Preferred Drug List

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. Injectable medications require prior authorization unless otherwise noted on the Preferred Drug List.

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.

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, CVS Caremark, 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.

¿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 aňo.
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, CVS Caremark, 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 topical cream, ointment, solution	Xylocaine	
lidocaine hcl viscous	Xylocaine	
lidocaine-prilocaine topical	Emla	
Lidocaine 5% Topical Patch	Lidoderm	
ANTIINFECTIVES		
CEPHALOSPORINS		
cefaclor	Ceclor	
cefaclor er	Ceclor	
cefadroxil	Duricef	
cefdinir	Omnicef	
cefpodoxime proxetil	Vantin	
cefprozil	Cefzil	
cefuroxime	Ceftin	
Cephalexin 250mg, 500mg capsules	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	
clarithromycin, er	Biaxin, Biaxin XL	
PENICILLINS		
amox tr-potassium clavulanate	Augmentin	
amoxicillin	Amoxil	
ampicillin	Principen	
dicloxacillin		
penicillin v potassium	Veetids	
SULFONAMIDES		
sulfamethoxazole/trimethoprim	Septra	
sulfadiazine		
TETRACYCLINES		
demeclocycline		
doxycycline	Doryx, Periostat, Vibramycin	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
minocycline hcl	Dynacin	
tetracycline hcl	Sumycin	
URINARY ANTIINFECTIVES		
nitrofurantoin25 MG/5 ML SUSPENSION	**FURADANTIN**	
methenamine hippurate		
nitrofurantoin macrocrystal	Macrodantin	
trimethoprim		
QUINOLONES		
ciprofloxacin oral suspension	**CIPRO ORAL SUSPENSION**	
ciprofloxacin er	Cipro XR	
ciprofloxacin hcl	Cipro	
ofloxacin	Floxin	
levofloxacin	Levaquin	
TOPICAL ANTIBACTERIAL DRUGS		
Bacitracin ointment		
bacitracin/polymyxin B	Polysporin	
erythromycin	Eryderm	
gentamicin sulfate	Genoptic	
mupirocin ointment, cream	Bactroban	QLL = #30gm/30days
neomycin/bacitracin/polymyxin B	Neosporin	
silver sulfadiazine	Silvadene	
sulfacetamide sodium	Ovace	
ORAL ANTIFUNGAL DRUGS		
clotrimazole	Mycelex	
fluconazole	Diflucan	
flucytosine	Ancobon	PA
griseofulvin microsize	**GRIFULVIN V**	
griseofulvin ultramicrosize	**GRIS-PEG**	
itraconazole	Sporanox	
ketoconazole	Nizoral	
NOXAFIL ORAL SUSPENSION		PA
nystatin	Mycostatin	
SPORANOX (ORAL SOLUTION)		
terbinafine	Lamisil	QLL #90 per 365 days
voriconazole	Vfend	PA
VAGINAL ANTIFUNGALS		
clotrimazole	Mycelex	
nystatin	Mycostatin	
terconazole	Terazol	
OTHER TOPICAL ANTIFUNGALS		
ciclopirox	Loprox/Penlac	
clotrimazole	Lotrimin	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
econazole nitrate	Spectazole	
ketoconazole	Nizoral	
miconazole		
nystatin	Mycostatin	
terbinafine	Lamisil	
tolnaftate		
TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.		
clotrimazole/betamethasone	Lotrisone	
nystatin w/triamcinolone	Mycolog II	
ANTIRETROVIRALS & PROTEASE INHIBITORS		
abacavir tablet	Ziagen	
Abacavir Sulfate-Lamivudine-Zidovudine 300mg-150mg-300mg	Trizivir	
APTIVUS		
ATRIPLA		
COMPLERA		
CRIXIVAN		
didanosine	Videx EC	
EDURANT		
EMTRIVA		
lamivudine oral solution	**EPIVIR oral solution**	
EPZICOM		
FUZEON		COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
INTELENCE		
INVIRASE		
ISENTRESS		
KALETRA		
Lamivudine 100mg HBV tablet	Epivir HBV	
Lamivudine 150mg, 300mg	Epivir	
lamivudine-zidovudine 150mg-300mg	Combivir	
LEXIVA		
nevirapine tablets, -XR tablets, oral suspension	Viramune, Viramune XR	
NORVIR		
PREZISTA		
RESCRIPTOR		
REYATAZ		
SELZENTRY		
stavudine	Zerit	
STRIBILD		
SUSTIVA		
TIVICAY		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
TRIUMEQ		
TRUVADA		
TYBOST		PA
VIDEX ORAL SOLUTION		
VIRACEPT		
VIREAD		
VITEKTA		
ZIAGEN oral solution		
zidovudine		
OTHER ANTIINFECTIVE DRUGS		
CLEOCIN (100 MG VAGINAL OVULE)		
dapsone		
atovaquone 750mg/5ml Suspension	Mepron	COVERED FOR ID SPECIALISTS; ALL OTHERS REQUIRE PA
vancomycin capsules	Vancocin pulvules	QLL=40 caps/30 days
linezolid	**ZYVOX**	PA
OTHER ANTIVIRAL DRUGS		
acyclovir	Zovirax	QLL=60 caps or tabs/30 days
acyclovir 5% ointment	Zovirax ointment	
adefovir dipivoxil	HEPSERA	PA
amantadine hcl	Symmetrel	
entecavir	BARACLUDE	
EPIVIR HBV 100mg tab, oral solution		
famciclovir	Famvir	
foscarnet injection	Foscavir	PA
ganciclovir	Cytovene	PA
HARVONI		PA
INFERGEN		PA
INTRON A		PA
PEGINTRON		PA
PEGINTRON REDIPEN		PA
PEGASYS		PA
rimantadine	Flumadine	QLL=14 tabs/RX
REBETOL (ORAL SOLUTION)		PA; MUST BE ON INTERFERON
RELENZA		QLL/Rx=20 inhalation diskus/Rx
ribavirin		PA; Will process at pharmacy if pharmacy fills Interferon, Sovaldi or Harvoni first
Sovaldi		PA QL #28 tablets/28days
SYNAGIS		PA

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
TAMIFLU		QLL/Rx=75mg: 10 capsules /Rx 45mg: 10 capsules /Rx 30mg: 20 capsules/Rx 6mg/ml oral suspension 3 bottles/Rx
TYZEKA		COVERED FOR GASTROENTEROLOGISTS OR ID SPECIALISTS; ALL OTHERS REQUIRE PA
valacyclovir	Valtrex	500 mg tablet QLL=60 tabs/30 days 1 gram tablet QLL=30 tabs/30 days
valganciclovir	**VALCYTE**	PA
cidofovir injection	**VISTIDE INJECTION**	PA
ZOVIRAX (5% CREAM)		
ANTITUBERCULOSIS DRUGS		
ethambutol	Myambutol	
isoniazid	Nydrazid	
isoniazid-rifampin	Isonarif, Rifamate	
rifabutin	MYCOBUTIN	
PRIFTIN		
pyrazinamide		
rifampin	Rifadin	
AMEBICIDES		
YODOXIN		
ANTHELMINTICS		
Albenza		
Biltricide		
mebendazole		
ivermectin	**STROMECTOL**	
PLASMODICIDES		
Atovaquone-proguanil	Malarone	
chloroquine phosphate	Aralen	
COARTEM		
DARAPRIM		PA
hydroxychloroquine sulfate	Plaquentil	
mefloquine	Lariam	
primaquine		
Quinine sulfate	Qualaquin	
TRICHOMONOCIDES		
metronidazole	Flagyl	
AMINOGLYCOSIDES		
neomycin		
paromomycin		
tobramycin inhalation solution	**TOBI**	PA
ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
MEDICATIONS WITHIN THIS CLASS ARE COVERED FOR FDA APPROVED INDICATIONS AND MAY REQUIRE PRIOR AUTHORIZATION. ALL INJECTABLE MEDICATIONS WITHIN THIS CLASS REQUIRE PRIOR AUTHORIZATION.		
