Advantage will then cover Drug B.

- **Generic Substitution:** When there is a generic version of a brand-name drug available, the Vantage Medicare Advantage network pharmacies will automatically give you the generic version.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 8. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.vhp-medicare.com.

You can ask Vantage Medicare Advantage to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Vantage Medicare Advantage Formulary?” below for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this list of covered drugs, you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so Vantage Medicare Advantage may cover your drug. You can contact Member Services at (888) 823-1910, 8 a.m. – 8 p.m., and seven days a week from October 15, 2011, through February 14, 2012. After February 14, 2012, Member Services may be reached from 8 a.m. – 8 p.m. Monday – Friday. TTY users should call (866) 524-5144.

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

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

How do I request an exception to the Vantage Medicare Advantage Formulary?

You can ask Vantage Medicare Advantage to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Vantage Medicare Advantage limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier (Tier 3), you can ask us to cover it at the cost-sharing amount that applies to the drugs in the preferred tier (Tier 2) instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Drug tier (Tier 4).

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

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber's or physician's supporting statement.

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

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

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

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

Current enrollees with a level of care change (e.g., from a hospital to a long-term care facility) must follow standard Prior Authorization procedures during the transition period. Vantage Medicare Advantage requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Vantage Medicare Advantage before you fill your prescriptions during the transition period.

For more information

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

If you have questions about Vantage Medicare Advantage, please call Member Services at (888) 823-1910, 8 a.m. – 8 p.m., and seven days a week from October 15, 2011, through February 14, 2012. After February 14, 2012, Member Services may be reached from 8 a.m. – 8 p.m. Monday – Friday. TTY users should call (866) 524-5144. Or, visit www.vhp-medicare.com.

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Effective: April 1, 2012

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

Vantage Medicare Advantage's Formulary

The abridged formulary that begins on the next page provides coverage information about some of the drugs covered by Vantage Medicare Advantage. If you have trouble finding your drug in the list, turn to the Index at the back of the book. Remember, this is only a partial list of drugs covered by Vantage Medicare Advantage. If your prescription is not in this partial formulary, please visit our website at www.vhp-medicare.com or call Member Services at (888) 823-1910, 8 a.m. – 8 p.m., and seven days a week from October 15, 2011, through February 14, 2012. After February 14, 2012, Member Services may be reached from 8 a.m. – 8 p.m. Monday – Friday. TTY users should call (866) 524-5144 for additional help.

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

The information in the Requirements/Limits column tells you if Vantage Medicare Advantage has any special requirements for coverage of your drug. The formulary includes drugs which may have a Quantity Limit (QL) for that particular drug, or which may require Prior Authorization (PA) from Vantage Medicare Advantage before receiving them. B versus D determination drugs require the plan to make a determination as to whether a drug is covered under the Medicare Part B or Part D benefits.

**Vantage Medicare Advantage
AAA0 Vantage Zero (HMO-POS)**

2012 Abridged Formulary

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**Vantage Medicare Advantage
AAA0 Vantage Zero (HMO-POS)**

2012 Abridged Formulary

CURRENT AS OF March 1, 2012

<p><u>Drugs</u> UPPERCASE BOLD= Brand name drugs <i>lowercase italics</i>= Generic drugs</p>	<p><u>Tier</u></p> <table border="0"> <tr> <td></td> <td align="center" colspan="2"><u>Copayment/Coinsurance</u></td> </tr> <tr> <td></td> <td align="center"><u>Retail</u></td> <td align="center"><u>Mail Order</u></td> </tr> <tr> <td>1= Tier 1</td> <td align="center">\$5</td> <td align="center">\$15</td> </tr> <tr> <td>2= Tier 2</td> <td align="center">\$40</td> <td align="center">\$120</td> </tr> <tr> <td>3= Tier 3</td> <td align="center">\$80</td> <td align="center">\$240</td> </tr> <tr> <td>4= Tier 4</td> <td align="center">33%</td> <td align="center">33%</td> </tr> </table> <p>Retail copayment/coinsurance amounts and Mail Order Tier 4 amounts shown above are for a 31-day supply (unless you have a prescription written for fewer days). Amounts for Mail Order Tiers 1, 2 and 3 are for a 90-day supply.</p>		<u>Copayment/Coinsurance</u>			<u>Retail</u>	<u>Mail Order</u>	1= Tier 1	\$5	\$15	2= Tier 2	\$40	\$120	3= Tier 3	\$80	\$240	4= Tier 4	33%	33%	<p><u>Requirements/Limits</u> PA= Prior Authorization PA-NS= PA-New Starts Only BvD= Part B vs. Part D PA Only ST= Step Therapy ST-NS= ST-New Starts Only LA= Limited Access QL= Quantity Limit *= Available by Mail Order or Retail</p>
	<u>Copayment/Coinsurance</u>																			
	<u>Retail</u>	<u>Mail Order</u>																		
1= Tier 1	\$5	\$15																		
2= Tier 2	\$40	\$120																		
3= Tier 3	\$80	\$240																		
4= Tier 4	33%	33%																		

Drug	Tier	Requirements/Limits
Analgesics		
Opioid Analgesics, Long-Acting		
AVINZA ORAL	2	QL (60 EA per 25 day(s))
EMBEDA CAP 30-1.2 mg, 50-2 mg	3	QL (60 EA per 30 day(s))
<i>fentanyl TD</i>	1	QL (10 EA per 25 day(s))
KADIAN ORAL	2	QL (60 EA per 25 day(s))
OPANA ER ORAL	2	QL (120 EA per 25 day(s))
OXYCONTIN ORAL	2	QL (120 EA per 25 day(s))
Opioid Analgesics, Short-Acting		
<i>acetaminophen-codeine Elixir</i>	1	

Drug	Tier	Requirements/Limits
<i>acetaminophen-codeine Tab 300-15 mg</i>	1	
ASCOMP W/CODEINE ORAL	1	
ASTRAMORPH-PF INJ	1	
<i>buprenorphine SL</i>	1	
CO-GESIC ORAL	1	
DILAUDID-5 ORAL	2	
DURAMORPH INJ	1	
ENDOCET ORAL	1	
FENTORA BUCL	4	PA; QL (120 EA per 25 day(s))
<i>hydrocodone-acetaminophen Oral Soln 7.5-500 mg/15 mL</i>	1	
<i>hydrocodone-acetaminophen Tab 10-325 mg, 10-500 mg, 10-650 mg, 10-660 mg, 5-325 mg, 5-500 mg, 7.5-325 mg, 7.5-500 mg, 7.5-650 mg, 7.5-750 mg</i>	1	
<i>hydromorphone Oral</i>	1	
<i>hydromorphone (PF) Inj</i>	1	
<i>ibuprofen-oxycodone Oral</i>	1	
<i>levorphanol tartrate Oral</i>	1	
MARGESIC-H ORAL	1	
<i>methadone Oral Concentrate</i>	1	
<i>methadone Oral Soln</i>	1	
<i>methadone Tab</i>	1	QL (240 EA per 25 day(s))
<i>methadone Inj</i>	3	
METHADOSE ORAL	1	QL (240 EA per 25 day(s))
<i>nalbuphine Inj</i>	1	
<i>oxycodone Tab</i>	1	
<i>oxycodone HCl-oxycodone-ASA Oral</i>	1	
<i>oxycodone-acetaminophen Cap</i>	1	
<i>oxycodone-acetaminophen Tab 10-650 mg, 2.5-325 mg, 5-325 mg</i>	1	

Drug	Tier	Requirements/Limits
<i>pentazocine-acetaminophen Oral</i>	1	PA
<i>pentazocine-naloxone Oral</i>	1	
ROXICET TAB 5-325 mg	1	
ROXICET ORAL SOLN	2	
ROXICET TAB 5-500 mg	3	
STAGESIC ORAL	1	
SUBOXONE SUBLINGUAL TAB	2	
VICODIN HP ORAL	1	
ZERLOR ORAL	1	
Anesthetics		
Local Anesthetics		
<i>lidocaine (PF) Inj</i>	1	
<i>lidocaine HCl Inj</i>	1	
<i>lidocaine Mucosal Gel</i>	1	
<i>lidocaine Mucosal Soln</i>	1	
<i>lidocaine HCl Top</i>	1	BvD
<i>lidocaine-prilocaine Top</i>	1	BvD
LIDODERM TOP	2	PA
PARCAINE OPHT	1	
Antibacterials		
Amino Derivative Penicillins		
<i>amoxicillin Oral</i>	1	
<i>amoxicillin-potassium clavulanate Chewable Tab</i>	1	
<i>amoxicillin-potassium clavulanate ER 12 hr Tab</i>	1	
<i>amoxicillin-potassium clavulanate Oral Susp</i>	1	
<i>amoxicillin-potassium clavulanate Tab 250-125 mg</i>	1	
<i>ampicillin Oral</i>	1	
<i>ampicillin sodium Inj</i>	1	

Drug	Tier	Requirements/Limits
<i>ampicillin-sulbactam Inj</i>	1	
Aminoglycosides		
<i>amikacin Inj</i>	1	
<i>gentamicin Inj</i>	1	
<i>gentamicin Opht</i>	1	
<i>gentamicin Top</i>	1	
<i>gentamicin sulfate (PF) IV</i>	1	
<i>kanamycin Inj</i>	1	
<i>neomycin Oral</i>	1	
<i>paromomycin Oral</i>	1	
<i>streptomycin IM</i>	1	
<i>tobramycin sulfate Inj</i>	1	
<i>tobramycin sulfate Opht</i>	1	
Antifolate Antibacterials		
<i>trimethoprim Oral</i>	1	
Beta-Lactam, Other		
INVANZ INJ	2	
Cephalosporin Antibacterials, 1St Generation		
<i>cefadroxil Oral</i>	1	
<i>cephalexin Oral</i>	1	
Cephalosporin Antibacterials, 2Nd Generation		
<i>cefaclor Oral</i>	1	
<i>cefoxitin IV</i>	1	
<i>cefprozil Oral</i>	1	
<i>cefuroxime axetil Oral</i>	1	
<i>cefuroxime sodium Inj</i>	1	
<i>cefuroxime sodium IV</i>	1	
ZINACEF IV SOLUTION 7.5 gram	1	
ZINACEF IV SOLUTION 1.5 gram, 750 mg	3	

Drug	Tier	Requirements/Limits
ZINACEF IN DEXTROSE (ISO-OSM) IV	3	
ZINACEF IN STERILE WATER IV	3	
Cephalosporin Antibacterials, 3Rd Generation		
<i>cefdinir Oral</i>	1	
<i>cefepime Inj</i>	1	
<i>cefotaxime Inj</i>	1	
<i>cefpodoxime Oral</i>	1	
<i>ceftriaxone Inj</i>	1	
TAZICEF INJ	1	
TAZICEF IV	1	
Extended Spectrum Penicillins		
ZOSYN IN DEXTROSE (ISO-OSM) IV	2	
Glycopeptide Antibacterials		
<i>vancomycin IV Solution 1,000 mg, 10 gram</i>	1	BvD
Lincomycin Antibacterials		
CLEOCIN CAP 75 mg	2	
CLEOCIN VAGINAL SUPPOSITORY	2	
<i>clindamycin HCl Oral</i>	1	
<i>clindamycin phosphate Vagl</i>	1	
Macrolides		
<i>azithromycin Oral</i>	1	
<i>azithromycin IV</i>	1	BvD
<i>clarithromycin Oral</i>	1	
E.E.S. 400 ORAL	1	
ERYTHROCIN IV	2	
ERYTHROCIN STEARATE ORAL	1	
<i>erythromycin Opht</i>	1	
<i>erythromycin Oral</i>	1	
<i>erythromycin-sulfisoxazole Oral</i>	1	

Drug	Tier	Requirements/Limits
Miscellaneous Antibacterials		
<i>alcohol swabs Top</i>	2	
ALTABAX TOP	2	
BACIIM IM	1	
BACTROBAN TOPICAL CREAM	2	
BACTROBAN NASAL NASL	3	
<i>colistin (colistimethate Na) Inj</i>	1	BvD
<i>methenamine hippurate Oral</i>	1	
METROGEL TOP	2	
<i>metronidazole Oral</i>	1	
<i>metronidazole Top</i>	1	
<i>metronidazole Vagl</i>	1	
<i>mupirocin Top</i>	1	
<i>neomycin-polymyxin-HC Ear Soln</i>	1	
<i>polymyxin B sulfate Inj</i>	1	
PREVPAC ORAL	2	
<i>silver sulfadiazine Top</i>	1	
SSD TOP	1	
VANDAZOLE VAGL	1	
Natural Penicillins		
BICILLIN C-R IM	2	
BICILLIN L-A IM	2	
<i>penicillin G sodium Inj</i>	1	
<i>penicillin V potassium Oral</i>	1	
Nitrofurantoin Antibacterials		
MACRODANTIN CAP 25 mg	2	PA
MACRODANTIN CAP 100 mg	3	PA
<i>nitrofurantoin monohyd/m-cryst Oral</i>	1	PA
Penicillinase-Resistant Penicillins		

