Preferred Drug List

PREFERRED DRUG LIST
REVISED JANUARY 11, 2010

What is the Mercy Care Plan Preferred Drug List?

A Preferred Drug List is a list of drugs chosen by Mercy Care Plan and a team of doctors and pharmacists. Mercy Care Plan will generally cover drugs listed in our Preferred Drug List as long as they are medically necessary. Prescriptions must also be filled at a Mercy Care Plan network pharmacy, and other Plan rules must be followed.

The Preferred Drug List begins on page 8. It gives you information about the drugs covered by Mercy Care Plan. The first column of the chart lists the drug that is covered by the plan. Brand name drugs are capitalized (e.g., AMOXIL). Generic drugs are listed in lower case italics (e.g., *amoxicillin*). The second column serves as a reference for providing the brand name of the drug when a generic is covered by the plan. The third column lists any requirements for the drug such as prior authorization (PA), quantity limits (QLL), step therapy (ST), or if the medication is covered for only the developmentally disabled (DD) or Arizona Long Term Care System (ALTCS) members.

Can the Preferred Drug List change?

Yes, Mercy Care Plan may add or take off drugs during the year. To get the latest information about covered drugs, go to our Web site at www.MercyCarePlan.com or call Member Services at (602) 263-3000 or (800) 624-3879.

If we take a drug off the Preferred Drug List or add restrictions to it, we will let you know at least 60 days before. Or, if you request a refill and it is no longer covered, you will get a 60-day supply of the drug until your doctor can write you a new prescription. Also, if the Food and Drug Administration says a drug on our Preferred Drug List is unsafe or the drug's maker takes the drug off the market, we will take the drug off our Preferred Drug List right away and let members who take the drug know.

How do I use the Preferred Drug List?

The Preferred Drug List begins on page 8. Drugs are grouped depending on the type of medical conditions 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 8. Then look under the category name for your drug.

How much will I pay for Mercy Care Plan covered drugs?

You do not have to pay for Mercy Care Plan covered benefits, including drugs.

Are there any other restrictions on coverage?

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

- **Prior Authorization:** Mercy Care Plan may require prior authorization for certain drugs on the Preferred Drug List. This means that your doctor will need to get approval from us before you can fill some of your prescriptions. If approval isn't given, Mercy Care Plan will not cover the drug.

- **Quantity Limits:** For certain drugs, Mercy Care Plan limits the amount of the drug it will cover. For example, we provide 60 pills in 30 days per prescription for Lisinopril 40 mg. Please refer to the quantity limit levels list at the end of this document.

- **Step Therapy:** In some cases, Mercy Care Plan requires you to try certain drugs first to treat your medical condition before we will cover another drug for that same condition. For example, if Drug A and Drug B both treat your medical condition, Mercy Care Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the second column of the list.

Key

Subject to non-formulary status when generic is available throughout the year.

INJ –Indicates that the drug is available in injectable form only
QLL – Quantity Limit Levels apply
PA – Prior Authorization required
STEP – Step Therapy

What if my drug is not on the Preferred Drug List?

If your drug is not on this Preferred Drug List, you should first call your doctor and ask if your drug is covered. If we do not cover it, you have two options:

- Ask your doctor to prescribe a similar drug that is covered.

- Your doctor can ask Mercy Care Plan to make an exception and cover your drug through the prior authorization process.

What are generic drugs?

Mercy Care Plan covers both brand name and generic drugs. Generic drugs usually cost less and are approved by the Food and Drug Administration (FDA).

Generic drugs are listed in lower-case (e.g., amoxicillin). Brand name drugs are capitalized (e.g., AMOXIL).

Mail order pharmacy service

You can use our network mail order pharmacy service, Express Scripts, to fill prescriptions for what are called “maintenance” drugs. These are drugs that you take on a regular basis for a chronic or long-term medical condition. These are the only drugs available through our mail order service. For more information on mail order pharmacy services, call Member Services.

For more information

For more detailed information about your Mercy Care Plan prescription drug coverage, please review your Member Handbook.

If you have questions about Mercy Care Plan, please call Member Services at (602) 263-3000 or (800) 624-3879. Or visit www.mercycareplan.com.

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¿Qué es el listado de medicamentos preferidos de Mercy Care Plan?

Un enlistado de medicamentos preferidos es una lista de fármacos escogidos por Mercy Care Plan y un equipo de médicos y farmacólogos. Por lo general, Mercy Care Plan cubrirá los medicamentos enumerados en nuestro listado de medicamentos preferidos, siempre y cuando sean médicamente necesarios. Además, los medicamentos recetados deben adquirirse en una farmacia perteneciente a la red de Mercy Care Plan, y existen otras reglas del plan que hay que respetar.

El listado de medicamentos preferidos comienza en la página 8. Le otorga información acerca de los medicamentos cubiertos por el Mercy Care Plan. Si tiene algún inconveniente para encontrar su medicamento en la lista, vea el índice, que comienza en la página 30.

La primera columna de la tabla ordena los medicamentos por nombre. Los medicamentos de marca están con mayúscula (por ejemplo, AMOXIL). Los medicamentos genéricos están en minúscula y cursiva (por ejemplo, *amoxicilina*). La segunda columna sirve como referencia para proveer el nombre de marca cuando la medicina genérica es cubierta por el plan. La tercera columna enlista cualquier requerimiento para el medicamento tal como autorización previa (PA), cantidades limitadas (QLL), terapia por pasos (ST), o si el medicamento es cubierto solo para incapacitados de desarrollo mental (DD) o miembros del Sistema de Arizona de Cuidado a Largo Plazo (ALTCS).

La información incluida en la columna de Requisitos/Límites le indica si Mercy Care Plan tiene algún requisito especial para su medicamento.

¿Es posible que se modifique el listado de medicamentos preferidos?

Sí, durante el año, Mercy Care Plan puede agregar algunos medicamentos a la lista o eliminar otros. Para obtener información actualizada sobre los medicamentos cubiertos, visite nuestro sitio Web en: www.MercyCarePlan.com o llame a Servicios a Miembros, al (602) 263-3000 ó (800) 624-3879.

Si eliminamos un medicamento del listado de medicamentos preferidos o le agregamos restricciones, se lo informaremos con al menos sesenta (60) días de anticipación. O, si usted debe repetir un medicamento que ya no está cubierto, le entregaremos una provisión de dicho medicamento que le alcanzará para 60 días, hasta que su médico pueda recetarle otro diferente. Además, si la *Food and Drug Administration* (Administración de Alimentos y Drogas) determina que un medicamento incluido en nuestro listado de medicamentos preferidos no es seguro o que su fabricante lo ha retirado del mercado, lo eliminaremos de nuestro listado de medicamentos preferidos de inmediato e informaremos al respecto a aquellos miembros que, a nuestro entender, lo estén tomando.

¿Cómo utilizo el listado de medicamentos preferidos?

Hay dos formas de encontrar su medicamento:

Por enfermedad

El listado de medicamentos preferidos comienza en la página 8. Los medicamentos se agrupan por tipo de enfermedades para las que están indicados. Por ejemplo, los medicamentos empleados para el tratamiento de una cardiopatía se encuentran en la categoría de “Agentes Cardiovasculares”. Si usted sabe para qué se usa el medicamento, busque el nombre de la categoría en la lista que comienza en la página 5. Luego busque su medicamento bajo el nombre de la categoría.