ACTIMMUNE		PA
ALKERAN TABS		
anastrozole	Arimidex	
azathioprine	Imuran	
bicalutamide	Casodex	
capecitabine	Xeloda	PA
CELLCEPT INJECTION		PA
cyclophosphamide	Cytoxan	PA (INJECTABLE ONLY)
cyclosporine	Neoral	PA (INJECTABLE ONLY)
DEPO-PROVERA 400mg/ml (INJ)		PA
ELIGARD (INJ)		PA
ENBREL		PA
exemestane	Aromasin	
fluorouracil	Adrucil	PA (INJECTABLE ONLY)
flutamide		
GLEEVEC		PA
HUMIRA		PA
hydroxyurea	Hydrea	
IRESSA		PA
leflunomide	Arava	
letrozole	Femara	
leucovorin tablets		
Leuprolide		PA
Lupron Depot PED		PA
Lupron Depot		PA
megestrol acetate	Megace	
mercaptopurine	Purinethol	
MESNEX TABLETS ONLY		
methotrexate 2.5mg tablet	Trexall	
methotrexate INJECTION		
mycophenolate mofetil	Cellcept	
Mycophenolic Acid 180mg & 360mg Delayed-Release Tablets	MYFORTIC	
NOVANTRONE [INJ]		PA
octreotide	Sandostatin	PA
ORENCIA		PA
REMICADE		PA
REVLIMID		PA
sirolimus	Rapamune	
STIVARGA		PA
TABLOID		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
tacrolimus	Prograf	
tamoxifen citrate	Nolvadex	
TARCEVA		PA
THALOMID		PA
tretinoin	Vesinoid	
VELCADE		PA
VOTRIENT		PA
ZOLADEX [INJ]		PA
ZOLINZA		COVERED FOR ONCOLOGISTS; ALL OTHERS REQUIRE PA
AUTONOMIC AND CNS MEDICATIONS		
ANALGESICS		
acetaminophen	Tylenol OTC	
aspirin, enteric-coated aspirin		
buffered aspirin	Bufferin, Ascriptin	
enteric-coated aspirin	Ecotrin	
tramadol hcl	Ultram	QLL=240 tabs/30 days
Tramadol ER	Ultram ER	QLL=#30/30days
tramadol hcl-acetaminophen	Ultracet	QLL= 4 grams APAP/day
CLASS II NARCOTICS		
fentanyl patches	Duragesic	QLL=#15 patches/30 days
fentanyl lozenges	Actiq	QLL=90 lozenges /30 days
hydrocodone/APAP tablets 5/325mg, *7.5/325mg, 10/325mg,*	Vicodin, Lortab	QLL= 4 grams APAP/day
hydrocodone-acetaminophen solution 7.5-325 MG/15ML		
hydrocodone bit-ibuprofen	Vicoprofen	QLL=240 tabs/30 days
hydromorphone hcl	Dilaudid	QLL =180 tabs/30 days
meperidine	Demerol	QLL=180 tabs/30 days
methadone hcl	Dolophine	QLL=180 tabs/30 days
morphine sulfate **morphine sulfate ER tablets**	MS Contin	
oxycodone-acetaminophen tab 2.5/325mg, 5/325mg, 7.5/325mg, 10/325mg	Percocet	QLL=240 tabs/30 days
oxycodone w/ acetaminophen SOLN 5-325 MG/5ML		QLL = 4gm APAP/day
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=180 tabs/30 days
OXYCONTIN		PA/QLL=90 tabs/30 days
oxymorphone IR	Opana IR	STEP, QL= #240/30days
oxymorphone ER	Opana ER	STEP, QL= #60/30days
CLASS III NARCOTICS		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
acetaminophen-codeine	Tylenol #3	QLL= 4 grams APAP/day
butalbital/aspirin/caffeine with codeine	Fiorinal with Codeine	QLL = 240/30days
DRUGS TO PREVENT AND TREAT HEADACHES		
butalbital/APAP 50-325mg tab		QLL=4gm apap/day
butalbital/acetaminophen/caffeine tab 50-325-40mg	Esgic/Fioricet/Triad	QLL=4gm apap/day
butalbital/acetaminophen/caffeine w/cod capsule 50-325-40-30mg		QLL=4gm apap/day
butalbital/aspirin/caffeine	Fiorinal, Fortabs	
ergotamine tartrate/caffeine	Cafergot	
ergoloid mesylates	Hydergine	
ERGOMAR		
naratriptan	Amerge	QLL=9 tabs/30 days
sumatriptan	Imitrex	QLL=6 nasal sprays/30 days; 9 tabs/30 days
sumatriptan (inj)	Imitrex	QLL=4 vials/30 days; 1 kit/30 days
dihydroergotamine nasal spray	**MIGRANAL**	QLL=8 units/30 days
MIGERGOT Suppository		QLL = 12/30days
RELPAX		QLL=6 tabs/30 days
rizatriptan benzoate (tablets only)	Maxalt 5mg, 10mg tablets	QLL= 12tabs/30days
ANXIOLYTICS		
alprazolam, -XR, intensol solution	Xanax, XR	
buspirone hcl	Buspar	QLL=120 tabs/30 days; 30mg tab QLL=60/30 days
chlordiazepoxide hcl	Librium	
clorazepate dipotassium	Tranxene T-Tab	
diazepam 2.5 mg, 10 mg, 20 mg rectal gel	Diastat	QLL=2 pkgs/30 days
diazepam	Valium	
lorazepam	Ativan	
oxazepam	Serax	
SEDATIVE/HYPNOTIC DRUGS		
SOMNOTE	chloral hydrate	QLL=30 caps/30 days
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
zolpidem	Ambien	QLL 5mg=60 tabs/30 days, QLL 10mg=30 tabs/30 days
ANTIMANIA DRUGS		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
lithium carbonate	Eskalith/CR	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
lithium citrate oral solution		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
CARBAMAZEPINES		
carbamazepine, ER	Tegretol, Tegretol XR	
carbamazepine SR	**CARBATROL**	
oxcarbazepine tablets, suspension	Trileptal	
carbamazepine SR 12HR	**TEGRETOL XR**	
ANTICONVULSANT/BENZODIAZEPINES		
clonazepam	Klonopin	
HYDANTOINS		
phenytoin sodium, extended	Dilantin, ER	
phenytoin infatabs 50mg chew	Dilantin Infatabs	
DILANTIN 30 MG EXTENDED RELEASE		
phenytoin sodium extended release capsules	**PHENYTEK**	
VALPROIC ACID AND DERIVATIVES		
divalproex sodium ER, delayed-release, sprinkle	Depakote ER, Delayed-Release, sprinkle	
valproic acid	Depakene	
ANTICONVULSANT BARBITURATES		
phenobarbital		
primidone	Mysoline	
OTHER ANTICONVULSANTS		
BANZEL		PA
CELONTIN		
ethosuximide		
felbamate	Felbatol	
gabapentin	Neurontin	
GABITRIL 12 mg, 16 mg		QLL=60 tabs/30 days
lamotrigine	Lamictal	
levetiracetam, -ER	Keppra, Keppra XR	
LYRICA		PA
gabapentin solution	**NEURONTIN SOLUTION**	
ONFI		PA
tiagabine 2 mg, 4 mg	Gabitril	QLL=60 tabs/30 days
topiramate	Topamax	
VIMPAT		PA
zonisamide	Zonegran	QLL=180 units/30 days
TERTIARY AMINES		
amitriptyline hcl	Elavil	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
clomipramine	Anafranil	
doxepin hcl	Sinequan	
imipramine hcl	Tofranil	
trimipramine	Surmontil	
SECONDARY AMINES		
amoxapine		
desipramine hcl	Norpramin	
nortriptyline hcl	Pamelor	
protriptyline	Vivactil	
SELECTIVE SEROTONIN REUPTAKE INHIBITORS		
citalopram	Celexa	QLL=30 tabs/30 days or 300 ml/30 days
escitalopram	Lexapro	QLL = 30/30days or
fluoxetine hcl	Prozac	QLL for 10 mg=30 caps/30 days 20mg caps= 60/30days 40 mg= 60 caps/30 days 60mg QLL = 30/30days Soln=150 ml/30 days
fluvoxamine maleate	Luvox	QLL for 100 mg=90 tabs/30 days; 50 mg=60 tabs/30 days; 25 mg= 30 tabs/30 days