Drug	Tier	Requirements/Limits
<i>dicloxacillin Oral</i>	1	
<i>nafcillin Inj</i>	1	
<i>oxacillin Inj</i>	1	
Quinolones		
AVELOX ORAL	2	
AVELOX ABC PACK ORAL	2	
AVELOX IN NAACL (ISO-OSMOTIC) IV	2	
<i>ciprofloxacin IV</i>	1	
<i>ciprofloxacin Opht</i>	1	
<i>ciprofloxacin Oral</i>	1	
<i>ciprofloxacin ER multiphase 24 hr Tab 1,000 mg</i>	1	
LEVAQUIN IV	2	
LEVAQUIN ORAL	2	
LEVAQUIN IN D5W IV	2	
<i>ofloxacin Opht</i>	1	
<i>ofloxacin Oral</i>	1	
<i>ofloxacin Otic</i>	1	
Sulfonamides		
<i>sulfacetamide sodium (acne) Top</i>	1	
<i>sulfadiazine Oral</i>	1	
<i>sulfamethoxazole-trimethoprim IV</i>	1	
<i>sulfamethoxazole-trimethoprim Oral Susp</i>	1	
<i>sulfamethoxazole-trimethoprim Tab 400-80 mg</i>	1	
Tetracyclines		
<i>demeclocycline Oral</i>	1	
<i>doxycycline monohydrate Tab</i>	1	
<i>minocycline Cap</i>	1	
<i>minocycline Tab</i>	1	
ORACEA ORAL	2	

Drug	Tier	Requirements/Limits
<i>tetracycline Oral</i>	1	
Anticonvulsants		
Anticonvulsants, Other		
<i>levetiracetam Oral Soln</i>	1	MO
<i>levetiracetam Tab</i>	1	MO
Calcium Channel Modifying Agents		
CELONTIN ORAL	2	MO
<i>ethosuximide Oral</i>	1	MO
LYRICA CAP 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 50 mg, 75 mg	2	MO; QL (120 EA per 25 day(s))
LYRICA CAP 300 mg	2	MO; QL (60 EA per 25 day(s))
<i>zonisamide Oral</i>	1	MO
Gamma-Aminobutyric Acid (Gaba) Augmenting Agents		
<i>divalproex sprinkle Cap</i>	1	MO
<i>divalproex Tab, Delayed Release</i>	1	MO
<i>gabapentin Cap 100 mg</i>	1	MO; QL (1080 EA per 25 day(s))
<i>gabapentin Tab 800 mg</i>	1	MO; QL (120 EA per 25 day(s))
<i>gabapentin Tab 600 mg</i>	1	MO; QL (180 EA per 25 day(s))
<i>gabapentin Cap 400 mg</i>	1	MO; QL (270 EA per 25 day(s))
<i>gabapentin Cap 300 mg</i>	1	MO; QL (360 EA per 25 day(s))
GABITRIL ORAL	2	MO
<i>primidone Oral</i>	1	MO
<i>valproate sodium IV</i>	1	
<i>valproic acid Oral</i>	1	MO
<i>valproic acid (as sodium salt) Oral</i>	1	MO
Glutamate Reducing Agents		
<i>lamotrigine Oral</i>	1	MO
Sodium Channel Inhibitors		
<i>carbamazepine Chewable Tab</i>	1	MO

Drug	Tier	Requirements/Limits
<i>carbamazepine Oral Susp</i>	1	MO
<i>carbamazepine Tab</i>	1	MO
CARBATROL ORAL	2	MO
DILANTIN EXTENDED ORAL	2	MO
DILANTIN INFATABS ORAL	2	MO
DILANTIN-125 ORAL	2	MO
EPITOL ORAL	1	MO
<i>fosphenytoin Inj</i>	1	
<i>oxcarbazepine Oral</i>	1	MO
PEGANONE ORAL	2	MO
PHENYTEK ORAL	3	MO
<i>phenytoin Oral</i>	1	MO
<i>phenytoin sodium extended Oral</i>	1	MO
TEGRETOL XR ORAL	2	MO
Antidementia Agents		
Antidementia Agents, Other		
<i>ergoloid Oral</i>	1	PA; MO
Cholinesterase Inhibitors		
EXELON ORAL SOLN	2	MO
EXELON TD	2	MO; QL (30 EA per 30 day(s))
<i>galantamine Oral Soln</i>	1	MO
<i>galantamine ER 24 hr Cap</i>	1	MO; QL (30 EA per 30 day(s))
<i>galantamine Tab</i>	1	MO; QL (60 EA per 30 day(s))
Glutamate Pathway Modifiers		
NAMENDA ORAL SOLN	2	MO
NAMENDA TAB 10 mg	2	MO; QL (60 EA per 30 day(s))
NAMENDA TAB 5 mg	2	MO; QL (90 EA per 30 day(s))
NAMENDA TITRATION PAK ORAL	2	
Antidepressants		

Drug	Tier	Requirements/Limits
Antidepressants, Other		
BUDEPRION SR ORAL	1	MO; QL (60 EA per 30 day(s))
BUDEPRION XL 24 HR TAB 300 mg	1	MO; QL (30 EA per 30 day(s))
BUDEPRION XL 24 HR TAB 150 mg	1	MO; QL (90 EA per 30 day(s))
BUPROBAN ORAL	1	PA-NS; QL (62 EA per 31 day(s))
<i>bupropion HCl Tab</i>	1	MO
<i>bupropion HCl SR Tab 100 mg, 200 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>bupropion HCl SR Tab 150 mg</i>	1	MO; QL (62 EA per 31 day(s))
<i>maprotiline Oral</i>	1	MO
<i>mirtazapine Oral</i>	1	MO; QL (30 EA per 30 day(s))
<i>nefazodone Oral</i>	1	MO; QL (60 EA per 30 day(s))
<i>trazodone Oral</i>	1	MO
Monoamine Oxidase Inhibitors		
EMSAM TD	2	MO; QL (30 EA per 30 day(s))
MARPLAN ORAL	2	MO
<i>tranylcypromine Oral</i>	1	MO
Serotonin/ Norepinephrine Reuptake Inhibitors		
CYMBALTA CAP 60 mg	2	MO; QL (30 EA per 30 day(s))
CYMBALTA CAP 20 mg, 30 mg	2	MO; QL (60 EA per 30 day(s))
PRISTIQ ORAL	2	MO; QL (30 EA per 30 day(s))
<i>venlafaxine Tab</i>	1	MO; QL (90 EA per 30 day(s))
Tricyclics		
<i>amitriptyline Oral</i>	1	MO
<i>amoxapine Oral</i>	1	MO
<i>clomipramine Oral</i>	1	MO
<i>desipramine Oral</i>	1	MO
<i>doxepin Cap 10 mg, 100 mg, 25 mg, 50 mg, 75 mg</i>	1	MO
<i>doxepin Oral Concentrate</i>	1	MO
<i>imipramine HCl Oral</i>	1	MO

Drug	Tier	Requirements/Limits
<i>imipramine pamoate Oral</i>	1	MO
<i>nortriptyline Oral</i>	1	MO
<i>perphenazine-amitriptyline Oral</i>	1	MO
<i>protriptyline Oral</i>	1	MO
Antidotes, Deterrents, And Toxicologic Agents		
Alcohol Deterrents		
ANTABUSE TAB 250 mg	2	MO
ANTABUSE TAB 500 mg	3	MO
CAMPRAL DOSE PAK ORAL	2	MO; QL (180 EA per 30 day(s))
Antidotes		
<i>acetylcysteine Misc</i>	1	BvD
<i>amifostine crystalline IV</i>	1	
EXJADE TAB 125 mg	3	MO
EXJADE TAB 250 mg, 500 mg	4	MO
<i>leucovorin calcium Inj</i>	1	
<i>leucovorin calcium Oral</i>	1	
<i>mesna IV</i>	1	
MESNEX ORAL	3	
SYPRINE ORAL	2	
Opioid Antagonists		
<i>buprenorphine Inj</i>	1	
DEPADE ORAL	1	
<i>naloxone Inj</i>	1	
<i>naltrexone Oral</i>	1	
Smoking Cessation Agents		
CHANTIX ORAL	2	PA; QL (60 EA per 30 day(s))
CHANTIX STARTING MONTH PAK ORAL	2	PA; QL (53 EA per 28 day(s))
NICOTROL INHL	3	PA; QL (174 EA per 31 day(s))
Antiemetics		

Drug	Tier	Requirements/Limits
5-Hydroxytryptamine 3 (5-Ht3) Antagonists		
<i>granisetron IV</i>	1	QL (14 ML per 30 day(s))
<i>granisetron Oral</i>	1	QL (60 EA per 30 day(s))
<i>granisetron (PF) IV</i>	1	
GRANISOL ORAL	1	
<i>ondansetron Oral</i>	1	QL (45 EA per 30 day(s))
<i>ondansetron HCl Oral Soln</i>	1	
<i>ondansetron HCl Tab 4 mg, 8 mg</i>	1	QL (45 EA per 30 day(s))
<i>ondansetron HCl Tab 24 mg</i>	1	QL (7 EA per 30 day(s))
<i>ondansetron HCl (PF) Inj</i>	1	
Antiemetics, Other		
COMPRO RECT	1	
<i>meclizine Oral</i>	1	
<i>metoclopramide Inj</i>	1	
<i>metoclopramide Oral</i>	1	
PHENADOZ RECT	1	PA
<i>prochlorperazine Rect</i>	1	
<i>prochlorperazine Edisylate Inj</i>	1	
<i>prochlorperazine maleate Oral</i>	1	MO
<i>promethazine Inj</i>	1	PA
<i>promethazine Oral</i>	1	PA
<i>promethazine Rect</i>	1	PA
PROMETHAZINE VC ORAL	1	PA
PROMETHEGAN RECT	1	PA
TRANSDERM-SCOP TD	2	PA
<i>trimethobenzamide IM</i>	1	PA
<i>trimethobenzamide Oral</i>	1	PA
Neurokinin 1 (Nk1) Receptor Antagonists		
EMEND CAP 40 mg	2	QL (1 EA per 30 day(s))

Drug	Tier	Requirements/Limits
EMEND CAPS IN DOSE PACK	2	QL (12 EA per 30 day(s))
EMEND CAP 125 mg	2	QL (2 EA per 25 day(s))
EMEND CAP 80 mg	2	QL (4 EA per 25 day(s))
Antifungals		
Allylamine Antifungals		
<i>terbinafine Oral</i>	1	PA
Antifungals (Other)		
ANCOBON ORAL	2	
<i>ciclopirox Top</i>	1	
GRIFULVIN V ORAL	3	
<i>griseofulvin microsize Oral</i>	1	
GRIS-PEG ORAL	2	
Azole Antifungals		
<i>clotrimazole MM</i>	1	
<i>clotrimazole Top</i>	1	
<i>econazole Top</i>	1	
ERTACZO TOP	3	
<i>fluconazole Oral</i>	1	
<i>itraconazole Oral</i>	1	PA
<i>ketoconazole Oral</i>	1	
<i>ketoconazole Shampoo</i>	1	
<i>ketoconazole Topical Cream</i>	1	
MICONAZOLE-3 VAGL	1	
<i>terconazole Vagl</i>	1	
ZAZOLE VAGL	1	
Polyene Antifungals		
<i>amphotericin B Inj</i>	1	BvD
NATACYN OPHT	2	
<i>nystatin Oral</i>	1	

Drug	Tier	Requirements/Limits
<i>nystatin Top</i>	1	
<i>nystatin-triamcinolone Top</i>	1	
NYSTOP TOP	1	
PEDI-DRI TOP	1	
Antigout Agents		
Antigout Agents (Non-Renal Tubular Blocking Agents And Non-Xanthine Inhibitors)		
COLCRYS ORAL	2	QL (120 EA per 30 day(s))
Renal Tubular Blocking Agents		
<i>colchicine-probenecid Oral</i>	1	MO
<i>probenecid Oral</i>	1	MO
Xanthine Oxidase Inhibitors		
<i>allopurinol sodium IV</i>	1	
Anti-Inflammatory Agents		
Nonsteroidal Anti-Inflammatory Drugs		
CELEBREX ORAL	2	MO; QL (60 EA per 30 day(s))
<i>diclofenac potassium Oral</i>	1	MO
<i>diclofenac sodium Oral</i>	1	MO
<i>diflunisal Oral</i>	1	MO
<i>etodolac Oral</i>	1	MO
<i>fenoprofen Oral</i>	1	MO
<i>flurbiprofen Oral</i>	1	MO
<i>ibuprofen Oral</i>	1	
<i>indomethacin Oral</i>	1	MO
<i>ketoprofen Oral</i>	1	MO
<i>meclofenamate Oral</i>	1	MO
<i>meloxicam Oral</i>	1	MO
<i>nabumetone Oral</i>	1	MO
<i>naproxen Oral Susp</i>	1	MO
<i>naproxen Tab 250 mg, 375 mg</i>	1	MO

