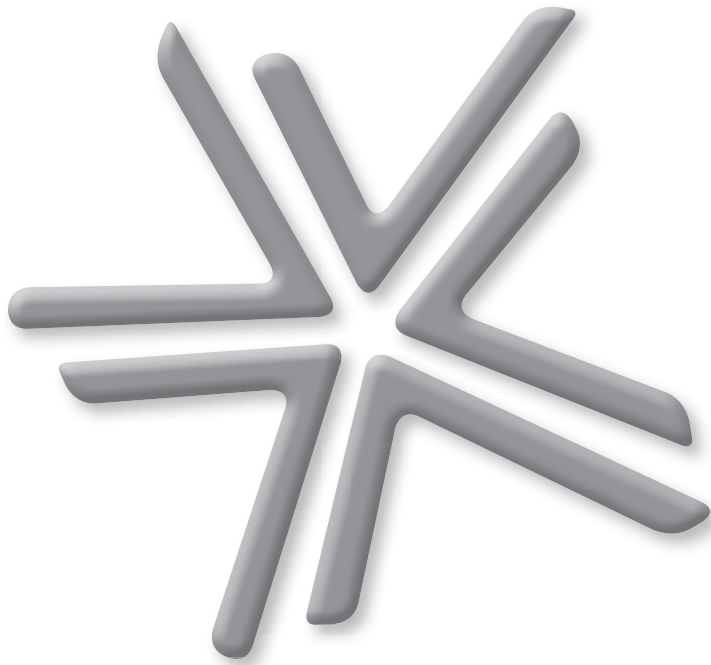


# Generations Healthcare HMO

*Medicare Advantage Health Plans*



Generations Healthcare  
Premier (HMO)

## 2012 **FORMULARY** **(LIST OF COVERED DRUGS)**

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

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

This document includes Generations Healthcare HMO's partial formulary as of 8/01/2011. For a complete, updated formulary, please visit our Web site at [www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc) or call 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone 7 days a week (TTY/TDD users should call 1-800-958-2692).

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

UNIVERSAL  
AMERICAN

A Healthy Collaboration®



## **What is the Generations Healthcare Formulary?**

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

This document is a partial formulary and includes only some of the drugs covered by Generations Healthcare. For a complete listing of all prescription drugs covered by Generations Healthcare, please visit our Web site at [www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc) or call 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone 7 days a week (TTY/TDD users should call 1-800-958-2692).

## **Can the Formulary change?**

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

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of August 1, 2011. To get updated information about the drugs covered by Generations Healthcare, please visit our Web site at [www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc) or call 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone 7 days a week (TTY/TDD users should call 1-800-958-2692). A monthly supplemental addendum to the formulary is available at [www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc) or call Member Services at the number listed above.

## How do I use the Formulary?

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

### Medical Condition

The formulary begins on page 9. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list that begins on page 7. Then look under the category name for your drug.

### Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 42. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

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

## Are there any restrictions on my coverage?

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

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at [www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc).

You can ask Generations Healthcare to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Generations Healthcare’s formulary?” on page 3 for information about how to request an exception.

## What if my drug is not on the Formulary?

If your drug is not included in this list of covered drugs, you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so Generations Healthcare may cover your drug. You can contact Member Services at 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone 7 days a week (TTY/TDD users should call 1-800-958-2692).

If you learn that Generations Healthcare does not cover your drug, you have two options:

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

## How do I request an exception to the Generations Healthcare Formulary?

You can ask Generations Healthcare to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

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

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

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your prescriber’s or physician supporting your request.** Generally, we must make our

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

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

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

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

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 91- and may be up to a 98-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 34-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

If you are a current member in our plan, we will also cover a temporary transition supply if you have a change in your medications because of a level-of-care change. This may include unplanned changes in treatment settings, such as being discharged from an acute care (hospital) setting or being admitted to, or discharged from, a long-term care facility. For each drug that is not in our formulary, or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (up to a 34-day supply if you are a resident of a long-term care facility) when you go to a network pharmacy.

## **For more information**

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

If you have questions about Generations Healthcare, please call Member Services at 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone 7 days a week (TTY/TDD users should call 1-800-958-2692). Or visit [www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc).

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

## Generations Healthcare's Formulary

The abridged formulary below provides coverage information about some of the drugs covered by Generations Healthcare. If you have trouble finding your drug in the list, turn to the Index that begins on page 42. Remember: This is only a partial list of drugs covered by Generations Healthcare. If your prescription is not in this partial formulary, please visit our Web site at [www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc) or call Member Services at 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone 7 days a week. (TTY/TDD users should call 1-800-958-2692) for additional help.

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

The information in the Requirements/Limits column tells you if Generations Healthcare has any special requirements for coverage of your drug.