paroxetine hcl	Paxil	QLL=60 tabs/30 days;
sertraline hcl	Zoloft	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	
bupropion IR, SR, XL	Wellbutrin, Wellbutrin XL	
duloxetine	Cymbalta	QLL= 60/30days
maprotiline		
mirtazapine, ODT	Remeron	QLL=30 tabs/30 days
trazodone hcl	Desyrel	
tranylcypromine		
venlafaxine	Effexor	
venlafaxine ER/XR tablets, capsules	Effexor XR	QLL=30 tabs or caps/30 days
ANTIVERTIGO AND ANTIEMETIC DRUGS		
ANZEMET		PA
Diclegis		QLL = maximum of 120 tablets per 365 days
granisetron	Kytril	COVERED FOR ONCOLOGISTS; ALL OTHERS REQUIRE PA
meclizine		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ondansetron, -ODT 4mg, 8mg, oral solution	Zofran, -ODT	QL 4mg: #180/30days QL 8mg: #90/30days QL Solution #150ml/30days
ondansetron 24mg	Zofran	PA
prochlorperazine maleate	Compazine	
promethazine hcl	Phenergan	
trimethobenzamide 250 mg, 300 mg capsules, 200 mg suppositories	Tigan	
EMEND		QLL=6 tabs/30 days
ANTIPARKINSON ANTICHOLINERGIC DRUGS		
benztropine mesylate		
trihexyphenidyl		
OTHER ANTIPARKINSON DRUGS		
bromocriptine mesylate	Parlodel	
carbidopa/levodopa	Sinemet	
carbidopa/levodopa/entacapone	Stalevo	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA QLL=270 tabs/30 days
EMSAM		COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA
entacapone	Comtan	QLL = 120/30days
pramipexole	Mirapex	
ropinirole	Requip	QLL=90 tabs/30 days
selegiline		
DRUGS FOR MULTIPLE SCLEROSIS		
AVONEX		PA
BETASERON		PA
COPAXONE 20mg, 40mg		PA
GILENYA		PA
REBIF		PA
ANTIPSYCHOTIC DRUGS age < 6 requires PA		
ABILIFY		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=30 tabs/30 days
chlorpromazine tablets	Thorazine	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
clozapine, -ODT	Clozaril, Fazaclo	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
fluphenazine	Prolixin	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
haloperidol	Haldol	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
loxapine	Loxitane	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
Olanzapine, -ODT	Zyprexa, Zyprexa Zydis	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		QLL=30 tabs/30 days
perphenazine	Trilafon	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
quetiapine	Seroquel	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=90 tabs/30 days; 300 mg=60 tabs/30 days
risperidone, -ODT	Risperdal, Risperdal M-tab	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=60 tabs/30 days
SEROQUEL XR		PA; QLL=60 tabs/30 days
thioridazine	Mellaril	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
thiothixene	Navane	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
trifluoperazine	Stelazine	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
ziprasidone	Geodon	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=60 caps/30 days
CNS STIMULANT DRUGS age < 6 requires PA		
amphetamine/dextroamphetamine, extended-release	Adderall, Adderall XR	Immediate release QLL=90 tabs/30 days, Extended release QLL=30 caps/30 days
dextroamphetamine		
methylin, er tabs, 10 mg, 20 mg	Ritalin, Ritalin SR	QLL=120 tabs/30 days
Methylphenidate CD	Metadate CD	QLL = 60/30days
methylphenidate er, sr	Concerta, Ritalin-LA, Ritalin-SR	QLL=60/30 days
methylphenidate hcl	Ritalin	QLL=120 tabs/30 days
methylphenidate hcl solution	**Methylin Suspension**	QLL suspension= 600ml/30 days
RITALIN LA 10mg		QLL=60/30 days
ANTIDEMENTIA DRUGS		
donepezil 5MG, 10 MG (23 MG IS NON-FORMULARY)	Aricept	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA QLL=30 tabs/30 days
donepezil ODT	Aricept ODT	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA; QLL=30 tabs/30 days
EXELON PATCH		PA
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
Memantine tablets, solution	**NAMENDA**	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA;
rivastigmine capsules	Exelon	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA;

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		QLL=60 caps/30 days
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=60 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 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 age <6 requires PA		
STRATTERA		PA
OTHER CNS DRUGS		
caffeine citrate oral solution		
naltrexone		COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA
phentermine	Adipex-P	PA

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
pyridostigmine		
CARDIOVASCULAR MEDICATIONS		
CARDIAC GLYCOSIDES		
digoxin	Lanoxin	
LANOXIN		
CALCIUM ANTAGONISTS		
amlodipine	Norvasc	QLL= 30 tabs/30 days
cartia xt	Cardizem CD	QLL=60 caps/30 days
diltiazem er	Tiazac/Taztia XT	QLL=60 caps or tabs/30 days
diltiazem hcl	Cardizem	QLL=120 tabs/30 days
diltia xt	Cardizem CD	QLL=60 caps/30 days
dilt-CD	Cardizem CD	QLL=60 caps/30 days
felodipine er	Plendil	
isradipine	Dynacirc	
Matzim LA	Cardizem LA	
nicardipine hcl	Cardene	
nifediac cc		QLL=90/30 days
nifedical xl		QLL=90/30 days
nifedipine, er	Procardia Procardia XL	Extended Release QLL=90/30 days
nimodipine	Nimotop	
Nisoldipine	Sular	QLL=60 tabs/30 days
verapamil, er	Verelan/Calan/Calan SR	QLL for Immediate Release=120 units/30days; QLL for Extended Release=60 units/30 days
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide, -ER	Diamox	
LOOP DIURETICS		
bumetanide	Bumex	
furosemide	Lasix	
torsemide	Demadex	
THIAZIDE AND RELATED DRUGS		
chlorthalidone		
chlorothiazide		
hydrochlorothiazide	Microzide	
indapamide	Lozol	
metolazone	Zaroxolyn	
methyclothiazide	Aquatensen, Enduron	
POTASSIUM SPARING DIURETICS		
amiloride		
amiloride hcl w/hctz	Midamor	
eplerenone	Inspra	PA
spironolactone	Aldactone	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
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 1mg, 2mg, 5mg=30/30 days; QLL 10 mg=60/30 days