Por orden alfabético

Si no está seguro por qué categoría buscar, debe ubicar su medicamento en el índice que comienza en la página 30. Ésta es una lista alfabética de todos los medicamentos incluidos en el listado de medicamentos preferidos. Se enumeran tanto los medicamentos de marca como los genéricos. Ubique su medicamento. Junto a él, encontrará el número de página donde podrá hallar más información. Diríjase allí y localice su medicamento en la primera columna del listado.

¿Cuánto pagaré por los medicamentos cubiertos de Mercy Care Plan?

Usted no tiene que pagar los beneficios cubiertos por Mercy Care Plan, los cuales incluyen los medicamentos.

¿Existe alguna otra restricción sobre la cobertura?

Algunos medicamentos pueden tener requisitos o límites adicionales sobre la cobertura. Ellos pueden incluir:

- **Antes de la autorización:** Mercy Care Plan puede requerir una autorización previa para ciertos medicamentos que figuran en el listado de medicamentos preferidos. Esto significa que su médico tendrá que conseguir nuestra aprobación antes de prescribirle algunos de los medicamentos recetados. Si no se extiende esta aprobación, Mercy Care Plan no cubrirá el medicamento.

- **Límites en cuanto a la cantidad:** para ciertos medicamentos, Mercy Care Plan limita la cantidad del mismo que cubrirá. Por ejemplo, entregamos 90 píldoras en 30 días por receta para la Oxicodona.

- **Terapia escalonada:** en algunos casos, Mercy Care Plan le exige que tome ciertos medicamentos primero para tratar su afección médica, antes de cubrir otro que esté

indicado para la misma enfermedad. Por ejemplo, si el Medicamento A y el Medicamento B sirven de igual modo como terapia para su afección médica, Mercy Care Plan puede no cubrir el Medicamento B, a menos que usted haya probado primero el Medicamento A. Si el Medicamento A no le da resultado, entonces cubriremos el Medicamento B.

Podrá averiguar si su medicamento tiene o no algún requisito o límite adicional remitiéndose a la segunda columna del listado.

Códigos
Sujeto a la categoría de no incluido en el formulario, cuando el genérico esta disponible durante todo el año.
INJ –Indica que el medicamento esta disponible solamente en forma de inyección.
QLL – Se aplican niveles límite de cantidad
PA – Se requiere la autorización previa
ST –Terapia escalonada

¿Qué sucede si mi medicamento no se encuentra en el listado de medicamentos preferidos?

Si su medicamento no figura en este listado de medicamentos preferidos, primero debe llamar a su doctor y preguntar si su medicamento está cubierto. Si no lo está, tiene dos opciones:

- Muéstresela al médico y pídale que le recete un medicamento similar que esté cubierto.
- Su médico puede solicitar al Mercy Care Plan que haga una excepción y cubra su medicamento a través del proceso de autorización previa.

¿Qué son los medicamentos genéricos?

Mercy Care Plan cubre tanto los medicamentos genéricos como los de marca. Los medicamentos genéricos por lo general cuestan menos y están aprobados por la *Food and Drug Administration* (FDA).

Los medicamentos genéricos se enumeran en letra minúscula (por ejemplo, amoxicilina). Los medicamentos de marca están en mayúscula (por ejemplo, AMOXIL).

Servicio de la farmacia del pedido por correo

Usted puede utilizar nuestro servicio de la farmacia del pedido por correo, Express Scripts, para llenar las prescripciones para qué se llaman las drogas del "mantenimiento". Éstas son las drogas que usted adquiere una base regular para una condición médica crónica o a largo plazo. Éstas son las únicas drogas disponibles por nuestro servicio del pedido por correo.

Para más información sobre servicios de la farmacia del pedido por correo, llame a Servicios a Miembros.

Para obtener más información

Si desea información más detallada sobre la cobertura de medicamentos recetados de Mercy Care Plan, remítase al Manual del Miembro.

Si tiene alguna duda sobre el Mercy Care Plan, llame a Servicios a Miembros, al (602) 263-3000 ó (800) 624-3879. También puede visitar el sitio en la Web: www.mercycareplan.com