Drug	Tier	Requirements/Limits
<i>naproxen Tab, Delayed Release</i>	1	MO
<i>naproxen sodium Oral</i>	1	MO
<i>oxaprozin Oral</i>	1	MO
<i>piroxicam Oral</i>	1	MO
<i>sulindac Oral</i>	1	MO
<i>tolmetin Oral</i>	1	MO
Antimigraine Agents		
Ergot Alkaloids		
<i>dihydroergotamine Inj</i>	1	
<i>ergotamine-caffeine Oral</i>	1	
MIGERGOT RECT	1	
MIGRANAL NASL	2	QL (8 ML per 25 day(s))
Triptans		
AXERT TAB 12.5 mg	3	QL (12 EA per 25 day(s))
FROVA ORAL	3	QL (18 EA per 25 day(s))
RELPAK ORAL	2	QL (12 EA per 25 day(s))
<i>sumatriptan Sub-Q 6 mg/0.5 mL</i>	1	QL (10 ML per 25 day(s))
<i>sumatriptan Sub-Q 4 mg/0.5 mL</i>	1	QL (4 ML per 25 day(s))
<i>sumatriptan succinate Oral</i>	1	QL (9 EA per 25 day(s))
Antimyasthenic Agents		
Parasympathomimetics		
<i>guanidine Oral</i>	2	
<i>pyridostigmine bromide Oral</i>	1	
Antimycobacterials		
Antimycobacterials, Other		
<i>dapsone Oral</i>	1	MO
MYCOBUTIN ORAL	2	
Antituberculars		
<i>ethambutol Oral</i>	1	

Drug	Tier	Requirements/Limits
ISONARIF ORAL	1	
<i>isoniazid Inj</i>	1	
<i>isoniazid Oral</i>	1	MO
<i>pyrazinamide Oral</i>	1	
<i>rifampin IV</i>	1	
<i>rifampin Oral</i>	1	
Antineoplastics		
Alkylating Agents, Other		
<i>carboplatin IV</i>	1	
<i>cisplatin IV</i>	1	
<i>dacarbazine IV</i>	1	
IFEX IV	3	
<i>ifosfamide IV</i>	1	
<i>ifosfamide-mesna IV</i>	4	
<i>thiotepa Inj</i>	1	
<i>vincristine IV</i>	1	
Antiangiogenic Agents		
REVLIMID ORAL	4	PA-NS; LA
THALOMID ORAL	4	PA-NS; MO
Anti-Cd20 Antibodies		
AVASTIN IV	4	
CAMPATH IV	4	
RITUXAN IV	4	PA-NS
Antimetabolites, Other		
DROXIA ORAL	2	MO
<i>fluorouracil IV</i>	1	
<i>hydroxyurea Oral</i>	1	
<i>idarubicin IV</i>	1	
Antineoplastics, Other		

Drug	Tier	Requirements/Limits
ADRIAMYCIN PFS IV	1	
<i>bleomycin Inj</i>	1	
COSMEGEN IV	4	
<i>daunorubicin IV</i>	1	
<i>doxorubicin IV</i>	1	
<i>epirubicin IV</i>	1	
<i>etoposide IV</i>	1	
<i>irinotecan IV</i>	1	
<i>mitomycin IV</i>	1	
<i>mitoxantrone IV</i>	1	
ONTAK IV	4	
<i>paclitaxel IV</i>	1	
TOPOSAR IV	1	
<i>vinorelbine IV</i>	1	
ZOLINZA ORAL	4	
Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitors		
IRESSA ORAL	4	
TARCEVA TAB 100 mg, 150 mg	4	PA-NS; QL (31 EA per 31 day(s))
TARCEVA TAB 25 mg	4	PA-NS; QL (62 EA per 31 day(s))
Estrogen-Nitrosoureas		
EMCYT ORAL	2	
FASLODEX IM	4	
Multitargeted Kinase Inhibitors, Bcr-Abl/C-Kit Receptor Tyrosine Kinase Inhibitors		
GLEEVEC ORAL	4	
SPRYCEL TAB 20 mg	4	QL (120 EA per 30 day(s))
SPRYCEL TAB 100 mg, 50 mg, 70 mg	4	QL (60 EA per 30 day(s))
TASIGNA CAP 200 mg	4	
Multitargeted Kinase Inhibitors, Her2 Receptor Tyrosine Kinase Inhibitors		
TYKERB ORAL	4	QL (180 EA per 30 day(s))

Drug	Tier	Requirements/Limits
Multitargeted Kinase Inhibitors, Vascular Endothelial Growth Factor Receptor Tyrosine Kinase Inhib.		
AFINITOR TAB 5 mg	4	PA-NS; QL (31 EA per 31 day(s))
AFINITOR TAB 10 mg	4	PA-NS; QL (62 EA per 31 day(s))
NEXAVAR ORAL	4	PA-NS; QL (124 EA per 31 day(s))
SUTENT CAP 12.5 mg	4	PA-NS; QL (124 EA per 31 day(s))
SUTENT CAP 50 mg	4	PA-NS; QL (31 EA per 31 day(s))
SUTENT CAP 25 mg	4	PA-NS; QL (62 EA per 31 day(s))
Nitrogen Mustards		
LEUKERAN ORAL	2	
MUSTARGEN INJ	3	
Nitrosoureas		
BICNU IV	3	
CEENU ORAL	2	
Purine Analogs And Related Inhibitors		
<i>cladribine IV</i>	4	
<i>cytarabine (PF) Solution for Injection</i>	1	
<i>fludarabine IV</i>	1	
<i>mercaptopurine Oral</i>	1	
<i>pentostatin IV</i>	4	
TABLOID ORAL	2	
Retinoids		
TARGRETIN ORAL	4	
TARGRETIN TOP	4	
<i>tretinoin (chemotherapy) Oral</i>	4	
Selective Estrogen Receptor Modulators, 1St Generation		
FARESTON ORAL	2	MO
<i>tamoxifen Oral</i>	1	MO
Antiparasitics		
Anthelmintics		

Drug	Tier	Requirements/Limits
ALBENZA ORAL	2	
<i>mebendazole Oral</i>	1	
Antimalarials		
<i>chloroquine phosphate Oral</i>	1	MO
DARAPRIM ORAL	2	
<i>hydroxychloroquine Oral</i>	1	MO
MALARONE ORAL	2	
<i>mefloquine Oral</i>	1	MO
QUALAQUIN ORAL	2	
Antiprotozoals (Non-Antimalarials)		
ALINIA TAB	2	QL (12 EA per 25 day(s))
ALINIA ORAL SUSP	2	QL (180 ML per 25 day(s))
Pediculicides/ Scabicides		
ACTICIN TOP	1	
EURAX TOP	2	
<i>lindane Top</i>	1	
<i>permethrin Top</i>	1	
Antiparkinson Agents		
Anticholinergics		
<i>benztropine Inj</i>	1	
<i>benztropine Oral</i>	1	MO
<i>trihexyphenidyl Oral</i>	1	MO
Antiparkinson Agents, Other		
<i>amantadine Oral</i>	1	MO
Catechol O-Methyltransferase (Comt) Inhibitors		
COMTAN ORAL	2	MO
TASMAR ORAL	3	MO
Dopamine Agonists, Ergot		
<i>bromocriptine Oral</i>	1	MO

Drug	Tier	Requirements/Limits
<i>cabergoline Oral</i>	1	
Dopamine Agonists, Nonergot		
<i>pramipexole Tab 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 1.5 mg</i>	1	MO
<i>ropinirole Oral</i>	1	MO
Dopamine Precursors		
<i>carbidopa-levodopa ER Tab</i>	1	MO
<i>carbidopa-levodopa Tab, Rapid Dissolve</i>	1	MO
STALEVO 100 ORAL	2	MO
STALEVO 125 ORAL	2	MO
STALEVO 150 ORAL	2	MO
STALEVO 200 ORAL	2	MO
STALEVO 50 ORAL	2	MO
STALEVO 75 ORAL	2	MO
Monoamine Oxidase B (Mao-B) Inhibitors		
AZILECT ORAL	2	MO
<i>selegiline HCl Oral</i>	1	MO
Antipsychotics		
Atypicals		
ABILIFY IM	3	
ABILIFY ORAL SOLN	3	MO
ABILIFY TAB 2 mg, 20 mg, 30 mg, 5 mg	3	MO; QL (30 EA per 30 day(s))
ABILIFY TAB 15 mg	3	MO; QL (60 EA per 30 day(s))
ABILIFY TAB 10 mg	3	MO; QL (90 EA per 30 day(s))
ABILIFY DISCMELT 15 mg	3	MO; QL (60 EA per 30 day(s))
ABILIFY DISCMELT 10 mg	3	MO; QL (90 EA per 30 day(s))
<i>clozapine Oral</i>	1	
FANAPT TAB 6 mg, 8 mg	3	ST-NS; QL (30 EA per 30 day(s))
FAZACLO TAB, RAPID DISSOLVE 100 mg, 12.5 mg, 25 mg	2	

Drug	Tier	Requirements/Limits
GEODON IM	2	
GEODON ORAL	2	MO; QL (60 EA per 30 day(s))
<i>risperidone Oral Soln</i>	1	MO
<i>risperidone Tab</i>	1	MO; QL (60 EA per 30 day(s))
SAPHRIS SL	3	MO; QL (62 EA per 31 day(s))
SEROQUEL TAB 25 mg, 300 mg, 400 mg	2	MO; QL (60 EA per 30 day(s))
SEROQUEL TAB 100 mg, 200 mg, 50 mg	2	MO; QL (90 EA per 30 day(s))
SEROQUEL XR 24 HR TAB 150 mg, 300 mg, 400 mg	2	MO; QL (60 EA per 30 day(s))
SEROQUEL XR 24 HR TAB 200 mg, 50 mg	2	MO; QL (90 EA per 30 day(s))
ZYPREXA IM	2	
ZYPREXA ORAL	2	MO; QL (30 EA per 30 day(s))
ZYPREXA ZYDIS ORAL	2	MO; QL (30 EA per 30 day(s))
Conventional		
<i>chlorpromazine Inj</i>	1	
<i>chlorpromazine Oral</i>	1	MO
<i>fluphenazine decanoate Inj</i>	1	
<i>fluphenazine HCl Inj</i>	1	
<i>fluphenazine HCl Oral</i>	1	MO
<i>haloperidol Oral</i>	1	MO
<i>haloperidol decanoate IM</i>	1	
<i>haloperidol lactate Inj</i>	1	
<i>haloperidol lactate Oral</i>	1	MO
<i>loxapine succinate Oral</i>	1	MO
ORAP ORAL	2	MO
<i>perphenazine Oral</i>	1	MO
<i>thioridazine Oral</i>	1	PA-NS; MO
<i>thiothixene Oral</i>	1	MO
<i>trifluoperazine Oral</i>	1	MO

Drug	Tier	Requirements/Limits
Antispasticity Agents		
Antispasticity Agents		
<i>baclofen Oral</i>	1	MO
<i>dantrolene Oral</i>	1	
<i>tizanidine Oral</i>	1	MO
Antivirals		
Anti-Cytomegalovirus (Cmv) Agents		
<i>foscarnet IV</i>	1	BvD
<i>ganciclovir Cap 250 mg</i>	1	MO
<i>ganciclovir Cap 500 mg</i>	4	MO
Antihepatitis Agents		
BARACLUDE ORAL SOLN	2	MO; QL (630 ML per 30 day(s))
BARACLUDE TAB	4	MO; QL (30 EA per 30 day(s))
HEPSERA ORAL	4	MO; QL (30 EA per 30 day(s))
REBETOL ORAL SOLN	3	PA
RIBAPAK DOSE PACK ORAL	4	PA
RIBASPHERE CAP	1	PA
RIBASPHERE TAB 200 mg	1	PA
RIBASPHERE TAB 400 mg, 600 mg	4	PA
TYZEKA ORAL	2	MO
Antiherpetic Agents		
<i>acyclovir Oral</i>	1	
<i>acyclovir sodium IV</i>	1	
DENAVIR TOP	2	
<i>famciclovir Oral</i>	1	
VALCYTE ORAL	4	MO
ZOVIRAX TOP	2	
Anti-Hiv Agents, Non-Nucleoside Reverse Transcriptase Inhibitors		
ATRIPLA ORAL	4	MO

Drug	Tier	Requirements/Limits
INTELENCE TAB 100 mg	4	MO
RESCRIPTOR ORAL	2	MO
SUSTIVA ORAL	2	MO
VIRAMUNE ORAL	2	MO
Anti-Hiv Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors		
COMBIVIR ORAL	2	MO
<i>didanosine Oral</i>	1	MO
EMTRIVA ORAL	2	MO
EPIVIR ORAL	2	MO
EPIVIR HBV ORAL	2	MO
EPZICOM ORAL	2	MO
RETROVIR IV	2	
<i>stavudine Oral</i>	1	MO
TRIZIVIR ORAL	4	MO
TRUVADA ORAL	4	MO
VIDEX 2 GRAM PEDIATRIC ORAL	2	MO
VIREAD ORAL	4	MO
ZIAGEN ORAL	2	MO
<i>zidovudine Oral</i>	1	MO
Anti-Hiv Agents, Other		
FUZEON SUBQ	4	MO
ISENTRESS ORAL	4	MO
SELZENTRY ORAL	4	MO
Anti-Hiv Agents, Protease Inhibitors		
APTIVUS ORAL	2	MO
CRIXIVAN ORAL	2	MO
INVIRASE CAP	2	MO
INVIRASE TAB	4	MO
KALETRA TAB 100-25 mg	2	MO