- **Prior Authorization** drugs are designated with the abbreviation 'PA.'
- **Quantity Limit** drugs are designated with the abbreviation 'QL.' Appendix A lists each drug with the dosage limits per timeframe.
- **Step Therapy** drugs are designated with the abbreviation 'ST.'
- **Limited Access** drugs are designated with the abbreviation 'LA.' This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone 7 days a week. (TTY/TDD users should call 1-800-958-2692).
- **High Risk** drugs are designated with the abbreviation 'HR.' According to medical experts, these drugs may cause more side effects if you are 65 years of age or older, since your body changes with age. If you are taking one of these drugs, ask your doctor if there are safer options available.
- **Gap coverage** drugs are designated with the **asterisk symbol (\*)**. We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

## Tier Indications

The amount you pay for your prescriptions depends on the medication's tier. The Generations Healthcare Optimal Med formulary has 4 tiers:

### **Tier 1: Generic Drugs**

Tier 1 is your lowest-cost tier. Most generic drugs on the formulary are included in this tier. Generic drugs contain the same active ingredients as brand drugs and are equally safe and effective. We have also included some preferred brands in this tier which allows you greater access to more drugs at lower prices.

### **Tier 2: Preferred Brand Drugs**

This is your middle-cost tier, and includes preferred brand drugs and some non-preferred generic drugs. Some Tier 2 drugs have lower-cost Tier 1 options. Ask your doctor if you could use a Tier 1 drug to lower your out-of-pocket expenses.

### **Tier 3: Non-Preferred Brand Drugs**

This is your higher-cost tier and includes non-preferred brand drugs and some non-preferred generic drugs. Some Tier 3 drugs have lower-cost Tier 1 or 2 options. Ask your doctor if you could use a Tier 1 or Tier 2 drug to lower your out-of-pocket expenses.

### **Tier 4: Specialty Tier Drugs**

The Specialty tier is your highest-cost tier. A Specialty Tier drug is a very high cost or unique prescription drug which may require special handling and/or close monitoring. Specialty drugs may be brand or generic.

## Generations Healthcare Benefit Design

Generations Healthcare Premier (HMO) Copays		
<i><b>Tier</b></i>	<i><b>30-day supply</b></i>	<i><b>90-day supply*</b></i>
Tier 1: Generic Drugs	\$4	\$10
Tier 2: Preferred Brand Drugs	\$40	\$100
Tier 3: Non-Preferred Brand Drugs	\$80	\$200
Tier 4: Specialty Tier Drugs	33%	33%

\*Available through select retail pharmacies.

# 2012 Therapeutic Classes and Categories

## Therapeutic Categories are listed in bold

*Therapeutic Classes are listed below each therapeutic category*

### **ADHD/Anti-Narcolepsy**

Amphetamines  
Stimulants – Misc.

### **Analgesics and Anesthetics**

Analgesics – Anti-Inflammatory  
Analgesics – Opioid  
Gout Agents  
Local Anesthetics  
Migraine Products

### **Anti-Infective Agents**

Aminoglycosides  
Anti-Infective Agents – Misc.  
Antifungals  
Antimalarials  
Antimycobacterial Agents  
Antivirals-Antiretrovirals  
Antivirals-CMV Agents  
Antivirals-Hepatitis Agents  
Antivirals-Herpes Agents  
Antivirals-Influenza Agents  
Cephalosporins  
Fluoroquinolones  
Macrolides  
Penicillins  
Tetracyclines

### **Antineoplastic Agents**

Antineoplastics – Enzyme Inhibitors  
Antineoplastics – Hormonal Agents  
Antineoplastics – Misc.  
Antineoplastics – Monoclonal  
Antibodies

### **Biologicals**

Biologicals Misc.  
Vaccines

### **Cardiovascular Agents**

Antianginal Agents  
Antiarrhythmics  
Antihyperlipidemics  
Antihypertensives – Angiotensin  
Converting Enzyme (ACE) Inhibitors  
Antihypertensives – Angiotensin  
Receptor Blockers  
Antihypertensives – Combinations  
Antihypertensives – Misc.  
Beta Blockers  
Calcium Channel Blockers  
Cardiovascular Agents – Misc.  
Diuretics  
Vasopressors

### **Central Nervous System Drugs**

Antianxiety Agents  
Antidepressants  
Antipsychotics/Antimanic Agents  
Hypnotics

### **Dermatologicals**

Acne Products  
Antibiotics – Topical  
Antifungals – Topical  
Antipsoriatics  
Burn Products  
Corticosteroids – Topical  
Miscellaneous – Topical  
Scabicides and Pediculicides  
Wound Care Products

**Endocrine and Metabolic Drugs**

Androgens – Anabolic  
Antidiabetics  
Calcium Regulators – Misc.  
Contraceptives  
Corticosteroids  
Diabetic Other  
Endocrine and Metabolic Agents – Misc.  
Estrogens  
Insulin  
Progestins  
Thyroid Agents