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ANESTHETICS		
TOPICAL ANESTHETICS		
lidocaine hcl	Xylocaine	
lidocaine hcl viscous	Xylocaine	
lidocaine-prilocaine	Emla	
ANTIINFECTIVES		
CEPHALOSPORINS		
cefaclor	Ceclor	
cefaclor er	Ceclor	
cefadroxil	Duricef	
cefdinir	Omnicef	
cefpodoxime proxetil	Vantin	
cefprozil	Cefzil	
cefuroxime	Ceftin	
cephalexin	Keflex	
ceftriaxone	Rocephin	QLL=2 grams/Rx
cefuroxime axetil	Ceftin	
SUPRAX		QLL= 1 tab/Rx
CLINDAMYCINS		
clindamycin	Cleocin	
ERYTHROMYCINS		
ERY-TAB		
erythromycin	Eryc	
erythromycin ethylsuccinate	E.E.S.	
erythromycin w/sulfisoxazole	Pediazole	
OTHER MACROLIDES		
azithromycin	Zithromax	QLL for 250 mg=12 tabs/30 days QLL for 600 mg=8 tabs/30 days
clarithromycin, er	Biaxin, Biaxin XL	QLL=14 tabs/30 days for extended-release; QLL=28 tabs/30 days for immediate-release
PENICILLINS		
amox tr-potassium clavulanate	Augmentin	QLL=28/30 days
amoxicillin	Amoxil	
ampicillin	Principen	
dicloxacillin		
penicillin v potassium	Veetids	
SULFONAMIDES		
GANTRISIN (SUSPENSION)		
sulfamethoxazole/trimethoprim	Septra	
sulfadiazine		
TETRACYCLINES		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
demeclocycline		
doxycycline	Vibramycin	
minocycline hcl	Dynacin	
tetracycline hcl	Sumycin	
URINARY ANTIINFECTIVES		
FURADANTIN (25 MG/5 ML SUSPENSION)		
MACRODANTIN (25 MG ONLY)		
methenamine hippurate		
nitrofurantoin macrocrystal	Macrodantin	
trimethoprim		
QUINOLONES		
ciprofloxacin er	Cipro XR	QLL=3 tabs/Rx
ciprofloxacin hcl	Cipro	QLL=28 tabs/30 days
ofloxacin	Floxin	
LEVAQUIN		QLL=14 tabs/90 days
TOPICAL ANTIBACTERIAL DRUGS		
BACTROBAN CREAM		
bacitracin/polymyxin B	Polysporin	
chlorhexidine gluconate	Peridex	
erythromycin	Eryderm	
gentamicin sulfate	Genoptic	
mupirocin ointment	Bactroban	
neomycin/bacitracin/polymyxin B	Neosporin	
permethrin cream	Elimite	
silver sulfadiazine	Silvadene	
sulfacetamide sodium	Ovace	
ORAL ANTIFUNGAL DRUGS		
clotrimazole	Mycelex	
fluconazole	Diflucan	150 MG QLL=1 tab/Rx
GRIFULVIN V		
GRIS-PEG		
itraconazole	Sporanox	
ketoconazole	Nizoral	
nystatin	Mycostatin	
SPORANOX (ORAL SOLUTION)		
terbinafine	Lamisil	
VAGINAL ANTIFUNGALS		
clotrimazole	Mycelex	
nystatin	Mycostatin	
terconazole	Terazol	
OTHER TOPICAL ANTIFUNGALS		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ciclopirox	Loprox/Penlac	
clotrimazole	Lotrimin	
econazole nitrate	Spectazole	
ketoconazole	Nizoral	
miconazole		
nystatin	Mycostatin	
tolnaftate		
TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.		
clotrimazole/betamethasone	Lotrisone	
nystatin w/triamcinolone	Mycolog II	
ANTIRETROVIRALS & PROTEASE INHIBITORS		
APTIVUS		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
ATRIPLA		
COMBIVIR		
CRIXIVAN		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
didanosine		
EMTRIVA		
EPIVIR, EPIVIR HBV		
EPZICOM		
FORTOVASE		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
FUZEON		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
INTELENCE		PA
INVIRASE		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
KALETRA		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
LEXIVA		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
NORVIR		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
PREZISTA		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
RESCRIPTOR		
REYATAZ		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
stavudine	Zerit	
SUSTIVA		
TRIZIR		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
TRUVADA		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
VIDEX SOLUTION		
VIRACEPT		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
VIRAMUNE		
VIREAD		
ZIAGEN		
zidovudine		
OTHER ANTIINFECTIVE DRUGS		
CLEOCIN (100 MG VAGINAL OVULE)		
dapsone		
MEPRON		COVERED FOR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
VANCOCIN PULVULES		QLL=40 caps/30 days
OTHER ANTIVIRAL DRUGS		
acyclovir	Zovirax	QLL=60 caps or tabs/30 days
amantadine hcl	Symmetrel	
BARACLUDE		
famciclovir	Famvir	
ISENTRESS		
PEGINTRON		PA
PEGINTRON REDIPEN		PA
PEGASYS		PA
rimantadine	Flumadine	QLL=7 tabs/30 days
REBETOL (ORAL SOLUTION)		PA; MUST BE ON INTERFERON
RELENZA		QLL/Rx=20 inhalation diskus/Rx
ribavirin		PA; MUST BE ON INTERFERON
SELZENTRY		
TAMIFLU		QLL/Rx=75mg: 10 capsules /Rx 45mg: 10 capsules /Rx 30mg: 20 capsules/Rx 12mg/ml oral suspension 3 bottles/Rx
TYZEKA		COVERED FOR GASTROENTEROLOGISTS OR ID SPECIALISTS; OTHER SPECIALISTS REQUIRE PA
VALCYTE		PA
VALTREX (1 GRAM TABLET ONLY)		QLL=30 tabs/30 days
ZOVIRAX (5% OINTMENT)		
ANTITUBERCULOSIS DRUGS		
ethambutol	Myambutol	
isoniazid	Nydrazid	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
MYCOBUTIN		
PRIFTIN		
pyrazinamide		
rifampin	Rifadin	
AMEBICIDES		
YODOXIN		
ANTHELMINTICS		
mebendazole		
PLASMODICIDES		
chloroquine phosphate		
DARAPRIM		
hydroxychloroquine sulfate	Plaquentil	
primaquine		
TRICHOMONOCIDES		
metronidazole	Flagyl	
AMINOGLYCOSIDES		
neomycin		
paromomycin		
ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS MEDICATIONS WITHIN THIS CLASS ARE COVERED FOR FDA APPROVED INDICATIONS AND MAY REQUIRE PRIOR AUTHORIZATION. ALL INJECTABLE MEDICATIONS WITHIN THIS CLASS REQUIRE PRIOR AUTHORIZATION.		
ARIMIDEX		
azathioprine	Imuran	
bicalutamide	Casodex	
CELLCEPT		PA (ALL DOSAGE FORMS)
cyclophosphamide	Cytoxan	PA (INJECTABLE ONLY)
cyclosporine	Neoral	PA (INJECTABLE ONLY)
DEPO-PROVERA (INJ)		QLL
ELIGARD (INJ)		PA
ENBREL		PA
FEMARA		
fluorouracil	Adrucil	PA (INJECTABLE ONLY)
flutamide		
HUMIRA		PA
hydroxyurea	Hydrea	
IRESSA		PA
leflunomide	Arava	COVERED FOR RHEUMATOLOGIST; OTHER SPECIALISTS REQUIRE PA
megestrol acetate	Megace	
mercaptopurine	Purinethol	
MESNEX TABLETS ONLY		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
methotrexate	Trexall	PA (INJECTABLE ONLY)
MYFORTIC		PA
NOVANTRONE [INJ]		PA
octreotide	Sandostatin	PA
RAPAMUNE		PA
TABLOID		
tacrolimus	Prograf	PA
tamoxifen citrate	Nolvadex	QLL
TARCEVA		
tretinoin	Vesinoid	
ZOLADEX [INJ]		PA
ZOLINZA		COVERED FOR ONCOLOGIST; OTHER SPECIALISTS REQUIRE PA
AUTONOMIC AND CNS MEDICATIONS		
ANALGESICS		
acetaminophen children drops/elixir OTC	Tylenol OTC	
tramadol hcl	Ultram	QLL=240 tabs/30 days
tramadol hcl-acetaminophen	Ultracet	QLL= 4 grams APAP/day
CLASS II NARCOTICS		
fentanyl patches	Duragesic	QLL=30 patches/30 days
fentanyl lozenges	Actiq	QLL=90 lozenges /30 days
hydromorphone hcl	Dilaudid	QLL for 8 mg=120 tabs/30 days
methadone hcl	Dolophine	QLL=540 tabs/30 days
morphine sulfate	MS Contin	
oxycodone-acetaminophen	Percocet	QLL=240 tabs/30 days
oxycodone-aspirin		QLL=240 tabs/30 days
oxycodone hcl	Oxyir	QLL for 5 mg=240 tabs/30 days, 10 mg, 15 mg, 20 mg, or 30 mg=150 tabs/30 days
OXYCONTIN		PA/QLL=90 tabs/30 days
CLASS III NARCOTICS		
acetaminophen-codeine	Tylenol #3	QLL= 4 grams APAP/day
hydrocodone-acetaminophen	Vicodin	QLL= 4 grams APAP/day
hydrocodone bit-ibuprofen	Vicoprofen	QLL=240 tabs/30 days
DRUGS TO PREVENT AND TREAT HEADACHES		
butalbital/acetaminophen/caffeine	Esgic/Fioricet/Triad	
butalbital/aspirin/caffeine	Fiorinal, Fortabs	
ERGOMAR		
sumatriptan	Imitrex	QLL=6 nasal sprays/30 days; 9 tabs/30 days
sumatriptan (inj)	Imitrex	QLL=4 vials/30 days; 1 kit/30 days
MIGRANAL		QLL=8 units/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
RELPAX		QLL=6 tabs/30 days
ANXIOLYTICS		
alprazolam, -XR, intensol solution	Xanax, XR	
buspirone hcl	Buspar	QLL=60 tabs/30 days
chlordiazepoxide hcl	Librium	
clorazepate dipotassium	Tranxene T-Tab	
DIASTAT		COVERED FOR NEUROLOGIST AND MCY DD/ALTCS; OTHER SPECIALISTS AND MCY ACUTE REQUIRE PA QLL=2 pkgs/30 days
diazepam	Valium	
lorazepam	Ativan	
oxazepam	Ativan	
SEDATIVE/HYPNOTIC DRUGS		
chloral hydrate		
estazolam		QLL=30 tabs/30 days
flurazepam hcl	Dalmane	QLL=30 caps/30 days
temazepam	Restoril	QLL=30 caps/30 days
triazolam	Halcion	COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA QLL=30 tabs/30 days
ROZEREM		QLL=30 tabs/30 days
zaleplon	Sonata	QLL=30 caps/30 days
ANTIMANIA DRUGS		
lithium carbonate	Eskalith/CR	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
lithium citrate		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
CARBAMAZEPINES		
carbamazepine, ER	Tegretol Tegretol XR	Extended-Release QLL=120 tabs/30 days
CARBATROL		
oxcarbazepine	Trileptal	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
TRILEPTAL SUSPENSION		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
ANTICONVULSANT/BENZODIAZEPINES		
clonazepam	Klonopin	
HYDANTOINS		
phenytoin sodium, extended	Dilantin, ER	
DILANTIN INFATABS, DILANTIN 30 MG EXTENDED RELEASE		
PHENYTEK		
VALPROIC ACID AND DERIVATIVES		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
DEPAKOTE ER, DELAYED RELEASE,SPRINKLE		
divalproex sodium ER, delayed-release	Depakote ER, Delayed-Release	
valproic acid	Depakene	
ANTICONVULSANT BARBITURATES		
mephobarbital	Mebaral	
phenobarbital		
primidone	Mysoline	
OTHER ANTICONVULSANTS		
CELONTIN		
ethosuximide		
FELBATOL		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
gabapentin	Neurontin	QLL=180 units/30 days
GABITRIL		QLL=60 tabs/30 days
lamotrigine	Lamictal	
levetiracetam	Keppra	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
NEURONTIN SOLUTION		
topiramate	Topamax	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA QLL=120 units/30 days
zonisamide	Zonegran	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA QLL=180 units/30 days
TERTIARY AMINES		
amitriptyline hcl	Elavil	
doxepin hcl	Sinequan	
imipramine hcl	Tofranil	
trimipramine	Surmontil	
SECONDARY AMINES		
amoxapine	Norpramin	
desipramine hcl	Norpramin	
nortriptyline hcl	Pamelor	
SELECTIVE SEROTONIN REUPTAKE INHIBITORS		
citalopram	Celexa	PA < 18 YEARS OF AGE; QLL=30 tabs/30 days or 300 ml/30 days
fluoxetine hcl	Prozac	PA < 18 YEARS OF AGE; QLL for 10 mg=30 caps/30 days; 20 mg, 40 mg= 60 tabs/caps/ 30 days Soln=150 ml/30 days
fluvoxamine maleate	Luvox	PA < 18 YEARS OF AGE; QLL for 100 mg=90 tabs/30 days;