Drug	Tier	Requirements/Limits
KALETRA ORAL SOLN	4	MO
KALETRA TAB 200-50 mg	4	MO
LEXIVA ORAL	2	MO
NORVIR ORAL	2	MO
PREZISTA TAB 75 mg	2	MO
PREZISTA TAB 400 mg, 600 mg	4	MO
REYATAZ CAP 100 mg	2	MO
REYATAZ CAP 150 mg, 200 mg, 300 mg	4	MO
VIRACEPT ORAL POWDER	2	MO
VIRACEPT TAB 250 mg	2	MO
VIRACEPT TAB 625 mg	4	MO
Anti-Influenza Agents		
<i>rimantadine Oral</i>	1	
TAMIFLU ORAL SUSP 12 mg/mL	2	
TAMIFLU CAP 30 mg	2	QL (112 EA per 365 day(s))
TAMIFLU CAP 45 mg, 75 mg	2	QL (56 EA per 365 day(s))
Anxiolytics		
Antidepressants		
<i>citalopram Oral Soln</i>	1	MO
<i>citalopram Tab 40 mg</i>	1	MO; QL (30 EA per 30 day(s))
<i>citalopram Tab 10 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>citalopram Tab 20 mg</i>	1	MO; QL (90 EA per 30 day(s))
<i>fluoxetine Oral Soln</i>	1	MO
<i>fluoxetine Cap 20 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>fluoxetine Tab 20 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>fluoxetine Cap 10 mg</i>	1	MO; QL (240 EA per 30 day(s))
<i>fluoxetine Tab 10 mg</i>	1	MO; QL (240 EA per 30 day(s))
<i>fluoxetine Cap, Delayed Release</i>	1	MO; QL (4 EA per 28 day(s))
<i>fluoxetine Cap 40 mg</i>	1	MO; QL (60 EA per 30 day(s))

Drug	Tier	Requirements/Limits
<i>fluvoxamine Oral</i>	1	MO; QL (90 EA per 30 day(s))
LEXAPRO ORAL SOLN	2	MO
LEXAPRO TAB	2	MO; QL (30 EA per 30 day(s))
<i>paroxetine Oral Susp</i>	1	MO
<i>paroxetine Tab 10 mg</i>	1	MO
<i>paroxetine Tab 20 mg, 40 mg</i>	1	MO; QL (30 EA per 30 day(s))
<i>paroxetine ER 24 hr Tab 12.5 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>paroxetine Tab 30 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>paroxetine ER 24 hr Tab 25 mg</i>	1	MO; QL (90 EA per 30 day(s))
<i>sertraline Oral Concentrate</i>	1	MO
<i>sertraline Tab 100 mg, 25 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>sertraline Tab 50 mg</i>	1	MO; QL (90 EA per 30 day(s))
Anxiolytics, Other		
<i>amitriptyline-chlordiazepoxide Oral</i>	1	PA-NS; MO
<i>buspirone Oral</i>	1	
<i>meprobamate Oral</i>	1	PA-NS
Bipolar Agents		
Bipolar Agents		
<i>lithium carbonate Oral</i>	1	MO
<i>lithium citrate Oral</i>	1	MO
Blood Glucose Regulators		
Alpha Glucosidase Inhibitors		
<i>acarbose Tab 25 mg</i>	1	MO
<i>acarbose Tab 100 mg, 50 mg</i>	1	MO; QL (90 EA per 30 day(s))
Amylinomimetics		
SYMLIN SUBQ	2	MO; QL (20 ML per 30 day(s))
SYMLINPEN 120 SUBQ	2	MO; QL (11 ML per 30 day(s))
SYMLINPEN 60 SUBQ	2	MO; QL (11 ML per 30 day(s))
Biguanides		

Drug	Tier	Requirements/Limits
FORTAMET 24 HR TAB CTRL REL 500 mg	3	MO; QL (150 EA per 30 day(s))
FORTAMET 24 HR TAB CTRL REL 1,000 mg	3	MO; QL (60 EA per 30 day(s))
GLUMETZA ORAL	3	MO; QL (120 EA per 30 day(s))
<i>metformin ER 24 hr Tab 500 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>metformin Tab 500 mg</i>	1	MO; QL (150 EA per 30 day(s))
<i>metformin ER 24 hr Tab 750 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>metformin Tab 1,000 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>metformin Tab 850 mg</i>	1	MO; QL (90 EA per 30 day(s))
Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors		
JANUMET ORAL	2	MO; QL (60 EA per 30 day(s))
JANUVIA ORAL	2	MO; QL (30 EA per 30 day(s))
ONGLYZA ORAL	2	MO; QL (30 EA per 30 day(s))
Glycemic Agents		
GLUCAGEN HYPOKIT INJ	2	
GLUCAGON EMERGENCY INJ	2	
Incretin Mimetics		
BYETTA SUBQ	2	MO; QL (2.4 ML per 30 day(s))
VICTOZA SUBQ	2	MO
Insulin Mixtures, Analogs		
HUMALOG MIX 50-50 SUBQ	2	MO
HUMALOG MIX 75-25 SUBQ	2	MO
NOVOLOG MIX 70-30 SUBQ	2	MO
Insulin Mixtures, Short-Acting And Intermediate-Acting		
HUMULIN 70/30 SUBQ	2	MO
HUMULIN 70/30 PEN SUBQ	2	MO
NOVOLIN 70/30 SUBQ	2	MO
Insulin, Intermediate-Acting		
HUMULIN N SUBQ	2	MO
NOVOLIN N SUBQ	2	MO

Drug	Tier	Requirements/Limits
Insulin, Long-Acting		
LANTUS SUBQ	2	MO
LEVEMIR SUBQ	2	MO
Insulin, Rapid-Acting		
APIDRA SUBQ	2	MO
HUMALOG SUBQ	2	MO
NOVOLOG SUBQ	2	MO
Insulin, Short-Acting		
HUMULIN R INJ	2	MO
HUMULIN R U-500 "CONCENTRATED" INJ	2	MO
NOVOLIN R INJ	2	MO
Meglitinides		
<i>nateglinide Oral</i>	1	MO; QL (90 EA per 30 day(s))
PRANDIN TAB 0.5 mg, 1 mg	2	MO; QL (120 EA per 30 day(s))
PRANDIN TAB 2 mg	2	MO; QL (240 EA per 30 day(s))
Sulfonylureas		
<i>chlorpropamide Tab 100 mg</i>	1	PA; MO; QL (210 EA per 30 day(s))
<i>chlorpropamide Tab 250 mg</i>	1	PA; MO; QL (90 EA per 30 day(s))
<i>glimepiride Tab 2 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>glimepiride Tab 1 mg</i>	1	MO; QL (240 EA per 30 day(s))
<i>glimepiride Tab 4 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>glipizide ER 24 hour Tab 5 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>glipizide Tab 10 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>glipizide ER 24 hour Tab 2.5 mg</i>	1	MO; QL (240 EA per 30 day(s))
<i>glipizide Tab 5 mg</i>	1	MO; QL (240 EA per 30 day(s))
<i>glipizide ER 24 hour Tab 10 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>glipizide-metformin Tab 2.5-500 mg, 5-500 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>glipizide-metformin Tab 2.5-250 mg</i>	1	MO; QL (240 EA per 30 day(s))

Drug	Tier	Requirements/Limits
<i>glyburide Tab 5 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>glyburide Tab 2.5 mg</i>	1	MO; QL (240 EA per 30 day(s))
<i>glyburide Tab 1.25 mg</i>	1	MO; QL (480 EA per 30 day(s))
<i>glyburide micronized Tab 3 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>glyburide micronized Tab 1.5 mg</i>	1	MO; QL (240 EA per 30 day(s))
<i>glyburide micronized Tab 6 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>glyburide-metformin Tab 2.5-500 mg, 5-500 mg</i>	1	MO; QL (120 EA per 30 day(s))
<i>glyburide-metformin Tab 1.25-250 mg</i>	1	MO; QL (240 EA per 30 day(s))
GLYCRON TAB 3 mg	1	MO; QL (120 EA per 30 day(s))
GLYCRON TAB 1.5 mg	1	MO; QL (240 EA per 30 day(s))
GLYCRON TAB 6 mg	1	MO; QL (60 EA per 30 day(s))
GLYCRON TAB 4.5 mg	3	MO; QL (60 EA per 30 day(s))
<i>tolazamide Tab 500 mg</i>	1	MO; QL (180 EA per 30 day(s))
<i>tolazamide Tab 250 mg</i>	1	MO; QL (360 EA per 30 day(s))
<i>tolbutamide Oral</i>	1	MO; QL (180 EA per 30 day(s))
Thiazolidinediones		
ACTOPLUS MET ORAL	2	MO; QL (90 EA per 30 day(s))
ACTOPLUS MET XR ORAL	2	MO; QL (60 EA per 30 day(s))
ACTOS TAB 30 mg, 45 mg	2	MO; QL (30 EA per 30 day(s))
ACTOS TAB 15 mg	2	MO; QL (90 EA per 30 day(s))
AVANDAMET TAB 2-500 mg	2	MO; QL (120 EA per 30 day(s))
AVANDAMET TAB 2-1,000 mg, 4-1,000 mg, 4-500 mg	2	MO; QL (60 EA per 30 day(s))
AVANDARYL TAB 4-4 mg, 8-2 mg, 8-4 mg	2	MO; QL (30 EA per 30 day(s))
AVANDARYL TAB 4-1 mg, 4-2 mg	2	MO; QL (60 EA per 30 day(s))
AVANDIA TAB 2 mg	2	MO; QL (120 EA per 30 day(s))
AVANDIA TAB 8 mg	2	MO; QL (30 EA per 30 day(s))
AVANDIA TAB 4 mg	2	MO; QL (60 EA per 30 day(s))
DUETACT ORAL	2	MO; QL (30 EA per 30 day(s))

Drug	Tier	Requirements/Limits
Blood Products/Modifiers/ Volume Expanders		
Adenosine Diphosphate P2y12 Inhibitors		
PLAVIX ORAL	2	MO
<i>ticlopidine Oral</i>	1	MO
Anticoagulants, Oral		
COUMADIN ORAL	2	MO
COUMADIN IV	3	
JANTOVEN ORAL	1	MO
<i>warfarin Oral</i>	1	MO
Colony Stimulating Factors		
LEUKINE INJ	4	PA
NEULASTA SUBQ	4	PA; QL (1.2 ML per 30 day(s))
NEUPOGEN INJECTION	4	PA
NEUPOGEN SYRINGE 480 mcg/0.8 mL	4	PA
NEUPOGEN SYRINGE 300 mcg/0.5 mL	4	PA; QL (7 ML per 30 day(s))
Cyclic Adenosine Monophosphate Reuptake Inhibitors		
AGGRENOX ORAL	2	MO
<i>anagrelide Oral</i>	1	MO
<i>dipyridamole Oral</i>	1	PA; MO
Erythropoietins		
ARANESP (POLYSORBATE) SYRINGE 100 mcg/0.5 mL	3	PA; QL (2 ML per 30 day(s))
ARANESP (POLYSORBATE) SYRINGE 60 mcg/0.3 mL	3	PA; QL (2.4 ML per 30 day(s))
ARANESP (POLYSORBATE) SYRINGE 40 mcg/0.4 mL	3	PA; QL (3.2 ML per 30 day(s))
ARANESP (POLYSORBATE) SYRINGE 25 mcg/0.42 mL	3	PA; QL (3.4 ML per 30 day(s))
ARANESP (POLYSORBATE) INJECTION 100 mcg/mL	3	PA; QL (4 ML per 30 day(s))

Drug	Tier	Requirements/Limits
ARANESP (POLYSORBATE) INJECTION 25 mcg/mL, 40 mcg/mL, 60 mcg/mL	3	PA; QL (8 ML per 30 day(s))
ARANESP (POLYSORBATE) SYRINGE 500 mcg/mL	4	PA; QL (1 ML per 30 day(s))
ARANESP (POLYSORBATE) SYRINGE 150 mcg/0.3 mL	4	PA; QL (1.2 ML per 30 day(s))
ARANESP (POLYSORBATE) SYRINGE 200 mcg/0.4 mL	4	PA; QL (1.6 ML per 30 day(s))
ARANESP (POLYSORBATE) SYRINGE 300 mcg/0.6 mL	4	PA; QL (2.4 ML per 30 day(s))
ARANESP (POLYSORBATE) INJECTION 200 mcg/mL, 300 mcg/mL	4	PA; QL (4 ML per 30 day(s))
EPOGEN INJECTION 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL	2	PA; QL (12 ML per 30 day(s))
EPOGEN INJECTION 20,000 unit/2 mL	3	PA; QL (12 ML per 30 day(s))
NEUMEGA SUBQ	4	PA; QL (21 EA per 30 day(s))
PROCRIT INJECTION 2,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL	2	PA; QL (12 ML per 30 day(s))
PROCRIT INJECTION 10,000 unit/mL	3	PA; QL (12 ML per 30 day(s))
PROCRIT INJECTION 20,000 unit/mL, 40,000 unit/mL	4	PA; QL (12 ML per 30 day(s))
PROMACTA TAB 50 mg	4	PA-NS; MO; QL (30 EA per 30 day(s))
PROMACTA TAB 25 mg	4	PA-NS; MO; QL (90 EA per 30 day(s))
Factor Xa Inhibitors, Indirect		
ARIXTRA SUB-Q SYRINGE 2.5 mg/0.5 mL	3	
ARIXTRA SUB-Q SYRINGE 10 mg/0.8 mL, 5 mg/0.4 mL, 7.5 mg/0.6 mL	4	
Low Molecular Weight Heparins		
FRAGMIN SUB-Q	3	
FRAGMIN SUB-Q SYRINGE 2,500 unit/0.2 mL, 5,000 unit/0.2 mL	3	