**Gastrointestinal Agents**

Antiemetics  
Digestive Aids  
Gastrointestinal Agents – Misc.  
Laxatives  
Ulcer Drugs

**Genitourinary Products**

Genitourinary Agents – Misc.  
Genitourinary Agents – Prostatic  
Hypertrophy Agents  
Urinary Antispasmodics  
Vaginal Products

**Hematological Agents**

Anticoagulants  
Hematological Agents – Misc.  
Hematopoietic Agents

**Miscellaneous Products**

Antidotes/Chelating Agents  
Immunomodulators  
Immunosuppressive Agents  
Irrigation Solutions  
Medical Devices

**Mouth/Throat/Dental Agents**

Mouth/Throat/Dental Agents

**Neuromuscular Drugs**

Anticonvulsants  
Antimyasthenic Agents  
Antiparkinson Agents  
Musculoskeletal Therapy Agents

**Nutritional Products**

Minerals and Electrolytes  
Nutrients  
Vitamins

**Ophthalmic Agents**

Anti-Infectives  
Antiallergic  
Antiglaucoma  
Miscellaneous  
Nonsteroidal Anti-Inflammatory Agents  
Ophthalmic Steroids

**Otic Agents**

Otic Agents

**Psychotherapeutic and****Neurological Agents – Misc.**

Antidementia Agents  
Multiple Sclerosis Agents  
Psychotherapeutic and Neurological  
Agents – Misc.  
Smoking Deterrents

**Respiratory Agents**

Antiasthmatic and Bronchodilator  
Agents  
Antihistamines  
Nasal Agents – Systemic and Topical  
Respiratory Agents – Misc.

## Generations Healthcare — Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
<b>ADHD/ANTI-NARCOLEPSY AGENTS</b>		
<b>AMPHETAMINES</b>		
<i>amphetamine-dextroamphetamine tab</i>	1*	PA, HR
<i>dextroamphetamine sulfate</i>	1*	PA, HR
<i>dextroamphetamine sulfate cr</i>	2	PA, HR
<b>STIMULANTS - MISC.</b>		
<i>metadate er</i>	1*	PA, HR
<i>methylin 20 mg tab</i>	1*	PA, HR
<i>methylin 5 mg, 10 mg tab</i>	1*	HR
<i>methylin er 10 mg tab</i>	1*	HR
<i>methylin er 20 mg tab</i>	1*	PA, HR
<i>methylphenidate hcl 20 mg tab</i>	1*	PA, HR
<i>methylphenidate hcl 5 mg, 10 mg tab; 10 mg er tab</i>	1*	HR
<i>methylphenidate hcl cr</i>	1*	PA, HR
DEXMETHYLPHENIDATE HCL	2	QL, PA, HR
PROVIGIL	3	QL, PA
STRATTERA	3	QL, ST
<b>ANALGESICS AND ANESTHETICS</b>		
<b>ANALGESICS - ANTI-INFLAMMATORY</b>		
<i>diclofenac potassium</i>	1*	
<i>diclofenac sodium cr</i>	1*	
<i>diclofenac sodium tab</i>	1*	
<i>etodolac</i>	1*	
<i>ibuprofen</i>	1*	
<i>indomethacin</i>	1*	
<i>ketorolac tab; 15 mg/ml, 30 mg/ml inj</i>	1*	QL, PA, HR
<i>leflunomide</i>	1*	
<i>meloxicam tab</i>	1*	

Drug Name	Drug Tier	Requirements/ Limits
<i>nabumetone</i>	1*	
<i>naproxen sodium</i>	1*	
<i>naproxen tab</i>	1*	
<i>oxaprozin</i>	1*	
<i>sulindac</i>	1*	
CELEBREX 100 MG, 200 MG CAP	2	QL
CELEBREX 400 MG CAP	2	QL, PA
<i>diflunisal</i>	2	
<i>etodolac cr</i>	2	
<i>indomethacin cr</i>	2	
<i>ketoprofen cr</i>	2	
RIDAURA	3	
ACTEMRA	4	QL, PA
ENBREL	4	QL, PA
HUMIRA	4	QL, PA
KINERET	4	QL, PA
<b>ANALGESICS - OPIOID</b>		
<i>acetaminophen-codeine #2, #3, #4</i>	1*	QL
<i>acetaminophen-codeine soln</i>	1*	QL
<i>co-gesic</i>	1*	QL
<i>endocet</i>	1*	QL
<i>hydrocodone-acetaminophen 2.5-500 mg, 5-325 mg, 5-500 mg, 7.5-325 mg, 7.5-500 mg, 7.5-650 mg, 7.5-750 mg, 10-325 mg, 10-500 mg, 10-650 mg, 10-660 mg, 10-750 mg tab; 7.5-500 mg/15ml soln</i>	1*	QL
<i>hydromorphone hcl tab</i>	1*	QL
<i>methadone hcl 5 mg, 10 mg tab; conc</i>	1*	QL
<i>methadose 5 mg, 10 mg tab; conc</i>	1*	QL