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		50 mg=60 tabs/30 days; 25 mg= 30 tabs/30 days
paroxetine hcl	Paxil	PA < 18 YEARS OF AGE; QLL=30 tabs/30 days; soln=300 ml/30 days
sertraline hcl	Zoloft	PA < 18 YEARS OF AGE; QLL for 25 mg=30 tabs/30 days; 50 mg or 100 mg=60 tabs/30 days; soln=75 ml/30 days
OTHER ANTIDEPRESSANTS		
amitriptyline/ chlordiazepoxide		
budeprion sr	Wellbutrin SR	QLL=60 tabs/30 days
bupropion hcl	Wellbutrin	QLL=90 tabs/30 days
maprotiline		
mirtazapine	Remeron	QLL=30 tabs/30 days
trazodone hcl	Desyrel	
EFFEXOR XR		COVERED FOR DD, ALTCS ONLY; MCY ACUTE REQUIRE PA QLL=30 caps/30 days
tranylcypromine		
venlafaxine	Effexor	
ANTIVERTIGO AND ANTIEMETIC DRUGS		
granisetron	Kytril	COVERED FOR ONCOLOGISTS; OTHER SPECIALISTS REQUIRE PA; QLL=2 tabs/Rx
meclizine		
ondansetron hcl	Zofran	COVERED FOR ONCOLOGISTS; OTHER SPECIALISTS REQUIRE PA
ondansetron ODT	Zofran ODT	COVERED FOR ONCOLOGISTS; OTHER SPECIALISTS REQUIRE PA
prochlorperazine maleate	Compazine	
promethazine hcl	Phenergan	
EMEND		PA
ANTIPARKINSON ANTICHOLINERGIC DRUGS		
benztropine mesylate		
trihexyphenidyl		
OTHER ANTIPARKINSON DRUGS		
bromocriptine mesylate	Parlodel	
carbidopa/levodopa	Sinemet	
COMTAN		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=120 tabs/30 days
KEMADRIN		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA;

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		QLL=120 tabs/30 days
MIRAPEX		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
ropinirole	Requip	COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=90 tabs/30 days
selegiline		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
STALEVO		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=270 tabs/30 days
ANTIPSYCHOTIC DRUGS		
ABILIFY		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=30 tabs/30 days
chlorpromazine tablets		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
clozapine		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
GEODON		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=30 caps/30 days
haloperidol		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
loxapine		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
risperidone	Risperdal	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=30 tabs/30 days
SEROQUEL		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=90 tabs/30 days; 300 mg=60 tabs/30 days
thioridazine		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
trifluoperazine		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
ZYPREXA		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
CNS STIMULANT DRUGS		
amphetamine/dextroamphetamine, extended-release	Adderall, Adderall XR	Immediate release QLL=90 tabs/30 days, Extended release QLL=30 caps/30 days
CONCERTA		PA
dextroamphetamine		
METADATE CD		QLL=60 caps/30 days
methylin tabs	Ritalin	QLL=120 tabs/30 days
methylphenidate er	Ritalin-SR	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
methylphenidate hcl	Ritalin	QLL=120 tabs/30 days
RITALIN LA		PA
ANTIDEMENTIA DRUGS		
ARICEPT		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA QLL=30 tabs/30 days
ARICEPT ODT		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=30 tabs/30 days
EXELON		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=60 caps/30 days
galantamine, -ER	Razadyne, Razadyne ER	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; galantamine QLL=60 tabs/30 days galantamine ER QLL=30 caps/30 days
NAMENDA		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA;
SMOKING CESSATION DRUGS		
bupropion SR **buproban**	Zyban	**MONTHLY QLL=60 tabs/30 days;** COVERED FOR TITLE 19 MEMBERS 18 YEARS OF AGE AND OLDER AND COVERED FOR 90 DAYS/ 6 MONTH PERIOD
CHANTIX		**MONTHLY COMBINED QLL=0.5 mg,1 mg=56 tabs/30 days; QLL=1 starter pack/month;** COVERED FOR TITLE 19 MEMBERS 18 YEARS OF AGE AND OLDER AND COVERED FOR 90 DAYS/ 6 MONTH PERIOD
nicotine gum OTC		**MONTHLY QLL 2 MG=660 pieces/30 days; MONTHLY QLL 4 MG=330 pieces/30 days;** COVERED FOR TITLE 19 MEMBERS 18 YEARS OF AGE AND OLDER AND COVERED FOR 90 DAYS/ 6 MONTH PERIOD
nicotine lozenge OTC		**MONTHLY QLL=324 lozenges/30 days;** COVERED FOR TITLE 19 MEMBERS 18 YEARS OF AGE AND OLDER AND COVERED FOR 90 DAYS/ 6 MONTH PERIOD
nicotine patch OTC		**MONTHLY QLL=30 patches/30 days;** COVERED FOR TITLE 19 MEMBERS 18 YEARS OF AGE AND OLDER AND COVERED FOR 90 DAYS/ 6 MONTH