Drug	Tier	Requirements/Limits
FRAGMIN SUB-Q SYRINGE 10,000 unit/mL, 7,500 unit/0.3 mL	4	
<i>heparin (porcine) Injection 1,000 unit/mL</i>	1	BvD
<i>heparin (porcine) in D5W IV</i>	1	BvD
LOVENOX SUB-Q	3	
Phosphodiesterase Iii/Adenosine Uptake Inhibitors		
<i>cilostazol Oral</i>	1	MO
Cardiovascular Agents		
3-Hydroxy-3-Methylglutaryl Coenzyme A (Hmg Coa) Reductase Inhibitors		
CRESTOR ORAL	2	MO; QL (30 EA per 30 day(s))
LIPITOR ORAL	2	MO; QL (30 EA per 30 day(s))
<i>lovastatin Tab 10 mg</i>	1	MO; QL (30 EA per 30 day(s))
<i>lovastatin Tab 20 mg, 40 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>pravastatin Tab 10 mg, 20 mg, 80 mg</i>	1	MO; QL (30 EA per 30 day(s))
<i>pravastatin Tab 40 mg</i>	1	MO; QL (60 EA per 30 day(s))
SIMCOR 24 HR TAB 500-20 mg, 750-20 mg	2	MO; QL (60 EA per 30 day(s))
<i>simvastatin Oral</i>	1	MO; QL (30 EA per 30 day(s))
Alpha-Adrenergic Agonists		
<i>clonidine Oral</i>	1	MO
<i>clonidine TD</i>	1	MO
CLORPRES TAB 0.2-15 mg	3	MO
<i>guanabenz Oral</i>	1	MO
<i>guanfacine Oral</i>	1	MO
<i>methyldopa Oral</i>	1	MO
<i>methyldopate IV</i>	1	
<i>midodrine Oral</i>	1	
Alpha-Adrenergic Blocking Agents		
CARDURA XL ORAL	3	MO
<i>doxazosin Oral</i>	1	MO; QL (60 EA per 30 day(s))

Drug	Tier	Requirements/Limits
<i>prazosin Oral</i>	1	MO; QL (120 EA per 30 day(s))
<i>terazosin Oral</i>	1	MO; QL (60 EA per 30 day(s))
Angiotensin II Receptor Antagonists		
BENICAR ORAL	3	MO
BENICAR HCT ORAL	3	MO
DIOVAN TAB 320 mg	2	MO; QL (30 EA per 30 day(s))
DIOVAN TAB 160 mg, 40 mg, 80 mg	2	MO; QL (60 EA per 30 day(s))
DIOVAN HCT ORAL	2	MO; QL (30 EA per 30 day(s))
Angiotensin-Converting Enzyme (Ace) Inhibitors		
AZOR TAB 5-20 mg	3	MO
<i>benazepril Oral</i>	1	MO
<i>captopril Oral</i>	1	MO
<i>captopril-hydrochlorothiazide Tab 25-15 mg</i>	1	MO; QL (30 EA per 30 day(s))
<i>enalapril maleate Oral</i>	1	MO
<i>enalapril-hydrochlorothiazide Tab 10-25 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>fosinopril Oral</i>	1	MO
<i>lisinopril Oral</i>	1	MO
<i>moexipril Oral</i>	1	MO
<i>quinapril Oral</i>	1	MO
<i>ramipril Oral</i>	1	MO
<i>trandolapril Oral</i>	1	MO
Antiarrhythmics - Class Ia/Ii/Iii/Iv		
<i>amiodarone IV</i>	1	
<i>amiodarone Oral</i>	1	MO
PACERONE TAB 200 mg	1	MO
PACERONE TAB 100 mg	2	MO
Antiarrhythmics - Class Ii		
<i>metoprolol tartrate IV</i>	1	
<i>propranolol IV</i>	1	

Drug	Tier	Requirements/Limits
Antiarrhythmics - Class Ii/Iii		
<i>sotalol Oral</i>	1	MO
Antiarrhythmics - Class Iii		
TIKOSYN ORAL	2	MO
Antiarrhythmics - Class Iv		
<i>diltiazem IV</i>	1	
<i>diltiazem IV powder for Solution</i>	3	
<i>verapamil IV</i>	1	
Antiarrhythmics - Classes Ia, B, And C		
<i>disopyramide Oral</i>	1	MO
<i>flecainide Oral</i>	1	MO
<i>mexiletine Oral</i>	1	MO
<i>propafenone Tab</i>	1	MO
<i>quinidine gluconate Oral</i>	1	MO
<i>quinidine sulfate Oral</i>	1	MO
Beta-Adrenergic Blocking Agents With Vasodilating Properties		
BYSTOLIC ORAL	2	MO
<i>carvedilol Oral</i>	1	MO
COREG CR ORAL	2	MO
<i>labetalol IV</i>	1	
<i>labetalol Oral</i>	1	MO
Bile Acid Sequestrants		
CHOLESTYRAMINE LIGHT ORAL	1	MO
<i>colestipol Oral</i>	1	MO
PREVALITE ORAL	1	MO
WELCHOL ORAL	2	MO
Calcium Channel Blocking Agents (Non-Dihydropyridines)		
CARDIZEM CD 24 HR CAP 360 mg	2	MO
CARDIZEM LA 24 HR TAB 120 mg	3	MO

Drug	Tier	Requirements/Limits
CARTIA XT ORAL	1	MO
<i>diltiazem CD 24 hr Cap</i>	1	MO
<i>diltiazem ER 12 hr Cap</i>	1	MO
<i>diltiazem ER Cap 360 mg, 420 mg</i>	1	MO
<i>diltiazem Tab</i>	1	MO
DILT-XR ORAL	1	MO
MATZIM LA ORAL	1	MO
TAZTIA XT ORAL	1	MO
<i>verapamil Oral</i>	1	MO
Carbonic Anhydrase Inhibitors		
<i>acetazolamide Oral</i>	1	MO
<i>acetazolamide sodium Inj</i>	1	
<i>methazolamide Oral</i>	1	MO
Cardioselective Beta-Adrenergic Blocking Agents		
<i>acebutolol Oral</i>	1	MO
<i>atenolol Oral</i>	1	MO
<i>atenolol-chlorthalidone Oral</i>	1	MO
<i>betaxolol Oral</i>	1	MO
<i>bisoprolol fumarate Oral</i>	1	MO
<i>metoprolol succinate Oral</i>	1	MO
<i>metoprolol tartrate Oral</i>	1	MO
Cardiovascular Agents, Other		
<i>dexrazoxane IV</i>	1	
<i>digoxin Inj</i>	1	
<i>digoxin Oral</i>	1	MO
LANOXIN ORAL	2	MO
RANEXA ORAL	2	MO
<i>reserpine Oral</i>	1	MO
Cholesterol Absorption Inhibitors		

Drug	Tier	Requirements/Limits
ZETIA ORAL	2	MO; QL (30 EA per 30 day(s))
Dihydropyridines		
AFEDITAB CR ORAL	1	MO
<i>amlodipine Oral</i>	1	MO
<i>amlodipine-benazepril Cap 10-20 mg</i>	1	MO; QL (30 EA per 30 day(s))
CADUET ORAL	3	MO; QL (30 EA per 30 day(s))
<i>felodipine Oral</i>	1	MO
<i>isradipine Oral</i>	1	MO
<i>nicardipine IV</i>	1	
<i>nicardipine Oral</i>	1	MO
NIFEDIAC CC ORAL	1	MO
NIFEDICAL XL ORAL	1	MO
<i>nifedipine ER 24 hr Tab</i>	1	MO
<i>nifedipine Cap 10 mg</i>	1	PA; MO
<i>nifedipine Cap 20 mg</i>	3	PA; MO
<i>nimodipine Oral</i>	1	MO
<i>nisoldipine ER 24 hr Tab 20 mg, 30 mg, 40 mg</i>	1	MO
Direct Renin Inhibitors		
TEKTURNA ORAL	2	MO; QL (30 EA per 30 day(s))
Fibrates		
<i>fenofibrate Oral</i>	1	MO
<i>fenofibrate micronized Oral</i>	1	MO
<i>gemfibrozil Oral</i>	1	MO
TRICOR ORAL	2	MO
Loop Diuretics		
<i>bumetanide Inj</i>	1	
<i>bumetanide Oral</i>	1	MO
<i>furosemide Inj</i>	1	
<i>furosemide Oral</i>	1	MO

Drug	Tier	Requirements/Limits
<i>torseamide IV</i>	1	
<i>torseamide Oral</i>	1	MO
Nicotinic Acid		
NIACOR ORAL	1	
NIASPAN EXTENDED-RELEASE ORAL	2	MO
Nonselective Beta-Adrenergic Blocking Agents		
<i>nadolol Oral</i>	1	MO
<i>nadolol-bendroflumethiazide Oral</i>	1	MO
<i>pindolol Oral</i>	1	MO
<i>propranolol Oral</i>	1	MO
SORINE ORAL	1	MO
<i>timolol maleate Oral</i>	1	MO
Potassium-Sparing Diuretics		
ALDACTAZIDE TAB 50-50 mg	2	MO
<i>amiloride Oral</i>	1	MO
<i>amiloride-hydrochlorothiazide Oral</i>	1	MO
<i>eplerenone Oral</i>	1	MO
<i>spironolactone Oral</i>	1	MO
Thiazide Diuretics		
<i>chlorothiazide Oral</i>	1	MO
<i>chlorthalidone Oral</i>	1	MO
DIURIL ORAL	3	MO
<i>hydrochlorothiazide Oral</i>	1	MO
<i>indapamide Oral</i>	1	MO
<i>methyclothiazide Oral</i>	1	MO
<i>metolazone Oral</i>	1	MO
THALITONE ORAL	2	MO
Vasodilators, Direct-Acting Arterial		
<i>hydralazine Inj</i>	1	

Drug	Tier	Requirements/Limits
<i>hydralazine Oral</i>	1	MO
<i>minoxidil Oral</i>	1	MO
Vasodilators, Direct-Acting Arterial/Venous		
BIDIL ORAL	2	MO; QL (180 EA per 30 day(s))
ISOCHRON ORAL	1	MO
<i>isosorbide dinitrate Oral</i>	1	MO
<i>isosorbide dinitrate SL</i>	1	MO
<i>isosorbide mononitrate Oral</i>	1	MO
<i>nitroglycerin IV</i>	1	BvD
<i>nitroglycerin TD</i>	1	MO
NITROLINGUAL TL	2	MO
NITROSTAT SL	2	MO
PENTOPAK ORAL	1	MO
<i>pentoxifylline Oral</i>	1	MO
PROGLYCEM ORAL	2	MO
Central Nervous System Agents		
Amphetamines, Adhd		
AMPHETAMINE SALT COMBO TAB 10 mg	1	PA; MO
Non-Amphetamines, Adhd		
<i>dexmethylphenidate Oral</i>	1	PA; MO
METADATE CD ORAL	3	PA; MO
METADATE ER ORAL	1	PA; MO
METHYLIN TAB	1	PA; MO
METHYLIN CHEWABLE TAB	3	PA; MO
METHYLIN ER ORAL	1	PA; MO
<i>methylphenidate ER Tab</i>	1	PA; MO
<i>methylphenidate Tab</i>	1	PA; MO
STRATTERA ORAL	2	PA; MO
Non-Amphetamines, Other		

Drug	Tier	Requirements/Limits
PROVIGIL TAB 100 mg	2	PA; MO; QL (31 EA per 31 day(s))
PROVIGIL TAB 200 mg	3	PA; MO; QL (31 EA per 31 day(s))
XENAZINE ORAL	4	PA; MO
XYREM ORAL	4	LA
Dental And Oral Agents		
Dental And Oral Agents		
CYKLOKAPRON IV	2	
EVOXAC ORAL	2	MO
PERIOGARD MM	1	
<i>pilocarpine Tab 7.5 mg</i>	1	MO
<i>tiamcinolone acetonide Dent</i>	1	
Dermatological Agents		
Dermatological Acne Agents		
AMNESTEEM ORAL	1	
AVITA TOP	1	PA
AZELEX TOP	2	
CLARAVIS ORAL	1	
<i>clindamycin phosphate Top</i>	1	
DIFFERIN TOPICAL GEL 0.3 %	2	PA
ERY PADS TOP	1	
<i>erythromycin with ethanol Top</i>	1	
<i>erythromycin-benzoyl peroxide Top</i>	1	
SOTRET ORAL	1	
<i>tretinoin Top</i>	1	PA
Dermatological Anti-Inflammatory Agents		
SOLARAZE TOP	2	
Dermatological Antipruritic Agents		
ZONALON TOP	2	
Dermatological Calcineurin Inhibitors		