CENTRALLY ACTING ANTIHYPERTENSIVES		
clonidine patches	Catapres TTS	COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA
clonidine tablets	Catapres	
guanfacine hcl	Tenex	
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	
perindopril	Aceon	
quinapril hcl	Accupril	
ramipril	Altace	
trandolapril	Mavik	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
BENICAR		STEP; COVERED FOR CARDIOLOGISTS; ALL OTHERS REQUIRE PA; QLL=30 tabs/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
BENICAR HCT		STEP; COVERED FOR CARDIOLOGISTS; ALL OTHERS REQUIRE PA; QLL=30 tabs/30 days
irbesartan	Avapro	
losartan	Cozaar	
losartan HCT	Hyzaar	
valsartan	Diovan	QLL=60 tabs/30 days;
valsartan HCTZ	Diovan-HCT	QLL=30 tabs/30 days
OTHER ANTIHYPERTENSIVES		
amlodipine/benazepril	Lotrel	
amlodipine/valsartan	Exforge	QLL = #30/30days
amlodipine/valsartan HCT	Exforge HCT	QLL = #30/30days
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	
lisinopril w/hctz	Prinzide/Zestoretic	
methyldopa w/hctz		
metoprolol w/hctz	Lopressor HCT	
moexipril w/hctz	Uniretic	
nadolol-bendroflumethiazide	Corzide	
propranolol hcl w/hctz	Inderide	
quinapril w/hctz	Quinaretic	
NITRATES		
isosorbide dinitrate	Isochron/Isordil	
isosorbide mononitrate	Imdur/Ismo/Monoket	
nitro-bid ointment		
nitroglycerin (patch, sublingual tablet,)	Nitro-Dur/Nitrostat	
NITROSTAT		
OTHER VASODILATING DRUGS		
ADCIRCA		PA
epoprostenol	Flolan	PA
LETAIRIS		PA
REMODULIN		PA
sildenafil	Revatio	COVERED WHEN PRESCRIBED BY CARDIOLOGISTS AND PULMONOLOGISTS; ALL OTHERS REQUIRE PA; QLL=90 tabs/30 days
TRACLEER		PA

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
TYVASO		PA
VENTAVIS		PA
CLASS 1A ANTIARRHYTHMICS		
disopyramide	Norpace	
quinidine gluconate		
quinidine sulfate		
CLASS 1B ANTIARRHYTHMICS		
mexiletine	Mexitil	
CLASS 1C ANTIARRHYTHMICS		
flecainide acetate	Tambocor	
propafenone hcl	Rythmol	
propafenone SR	RYTHMOL SR CAP	
OTHER ANTIARRHYTHMICS		
amiodarone	Pacerone	
MULTAQ		COVERED FOR CARDIOLOGISTS; ALL OTHERS REQUIRE PA
RANEXA		PA
sotalol	Betapace	
TIKOSYN		PA
HYPOLIPOPROTEINEMICS		
cholestyramine, -light	Questran, Questran Light	
colestipol hcl	Colestid	
Fenofibrate 54mg, 67mg, 134mg, 160mg, 200mg	Lofibra	
fenofibrate 48 mg, 145 mg	Tricor	
fenofibric acid	Trilipix	
gemfibrozil	Lopid	QLL= #60/30days
OTC niacin		
Niacin tab CR	**SLO NIACIN OTC**	
ZETIA		STEP
HMG-COA REDUCTASE INHIBITORS		
atorvastatin	Lipitor	QLL=30 tabs/30 days
fluvastatin	Lescol	QLL=30 caps/30 days
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
fluvastatin ER	**LESCOL XL**	QLL=30 tabs/30 days
OTHER CARDIOVASCULAR DRUGS		
midodrine	ProAmatine	
pentoxifylline	Trental	
DERMATOLOGICAL MEDICATIONS		
TOPICAL CORTICOSTEROID DRUGS		
alclometasone dipropionate	Aclovate	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
amcinonide		
betamethasone dipropionate	Diprolene	
betamethasone valerate	Beta-Val	
CAPEX SHAMPOO		
clobetasol propionate	Clobevate/Temovate	
CORDRAN TAPE		
desonide	Desowen/Lokara	
desoximetasone	Topicort	
diflorasone diacetate	Apexicon/Maxiflor/Psorcon	
fluocinolone cream, solution	Synalar	
fluocinolone body oil, scalp oil	Derma-Smoothe FS Oil	
Fluocinonide 0.05%		
fluticasone propionate	Cutivate	
halobetasol	Ultravate	
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		
adapalene cream, 0.1% gel	Differin	
amnesteem	Accutane	
benzoyl peroxide		
benzoyl peroxide-erythromycin 5%-3% gel	Benzamycin	
claravis	Accutane	
clindamycin phosphate	Cleocin T/Clindamax	
erythromycin	A/T/S / Emgel/Erycette	
Metronidazole cream, gel, lotion	Metrocream, Metrogel, Metrolotion	
salicylic acid cream, gel, lotion,		
sod.sulfacetamide/sulfur	Avar/Plexion	
sotret	Accutane	
tretinoin	Avita/Retin-A	QLL = 45 gm/30 days
KERATOLYTIC DRUGS		
CONDYLOX GEL		
podofilox solution	Condylox	
ANTIPSORIASIS AND ANTIECZEMA DRUGS		
calcipotriene cream, ointment, scalp solution	Dovonex	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
Coal tar		
DOAK TAR DISTILLATE		
DRITHO-SCALP		
POLYTAR		
selenium sulfide	Selseb	
sulfacetamide sodium	Carmol Scalp	
VECTICAL OINTMENT		
ORAL DERMATOLOGICAL DRUGS		
methoxsalen rapid cap 10mg	**OXSORALEN ULTRA**	
TOPICAL DERMATOLOGICAL DRUGS		
ammonium lactate OTC lotion, cream	Lac-Hydrin	
FLUOROPLEX		
fluorouracil	Efudex	
capsaicin OTC		
CARAC		
DRYSOL 20%	aluminum chloride 20% solution	
ELIDEL		COVERED FOR AGE 2 THROUGH10; STEP FOR ALL OTHERS QLL=30 gm/30 days
HYPERCARE 20%	aluminum chloride	
imiquimod 5% cream	Aldara	
SANTYL		
urea 40% cream, 50% ointment		
wart remover (salicylic acid 17%)	Occlusal-HP	
SCABICIDES/PEDICULICIDES cumulative QLL = 454gm per 180days		
EURAX		PA
malathion 0.5% lotion	Ovide	QLL = 1 pkg per 180days
spinosad 0.9% topical suspension	**NATROBA 0.9% TOPICAL SUSPENSION**	STEP; QLL=240ml/30 days
permethrin 5% cream, lotion	Elimite	QLL = 2 pkg per 180days
piperonyl butoxide/pyrethrins OTC shampoo	Rid	QLL = 1 pkg per 180days
pyrethrin 0.33% OTC shampoo		QLL = 1 pkg per 180days
Sklice		STEP QLL = 1 pkg per 180days
ULESFIA 5% LOTION		QLL = 2 pkg per 180days
EAR-NOSE-THROAT MEDICATIONS		
DRUGS AFFECTING THE EAR		
antipyrine/benzocaine otic	Benzotic/Otogesic	
acetic acid, -HC otic		
carbamide peroxide	Debrox	
CIPRO HC		
CIPRODEX OTIC		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
neomycin/polymixin/hydrocortisone		
ofloxacin		
DRUGS AFFECTING THE NOSE		
azelastine	Astelin	
flunisolide	Nasarel	
fluticasone propionate	Flonase	
fluticasone OTC		
ipratropium bromide	Atrovent	
NASONEX		covered for members 2-3 years old; all others STEP/QLL=2 bottles/30 days
OTC Nasacort Allergy 24 hour spray		
OTC oxymetazoline nasal spray		
Triamcinolone acetonide nasal	Nasacort AQ	PA
DRUGS AFFECTING THE THROAT AND MOUTH		
ABREVA		
APHTHASOL		
chlorhexidine gluconate 0.12% rinse	Peridex	