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		PERIOD
NICOTROL CARTRIDGE		**MONTHLY QLL=3 boxes/30 days;** COVERED FOR TITLE 19 MEMBERS 18 YEARS OF AGE AND OLDER AND COVERED FOR 90 DAYS/ 6 MONTH PERIOD
NICOTROL NASAL SPRAY		**MONTHLY QLL=15 bottle/30 days;** COVERED FOR TITLE 19 MEMBERS 18 YEARS OF AGE AND OLDER AND COVERED FOR 90 DAYS/ 6 MONTH PERIOD
OTHER ADHD DRUGS		
STRATTERA		PA
OTHER CNS DRUGS		
caffeine citrate oral solution		
naltrexone		COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA
pyridostigmine		
CARDIOVASCULAR MEDICATIONS		
CARDIAC GLYCOSIDES		
digoxin	Lanoxin	
LANOXIN		
CALCIUM ANTAGONISTS		
amlodipine	Norvasc	QLL= 30 tabs/30 days
cartia xt	Cardizem CD	
diltiazem er	Tiazac/Taztia XT	QLL=30 caps or tabs/30 days
diltiazem hcl	Cardizem	QLL=30 tabs/30 days
diltia xt	Cardizem CD	
dilt-CD	Cardizem CD	
felodipine er	Plendil	
nicardipine hcl	Cardene	
nifedipine, er	Procardia Procardia XL	QLL=30/30 days
verapamil, er	Verelan/Calan/Calan SR	QLL=30 untis/30days
LOOP DIURETICS		
bumetanide	Bumex	
furosemide	Lasix	
torsemide	Demadex	
THIAZIDE AND RELATED DRUGS		
chlorthalidone		
chlorothiazide		
hydrochlorothiazide	Microzide	
indapamide	Lozol	
metolazone	Zaroxolyn	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
POTASSIUM SPARING DIURETICS		
amiloride		
amiloride hcl w/hctz	Midamor	
spironolactone	Aldactone	
spironolactone w/hctz	Aldactazide	
triamterene w/hctz	Maxzide/Diazide	
BETA-ADRENERGIC ANTAGONIST DRUGS		
acebutolol		
atenolol	Tenormin	
bisoprolol fumarate	Zebeta	
carvedilol	Coreg	
labetalol hcl	Normodyne/Trandate	
metoprolol succinate	Toprol XL	
metoprolol tartrate	Lopressor	
nadolol	Corgard	
pindolol		
propranolol, er	Inderal/LA	
timolol maleate		
VASODILATOR ANTIHYPERTENSIVES		
doxazosin mesylate	Cardura	QLL=30 tabs/30 days
hydralazine hcl	Apresoline	
minoxidil		
prazosin hcl	Minipress	
terazosin hcl	Hytrin	QLL=30 units/30 days
CENTRALLY ACTING ANTIHYPERTENSIVES		
clonidine patches	Catapres TTS	COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA
clonidine tablets	Catapres	
guanfacine hcl	Tenex	COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA
methyldopa		
ANGIOTENSIN CONVERTING ENZYME INHIBITORS		
benazepril hcl	Lotensin	
captopril	Capoten	
enalapril maleate	Vasotec	
fosinopril sodium	Monopril	
lisinopril	Prinivil/Zestril	QLL=30 tabs/30 days; 40 mg=60 tabs/30 days
moexipril hcl	Univasc	
quinapril hcl	Accupril	
trandolapril	Mavik	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
BENICAR		STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days
DIOVAN		STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=60 tabs/30 days;
OTHER ANTIHYPERTENSIVES		
amlodipine/benazepril	Lotrel	
atenolol w/chlorthalidone	Tenoretic	
benazepril hcl w/hctz	Lotensin HCT	
bisoprolol fumarate w/hctz	Ziac	
captopril w/hctz	Capozide	
enalapril maleate w/hctz	Vaseretic	
fosinopril w/hctz	Monopril HCT	
hydra-zide		
lisinopril w/hctz	Prinzide/Zestoretic	
methyldopa w/hctz		
metoprolol w/hctz	Lopressor HCT	
moexipril w/hctz	Uniretic	
propranolol hcl w/hctz	Inderide	
quinapril w/hctz	Quinaretic	
BENICAR HCT		STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days
DIOVAN HCT		STEP; COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA; QLL=30 tabs/30 days
NITRATES		
isosorbide dinitrate	Isochron/Isordil	
isosorbide mononitrate	Imdur/Ismo/Monoket	
nitro-bid ointment		
nitroglycerin (patch, sublingual tablet, extended-release capsule)	Nitro-Dur/Nitrostat	
OTHER VASODILATING DRUGS		
REVATIO		PA/QLL=90 tabs/30 days
CLASS 1A ANTIARRHYTHMICS		
disopyramide	Norpace	
procainamide		
quinidine gluconate		
quinidine sulfate		
CLASS 1B ANTIARRHYTHMICS		
mexiletine	Mexitil	COVERED FOR CARDIOLOGIST;

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		OTHER SPECIALISTS REQUIRE PA
CLASS 1C ANTIARRHYTHMICS		
flecainide acetate	Tambocor	
propafenone hcl	Rythmol	COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA
OTHER ANTIARRHYTHMICS		
amiodarone	Pacerone	COVERED FOR CARDIOLOGIST; OTHER SPECIALISTS REQUIRE PA
sotalol	Betapace	
HYPOLIPOPROTEINEMICS		
cholestyramine		
colestipol hcl	Colestid	
fenofibrate	Lofibra	
gemfibrozil	Lopid	QLL
niacin		
SLO NIACIN OTC		
TRILIPIX		
ZETIA		STEP
HMG-COA REDUCTASE INHIBITORS		
lovastatin	Mevacor	QLL=30 tabs/30 days; 40 mg=60 tabs/30 days
pravastatin	Pravachol	QLL=30 tabs/30 days
simvastatin	Zocor	QLL=30 tabs/30 days
LESCOL		QLL=30 caps/30 days
LESCOL XL		QLL=30 tabs/30 days
OTHER CARDIOVASCULAR DRUGS		
midodrine	ProAmatine	
pentoxifylline	Trental	
DERMATOLOGICAL MEDICATIONS		
TOPICAL CORTICOSTEROID DRUGS		
alclometasone dipropionate	Aclovate	
amcinonide		
betamethasone dipropionate	Diprolene	
betamethasone valerate	Beta-Val	
clobetasol propionate	Clobevate/Temovate	
desonide	Desowen/Lokara	
desoximetasone	Topicort	
diflorasone diacetate	Apexicon/Maxiflor/Psorcon	
fluocinolone		
fluocinonide		
fluticasone propionate	Cutivate	
halobetasol	Ultravate	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
hydrocortisone	Ala-Cort/Cetacort/Hytone	
hydrocortisone butyrate	Locoid	
hydrocortisone valerate	Westcort	
mometasone furoate	Elocon	
prednicarbate	Dermatop	
triamcinolone acetonide	Kenalog	
ANTIPRURITIC DRUGS		
hydroxyzine hcl		
hydroxyzine pamoate		
ANTIACNE DRUGS		
amnesteem	Accutane	
claravis	Accutane	
clindamycin phosphate	Cleocin T/Clindamax	
erythromycin	A/T/S / Emgel/Erycette	
METROGEL 1% TOPICAL GEL		
metronidazole	Metrocream/Metrolotion	
salicylic acid		
sod.sulfacetamide/sulfur tf	Avar/Plexion	
sotret	Accutane	
tretinoin	Avita/Retin-A	QLL
KERATOLYTIC DRUGS		
CONDYLOX GEL		
podofilox solution	Condylox	
ANTIPSORIASIS AND ANTIECZEMA DRUGS		
calcipotriene scalp solution	Dovonex	
DOAK TAR DISTILLATE		
DRITHO-SCALP		
DOVONEX CREAM		
POLYTAR		
selenium sulfide	Selseb	
sulfacetamide sodium	Carmol Scalp	
VECTICAL OINTMENT		
ORAL DERMATOLOGICAL DRUGS		
OXSORALEN ULTRA		
TOPICAL DERMATOLOGICAL DRUGS		
ALDARA		
ammonium lactate OTC lotion, cream	Lac-Hydrin	
FLUOROPLEX		
fluorouracil	Efudex	
capsaicin		
CARAC		
ELIDEL		PA FOR AGE < 2 AND > 10;