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>methadose sugar-free</i>	1*	QL
<i>morphine sulfate 15 mg tab</i>	1*	QL
MORPHINE SULFATE 30 MG TAB	1*	QL
<i>morphine sulfate cr</i>	1*	QL
<i>oxycodone hcl 5 mg, 10 mg, 15 mg, 30 mg tab; cap</i>	1*	QL
<i>oxycodone-acetaminophen 5-325 mg, 7.5-325 mg, 7.5-500 mg, 10-325 mg, 10-650 mg tab; cap</i>	1*	QL
<i>roxicet 5-325 mg tab</i>	1*	QL
<i>tramadol hcl tab</i>	1*	QL
<i>tramadol-acetaminophen</i>	1*	QL
<i>butorphanol tartrate inj</i>	2	
<i>butorphanol tartrate soln</i>	2	QL
EXALGO	2	QL
<i>fentanyl patch</i>	2	QL
<i>hydromorphone hcl inj</i>	2	PA
KADIAN	2	QL
<i>methadone hcl 5 mg/5ml, 10 mg/5ml soln</i>	2	QL
OPANA ER	2	QL
OXYCONTIN	2	QL
AVINZA	3	QL
<i>fentanyl citrate 200 mcg lollipop</i>	3	QL, PA
SUBOXONE SUBLINGUAL TABLET	3	QL, PA
<i>fentanyl citrate 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg lollipop</i>	4	QL, PA
<b>GOUT AGENTS</b>		
<i>allopurinol</i>	1*	
<i>colchicine-probenecid</i>	1*	
<i>probenecid</i>	1*	

Drug Name	Drug Tier	Requirements/Limits
COLCRYS	2	QL
ULORIC	2	ST
<b>LOCAL ANESTHETICS</b>		
<i>lidocaine hcl gel; soln; ointment</i>	1*	
<i>lidocaine-prilocaine cream</i>	1*	
LIDODERM	2	QL
<b>MIGRAINE PRODUCTS</b>		
<i>naratriptan hcl</i>	1*	QL
MAXALT	2	QL
MAXALT-MLT	2	QL
<i>sumatriptan succinate tab; inj</i>	2	QL
<i>dihydroergotamine</i>	3	
<i>ergomar</i>	3	
<b>ANTI-INFECTIVE AGENTS</b>		
<b>AMINOGLYCOSIDES</b>		
<i>amikacin sulfate 1 gm/4ml inj</i>	1*	
<i>gentamicin sulfate 40 mg/ml inj</i>	1*	
<i>neomycin sulfate</i>	1*	
<i>tobramycin sulfate 1.2 gm/30ml, 10 mg/ml, 2 gm/50ml, 80 mg/2ml inj</i>	2	
<i>tobramycin sulfate in saline</i>	2	
TOBI	4	PA
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
<i>clindamycin hcl</i>	1*	
<i>mebendazole</i>	1*	
<i>metronidazole tab; cap</i>	1*	
<i>sulfamethoxazole-tmp ds</i>	1*	
<i>sulfamethoxazole- trimethoprim</i>	1*	
<i>trimethoprim</i>	1*	
BILTRICIDE	2	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>vancomycin hcl</i>	2	PA
ALBENZA	3	
ALINIA	3	
<i>colistimethate sodium</i>	3	
<i>dapsone</i>	3	
DORIBAX 500 MG INJ	3	
INVANZ	3	
<i>meropenem</i>	3	
NEBUPENT	3	PA
PENTAM	3	
PRIMAXIN IM	3	
<i>primaxin iv</i>	3	
TYGACIL	3	
MEPRON	4	ST
VANCOCIN HCL CAP	4	ST
ZYVOX INJ	4	
ZYVOX SUSP; TAB	4	QL
<b>ANTIFUNGALS</b>		
<i>fluconazole 150 mg tab</i>	1*	QL
<i>fluconazole susp; 50 mg, 100 mg, 200 mg tab; 200 mg/100ml, 200-0.9 mg/100ml-%, 400 mg/200ml, 400-0.9 mg/200ml-% inj</i>	1*	
<i>griseofulvin microsize</i>	1*	
<i>ketoconazole tab</i>	1*	
<i>nystatin 500000 unit tab</i>	1*	
<i>terbinafine hcl</i>	1*	QL, PA
<i>amphotericin b</i>	2	PA
GRIS-PEG	2	
<i>itraconazole</i>	2	QL, PA
ERAXIS	3	PA
<i>grifulvin v</i>	3	
ANCOBON	4	