Drug	Tier	Requirements/Limits
ELIDEL TOP	2	ST-NS
PROTOPIC TOP	2	ST-NS
Dermatological Caustic Agents		
<i>podofilox Top</i>	1	
Dermatological Emollients		
<i>ammonium lactate Top</i>	1	
LACLOTION TOP	1	
Dermatological Genital Wart Agents		
<i>imiquimod Top</i>	1	
Dermatological Mitotic Inhibitors		
<i>selenium sulfide Top</i>	1	
Dermatological Non-Melanoma Skin Cancer Agents		
CARAC TOP	2	
FLUOROPLEX TOP	2	
<i>fluorouracil Top</i>	1	
Dermatological Photochemotherapy Agents		
OXSORALEN ULTRA ORAL	4	
Dermatological Psoriasis Agents		
<i>calcipotriene Topical Soln</i>	1	
DOVONEX TOPICAL CREAM	2	
Dermatological Wound Care Agents		
REGRANEX TOP	4	PA
SANTYL TOP	2	
<i>water for irrigation, sterile IR</i>	1	
Enzyme Replacements/ Modifiers		
Anti-Cystine Agents		
CYSTAGON ORAL	2	
Pancrelipase Replacement		
CREON ORAL	2	MO

Drug	Tier	Requirements/Limits
ZENPEP CAP 10,000-34,000 -55,000 unit, 15,000-51,000 -82,000 unit, 20,000-68,000 - 109,000 unit, 5,000-17,000 -27,000 unit	2	MO
Gastrointestinal Agents		
Antispasmodics, Gastrointestinal		
<i>atropine Inj</i>	1	PA
<i>dicyclomine IM</i>	1	PA
<i>dicyclomine Oral</i>	1	PA
<i>glycopyrrolate Inj</i>	1	
<i>glycopyrrolate Oral</i>	1	
<i>methscopolamine Oral</i>	1	
Gastrointestinal Agents, Other		
AMITIZA ORAL	2	MO
CONSTULOSE ORAL	1	MO
DIPENTUM ORAL	2	MO
<i>diphenoxylate-atropine Oral</i>	1	PA
ENULOSE ORAL	1	MO
GAVILYTE-C ORAL	1	
GAVILYTE-G ORAL	1	
HELIDAC ORAL	3	
<i>lactulose Oral</i>	1	MO
<i>loperamide Oral</i>	1	
RELISTOR SUBQ	2	
TRILYTE WITH FLAVOR PACKETS ORAL	1	
<i>ursodiol Oral</i>	1	MO
Histamine2 (H2) Blocking Agents		
<i>cimetidine Inj</i>	1	
<i>cimetidine Tab 200 mg</i>	1	
<i>cimetidine Oral Soln</i>	1	MO
<i>famotidine Tab</i>	1	MO

Drug	Tier	Requirements/Limits
<i>famotidine (PF) IV</i>	1	
<i>famotidine (PF)-NaCl (iso-os) IV</i>	1	
<i>nizatidine Oral</i>	1	MO
<i>ranitidine HCl Inj</i>	1	
<i>ranitidine HCl Oral</i>	1	MO
Irritable Bowel Syndrome Agents		
LOTRONEX ORAL	2	MO; QL (60 EA per 30 day(s))
Protectants		
CARAFATE ORAL SUSP	2	MO
<i>misoprostol Oral</i>	1	MO
<i>sucralfate Oral</i>	1	MO
Proton Pump Inhibitors		
<i>lansoprazole Cap, Delayed Release</i>	1	MO; QL (60 EA per 30 day(s))
<i>omeprazole Cap, Delayed Release 20 mg</i>	1	MO
<i>omeprazole Cap, Delayed Release 40 mg</i>	1	MO; QL (30 EA per 30 day(s))
<i>omeprazole Cap, Delayed Release 10 mg</i>	1	MO; QL (60 EA per 30 day(s))
<i>pantoprazole Oral</i>	1	MO
Genitourinary Agents		
5 Alpha-Reductase Inhibitors		
AVODART ORAL	2	MO; QL (30 EA per 30 day(s))
<i>finasteride Oral</i>	1	MO; QL (30 EA per 30 day(s))
Alpha 1-Adrenergic Blocking Agents		
UROXATRAL ORAL	2	MO; QL (30 EA per 30 day(s))
Antispasmodics, Urinary		
DETROL LA ORAL	2	MO; QL (30 EA per 30 day(s))
ENABLEX ORAL	2	MO; QL (30 EA per 30 day(s))
<i>flavoxate Oral</i>	1	MO
<i>oxybutynin chloride Syrup</i>	1	MO
<i>oxybutynin chloride Tab</i>	1	MO

Drug	Tier	Requirements/Limits
<i>oxybutynin chloride ER 24 hr Tab 5 mg</i>	1	MO; QL (30 EA per 30 day(s))
<i>oxybutynin chloride ER 24 hr Tab 10 mg, 15 mg</i>	1	MO; QL (60 EA per 30 day(s))
OXYTROL TD	2	MO
SANCTURA XR ORAL	2	MO
VESICARE ORAL	2	MO
Genitourinary Agents, Other		
<i>bethanechol chloride Oral</i>	1	
ELMIRON ORAL	2	
Phosphate Binders		
<i>calcium acetate Cap</i>	1	MO
FOSRENOL CHEWABLE TAB 750 mg	3	MO
RENVELA ORAL	2	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
Glucocorticoids-Systemic		
A-HYDROCORT INJ	1	
A-METHAPRED INJ	1	
<i>cortisone Oral</i>	1	
<i>dexamethasone Oral</i>	1	
DEXAMETHASONE INTENSOL ORAL	1	
<i>hydrocortisone Oral</i>	1	
<i>methylprednisolone Oral</i>	1	
<i>methylprednisolone acetate Inj</i>	1	
<i>prednisolone sodium phosphate Oral Soln 15 mg/5 mL</i>	1	
<i>prednisone Oral</i>	1	
PREDNISON INTENSOL ORAL	2	
Glucocorticoids-Topical-High Potency		
<i>amcinonide Top</i>	1	
<i>betamethasone valerate Top</i>	1	

Drug	Tier	Requirements/Limits
<i>desoximetasone Top</i>	1	
<i>fluocinolone Ointment</i>	1	
<i>fluocinolone Topical Cream</i>	1	
<i>fluocinonide Top</i>	1	
HALOG OINTMENT	3	
<i>triamcinolone acetonide Ointment 0.5 %</i>	1	
<i>triamcinolone acetonide Topical Cream</i>	1	
TRIDERM TOP	1	
Glucocorticoids-Topical-Low Potency		
ALA-CORT LOTION	1	
<i>alclometasone Top</i>	1	
COLOCORT RECT	1	
DESONATE TOP	3	
<i>desonide Top</i>	1	
<i>hydrocortisone Rect</i>	1	
<i>hydrocortisone Top</i>	1	
LOKARA TOP	1	
PROCTOCREAM-HC RECT	1	
PROCTOSOL HC RECT	1	
PROCTOZONE-HC RECT	1	
SOLU-CORTEF (PF) SOLUTION FOR INJECTION 250 mg/2 mL	2	
U-CORT TOP	1	
Glucocorticoids-Topical-Medium Potency		
<i>betamethasone valerate Top</i>	1	
<i>desoximetasone Top</i>	1	
<i>fluocinolone Topical Cream</i>	1	
<i>fluocinolone Topical Soln</i>	1	
<i>fluticasone Top</i>	1	

Drug	Tier	Requirements/Limits
<i>hydrocortisone butyrate Top</i>	1	
<i>hydrocortisone valerate Top</i>	1	
<i>mometasone Top</i>	1	
<i>prednicarbate Top</i>	1	
<i>triamcinolone acetonide Lotion</i>	1	
<i>triamcinolone acetonide Ointment 0.025 %, 0.1 %</i>	1	
<i>triamcinolone acetonide Topical Cream</i>	1	
Glucocorticoids-Topical-Very High Potency		
<i>betamethasone dipropionate Ointment</i>	1	
<i>betamethasone dipropionate Topical Cream</i>	1	
<i>betamethasone, augmented Lotion</i>	1	
<i>clobetasol Ointment</i>	1	
<i>clobetasol Topical Gel</i>	1	
<i>clobetasol Topical Soln</i>	1	
<i>clobetasol-emollient Top</i>	1	
<i>diflorasone Top</i>	1	
FLUOCINONIDE-E TOP	1	
<i>halobetasol propionate Top</i>	1	
Mineralocorticoids		
<i>fludrocortisone Oral</i>	1	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
Gonadotropins		
<i>chorionic gonadotropin, human IM</i>	1	BvD
NOVAREL IM	1	BvD
PREGNYL IM	1	BvD
Growth Hormone Analogs		
GENOTROPIN SUBQ	4	PA; MO
GENOTROPIN MINIQUICK SUB-Q SYRINGE 0.2 mg/0.25 mL	2	PA; MO

Drug	Tier	Requirements/Limits
GENOTROPIN MINIQUICK SUB-Q SYRINGE 0.4 mg/0.25 mL, 0.6 mg/0.25 mL, 0.8 mg/0.25 mL, 1 mg/0.25 mL, 1.2 mg/0.25 mL, 1.4 mg/0.25 mL, 1.6 mg/0.25 mL, 1.8 mg/0.25 mL, 2 mg/0.25 mL	4	PA; MO
HUMATROPE INJECTION, CARTRIDGE 6 (18 unit) mg	3	PA; MO
HUMATROPE INJECTION, CARTRIDGE 12 (36 unit) mg, 24 (72 unit) mg	4	PA; MO
HUMATROPE SOLUTION FOR INJECTION	4	PA; MO
NORDITROPIN FLEXPEN SUB-Q PEN INJECTOR 10 mg/1.5 mL (6.7 mg/mL)	4	PA; MO
NUTROPIN SUBQ	4	PA; MO
SAIZEN SUBQ	4	PA; MO
SAIZEN CLICK.EASY SUBQ	4	PA; MO
SEROSTIM SUBQ	4	PA; MO
TEV-TROPIN SUBQ	3	PA; MO
ZORBTIVE SUBQ	4	PA; MO
Insulin-Like Growth Factor Analogs		
INCRELEX SUBQ	4	PA; MO
Vasopressin Analogs		
DDAVP NASAL SPRAY AEROSOL	3	MO
<i>desmopressin Inj</i>	1	
<i>desmopressin Nasl</i>	1	MO
<i>desmopressin Oral</i>	1	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
Androgens		
ANDROGEL TRANSDERMAL PACKET	2	PA; MO
<i>danazol Oral</i>	1	
TESTIM TD	2	PA; MO
<i>testosterone cypionate IM Oil 100 mg/mL</i>	1	PA-NS

Drug	Tier	Requirements/Limits
<i>testosterone enanthate IM</i>	1	PA-NS
Estrogens		
ALORA TD	2	MO
APRI ORAL	1	MO
CENESTIN TAB 0.9 mg, 1.25 mg	3	PA; MO
CESIA ORAL	1	MO
COMBIPATCH TD	2	MO
CRYSSELLE (28) ORAL	1	MO
ELESTRIN TD	3	MO
ESTRADERM TD	2	MO
<i>estradiol Oral</i>	1	MO
<i>estradiol TD</i>	1	MO
<i>estradiol valerate IM</i>	1	
<i>estradiol-norethindrone acet Oral</i>	1	MO
<i>estropipate Oral</i>	1	PA; MO
KARIVA ORAL	1	MO
KELNOR 1/35 (28) ORAL	1	MO
MONONESSA (28) ORAL	1	MO
NUVARING VAGL	2	MO
OCELLA ORAL	1	MO
OGESTREL (28) ORAL	1	MO
ORTHO TRI-CYCLLEN LO ORAL	2	MO
ORTHO-EST 0.625 ORAL	1	PA; MO
ORTHO-EST 1.25 ORAL	1	PA; MO
PREMARIN VAGL	2	MO
PREMARIN INJ	2	PA
PREMARIN ORAL	2	PA; MO
PREMPHASE ORAL	2	PA; MO
PREMPRO ORAL	2	PA; MO