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		QLL=30 gm/30 days
OCCLUSAL-HP		
SANTYL		
SCABICIDES		
malathion 0.5% lotion	Ovide	
permethrin	Elimite	
ULESFIA 5% LOTION		
EAR-NOSE-THROAT MEDICATIONS		
DRUGS AFFECTING THE EAR		
antipyrine/benzocaine otic	Benzotic/Otogesic	
acetic acid otic		
CIPRO HC		
CIPRODEX OTIC		
neomycin/polymixin/hydrocortisone		
ofloxacin		
DRUGS AFFECTING THE NOSE		
flunisolide	Nasarel	
fluticasone propionate	Flonase	
ipratropium bromide	Atrovent	
NASONEX		STEP/QLL=2 bottles/30 days
DRUGS AFFECTING THE THROAT AND MOUTH		
chlorhexidine gluconate	Peridex	
doxycycline hyclate	Periostat	
pilocarpine hcl	Salagen	
triamcinolone acetonide	Kenalog	
ENDOCRINE MEDICATIONS		
ORAL HYPOGLYCEMIC DRUGS		
acarbose	Precose	
chlorpropamide	Diabinese	
glimepiride	Amaryl	
glipizide, er	Glucotrol, XL	
glipizide-metformin	Metaglip	
glyburide	Diabeta/Micronase	
glyburide-metformin	Glucovance	
metformin, er	Glucophage, XR	
nateglinide	Starlix	
PRANDIN		
PRANDIMET		
tolazamide		
tolbutamide		
INSULIN SENSITIZERS		
ACTOPLUS MET		QLL=90 tabs/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ACTOS		QLL=30 tabs/30 days
AVANDAMET		QLL=60 tabs/30 days
AVANDARYL		QLL=60 tabs/30 days
AVANDIA		QLL=30 tabs/30 days
DUETACT		QLL=30 tabs/30 days
GLUCOSE ELEVATING DRUGS		
GLUCAGON		
glucose chewable tablets OTC		
INSULIN (VIALS ONLY)		
HUMULIN 50/50		
HUMULIN R (500 U/ML VIAL)		
HUMULIN 70/30		
NOVOLIN 70/30		
NOVOLIN R		
NOVOLIN N		
NOVOLOG		
NOVOLOG MIX 70/30		
LANTUS		
LEVEMIR		
GLUCOCORTICOID DRUGS		
cortisone		
dexamethasone		
hydrocortisone	Cortef	
methylprednisolone	Medrol	
prednisolone	Prelone	
prednisone	Sterapred	
ORAPRED, -ODT		
GROWTH HORMONES		
NORDITROPIN		PA
NORDITROPIN NORDIFLEX		PA
NUTROPIN		PA
NUTROPIN AQ		PA
MINERALOCORTICOID DRUGS		
fludrocortisone acetate	Florinef	
THYROID SUPPLEMENTS		
ARMOUR THYROID		
levothroid		
levothyroxine sodium	Synthroid	
levoxyl	Synthroid	
liothyronine	Cytomel	
thyroid, dessicated	Armour Thyroid	
unithroid	Synthroid	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ANTITHYROID DRUGS		
methimazole	Tapazole	
propylthiouracil		
ANDROGEN DRUGS		
danazol		
METHITEST		
testosterone cypionate (200 mg/ml only)		
OTHER ENDOCRINE DRUGS		
alendronate sodium	Fosamax	QLL 35 mg or 70 mg=4 tabs/30 days; QLL 5 mg,10 mg, 40 mg=30 tabs/30 days
cabergoline	Dostinex	COVERED FOR ENDO; OTHER SPECIALISTS REQUIRE PA;
calcitonin nasal spray	Miacalcin	
desmopressin acetate	DDAVP/Minirin	COVERED FOR DD AND ENDO/NEURO; OTHER SPECIALISTS AND MCY ACUTE AND ALTCS REQUIRE PA; QLL=1 bottle/30 days; QLL=90 tabs/30 days
etidronate	Didronel	
fortical nasal spray		
KUVAN		PA
MIACALCIN (INJ)		PA
SENSIPAR		COVERED FOR NEPHROLOGIST; OTHER SPECIALISTS REQUIRE PA
GASTROINTESTINAL MEDICATIONS		
ANTIDIARRHEAL DRUGS		
bismuth subsalicylate	Kaopectate	
diphenoxylate w/atropine	Lomotil	
loperamide hcl	Imodium	
ANTISPASMODICS/DRUGS AFFECT GI MOTILITY		
dicyclomine hcl	Bentyl	
glycopyrrolate tablets	Robinul	COVERED FOR DD; MCY ACUTE AND ALTCS REQUIRE PA
hyoscyamine	Nulev/Levbrel	
metoclopramide hcl	Reglan	
ANTIULCER DRUGS		
cimetidine	Tagamet	
famotidine	Pepcid	
nizatidine	Axid	
ranitidine	Zantac	
OTHER ANTIULCER DRUGS		
misoprostol	Cytotec	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
sucralfate	Carafate	
CARAFATE SUSPENSION		
PROTON PUMP INHIBITORS		
PREVACID SOLUTAB		COVERED FOR PULMONOLOGISTS (INCLUDING PEDIATRIC PULMONOLOGISTS) AND PEDIATRIC GASTROENTEROLOGISTS FOR CHILDREN 17 YEARS OF AGE AND YOUNGER
omeprazole, omeprazole OTC, PRILOSEC OTC		STEP/ Combined QLL=120 tabs and caps /30 days
pantoprazole	Protonix	PA/QLL=30 tabs/30 days
LAXATIVES AND CATHARTICS		
bisacodyl		
docusate	Colace	
KONSYL OTC		COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA
MIRALAX OTC		QLL=510 g/30 days
OTHER GI DRUGS		
AMITIZA		QLL=60 caps/30 days
antacids		UP TO $30/MONTH
ASACOL, ASACOL HD		
belladonna alkaloids-opium		
CANASA		
CREON		
DIPENTUM		
hydrocortisone rectal enema suspension	Colocort/ Cortenema	
IPECAC SYRUP		
mesalamine enema		
NULYTELY WITH FLAVOR PACKS		
simethicone drops OTC		PA>2 years
PANCREASE MT 4		
PANCRELIPASE		
PEG 3350 ELECTROLYTE SOLUTION		
PENTASA		
PROCTOFOAM-HC		
propantheline		
sulfasalazine	Azulfidine	
ultracaps MT 20	Ultrase MT 20	
ULTRASE		
ursodiol	Actigall	
VIOKASE		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
IMMUNOLOGICALS AND VACCINES		
FLUMIST		PA FOR AGES <2 OR >49
RHOGAM		
MUSCULOSKELETAL MEDICATIONS		
SALICYLATES AND RELATED DRUGS		
aspirin		
choline magnesium trisalicylate		
diflunisal	Dolobid	
salsalate	Disalcid	
NON-STEROIDAL ANTIINFLAMMATORY AGENTS		
diclofenac sodium	Voltaren	
etodolac	Lodine/Lodine XL	
fenoprofen		
flurbiprofen	Anasaid	
ibuprofen	Motrin	
indomethacin	Indocin SR	
ketoprofen	Orudis/Oruvail	
ketorolac	Toradol	QLL=20 tabs/30 days and 2 Rxs per 90 days
meclofenamate		
meloxicam	Mobic	
nabumetone	Relafen	
naproxen	Naprosyn	
oxaprozin	Daypro	
piroxicam	Feldene	
sulindac	Clinoril	
tolmetin		
OTHER DRUGS FOR ARTHRITIS		
RIDAURA		COVERED FOR RHEUMATOLOGIST; OTHER SPECIALISTS REQUIRE PA
DRUGS TO PREVENT AND TREAT GOUT		
allopurinol	Zyloprim	
colchicine		
colchicine / probenecid		
probenecid		
DIRECT MUSCLE RELAXANTS		
baclofen		
tizanidine hcl	Zanaflex	
CNS MUSCLE RELAXANTS		
carisoprodol	Soma	QLL=120 tabs/30 days
cyclobenzaprine hcl	Flexeril	QLL=120 tabs/30 days
dantrolene capsule	Dantrium	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