Drug Name	Drug Tier	Requirements/Limits
NOXAFIL	4	QL, PA
VFEND SUSP	4	QL, PA
<b>ANTIMALARIALS</b>		
<i>hydroxychloroquine sulfate</i>	1*	
<i>mefloquine hcl</i>	1*	
<b>ANTIMYCOBACTERIAL AGENTS</b>		
<i>ethambutol hcl</i>	1*	
<i>isoniazid tab</i>	1*	
<i>rifampin cap</i>	1*	
<i>rifampin inj</i>	3	
<b>ANTIVIRALS-ANTIRETROVIRALS</b>		
<i>zidovudine tab</i>	1*	
<i>didanosine</i>	2	
NORVIR	2	
PREZISTA 75 MG TAB	2	QL
REYATAZ	2	
<i>stavudine</i>	2	
SUSTIVA	2	
VIREAD	2	
<i>zidovudine cap; syrup</i>	2	
CRIXIVAN	3	
EMTRIVA	3	
EPIVIR	3	
EPZICOM	3	
INVIRASE CAP	3	
KALETRA 100-25 MG TAB	3	QL
LEXIVA	3	
RESCRIPTOR	3	
TRIZIVIR	3	
VIDEX 2 GM SOLN	3	
VIRAMUNE	3	
ZIAGEN	3	
ATRIPLA	4	QL
COMBIVIR	4	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
FUZEON	4	QL
INTELENCE	4	QL
INVIRASE TAB	4	
ISENTRESS	4	QL
KALETRA 200-50 MG TAB; SOLN	4	
PREZISTA 150 MG, 400 MG, 600 MG TAB	4	QL
SELZENTRY	4	QL
TRUVADA	4	
VIRACEPT TAB	4	
<b>ANTIVIRALS-CMV AGENTS</b>		
<i>ganciclovir 250 mg cap</i>	2	
<i>ganciclovir 500 mg cap</i>	4	
VALCYTE	4	PA
<b>ANTIVIRALS-HEPATITIS AGENTS</b>		
BARACLUDE	2	
EPIVIR HBV	2	
<i>ribasphere cap; 200 mg tab</i>	2	PA
<i>ribavirin cap; 200 mg tab</i>	2	PA
REBETOL SOLN	3	PA
TYZEKA	3	
HEPSERA	4	QL, ST
INFERGEN	4	QL, PA
PEG-INTRON	4	QL, PA
PEGASYS	4	QL, PA
<i>ribasphere 400 mg, 600 mg tab</i>	4	PA
<i>ribavirin 400 mg, 600 mg tab</i>	4	PA
<b>ANTIVIRALS-HERPES AGENTS</b>		
<i>acyclovir cap; susp; tab</i>	1*	
<i>valacyclovir hcl</i>	2	QL
<i>famciclovir</i>	3	QL

Drug Name	Drug Tier	Requirements/Limits
<b>ANTIVIRALS-INFLUENZA AGENTS</b>		
<i>rimantadine hcl</i>	1*	
TAMIFLU	2	QL
<b>CEPHALOSPORINS</b>		
<i>cefdinir cap</i>	1*	
<i>cefuroxime axetil</i>	1*	
<i>cephalexin susp; cap</i>	1*	
<i>cefaclor</i>	2	
<i>cefazolin sodium 1 gm, 1-5 gm-%, 500 mg inj</i>	2	
<i>cefdinir susp</i>	2	
<i>cefotaxime sodium</i>	2	
<i>cefpodoxime</i>	2	
<i>cefprozil</i>	2	
<i>ceftriaxone sodium 1 gm, 2 gm, 250 mg, 500 mg inj</i>	2	
<i>cefuroxime sodium 1.5 gm, 7.5 gm, 750 mg inj</i>	2	
<i>cefepime hcl 1 gm, 2 gm inj</i>	3	
<b>FLUOROQUINOLONES</b>		
<i>ciprofloxacin hcl tab</i>	1*	
<i>ofloxacin tab</i>	1*	
CIPRO SUSP	3	
<b>MACROLIDES</b>		
<i>azithromycin susp; tab</i>	1*	
<i>clarithromycin susp; tab</i>	1*	
<i>e.e.s. 400</i>	1*	
<i>ery-tab</i>	1*	
<i>erythrocin stearate</i>	1*	
<i>erythromycin base tab</i>	1*	
<i>erythromycin ethylsuccinate</i>	1*	
<i>azithromycin inj</i>	2	
<i>clarithromycin er tab</i>	2	
E.E.S. GRANULES 200 MG/5ML SUSP	2	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
ZMAX	2	
<b>PENICILLINS</b>		
<i>amoxicillin</i>	1*	
<i>amoxicillin-pot clavulanate chew; 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml susp; tab</i>	1*	
<i>dicloxacillin sodium</i>	1*	
<i>penicillin v potassium</i>	1*	
<i>amoxicillin-pot clavulanate er tab; 250-62.5 mg/5ml susp</i>	2	
<b>TETRACYCLINES</b>		
<i>doxycycline hyclate 50 mg, 100 mg cap; 20 mg, 100 mg tab</i>	1*	
<i>minocycline hcl cap</i>	1*	
<i>tetracycline hcl</i>	1*	
<i>doxycycline hyclate inj</i>	2	
<i>demeclocycline hcl</i>	3	PA
<b>ANTINEOPLASTIC AGENTS</b>		
<b>ANTINEOPLASTICS - ENZYME INHIBITORS</b>		
AFINITOR	4	QL, PA
GLEEVEC	4	QL, PA
NEXAVAR	4	QL, PA, LA
SPRYCEL	4	QL, PA
SUTENT	4	QL, PA
TARCEVA	4	QL, PA
TASIGNA	4	QL, PA
TYKERB	4	QL, PA, LA
VELCADE	4	PA
VOTRIENT	4	QL, PA
ZOLINZA	4	QL, PA