DENAVIR		
doxycycline hyclate, hyclate DR, monohydrate	Adoxa, Doryx, Periostat, Vibramycin	
pilocarpine hcl	Salagen	
triamcinolone acetonide	Kenalog in Orabase	
ENDOCRINE MEDICATIONS		
ORAL HYPOGLYCEMIC DRUGS		
acarbose	Precose	
chlorpropamide	Diabinese	
glimepiride	Amaryl	
glipizide, er	Glucotrol, XL	
glipizide-metformin	Metaglip	
glyburide, -micro	Diabeta/Micronase	
glyburide-metformin	Glucovance	
JANUMET, JANUMET XR		STEP
JANUVIA		STEP
metformin **metformin ER 500mg, 750mg (generics for Glucophage XR only)**	Glucophage Glucophage XR	
nateglinide	Starlix	
PRANDIMET		
repaglinide	Prandin	
tolazamide		
tolbutamide		
INSULIN SENSITIZERS		
AVANDAMET		QLL=60 tabs/30 days
AVANDARYL		QLL=60 tabs/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
AVANDIA		QLL=30 tabs/30 days
DUETACT		QLL=30 tabs/30 days
pioglitazone	Actos	QLL=30 tabs/30 days
pioglitazone-metformin	Actoplus Met	QLL=90 tabs/30 days
GLUCOSE ELEVATING DRUGS		
GLUCAGON		
glucose chewable tablets OTC		
INSULIN (INSULIN PENS REQUIRE PA)		
HUMULIN 50/50		
HUMULIN N PEN		PA
HUMULIN R (500 U/ML VIAL)		
HUMULIN 70/30		
NOVOLIN 70/30		
NOVOLIN R		
NOVOLIN N		
NOVOLOG		
NOVOLOG FLEXPEN		PA
NOVOLOG MIX 70/30		
NOVOLOG MIX 70/30 FLEXPEN		PA
LANTUS		
LANTUS SOLOSTAR		PA
LEVEMIR		
LEVEMIR PEN		PA
OTHER GLUCOSE-LOWERING DRUGS		
BYETTA		STEP
VICTOZA		STEP
GLUCOCORTICOID DRUGS		
cortisone		
dexamethasone		
hydrocortisone	Cortef	
hydrocortisone injection	Solu-Cortef	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
methylprednisolone	Medrol	
methylprednisolone injection	Solu-Medrol	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
prednisolone	Prelone	
prednisone	Sterapred	
prednisolone sodium phospate, -ODT	**ORAPRED, -ODT**	
Solu-Cortef injection		COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
triamcinolone injection	Kenalog	COVERED FOR MCY ALTCS; MCY ACUTE/DD REQUIRE PA
GROWTH HORMONES AND RELATED AGENTS		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
INCRELEX		PA
NORDITROPIN		PA
NORDITROPIN NORDIFLEX		PA
NUTROPIN		PA
NUTROPIN AQ		PA
SEROSTIM		PA
TEV-TROPIN		PA
MINERALOCORTICOID DRUGS		
fludrocortisone acetate	Florinef	
THYROID SUPPLEMENTS		
ARMOUR THYROID		
levothroid		
levothyroxine sodium	Synthroid	
levoxyl	Synthroid	
liothyronine	Cytomel	
thyroid, dessicated	Armour Thyroid	
unithroid	Synthroid	
ANTITHYROID DRUGS		
methimazole	Tapazole	
propylthiouracil		
ANDROGEN DRUGS		
ANDRODERM PATCH		PA
ANDROGEL		PA
ANDROXY		
danazol		
fluoxymesterone		PA
METHITEST		
TESTIM		PA
testosterone cypionate injection (200 mg/ml only)		
testosterone enanthate injection		PA
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; ALL OTHERS REQUIRE PA
calcitonin nasal spray	Miacalcin	
desmopressin acetate	DDAVP/Minirin	QLL=1 bottle/30 days; QLL=90 tabs/30 days
etidronate	Didronel	
fortical nasal spray		
KUVAN		PA
MIACALCIN (INJ)		PA
zoledronic acid solution (INJ)	**RECLAST (INJ)**	PA

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
SENSIPAR		COVERED FOR NEPHROLOGIST; ALL OTHERS 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	
hyoscyamine	Nulev/Levbrel	
metoclopramide hcl	Reglan	
ANTIULCER DRUGS		
cimetidine tablets	Tagamet	
Famotidine tablets	Pepcid	
Nizatidine tablets	Axid	
Ranitidine tablets, syrup, solution	Zantac	
OTHER ANTIULCER DRUGS		
misoprostol	Cytotec	
sucralfate	Carafate	
CARAFATE SUSPENSION		
PROTON PUMP INHIBITORS		
First-lansoprazole 3mg/ml oral suspension		
First-omeprazole 2mg/ml oral suspension		
lansoprazole capsule	Prevacid,	QLL=30 caps or tabs/30 days
Omeprazole RX, omeprazole OTC	Prilosec, OTC Prilosec	omeprazole 10mg QLL=30 caps/30 days, omeprazole 20mg QLL=120 caps or tabs/30 days, omeprazole 40mg QLL=270 caps/30 days.
pantoprazole	Protonix	QLL=30 tabs/30 days
LAXATIVES AND CATHARTICS		
bisacodyl		
constulose		
DOCUSOL ENEMA		
docusate	Colace	
ENEMEEZ ENEMA		
OTC FLEET BISACODYL ENEMA		
KONSYL D OTC		COVERED FOR MCY DD/ALTCS; MCY ACUTE REQUIRE PA
MIRALAX OTC		QLL=510 gm/30 days
polyethylene glycol 3350 powder for solution		QLL=527 gm/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
psyllium OTC		
SENOKOT OTC (brand and generic OTC dosage forms covered)		
SORBITOL OTC 70% ORAL SOLN		
VACUANT ENEMA		
OTHER GI DRUGS		
OTC aluminum hydroxide gel	Alternagel	
AMITIZA		QLL=60 caps/30 days
antacids	Mylanta, Maalox	
ASACOL HD		
balsalazide	Colazal	QLL=270 caps/30 days
belladonna alkaloids-opium		
budesonide	Entocort EC	QLL=90 caps/30 days
CANASA		
CORTIFOAM		
CREON LIPASE 3,000; 6,000; 12,000; 24,000 UNITS		
Delzicol		
DIPENTUM		
Hydrocortisone 1%, 2.5% rectal cream	Proctocort 1%, Proctosol-HC 2.5%	
hydrocortisone rectal enema suspension	Colocort/ Cortenema	
IPECAC SYRUP		
Linzess		145mcg Capsule QLL= 60/30days 290mcg Capsule QLL= 30/30days
mesalamine enema	Rowasa	
NULYTELY WITH FLAVOR PACKS		
simethicone drops OTC		PA>2 years
PANCREAZE		
PANCRELIPASE 5,000 UNITS		
PEG 3350 ELECTROLYTE SOLUTION		
PENTASA		
PramCort 1%-1% Topical Cream		
Pramosone 1%-1% Topical Cream		
Proctocort 1%, Procto Pak		
Proctocream- HC, PROCTOFOAM-HC		
Proctosol-HC, Proctozone-HC		
propantheline		
sulfasalazine	Azulfidine	
ULTRASE, ULTRASE MT12, MT18, MT20		
Ultresa Lipase 13,800unit; 20,700unit; 23,000unit		
ursodiol	Actigall	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ZENPEP 5,000U; 10,000U, 15,000U, 20,000U		
IMMUNOLOGICALS AND VACCINES		
FLUMIST		PA FOR AGES <2 OR >49
GARDASIL		COVERED BY AHCCCS (THROUGH MEDICAL BENEFIT) for MALES AND FEMALES THROUGH AGE 26
RHOGAM		
WINRHO		
MUSCULOSKELETAL MEDICATIONS		
SALICYLATES AND RELATED DRUGS		
aspirin		
choline magnesium trisalicylate		
diflunisal	Dolobid	
salsalate	Disalcid	
NON-STEROIDAL ANTIINFLAMMATORY AGENTS		
celecoxib	**CELEBREX**	STEP QLL = #60/30days 400mg QLL = 30/30days
diclofenac sodium	Voltaren	