methocarbamol	Robaxin	QLL=120 tabs/30 days
SKELAXIN		QLL=120 tabs/30 days
OTHER MUSCULOSKELETAL MEDICATIONS		
RILUTEK		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
NUTRITION, BLOOD MODIFIERS, ELECTROLYTES		
THERAPEUTIC VITAMINS & MINERALS		
CALCIFEROL		
calcitriol	Calcijex/Rocaltrol	
calcium acetate	Phoslo	
calcium carbonate	Tums/Maalox	
calcium citrate	Citracal	
cyanocobalamin [inj]		PA
ergocalciferol	Vitamin D	
ferrous gluconate		
ferrous sulfate		
folic acid		
levocarnitine		COVERED FOR NEUROLOGIST; OTHER SPECIALISTS REQUIRE PA
multivitamin with fluoride		
pediatric multivitamin with fluoride and iron		
poly-vitamin, -w iron drops		QLL=1 bottle/30 days
NEPHROCAPS		
pyridoxine		
sodium bicarbonate		
sodium fluoride		
thiamine		
ZEMPLAR		COVERED FOR NEPHROLOGIST; OTHER SPECIALISTS REQUIRE PA
POTASSIUM SUPPLEMENTS		
BICITRA		
KLOR-CON, KLOR-CON M		
potassium chloride	K-Dur/Klotrix	
SHOHL'S MODIFIED		
POTASSIUM REMOVING RESINS		
sodium polystyrene sulfonate	Kayexalate	
ORAL ANTICOAGULANTS, VITAMIN K		
warfarin sodium	Coumadin	
HEPARINS		
heparin sodium [inj] (heparin lock flush solution not covered)		
LOW-MOLECULAR WEIGHT HEPARINS (LMWH)		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
FRAGMIN [inj]		10 DAYS W/O PA (10 DAYS=10 SYRINGES)
LOVENOX [inj]		10 DAYS W/O PA (10 DAYS=20 SYRINGES)
ANTIPLATELET DRUGS		
cilostazol	Pletal	
dipyridamole	Persantine	
ticlopidine hcl	Ticlid	
PLAVIX		QLL=30 tabs/30 days
HEMOSTATICS		
aminocaproic acid	Amicar	
MEPHYTON		
BLOOD DETOXICANTS		
lactulose	Enulose	
FOSRENOL		PA
RENAGEL		
RENVELA		
OTHER BLOOD MODIFIERS		
anagrelide	Agrylin	
ARCALYST		PA
SOLIRIS		COVERED FOR HEMATOLOGIST; OTHER SPECIALISTS REQUIRE PA
OBSTETRICAL & GYNECOLOGICAL MEDICATIONS		
PRENATAL VITAMINS (COVERED FOR FEMALES AGES 11 to 49) QLL=100 tabs/90 days for all legend prenatal vitamins		
cal-nate		
complete natal DHA		
fe plus tablet		
prenatal advantage (prenatal AD)		
prenatal low iron		
prenatal H		
prenatal U		
trinate		
ultra-natal		
vinatal forte		
vinate ultra		
vinate calcium		
vitafol-ob		
vitafol-pn		
OB/GYN TOPICAL ANTIINFECTIVES		
acidic vaginal jelly		
CLEOCIN OVULE		
clindamycin 2% vaginal cream	Clindamax	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
metronidazole 0.75% vaginal gel	MetroGel	
miconazole vaginal suppositories, cream		
ESTROGEN DRUGS		
estradiol tablets	Estrace	
estradiol transdermal patch	Climara	QLL=8 patches/30 days
estropipate	Ogen/Ortho-Est	
ESTRACE VAGINAL CREAM		
ESTRING		
FEMRING		
MENEST		
PREMARIN		
VAGIFEM		
ESTROGEN/PROGESTIN COMBINATIONS		
ACTIVELLA		
CLIMARA PRO		
COMBIPATCH		
FEMHRT		
PREFEST		
PREMPHASE		
PREMPRO		
SELECTIVE ESTROGEN RECEPTOR MODULATOR		
EVISTA		QLL=30 tabs/30 days
PROGESTIN DRUGS		
camila	Micronor/Nor-Q-D	
errin	Micronor/Nor-Q-D	
jolivette	Micronor/Nor-Q-D	
medroxyprogesterone acetate	Provera	QLL for injection=1/90 days
nora-be	Micronor/Nor-Q-D	
norethindrone acetate	Aygestin	
PROMETRIUM		
OTHER OB/GYN DRUGS		
METHERGINE TABLETS		
OPHTHALMIC MEDICATIONS		
OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS		
bacitracin ophth ointment		
ciprofloxacin hcl (ophth drops)	Ciloxan	
CILOXAN OPTHALMIC OINTMENT		
erythromycin		
gentamicin sulfate	Garamycin/Gentak	
neomycin/polymyxin/bacitracin	Neosporin	
neomycin/polymyxin/gramicidin		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ofloxacin	Ocuflox	
polymyxin/trimethoprim	Polytrim	
sulfacetamide sodium	Bleph-10	
tobramycin sulfate	Tobrex	
TOBREX OINTMENT		
VIGAMOX		
ZYMAR		
OPHTHALMIC CORTICOSTEROID DRUGS		
dexamethasone		
PRED MILD		
prednisolone	Omnipred/Pred Forte	
fluorometholone		
FML FORTE		
OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS		
neomycin/polymixin/hydrocortisone	Cortisporin	
neomycin/polymyxin/dexamethasone	Methadex/Maxitrol	
prednisolone/sulfacetamide		
TOBRADEX OINTMENT		
tobramycin/dexamethasone susp	Tobradex	
ANTIGLAUCOMA DRUGS		
AZOPT		
BETOPTIC S		
betaxolol hcl		
brimonidine tartrate	Alphagan, Alphagan P	
carteolol hcl		
COMBIGAN		
dipivefrin hcl	Propine	
dorzolamide	Trusopt	
dorzolamide/timolol	Cosopt	
ISOPTO CARBACHOL		
levobunolol hcl	Betagan	
LUMIGAN		
methazolamide		
metipranolol	Optipranolol	
PHOSPHOLINE IODIDE		
pilocarpine hcl	Isopto Carpine	
timolol maleate	Timoptic/Timoptic-XE	
TRAVATAN		
TRAVATAN Z		
OTHER OPHTHALMIC DRUGS		
atropine sulfate	Isopto Atropine	
cromolyn sodium	Crolom	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
cyclopentolate	Cyclogyl	
diclofenac sodium	Voltaren	
flurbiprofen sodium	Ocufen	
ISOPTO HOMATROPINE		
ISOPTO HYOSCINE		
ketoralac tromethamine	Acular, Acular LS	
MUROCOLL-2		
naphazoline	AK-Con	
NEVANAC		
PATANOL		
phenylephrine		
REFRESH TEARS, LIQUIGEL (15 ML AND 30 ML BOTTLE ONLY)		
SYSTANE (15 ML AND 30 ML BOTTLE ONLY)		
trifluridine		
tropicamide		
ZADITOR OTC		
RESPIRATORY MEDICATIONS		
BETA-2 ADRENERGIC DRUGS		
albuterol sulfate (inhalation soln, syrup, tablet)		QLL=375 ml/30 days for inhalation soln
ALUPENT (650 MCG INHALER)		
MAXAIR AUTOHALER		
metaproterenol		
PROAIR HFA		QLL= 2 inhalers/30 days
PROVENTIL HFA		QLL= 2 inhalers/30 days
SEREVENT DISKUS		
terbutaline		
VENTOLIN HFA		QLL= 2 inhalers/30 days
INHALED CORTICOSTEROIDS		
ADVAIR DISKUS		
ADVAIR HFA		
AZMACORT		
FLOVENT DISKUS		
FLOVENT HFA		
PULMICORT RESPULES		QLL=60 ml/30 days (30 respules/30 days)
PULMICORT FLEXHALER/INHALER		QLL=1 inhaler or flexhaler/30 days
SYMBICORT		
LEUKOTRIENE MODIFIERS		
ACCOLATE		COVERED FOR MEMBERS WITH DIAGNOSIS OF ASTHMA;