Drug	Tier	Requirements/Limits
PREVIFEM ORAL	1	MO
RECLIPSEN (28) ORAL	1	MO
SOLIA ORAL	1	MO
SPRINTEC (28) ORAL	1	MO
TRI-PREVIFEM (28) ORAL	1	MO
TRI-SPRINTEC (28) ORAL	1	MO
VAGIFEM VAGL	2	MO
VELIVET ORAL	1	MO
VIVELLE-DOT TD	2	MO
ZOVIA 1/35E (28) ORAL	1	MO
ZOVIA 1/50E (28) ORAL	1	MO
Progestins		
ARANELLE (28) ORAL	1	MO
AVIANE ORAL	1	MO
BALZIVA (28) ORAL	1	MO
CAMILA ORAL	1	MO
CLIMARA PRO TD	2	MO
DEPO-PROVERA IM	2	
DEPO-SUBQ PROVERA 104 SUBQ	3	
ENPRESSE ORAL	1	MO
ERRIN ORAL	1	MO
JOLIVETTE ORAL	1	MO
JUNEL 1.5/30 (21) ORAL	1	MO
JUNEL 1/20 (21) ORAL	1	MO
JUNEL FE 1.5/30 (28) ORAL	1	MO
JUNEL FE 1/20 (28) ORAL	1	MO
LEENA 28 ORAL	1	MO
LESSINA ORAL	1	MO
LEVORA-28 ORAL	1	MO

Drug	Tier	Requirements/Limits
LOW-OGESTREL (28) ORAL	1	MO
LUTERA (28) ORAL	1	MO
<i>medroxyprogesterone IM</i>	1	
<i>medroxyprogesterone Oral</i>	1	MO
MEGACE ES ORAL	3	MO
<i>megestrol Oral</i>	1	
MICROGESTIN 1.5/30 (21) ORAL	1	MO
MICROGESTIN 1/20 (21) ORAL	1	MO
MICROGESTIN FE 1.5/30 (28) ORAL	1	MO
MICROGESTIN FE 1/20 (28) ORAL	1	MO
NECON 0.5/35 (28) ORAL	1	MO
NECON 1/35 (28) ORAL	1	MO
NECON 10/11 (28) ORAL	2	MO
NECON 7/7/7 (28) ORAL	1	MO
<i>norethindrone acetate Oral</i>	1	MO
NORTREL 0.5/35 (28) ORAL	1	MO
NORTREL 1/35 (21) ORAL	1	MO
NORTREL 1/35 (28) ORAL	1	MO
NORTREL 7/7/7 (28) ORAL	1	MO
ORTHO EVRA TD	2	MO
PORTIA ORAL	1	MO
PROMETRIUM ORAL	3	MO
QUASENSE ORAL	1	MO
SRONYX ORAL	1	MO
TRI-LEGEST FE ORAL	1	MO
TRIVORA (28) ORAL	1	MO
Selective Estrogen Receptor Modifying Agents		
EVISTA ORAL	2	MO; QL (30 EA per 30 day(s))
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		

Drug	Tier	Requirements/Limits
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
LEVOTHROID ORAL	1	MO
<i>levothyroxine Oral</i>	1	MO
LEVOXYL ORAL	1	MO
<i>liothyronine IV</i>	1	
<i>liothyronine Oral</i>	1	MO
SYNTHROID ORAL	2	MO
UNITHROID ORAL	1	MO
Hormonal Agents, Suppressant (Parathyroid)		
Calcimimetics		
SENSIPAR TAB 30 mg	2	MO
SENSIPAR TAB 60 mg, 90 mg	4	MO
Hormonal Agents, Suppressant (Pituitary)		
Gonadotropin-Releasing Hormone Analogs		
ELIGARD SUB-Q SYRINGE 22.5 mg, 30 mg	3	BvD
ELIGARD SUB-Q SYRINGE 45 mg	4	BvD
<i>leuprolide SubQ</i>	1	BvD
LUPRON DEPOT IM	4	BvD
LUPRON DEPOT (3 MONTH) IM	4	BvD
LUPRON DEPOT (4 MONTH) IM	4	BvD
LUPRON DEPOT-PED IM	4	
SYNAREL NASL	4	
Growth Hormone Antagonists		
SOMAVERT SUBQ	4	PA; MO; QL (30 EA per 30 day(s))
Somatostatin Analogs		
<i>octreotide acetate Injection 100 mcg/mL, 200 mcg/mL, 50 mcg/mL</i>	1	PA; MO
<i>octreotide acetate Injection 1,000 mcg/mL, 500 mcg/mL</i>	4	PA; MO
SANDOSTATIN LAR DEPOT IM	4	PA

Drug	Tier	Requirements/Limits
SOMATULINE DEPOT SUBQ	4	PA
Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)		
Antiandrogens		
<i>flutamide Oral</i>	1	
NILANDRON ORAL	2	
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
<i>methimazole Oral</i>	1	MO
<i>propylthiouracil Oral</i>	1	MO
Immunological Agents		
Immune Suppressants (Non-Tnf Inhibitors)		
AZASAN ORAL	2	BvD; MO
<i>azathioprine Oral</i>	1	BvD; MO
<i>azathioprine sodium Inj</i>	1	
CELLCEPT ORAL SUSP	2	BvD; MO
CUPRIMINE ORAL	2	
<i>cyclosporine IV</i>	1	BvD
<i>cyclosporine Oral</i>	1	BvD; MO
GENGRAF ORAL	1	BvD; MO
<i>methotrexate sodium Inj</i>	1	
<i>methotrexate sodium Oral</i>	1	
<i>methotrexate sodium (PF) Inj</i>	1	
NEORAL ORAL	2	BvD; MO
ORENCIA IV	4	PA; MO
PROGRAF IV	3	BvD
RAPAMUNE ORAL SOLN	2	BvD; MO
RAPAMUNE TAB 1 mg, 2 mg	2	BvD; MO
RHEUMATREX ORAL	2	MO
<i>tacrolimus Oral</i>	1	BvD; MO

Drug	Tier	Requirements/Limits
Immunoglobulins		
GAMASTAN S/D IM	2	PA
GAMMAGARD LIQUID IV	4	PA
GAMUNEX IV	4	PA
Immunomodulators, Other		
COPAXONE SUBQ	4	PA; MO; QL (30 EA per 30 day(s))
KINERET SUBQ	4	PA; MO
<i>leflunomide Tab 20 mg</i>	1	MO
<i>leflunomide Tab 10 mg</i>	1	MO; QL (30 EA per 30 day(s))
PROLEUKIN IV	4	
RIDAURA ORAL	2	MO
SYNAGIS IM	4	
Interferons, Alfa		
INFERGEN SUBQ	4	PA
INTRON A SUBQ PEN KIT 3 million unit /0.2 mL-6 doses	2	PA-NS; MO
INTRON A INJECTION	3	PA-NS; MO
INTRON A SOLUTION FOR INJECTION	4	PA-NS; MO
INTRON A SUBQ PEN KIT 10 million unit/0.2 mL, 5 million unit/0.2 mL	4	PA-NS; MO
PEGASYS CONVENIENCE PACK SUBQ	4	PA-NS; QL (2 EA per 28 day(s))
PEGINTRON SUBQ	4	PA-NS; QL (4 EA per 30 day(s))
PEGINTRON REDIPEN SUBQ	4	PA-NS; QL (4 EA per 30 day(s))
Interferons, Beta		
AVONEX IM	4	PA-NS; MO
AVONEX ADMINISTRATION PACK IM	4	PA; MO; QL (4 EA per 30 day(s))
BETASERON SUBQ	4	PA; MO; QL (15 EA per 30 day(s))
REBIF SUBQ	4	PA; MO; QL (6 ML per 30 day(s))
REBIF TITRATION PACK SUBQ	4	PA-NS; MO
Interferons, Gamma		

Drug	Tier	Requirements/Limits
ACTIMMUNE SUBQ	4	MO
Tumor Necrosis Factor (Tnf) Inhibitors		
ENBREL SUBQ	4	PA; MO; QL (200 EA per 30 day(s))
HUMIRA SUB-Q KIT 20 mg/0.4 mL	4	PA; MO; QL (0.8 EA per 30 day(s))
HUMIRA SUB-Q KIT 40 mg/0.8 mL	4	PA; MO; QL (2.4 EA per 28 day(s))
HUMIRA CROHN'S DIS START PCK SUBQ	4	PA; MO
REMICADE IV	4	PA
Vaccines To Prevent Diphtheria		
ADACEL (ADOLESCENT & ADULT) IM	2	
DECAVAC IM	2	BvD
<i>tetanus, diphtheria toxoid ped-PF IM</i>	2	BvD
Vaccines To Prevent Haemophilus Type B		
ACTHIB IM	2	
COMVAX IM	2	
PEDVAX HIB (PF) IM	2	
Vaccines To Prevent Hepatitis A		
HAVRIX (PF) IM	2	
TWINRIX (PF) IM	2	
VAQTA (PF) IM	2	
Vaccines To Prevent Hepatitis B		
ENGERIX-B (PF) IM	2	BvD
RECOMBIVAX HB (PF) IM	2	BvD
Vaccines To Prevent Japanese Encephalitis		
IXIARO (PF) IM	2	
JE-VAX SUBQ	2	
Vaccines To Prevent Measles		
M-M-R II (PF) SUBQ	2	

Drug	Tier	Requirements/Limits
Vaccines To Prevent Meningococcal Disease		
MENACTRA (PF) IM	2	
MENOMUNE - A/C/Y/W-135 (PF) SUBQ	2	
MENVEO A-C-Y-W-135-DIP (PF) IM	2	
Vaccines To Prevent Mumps		
PROQUAD SUBQ	2	
Vaccines To Prevent Papillomavirus Disease		
CERVARIX VACCINE IM	2	
GARDASIL IM	2	
Vaccines To Prevent Pertussis		
TRIPEDIA (PF) IM	2	
Vaccines To Prevent Poliovirus		
IPOL INJ	2	
Vaccines To Prevent Rabies		
IMOVAX RABIES VACCINE IM	2	
RABAVERT (PF) IM	2	
Vaccines To Prevent Rotavirus Disease		
ROTATEQ VACCINE ORAL	2	
Vaccines To Prevent Tetanus		
BOOSTRIX IM SYRINGE	2	
DAPTACEL (PEDIATRIC) (PF) IM	2	
INFANRIX (PF) IM	2	
<i>tetanus toxoid,adsorbed (PF) IM</i>	2	BvD
<i>tetanus-diphtheria toxoids-Td IM</i>	2	BvD
Vaccines To Prevent Typhoid		
TYPHIM VI IM	2	
Vaccines To Prevent Varicella		
VARIVAX (PF) SUBQ	2	
Vaccines To Prevent Yellow Fever		

Drug	Tier	Requirements/Limits
YF-VAX SUBQ	2	
Vaccines To Prevent Zoster		
ZOSTAVAX SUBQ	2	
Inflammatory Bowel Disease Agents		
Glucocorticoids		
ENTOCORT EC ORAL	2	
Salicylates		
<i>balsalazide Oral</i>	1	
CANASA RECT	2	
<i>mesalamine Rect</i>	1	
Sulfonamides		
<i>sulfasalazine Oral</i>	1	MO
Metabolic Bone Disease Agents		
Bisphosphonates, Oral		
<i>alendronate Oral</i>	1	
<i>etidronate disodium Oral</i>	1	
Bisphosphonates, Parenteral		
<i>pamidronate IV 30 mg/10 mL (3 mg/mL), 90 mg/10 mL (9 mg/mL)</i>	1	
<i>pamidronate IV 60 mg/10 mL (6 mg/mL)</i>	3	
Calcium Regulating Hormones		
FORTICAL NASL	1	BvD; MO; QL (4 ML per 28 day(s))
MIACALCIN INJ	2	BvD
Parathyroid Hormone Analogs		
FORTEO SUBQ	4	PA; MO; QL (2.4 ML per 30 day(s))
Vitamin D–Related Agents/Metabolic Bone Disease Agents		
<i>calcitriol Cap 0.5 mcg</i>	1	BvD; MO
CYSTADANE ORAL	2	MO

Drug	Tier	Requirements/Limits
HECTOROL IV	2	BvD
HECTOROL ORAL	2	BvD; MO
Ophthalmic Agents		
Alpha-Adrenergic Agonists, Ophthalmic		
ALPHAGAN P OPHT	2	MO
<i>brimonidine Eye Drops 0.2 %</i>	1	MO
Beta-Adrenergic Blocking Agents, Ophthalmic		
<i>betaxolol Opht</i>	1	MO
BETOPTIC S OPHT	2	MO
<i>carteolol Opht</i>	1	MO
COMBIGAN OPHT	2	MO
<i>levobunolol Opht</i>	1	MO
<i>metipranolol Opht</i>	1	MO
<i>timolol maleate Eye Drops</i>	1	MO
Carbonic Anhydrase Inhibitors, Ophthalmic		
AZOPT OPHT	2	MO
<i>dorzolamide Opht</i>	1	MO
Cholinergic Agonists, Ophthalmic		
PILOPINE HS OPHT	2	MO
Glucocorticoids, Ophthalmic		
<i>fluorometholone Opht</i>	1	
FML S.O.P. OPHT	2	
POLY-PRED OPHT	3	
<i>prednisolone acetate Opht</i>	1	
<i>prednisolone sodium phosphate Opht</i>	1	
Nonsteroidal Anti-Inflammatory Drugs, Ophthalmic		
<i>diclofenac sodium Opht</i>	1	
<i>flurbiprofen sodium Opht</i>	1	
Ophthalmic Agents, Other		