diclofenac ER	Voltaren-XR	
etodolac	Lodine/Lodine XL	
fenoprofen		
flurbiprofen	Anasaid	
ibuprofen	Motrin, Advil	
indomethacin	Indocin SR	
ketoprofen	Orudis/Oruvail	
ketorolac	Toradol	QLL=20 tabs/30 days
meclofenamate		
meloxicam	Mobic	
nabumetone	Relafen	
naproxen	Naprosyn, Aleve	
oxaprozin	Daypro	
piroxicam	Feldene	
sulindac	Clinoril	
tolmetin		
OTHER DRUGS FOR ARTHRITIS		
RIDAURA		COVERED FOR RHEUMATOLOGIST; ALL OTHERS REQUIRE PA
DRUGS TO PREVENT AND TREAT GOUT		
allopurinol	Zyloprim	
colchicine / probenecid		
colchicine 0.6mg	**COLCRYS**	
probenecid		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ULORIC		STEP
DIRECT MUSCLE RELAXANTS		
baclofen		
tizanidine hcl tablets, capsules	Zanaflex tablets, capsules	
CNS MUSCLE RELAXANTS		
carisoprodol	Soma	QLL=120 tabs/30 days
cyclobenzaprine hcl	Flexeril	QLL=120 tabs/30 days
dantrolene capsule	Dantrium	
methocarbamol	Robaxin	QLL=120 tabs/30 days
metaxalone	Skelaxin	QLL=120 tabs/30 days
OTHER MUSCULOSKELETAL MEDICATIONS		
riluzole	Rilutek	COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA
NUTRITION, BLOOD MODIFIERS, ELECTROLYTES, ENZYME REPLACEMENT		
THERAPEUTIC VITAMINS & MINERALS		
CALCIFEROL	Drisdol	
calcitriol	Calcijex/Rocaltrol	
calcium acetate capsules, tablets	Phoslo	
calcium carbonate, - with vitamin D	Tums/Maalox, Calcitrate +D, Caltrate +D	
calcium citrate	Citracal	
OTC cholecalciferol	Vitamin D3	
cyanocobalamin 500mcg, 1000mcg	Vitamin B12	
cyanocobalamin [inj]		PA
ergocalciferol	Vitamin D2	
ferrous gluconate		
ferrous sulfate tabs, liquid		
folic acid		
Iron up liquid		
OTC Fish Oil (omega-3 fatty acids)		
levocarnitine		COVERED FOR NEUROLOGIST; ALL OTHERS REQUIRE PA
magnesium oxide tablets		
multivitamin with fluoride		
pediatric multivitamin -with fluoride; -with iron; -with fluoride and iron		
poly-vitamin drops, -w iron drops		QLL=1 bottle/30 days
NEPHROCAPS		
Paricalcitol	ZEMPLAR	**COVERED FOR NEPHROLOGIST; ALL OTHERS REQUIRE PA**
PHOS-NAK, K-PHOS NEUTRAL TABLETS		
pyridoxine		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
sodium bicarbonate		
sodium fluoride drops, chewable tablets, tablets		
thiamine		
POTASSIUM SUPPLEMENTS		
citric acid/sodium citrate oral soln	Bicitra	
klor con, klor con m, klor con effervescent		
potassium chloride caps, tabs, oral solution	K-Dur/Klotrix	
SHOHL'S MODIFIED		
POTASSIUM REMOVING RESINS		
sodium polystyrene sulfonate	Kayexalate	
ORAL ANTICOAGULANTS		
ELIQUIS		
PRADAXA		QLL=60 caps/30 days
warfarin sodium	Coumadin	
XARELTO		
HEPARINS		
heparin sodium [inj] (heparin lock flush solution not covered)		
LOW-MOLECULAR WEIGHT HEPARINS (LMWH)		
enoxaparin [inj]	Lovenox	10 DAYS W/O PA (10 DAYS=20 SYRINGES)
FRAGMIN [inj]		10 DAYS W/O PA (10 DAYS=10 SYRINGES)
ANTIPLATELET DRUGS		
BRILINTA		PA, QLL = 60/30 days
cilostazol	Pletal	
clopidogrel	Plavix	QLL=30 tabs/30 days
dipyridamole	Persantine	
ticlopidine hcl	Ticlid	
HEMOSTATICS		
Amicar	aminocaproic acid	
MEPHYTON		
HEMATOPOIETIC AGENTS		
EPOGEN, PROCRIT		PA
PROMACTA		PA
NEUPOGEN		PA
NEULASTA		PA
BLOOD DETOXICANTS		
enulose		
generlac		
lactulose		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
FOSRENOL		PA
RENAGEL		
sevelamer	RENVELA	
OTHER BLOOD MODIFIERS		
anagrelide	Agrylin	
ARCALYST		PA
SOLIRIS		COVERED FOR HEMATOLOGIST; ALL OTHERS REQUIRE PA
ENZYME REPLACEMENTS		
CEREZYME		PA
ELAPRASE		PA
SUCRAID		PA
OBSTETRICAL & GYNECOLOGICAL MEDICATIONS		
PRENATAL VITAMINS QLL=100 tabs/90 days for single prenatal vitamins; QLL=60/30 days for combo pack prenatal vitamins		
complete natal DHA		
CONCEPT DHA		QLL = 100 tabs per 90days
fe plus tablet		
prenatal advantage (prenatal AD)		
prenatal low iron		
SELECT-OB, SELECT-OB + DHA		
Taron-C DHA		
trinate		QLL = 100 tabs per 90days
vinatal forte		
vinate II		
vinate az		
vinate calcium		
vinate gt		
vinate one		QLL = 100 tabs per 90days
vinate m		QLL = 100 tabs per 90days
vinate ultra		
vitafol-ob		
vitafol-pn		
OB/GYN TOPICAL ANTIINFECTIVES		
acidic vaginal jelly		
AVC vaginal cream		
CLEOCIN OVULE		
clindamycin 2% vaginal cream	Clindamax	
metronidazole 0.75% vaginal gel	MetroGel	
miconazole vaginal suppositories, cream		
MONISTAT 3 and 7 OTC VAGINAL CREAM AND COMBINATION PACK		
ESTROGEN DRUGS		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
CENESTIN		
estradiol tablets	Estrace	
estradiol transdermal patch	Climara	QLL=4 patches/30 days
estropipate	Ogen/Ortho-Est	
ESTRACE VAGINAL CREAM		
ESTRING		
FEMRING		
MENEST		
PREMARIN		
PREMARIN CREAM		
VAGIFEM		
Estradiol Dis (twice weekly) patch	**VIVELLE DOT**	QLL=8 patches/30 days
ESTROGEN/PROGESTIN COMBINATIONS		
CLIMARA PRO		
COMBIPATCH		
estradiol/norethindrone acetate 0.5mg-0.1mg, 1 mg-0.5 mg	Activella 0.5mg-0.1mg Activella1 mg-0.5mg	
Norethindrone Acetate/Ethinyl Estradiol 0.5mg/2.5mcg Tablet	FEMHRT	
PREFEST		
PREMPHASE		
PREMPRO		
SELECTIVE ESTROGEN RECEPTOR MODULATOR		
raloxifene hcl	**EVISTA**	QLL=30 tabs/30 days
PROGESTIN DRUGS		
medroxyprogesterone acetate	Provera	QLL for injection=1/90 days
norethindrone acetate	Aygestin	
progesterone capsule	Prometrium	
OTHER OB/GYN DRUGS		
methylergonovine maleate tablets	**METHERGINE**	
OPHTHALMIC MEDICATIONS		
OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS		
bacitracin ophth ointment		
bacitracin/polymixin ophth ointment	AK-Poly Bac	
ciprofloxacin hcl (ophth drops)	Ciloxan	
CILOXAN OPTHALMIC OINTMENT		
erythromycin		
Gatifloxacin 0.5% ophthalmic solution	ZYMAXID	
gentamicin sulfate	Garamycin/Gentak	
levofloxacin 0.5% ophth soln	Quixin	
neomycin/polymyxin/bacitracin	Neosporin	
neomycin/polymyxin/gramicidin		
ofloxacin	Ocuflox	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
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		
bacitracin/neomycin/polymixinB/ hydrocortisone		
BLEPHAMIDE DROPS, OINT.		