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		QLL=60 tabs/30 days
SINGULAIR		COVERED FOR MEMBERS WITH DIAGNOSIS OF ASTHMA; PA FOR ALLERGIC RHINITIS; QLL=30 tabs/30 days
METHYL XANTHINE DRUGS		
theophylline, er		
OTHER DRUGS FOR ASTHMA		
ATROVENT (INHALER)		
COMBIVENT		
cromolyn sodium inhalation soln		
EPIPEN, EPIPEN JR		
INTAL		
ipratropium bromide		
ipratropium bromide/albuterol inhalation soln		
sodium chloride 0.9% nebulizer solution OTC		
OTHER RESPIRATORY DRUGS		
SPIRIVA		STEP; QLL=30 caps/30 days (pkg size=30); 6 caps/30 days (pkg size=6); 1 pkg/30 days (pkg size=5); 1/30 days (pkg size=90)
ANTIHISTAMINES		
brompheniramine maleate		
cetirizine OTC tablets, solution	OTC Zyrtec	QLL=150 ml/30 days
chlorpheniramine maleate		
clemastine fumarate	Tavist	
cyproheptadine hcl	Periactin	
dexchlorpheniramine		
diphenhydramine hcl	Benadryl	
hydroxyzine hcl		
loratadine, loratadine-D OTC	OTC Claritin,Claritin D	
ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
andehist nr syrup	Rondec syrup	
bromaxefed rf syrup	Rondec syrup	
chlor-pseudo sr capsule	Deconamine SR	
colfed-a capsule sr	Deconamine SR	
duradryl syrup		
histade capsule sa		
p-ephed-cpm 120-8 mg SA	Deconamine SR	
pseudo-chlor capsule	Rynatan pediatric susp	
rhinacon a liquid, tablet		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ANTITUSSIVE AND EXPECTORANT DRUGS		
benzonatate	Tessalon	QLL=90 capsules/30 days
ceron dm syrup	Rondec DM syrup	
cphen, cphen dm drops, syrup	Rondec, DM drops, syrup	
dextromethorphan-GG		
guaifenesin	Robitussin	
guaifenesin w/codeine	Romilar AC/Tussi-Organidin DM NR	
guaifenesin-dm	Robitussin DM	
guaifenesin-pseudoephedrine hcl	Robitussin PE	
guaifenex pse	Entex PSE/Zephrex-LA	
MUCINEX ER, MUCINEX D ER, MUCINEX DM ER OTC		
promethazine vc w/codeine	Phenergan VC w/Codeine	
promethazine vc	Phenergan VC	
promethazine w/dm	Phenergan DM	
TOXICOLOGY MEDICATIONS		
acetylcysteine		
CUPRIMINE		
UROLOGICAL MEDICATIONS		
ANTICHOLINERGIC ANTISPASMODICS DRUGS		
flavoxate	Urispas	
oxybutynin chloride	Ditropan	
oxybutynin chloride er	Ditropan XL	
SANCTURA		STEP; QLL=60 tabs/30 days
SANCTURA XR		STEP
CHOLINERGIC STIMULANTS		
bethanecol		
URINARY ANESTHETICS		
phenazopyridine hcl	Pyridium/Urodol	
OTHER GENITOURINARY PRODUCTS		
CYTRA, K		
ELMIRON		
finasteride	Proscar	
K-PHOS		
potassium citrate		
UROXATRAL		
MEDICAL (MISCELLANEOUS) SUPPLIES		
DIABETIC SUPPLIES TEST STRIPS COMBINED QLL=204 TEST STRIPS/30 DAYS		
ACCU-CHEK		
ACCU-CHEK III		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ACCU-CHEK AVIVA GLUCOMETER/TEST STRIPS		Combined QLL for test strips= 204 strips/30 days
ACCU-CHEK ACTIVE GLUCOMETER/TEST STRIPS		Combined QLL for test strips= 204 strips/30 days
ACCU-CHEK ADVANTAGE GLUCOMETER/TEST STRIPS		Combined QLL for test strips= 204 strips/30 days
ACCU-CHEK COMPACT GLUCOMETER/TEST STRIPS		Combined QLL for test strips= 204 strips/30 days
ACCU-CHEK COMPLETE GLUCOMETER		
ACCU-CHEK SIMPLICITY		
ACCU-CHEK COMFORT CURVE TEST STRIPS		Combined QLL for test strips= 204 strips/30 days
ACCU-CHEK MULTICLIX LANCET DEVICE/LANCETS		
ACCU-CHEK SOFTCLIX LANCET DEVICE/LANCETS		
MICROLET LANCING DEVICE/LANCETS		
AUTOJECT 2 INJECTION DEVICE		
insulin syringes		
NOVOFINE 31		
ONE TOUCH ULTRA2, UKTRALINK, ULTRAMINI, ULTRASMART		
ONE TOUCH SELECT		
ONE TOUCH TEST STRIPS, CONTROL SOLUTION		Combined QLL for test strips= 204 strips/30 days
SOFT TOUCH		
SOFTCLIX		
CHEMSTRIP		
KETOSTIX		
OTHER SUPPLIES		
AEROCHAMBER, MICROCHAMBER		QLL=1/year