Drug Name	Drug Tier	Requirements/Limits
<b>ANTINEOPLASTICS - HORMONAL AGENTS</b>		
<i>anastrozole</i>	1*	QL
<i>megestrol acetate tab</i>	1*	
<i>tamoxifen citrate</i>	1*	
<i>exemestane</i>	2	ST
<i>letrozole</i>	2	QL, ST
<i>leuprolide acetate</i>	2	PA
<i>megestrol acetate susp</i>	2	
FASLODEX	4	QL, PA
LUPRON DEPOT 3.75 MG, 11.25 MG KIT	4	QL, PA
LYSODREN	4	
TRELSTAR DEPOT	4	QL, PA
TRELSTAR LA	4	QL, PA
<b>ANTINEOPLASTICS - MISC.</b>		
<i>hydroxyurea</i>	1*	
<i>mercaptopurine</i>	1*	
<i>methotrexate</i>	1*	PA
<i>bleomycin sulfite</i>	2	PA
<i>cyclophosphamide tab</i>	2	PA
INTRON-A 10000000 UNIT INJ; 3000000 UNIT/0.2ML KIT	2	PA
LEUKERAN	2	
<i>trexall</i>	3	PA
<i>amifostine</i>	4	PA
HEXALEN	4	PA
INTRON-A 5000000 UNIT/0.2ML, 10000000 UNIT/0.2ML KIT; 6000000 UNIT/ML, 10000000 UNIT/ML, 18000000 UNIT, 50000000 UNIT INJ	4	PA
<i>tretinoin (chemotherapy)</i>	4	PA

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<b>ANTINEOPLASTICS - MONOCLONAL ANTIBODIES</b>		
AVASTIN	4	PA, LA
RITUXAN	4	PA, LA
<b>BIOLOGICALS</b>		
<b>BIOLOGICALS - MISC.</b>		
ADACEL	2	
DIPHThERIA-TETANUS TOXOIDS	2	
<b>VACCINES</b>		
VAQTA	2	
ZOSTAVAX	2	QL
<b>CARDIOVASCULAR AGENTS</b>		
<b>ANTIANGINAL AGENTS</b>		
<i>isosorbide dinitrate tab</i>	1*	
<i>isosorbide mononitrate</i>	1*	
<i>nitroglycerin patch</i>	1*	
NITRO-DUR 0.3 MG/HR, 0.8 MG/HR PATCH	3	
NITROSTAT	3	
RANEXA	3	QL, ST
<b>ANTIARRHYTHMICS</b>		
<i>amiodarone hcl 200 mg tab</i>	1*	
<i>disopyramide phosphate</i>	1*	
<i>flecainide acetate</i>	1*	
<i>mexiletine hcl</i>	1*	
<i>pacerone 200 mg tab</i>	1*	
<i>propafenone hcl tab</i>	1*	
<i>quinidine sulfate</i>	1*	
<i>amiodarone hcl 400 mg tab</i>	2	
MULTAQ	2	QL
<i>pacerone 100 mg tab</i>	2	
NORPACE CR	3	
<i>propafenone hcl cap</i>	3	
TIKOSYN	3	