neomycin/polymixin/hydrocortisone	Cortisporin	
Neomycin/bacitracin/polymixin B/hydrocortisone		
neomycin/polymyxin/dexamethasone	Methadex/Maxitrol	
prednisolone/sulfacetamide		
prednisolone/gentamicin sulfate	Pred G	
TOBRADEX OINTMENT		
tobramycin/dexamethasone susp	Tobradex	
ANTIGLAUCOMA DRUGS		
acetazolamide, -ER		
AZOPT		
BETOPTIC S		
betaxolol hcl 0.5%		
brimonidine tartrate	Alphagan, Alphagan P	
carteolol hcl		
COMBIGAN		
dorzolamide	Trusopt	
dorzolamide/timolol	Cosopt	
ISOPTO CARBACHOL		
latanoprost	Xalatan	QLL = 5ml (2 bottles)/30days
levobunolol hcl	Betagan	
LUMIGAN		
methazolamide		
metipranolol	Optipranolol	
PHOSPHOLINE IODIDE		
pilocarpine hcl	Isopto Carpine	
timolol maleate	Timoptic/Timoptic-XE	
travoprost	Travatan	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
TRAVATAN Z		
ZIOPTAN		PA
OTHER OPHTHALMIC DRUGS		
artificial tears drops, ointment		
atropine sulfate	Isopto Atropine	
cromolyn sodium	Crolom	
cyclopentolate	Cyclogyl	
diclofenac sodium	Voltaren	
flurbiprofen sodium	Ocufen	
ISOPTO HOMATROPINE		
ISOPTO HYOSCINE		
ketorolac tromethamine	Acular, Acular LS	
ketotifen		
MUROCOLL-2		
naphazoline 0.1% eye drops	AK-Con, Naphcon-Forte	
napahzoline/pheniramine maleate	Naphcon A, Opcon A	
NATACYN		
NEVANAC		
PATANOL		
phenylephrine		
REFRESH TEARS, LIQUIGEL (15 ML AND 30 ML BOTTLE ONLY)		
RESTASIS		PA
SYSTANE (15 ML AND 30 ML BOTTLE ONLY)		
trifluridine		
tropicamide	Tropicacyl	
ketotifen fumarate ophthalmic solution	**ZADITOR OTC**	
RESPIRATORY MEDICATIONS		
BETA-2 ADRENERGIC DRUGS		
albuterol sulfate (inhalation soln, syrup, tablet)		
FORADIL		PA
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		
ASMANEX		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
budesonide respules	Pulmicort Respules	QLL=60 respules/30 days
DULERA		
FLOVENT DISKUS		
FLOVENT HFA		
PULMICORT FLEXHALER/INHALER		QLL=1 inhaler or flexhaler/30 days
QVAR		
SYMBICORT		
LEUKOTRIENE MODIFIERS		
montelukast 4mg, 5mg 10mg tablets, 4mg granules	Singulair	QLL=30/30 days
zafirlukast	Accolate	QLL=60 tabs/30 days
METHYL XANTHINE DRUGS		
theophylline, er		
OTHER DRUGS FOR ASTHMA		
ATROVENT (INHALER)		
COMBIVENT RESPIMAT		
cromolyn sodium nebulizer soln		
epinephrine 0.3mg/0.3ml, epinephrine 0.15mg/0.15ml	ADRENACLICK	
EPIPEN, EPIPEN JR		
ipratropium bromide		
ipratropium bromide/albuterol inhalation soln		
sodium chloride 0.9% nebulizer solution OTC		
OTHER RESPIRATORY DRUGS		
ARALAST NP, PROLASTIN		PA
PULMOZYME		PA
sodium chloride 3%, 7% for inhalation	HYPERSAL	
SPIRIVA, SPIRIVA Respimat		QLL=1pkg per 30days
Tobramycin inhalation solution	TOBI	PA
Tudorza Pressair		
ANTIHISTAMINES AND DECONGESTANTS		
fexofenadine 30mg/5ml Suspension	**Allegra 30mg/5ml Suspension**	
brompheniramine		
Bromax ER tablets	brompheniramine maleate	
carbinoxamine		
cetirizine, cetirizine-D OTC	OTC Zyrtec	cetirizine-D QLL=60 tabs/30 days cetirizine syrup: Under 6 years of age QLL=150 ml/30 days. 6 years and older QLL= 300ml/30Days
chlorpheniramine maleate		
clemastine fumarate	Tavist	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
cyproheptadine hcl	Periactin	
dexchlorpheniramine		
diphenhydramine hcl	Benadryl	
fexofenadine tablets, fexofenadine-D	Allegra	30mg, 60mg QLL= 60 tabs/30 days; 180mg QLL=30 tabs/30 days
hydroxyzine hcl	Atarax	
loratadine, loratadine-D OTC, syrup	OTC Claritin,Claritin D	loratadine-D 12hr QLL=#60 tabs/30 loratadine 24 hours QLL = 30/30days syrup QL 300ml/30days
pseudoephedrine	Sudafed	QLL=120 tabs/30 days
Vazol oral solution	brompheniramine maleate	
ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
brompheniramine/phenylephrine		
promethazine vc plain syrup *(promethazine-phenylephrine)*	Phenergan VC	
Sildec syrup *(brompheniramine/pseudoephedrine)*	Rondec, Cardec syrup	
Virdec drops *(chlorpheniramine/phenylephrine)*	Rondec drops	
ANTITUSSIVE AND EXPECTORANT DRUGS		
benzonatate	Tessalon	QLL=90 capsules/30 days
brompheniramine-dm-phenylephrine	Alahist-DM	
brompheniramine-dm-pseudoephedrine	Sildec DM	QLL=480ml/30 days
CHERATUSSIN AC OTC *(guaifensin-codeine)*		
CHERATUSSIN DAC OTC *(guaifensin-pseudoephed-codeine)*		
DELSYM SUSPENSION		
guaifenesin plain syrup, MUCINEX ER	Robitussin	
guaifenesin w/codeine syrup	Tussi-Organidin NR	
guaifenesin-dm syrup, MUCINEX DM ER	Robitussin DM	
guaifenesin-dm-pseudoephedrine	Robitussin CF	QLL=480ml/30 days
guaifenesin / dextromethorphan / phenylephrine	Robitussin PE	
guaifenesin-phenylephrine	Despec	
hydrocodone-homatropine	Hycodan,Hydromet	QLL=480ml/30 days
MUCINEX D ER *(guaifenesin-pseudoephedrine)*		