Drug	Tier	Requirements/Limits
AK-CON OPHT	1	
AK-TOB OPHT	1	
AZASITE OPHT	3	
<i>bacitracin-polymyxin B Opht</i>	1	
BLEPHAMIDE OPHT	3	
BLEPHAMIDE S.O.P. OPHT	2	
CILOXAN EYE OINTMENT	2	
GENTAK OPHT	1	
GENTASOL OPHT	1	
LACRISERT OPHT	2	
<i>neomycin-polymyxin-gramicidin Opht</i>	1	
POLY-DEX OPHT	1	
<i>proparacaine Opht</i>	1	
RESTASIS OPHT	2	MO
ROMYCIN OPHT	1	
<i>sulfacetamide sodium Opht</i>	1	
<i>tobramycin-dexamethasone Opht</i>	1	
TOBRASOL OPHT	1	
TOBEX EYE OINTMENT	2	
<i>trifluridine Opht</i>	1	
<i>tropicamide Opht</i>	1	MO
VIGAMOX OPHT	2	
Ophthalmic Anti-Allergy Agents		
ALREX OPHT	2	
<i>cromolyn Opht</i>	1	
PATADAY OPHT	2	
PATANOL OPHT	2	
Ophthalmic Prostaglandin And Prostamide Analogs		
TRAVATAN Z OPHT	2	MO

Drug	Tier	Requirements/Limits
Otic Agents		
Otic Anti-Inflammatories		
ACETASOL HC OTIC	1	
<i>acetic acid Otic</i>	1	
CORTOMYCIN OTIC	1	
DERMOTIC OIL OTIC	2	
Respiratory Tract Agents		
Anti-Inflammatories, Inhaled Corticosteroids		
ADVAIR DISKUS INHL	2	MO; QL (60 EA per 25 day(s))
ADVAIR HFA INHL	2	MO; QL (12 GM per 25 day(s))
ASMANEX TWISTHALER BREATH ACTIVATED 220 mcg (30 doses)	2	MO; QL (15 GM per 25 day(s))
ASMANEX TWISTHALER BREATH ACTIVATED 220 mcg (60 doses)	2	MO; QL (29 GM per 25 day(s))
ASMANEX TWISTHALER BREATH ACTIVATED 110 mcg (30 doses)	2	MO; QL (30 GM per 25 day(s))
ASMANEX TWISTHALER BREATH ACTIVATED 220 mcg (120 doses)	2	MO; QL (58 GM per 25 day(s))
ASMANEX TWISTHALER BREATH ACTIVATED 220 mcg (14 doses)	2	MO; QL (7 GM per 25 day(s))
<i>budesonide Inhl</i>	1	MO; QL (120 ML per 25 day(s))
FLOVENT DISKUS INHL	2	MO; QL (120 EA per 25 day(s))
FLOVENT HFA INHL	2	MO; QL (24 GM per 25 day(s))
<i>flunisolide Nasl</i>	1	QL (50 ML per 25 day(s))
<i>fluticasone Nasl</i>	1	QL (16 GM per 25 day(s))
NASONEX NASL	2	QL (34 GM per 25 day(s))
QVAR INHL	2	MO; QL (24 GM per 25 day(s))
SYMBICORT INHL	2	MO; QL (11 GM per 25 day(s))
Bronchodilators, Anticholinergic		
ATROVENT HFA INHL	2	MO; QL (26 GM per 25 day(s))
COMBIVENT INHL	2	MO; QL (30 GM per 25 day(s))

Drug	Tier	Requirements/Limits
SPIRIVA WITH HANDIHALER INHL	2	MO; QL (30 EA per 25 day(s))
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)		
<i>aminophylline IV</i>	1	
<i>aminophylline Oral</i>	1	MO
ELIXOPHYLLIN ORAL	2	MO
THEO-24 ORAL	2	MO
THEOCHRON ORAL	1	MO
<i>theophylline Oral</i>	1	MO
Bronchodilators, Sympathomimetic		
<i>albuterol sulfate Syrup</i>	1	MO
<i>albuterol sulfate Tab 2 mg</i>	1	MO
<i>albuterol sulfate Neb Solution 0.63 mg/3 mL</i>	1	MO; QL (300 ML per 25 day(s))
<i>epinephrine HCl Inj</i>	1	
EPIPEN IM	2	
EPIPEN JR IM	2	
<i>metaproterenol Oral</i>	1	MO
PROAIR HFA INHL	2	MO; QL (18 GM per 25 day(s))
SEREVENT DISKUS INHL	2	MO; QL (60 EA per 25 day(s))
<i>terbutaline SubQ</i>	1	
<i>terbutaline Oral</i>	1	MO
H1 Blocking Agents, Sedating		
<i>clemastine Oral</i>	1	
<i>cyproheptadine Oral</i>	1	PA
<i>dexchlorpheniramine maleate Oral</i>	1	PA
<i>diphenhydramine HCl Inj</i>	1	PA
<i>diphenhydramine HCl Oral</i>	1	PA
<i>hydroxyzine HCl IM</i>	1	PA
<i>hydroxyzine HCl Oral</i>	1	PA
<i>hydroxyzine pamoate Oral</i>	1	PA

Drug	Tier	Requirements/Limits
Histamine1 (H1) Blocking Agents, Mildly/Non-Sedating		
<i>azelastine Nasl</i>	1	QL (60 ML per 25 day(s))
CLARINEX-D 12 HOUR ORAL	3	QL (60 EA per 30 day(s))
Mast Cell Stabilizers		
<i>cromolyn Inhl</i>	1	BvD; MO; QL (240 ML per 25 day(s))
GASTROCROM ORAL	2	MO
Pulmonary Antihypertensives		
LETAIRIS ORAL	4	MO; QL (30 EA per 30 day(s))
REMODULIN INJ	4	
REVATIO IV	4	PA
REVATIO ORAL	4	PA; MO; QL (90 EA per 30 day(s))
TRACLEER ORAL	4	LA; MO; QL (60 EA per 30 day(s))
VENTAVIS INHL	4	BvD; MO
Receptor Antagonists		
SINGULAIR ORAL	2	MO; QL (30 EA per 30 day(s))
Respiratory Tract Agents, Other		
TYZINE NASL	2	
Sedatives/Hypnotics		
Sedatives/Hypnotics		
<i>zaleplon Oral</i>	1	
<i>zolpidem Tab</i>	1	
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
<i>carisoprodol Oral</i>	1	PA
<i>carisoprodol-ASA-codeine Oral</i>	1	
<i>carisoprodol-aspirin Oral</i>	1	PA
<i>chlorzoxazone Oral</i>	1	PA
<i>cyclobenzaprine Tab 10 mg, 5 mg</i>	1	PA

Drug	Tier	Requirements/Limits
<i>metaxalone Oral</i>	1	PA
<i>methocarbamol Oral</i>	1	PA
<i>orphenadrine citrate Inj</i>	1	PA
<i>orphenadrine citrate Oral</i>	1	PA
ORPHENADRINE COMPOUND ORAL	1	PA
ORPHENADRINE COMPOUND-DS ORAL	1	PA
Therapeutic Nutrients/Minerals/ Electrolytes		
Electrolytes/Minerals		
AMINOSYN 10 % IV	2	BvD
AMINOSYN 3.5 % IV	2	BvD
AMINOSYN 5 % (SULFITE-FREE) IV	2	BvD
AMINOSYN 7 % IV	2	BvD
AMINOSYN 8.5 % IV	2	BvD
AMINOSYN 8.5 %-ELECTROLYTES IV	1	BvD
AMINOSYN II 10 % IV	2	BvD
AMINOSYN II 3.5 %-DEXTROSE 25% IV	2	BvD
AMINOSYN II 3.5% M/DEXTROSE 5% IV	2	BvD
AMINOSYN II 4.25%/DEXTROSE 20% IV	2	BvD
AMINOSYN II 4.25%-DEXTROSE 10% IV	2	BvD
AMINOSYN II 5%/DEXTROSE 25% IV	2	BvD
AMINOSYN II 7 % IV	2	BvD
AMINOSYN II 8.5 % IV	2	BvD
AMINOSYN II 8.5 %-ELECTROLYTES IV	1	BvD
AMINOSYN M 3.5 % IV	2	BvD
AMINOSYN-HBC 7% IV	2	BvD
AMINOSYN-HF 8 % IV	1	BvD
AMINOSYN-PF 10 % IV	2	BvD
AMINOSYN-PF 7 % (SULFITE-FREE) IV	2	BvD
CLINIMIX 2.75%/D5 SULFITE FREE IV	2	BvD

Drug	Tier	Requirements/Limits
CLINIMIX 4.25%/D5 SULFITE FREE IV	2	BvD
CLINIMIX 4.25/D10 SULFITE FREE IV	1	BvD
CLINIMIX 4.25/D20 SULFITE FREE IV	1	BvD
CLINIMIX 4.25/D25 SULFITE FREE IV	1	BvD
CLINIMIX 5%/D15 SULFITE FREE IV	2	BvD
CLINIMIX 5%/D20 SULFITE FREE IV	2	BvD
CLINIMIX 5%/D25 SULFITE FREE IV	2	BvD
CLINIMIX E 2.75/D10 SULFITFREE IV	2	BvD
CLINIMIX E 2.75/D5 SULFITEFREE IV	2	BvD
CLINIMIX E 4.25/D25 SULFITFREE IV	2	BvD
CLINIMIX E 4.25/D5 SULFITEFREE IV	2	BvD
CLINIMIX E 5%/D15 SULFITE FREE IV	2	BvD
CLINIMIX E 5%/D20 SULFITE FREE IV	2	BvD
CLINIMIX E 5%/D25 SULFITE FREE IV	2	BvD
CLINISOL SF 15% IV	1	BvD
<i>D10 %-0.45 % sodium chloride IV</i>	1	
<i>D10-0.2 % NaCl & Potassium Cl IV</i>	2	
<i>D5 %-0.45 % sodium chloride IV</i>	1	
<i>D5 %-0.9 % sodium chloride IV</i>	1	
<i>D5-0.45 % sodium chloride & potassium chloride IV 10 mEq/L, 40 mEq/L</i>	1	
<i>D5-0.225 % sodium chloride & potassium chloride IV 20 mEq/L, 40 mEq/L</i>	1	
<i>D5 & 0.9 % sodium chloride with potassium chloride IV 20 mEq/L</i>	1	
<i>D5 & 0.9 % sodium chloride with potassium chloride IV 40 mEq/L</i>	2	
<i>D5-LR with potassium chloride IV 20 mEq/L</i>	2	
<i>dextrose 10 % & 0.225 % NaCl IV</i>	1	
<i>dextrose 5% in water (D5W) IV</i>	1	

Drug	Tier	Requirements/Limits
<i>dextrose 5%-0.225 % NaCl IV</i>	1	
<i>dextrose 5%-0.33% sod.chloride IV</i>	1	
ED K+10 ORAL	1	MO
<i>electrolyte-48 in D5W IV</i>	2	
FREAMINE III 3 %-ELECTROLYTES IV	2	BvD
FREAMINE III 8.5 % IV	1	BvD
HEPATAMINE 8% IV	1	BvD
HEPATASOL 8 % IV	2	BvD
INTRALIPID IV 20 %	1	BvD
IONOSOL-B IN D5W IV	2	
IONOSOL-MB IN D5W IV	2	
IONOSOL-T IN D5W IV	2	
ISOLYTE-H IN D5W IV	2	
ISOLYTE-M IN D5W IV	1	
ISOLYTE-P IN D5W IV	2	
ISOLYTE-S IV	2	
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KLOR-CON ORAL	1	MO
KLOR-CON 10 ORAL	1	MO
KLOR-CON M15 ORAL	1	MO
KLOR-CON M20 ORAL	1	MO
<i>levocarnitine IV</i>	1	BvD
<i>levocarnitine Oral</i>	1	BvD; MO
<i>levocarnitine (with sugar) Oral</i>	1	BvD; MO
<i>magnesium sulfate in D5W IV</i>	2	
NEPHRAMINE 5.4 % IV	2	BvD
NORMOSOL-M IN D5W IV	1	
NORMOSOL-R IN D5W IV	1	
NORMOSOL-R PH 7.4 IV	2	

Drug	Tier	Requirements/Limits
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PLASMA-LYTE 148 IV	2	
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PLASMA-LYTE 56 IV	2	
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PLASMA-LYTE R IV	1	
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<i>potassium chloride IV</i>	1	
<i>potassium chloride Oral</i>	1	MO
PREMASOL 10 % IV	2	BvD
PREMASOL 6 % IV	1	BvD
PRENATABS OBN ORAL	1	
PROCALAMINE 3% IV	2	BvD
PROSOL 20% IV	2	BvD
<i>sodium bicarbonate IV</i>	1	
<i>sodium chloride IV</i>	1	
<i>sodium chloride 0.9 % IV</i>	1	
<i>sodium chloride 3 % IV</i>	1	
<i>sodium chloride 5 % IV</i>	1	
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<i>sodium lactate IV</i>	1	
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