Drug Name	Drug Tier	Requirements/Limits
<b>ANTHYPERLIPIDEMICS</b>		
<i>colestipol hcl tab; granule</i>	1*	
CRESTOR	1*	QL
<i>fenofibrate</i>	1*	QL
<i>fenofibrate micronized</i>	1*	QL
<i>gemfibrozil</i>	1*	QL
LIPITOR	1*	QL
<i>lovastatin</i>	1*	QL
<i>pravastatin sodium</i>	1*	QL
<i>simvastatin</i>	1*	QL
ANTARA	2	QL
NIASPAN	2	QL
SIMCOR	2	QL
TRICOR	2	QL
TRILIPIX	2	QL
WELCHOL	2	
ZETIA	2	QL
LOVAZA	3	QL
<b>ANTHYPERTENSIVES - ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS</b>		
<i>benazepril hcl</i>	1*	
<i>captopril</i>	1*	
<i>enalapril maleate</i>	1*	
<i>fosinopril sodium</i>	1*	
<i>lisinopril</i>	1*	
<i>moexipril hcl</i>	1*	QL
<i>quinapril hcl</i>	1*	
<i>ramipril</i>	1*	QL
<b>ANTHYPERTENSIVES - ANGIOTENSIN RECEPTOR BLOCKERS</b>		
<i>losartan potassium</i>	1*	QL
BENICAR	2	QL
DIOVAN	2	QL

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits
<b>ANTIHYPERTENSIVES - COMBINATIONS</b>		
<i>atenolol-chlorthalidone</i>	1*	
<i>benazepril-hctz</i>	1*	
<i>bisoprolol-hctz</i>	1*	
<i>captopril-hctz</i>	1*	
<i>enalapril-hctz</i>	1*	
<i>fosinopril-hctz</i>	1*	
<i>lisinopril-hctz</i>	1*	
<i>losartan potassium-hctz</i>	1*	QL
<i>methyldopa-hctz</i>	1*	PA, HR
<i>metoprolol-hctz</i>	1*	
<i>moexipril-hctz</i>	1*	QL
<i>propranolol-hctz</i>	1*	
<i>quinapril-hctz</i>	1*	
<i>amlodipine-benazepril</i>	2	QL
AMTURNIDE	2	QL
AZOR	2	QL
BENICAR HCT	2	QL
DIOVAN HCT	2	QL
EXFORGE	2	QL
EXFORGE HCT	2	QL
TEKAMLO	2	QL
TEKTURNA HCT	2	QL
TRIBENZOR	2	QL
VALTURNA	2	QL
<b>ANTIHYPERTENSIVES - MISC.</b>		
<i>clonidine hcl tab</i>	1*	
<i>doxazosin mesylate</i>	1*	QL
<i>guanfacine hcl</i>	1*	
<i>hydralazine hcl tab</i>	1*	
<i>methyldopa</i>	1*	PA, HR
<i>minoxidil</i>	1*	
<i>prazosin hcl</i>	1*	
<i>terazosin hcl</i>	1*	QL

Drug Name	Drug Tier	Requirements/ Limits
TEKTURNA	2	QL
DIBENZYLINE	3	
<b>BETA BLOCKERS</b>		
<i>acebutolol hcl</i>	1*	
<i>atenolol</i>	1*	
<i>bisoprolol fumarate</i>	1*	
<i>carvedilol</i>	1*	QL
<i>labetalol hcl tab</i>	1*	
<i>metoprolol succinate</i>	1*	QL
<i>metoprolol tartrate tab</i>	1*	
<i>nadolol</i>	1*	
<i>propranolol hcl cr</i>	1*	QL
<i>propranolol hcl tab; soln</i>	1*	
<i>sorine</i>	1*	
<i>sotalol hcl tab</i>	1*	
BYSTOLIC	2	QL
COREG CR	2	QL
INNOPRAN XL	3	QL
<b>CALCIUM CHANNEL BLOCKERS</b>		
<i>afeditab cr</i>	1*	QL, ST
<i>amlodipine besylate</i>	1*	QL
<i>cartia xt</i>	1*	QL
<i>dilt-cd</i>	1*	QL
<i>dilt-xr</i>	1*	QL
<i>diltiazem cd 120 mg, 180 mg, 240 mg, 300 mg, 360 mg cap</i>	1*	QL
DILTIAZEM CD 420 MG CAP	1*	QL
<i>diltiazem hcl cr 120 mg, 180 mg, 240 mg cap</i>	1*	QL
<i>diltiazem hcl cr 60 mg, 90 mg, 120 mg cap</i>	1*	
<i>diltiazem hcl tab</i>	1*	
<i>diltzac</i>	1*	QL
<i>felodipine</i>	1*	QL, ST