NoHist-DM syrup *(chlorpheniramine-dm-phenylephrine)*	Rondec DM	QLL = 480ml/30days
promethazine-codeine	Phenergan w/Codeine	
promethazine vc w/codeine syrup *(promethazine-phenylephrine-*	Phenergan VC w/Codeine	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
codeine)		
promethazine-dm	Phenergan DM	
Virdec-DM drops *(chlorpheniramine-dm-phenylephrine)*	Rondec-DM drops	
TOXICOLOGY MEDICATIONS		
acetylcysteine		
CUPRIMINE		
UROLOGICAL MEDICATIONS		
ANTICHOLINERGIC ANTISPASMODICS DRUGS		
flavoxate	Urispas	
oxybutynin chloride	Ditropan	
oxybutynin chloride er	Ditropan XL	
Tolterodine, - extended release capsules	Detrol, -LA	STEP
trospium	Sanctura	QLL=60 tabs/30 days
trospium ER	Sanctura XR	STEP, QLL = 30 tabs/30 days
CHOLINERGIC STIMULANTS		
bethanecol		
URINARY ANESTHETICS		
phenazopyridine hcl	Pyridium/Urodol	
OTHER GENITOURINARY PRODUCTS		
alfuzosin	Uroxatral	
CYTRA, K		
ELMIRON		
finasteride	Proscar	
K-PHOS		
potassium citrate ER	Urocit K	
tamsulosin	Flomax	QLL=60 caps/30 days
MEDICAL (MISCELLANEOUS) SUPPLIES		
DIABETIC SUPPLIES ***TEST STRIPS COMBINED QLL=150 TEST STRIPS/30 DAYS***		
MICROLET LANCING DEVICE/LANCETS		
AUTOJECT 2 INJECTION DEVICE		
insulin syringes		
ONE TOUCH DELICA LANCETS		
ONE TOUCH SELECT		
ONE TOUCH SURESOFT LANCETS		
ONE TOUCH TEST STRIPS, CONTROL SOLUTION		Combined QLL for test strips= 150 strips/30 days
ONE TOUCH ULTRA2, ULTRALINK, ULTRAMINI, ULTRASMART, VERIO GLUCOMETERS/TEST STRIPS		Combined QLL for test strips= 150 strips/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ONE TOUCH ULTRASOFT LANCETS		
CHEMSTRIP		
KETOSTIX		
OTHER SUPPLIES		
AEROCHAMBER, MICROCHAMBER, OPTICHAMBER		QLL=2/year
ALCOHOL PREP PADS		
PEAK FLOW METERS		QLL = 1/year
REPRODUCTIVE HEALTH* ***Family planning services are administered by Aetna Medicaid Administrators, LLC.**		
COVERED CONTRACEPTIVES		
ALTAVERA	NORDETTE-28	
AMETHYST TAB 90-20MCG		
AMETHIA, DAYSEE, CAMRESE	SEASONIQUE	
APRI	DESOGEN	
ARANELLE	TRI-NORINYL	
AVIANE	ALESSE-28	
AZURETTE	MIRCETTE	
BALZIVA	OVCON-35	
CAMILA	NOR-Q-D	
CAZIANT	CYCLESSA	
CESIA	CYCLESSA	
CRYSELLE	LO/OVRAL-28	
CYCLAFEM 1-35	ORTHO-NOVUM 1/35	
CYCLAFEM 7/7/7	ORTHO-NOVUM 7/7/7	
ELLA		QL: 1pack/month 3 pack/year
EMOQUETTE	DESOGEN	
ENPRESSE	TRI-LEVLEN 28	
ERRIN	NOR-Q-D	
GIANVI TAB 3-0.02MG	YAZ-28	
GILDESS FE1-20	LOESTRIN FE 1/20	
GILDESS FE 1.5-30	LOESTRIN FE 1.5/30	
INTROVALE- 91 tablet pack	SEASONALE	
JOLESSA - 91 tablet pack	SEASONALE	
JOLIVETTE	NOR-Q-D	
JUNEL 1/20	LOESTRIN 1/20	
JUNEL 1.5/30	LOESTRIN 1.5/30	
JUNEL FE 1/20	LOESTRIN FE 1/20	
JUNEL FE 1.5/30	LOESTRIN FE	
JUNEL FE 24 1/20, LARIN 24, GILDESS 24, LOMEDIA 24	LOESTRIN FE 24	
KARIVA	MIRCETTE	
KELNOR 1/35	DEMULEN 1/35-28	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
LAYOLIS FE CHEW		
LEENA	TRI-NORINYL	
LESSINA	ALESSE-28	
Levonorgestrel/Ethinyl Estradiol 0.15mg-0.03mg Tablet	SEASONALE	
LEVONORGESTREL 0.75MG	PLAN B	QL: 1pack/month 3 pack/year
LEVORA-28	NORDETTE-28	
LO LOESTRIN, CAMRESE LO, AMETHIA LO	LO SEASONIQUE	
LORYNA TAB 3-0.02MG	YAZ-28	
LOW-OGESTREL	LO/OVRAL-28	
LUTERA	ALESSE-28	
MARLISSA-28	NORDETTE-28	
MICROGESTIN 1/20	LOESTRIN	
MICROGESTIN 1.5/30	LOESTRIN	
MICROGESTIN FE 1/20	LOESTRIN FE 1/20	
MICROGESTIN FE 1.5/30	LOESTRIN FE	
MONONESSA	ORTHO-CYCLEN	
MYZILRA-28	TRI-LEVLEN 28	
NECON	MODICON	
NECON	NECON	
NECON 1/35	ORTHO-NOVUM 1/35	
NECON	NORINYL 1+50	
NECON 7/7/7	ORTHO-NOVUM 7/7/7	
NEXT CHOICE	PLAN B	QL: 1pack/month 3 pack/year
NEXT CHOICE ONE DOSE	PLAN B ONE STEP	QL: 1pack/month 3 pack/year
NORA-BE	NOR-Q-D	
NORTREL	MODICON	
NORTREL 1/35	ORTHO-NOVUM 1/35	
NORTREL	ORTHO-NOVUM	
OGESTREL	OVRAL-28	
PLAN B ONE STEP		QL: 1pack/month 3 pack/year
PORTIA	NORDETTE-28	
PREVIFEM	ORTHO-CYCLEN	
QUASENSE 91 tablet pack	SEASONALE	
RECLIPSEN	DESOGEN	
SOLIA	DESOGEN	
SPRINTEC	ORTHO-CYCLEN	
SRONYX	ALESSE-28	
TILIA FE	ESTROSTEP FE	
TRINESSA	ORTHO TRI-CYCLEN	
TRI-PREVIFEM	ORTHO TRI-CYCLEN	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
TRI-SPRINTEC	ORTHO TRI-CYCLEN	
TRIVORA-28	TRI-LEVLEN 28	
VELIVET	CYCLESSA	
VESTURA TAB 3-0.02MG	YAZ-28	
VIORELE	MIRCETTE	
XULANE PATCH	Ortho Evra	QL: 3 patches / month
OCELLA 28	YASMIN 28	
WYMZYA CHW		
ZENCHENT	OVCON-35	
ZENCHENT FE CHW		
ZOVIA 1/35E	DEMULEN 1/35-28	
ZOVIA 1/50E	DEMULEN 1/50-21	
IMPLANTS AND IUDS		
MIRENA IUD		
IMPLANON IMPLANT		
LILETTA		
NEXPLANON IMPLANT		
SKYLA		
INTRAVAGINAL CONTRACEPTION		
NUVARING		
INJECTABLE CONTRACEPTION		
Medroxyprogesterone acetate 150mg	DEPO-PROVERA MPA	QLL for injection=1/90 days
OTHER PRODUCTS- MISC.		
DIAPHRAGMS	Various	
OTC CONDOMS	Various	
Spermacidal Foam / Jelly	Various	