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>nifediac cc 30 mg, 60 mg er tab</i>	1*	QL, ST
<i>nifediac cc 90 mg er tab</i>	1*	ST
<i>nifedical xl</i>	1*	QL, ST
<i>nifedipine 30 mg, 60 mg er tab</i>	1*	QL, ST
<i>nifedipine 90 mg er tab</i>	1*	ST
<i>nifedipine cr osmotic 30 mg, 60 mg er tab</i>	1*	QL, ST
<i>nifedipine cr osmotic 90 mg er tab</i>	1*	ST
<i>taztia xt</i>	1*	QL
<i>verapamil hcl cr 120 mg, 180 mg, 240 mg cap; tab</i>	1*	
VERAPAMIL HCL CR 360 MG CAP	1*	
<i>verapamil hcl tab</i>	1*	
<i>nimodipine</i>	4	
<b>CARDIOVASCULAR AGENTS - MISC.</b>		
DIGOXIN SOLN	1*	
<i>digoxin tab; inj</i>	1*	
BIDIL	2	
LANOXIN	2	
ADCIRCA	4	QL, PA
LETAIRIS	4	QL, ST, LA
REMODULIN	4	PA, LA
REVATIO TAB	4	QL, PA
TRACLEER	4	QL, ST, LA
<b>DIURETICS</b>		
<i>acetazolamide tab</i>	1*	
<i>amiloride hcl</i>	1*	
<i>amiloride-hctz</i>	1*	
<i>bumetanide</i>	1*	
<i>chlorthalidone 25 mg, 50 mg tab</i>	1*	

Drug Name	Drug Tier	Requirements/Limits
<i>furosemide inj; 10 mg/ml soln; tab</i>	1*	
<i>hydrochlorothiazide</i>	1*	
<i>metolazone</i>	1*	
<i>spironolactone</i>	1*	
<i>spironolactone-hctz</i>	1*	
<i>torseamide tab</i>	1*	
<i>triamterene-hctz</i>	1*	
<i>acetazolamide cap</i>	2	
<i>furosemide 8 mg/ml soln</i>	2	
EDECIN	3	
<b>VASOPRESSORS</b>		
<i>midodrine hcl</i>	2	
ADRENALICK	3	QL
EPINEPHRINE	3	QL
EPIPEN	3	QL
EPIPEN JR	3	QL
TWINJECT	3	QL
<b>CENTRAL NERVOUS SYSTEM DRUGS</b>		
<b>ANTI-ANXIETY AGENTS</b>		
<i>buspirone hcl</i>	1*	
<i>hydroxyzine hcl inj</i>	1*	
<i>hydroxyzine hcl tab; soln; syrup</i>	1*	PA, HR
<i>hydroxyzine pamoate</i>	1*	PA, HR
<b>ANTIDEPRESSANTS</b>		
<i>amitriptyline hcl</i>	1*	
<i>budeprion sr er tab 12 hr</i>	1*	
<i>bupropion tab; 100 mg, 200 mg er tab 12 hr</i>	1*	
<i>citalopram hydrobromide</i>	1*	QL
<i>clomipramine hcl</i>	1*	
<i>desipramine hcl</i>	1*	
<i>doxepin hcl</i>	1*	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>fluoxetine hcl 10 mg, 20 mg, 40 mg cap; tab; soln</i>	1*	QL
<i>fluvoxamine maleate</i>	1*	
<i>imipramine hcl</i>	1*	
<i>mirtazapine</i>	1*	
<i>nortriptyline hcl</i>	1*	
<i>paroxetine hcl tab</i>	1*	QL
<i>phenelzine sulfate</i>	1*	
<i>sertraline hcl 100 mg tab</i>	1*	
<i>sertraline hcl conc; 25 mg, 50 mg tab</i>	1*	QL
<i>trazodone hcl 50 mg, 100 mg, 150 mg tab</i>	1*	
<i>venlafaxine hcl cap</i>	1*	QL
<i>venlafaxine hcl tab</i>	1*	
<i>bupropion 150 mg, 300 mg er tab 24 hr</i>	2	QL
<i>bupropion 150 mg, 300 mg er tab 24 hr</i>	2	QL
CYMBALTA	2	QL
<i>paroxetine hcl susp</i>	2	QL
PRISTIQ	2	QL
<i>protriptyline hcl</i>	2	
<i>tranylcypromine sulfate</i>	2	
EMSAM	3	QL, PA
LEXAPRO	3	QL, ST
MARPLAN	3	
SURMONTIL	3	
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS</b>		
<i>chlorpromazine hcl</i>	1*	
<i>clozapine 25 mg, 50 mg tab</i>	1*	QL
<i>compro</i>	1*	
<i>fluphenazine hcl</i>	1*	
<i>haloperidol</i>	1*	
<i>lithium carbonate 150 mg, 300 mg, 600 mg cap; tab; er tab</i>	1*	

Drug Name	Drug Tier	Requirements/Limits
LITHIUM CITRATE SOLN; SYRUP	1*	
<i>loxapine succinate</i>	1*	
<i>perphenazine</i>	1*	
<i>prochlorperazine</i>	1*	
<i>prochlorperazine maleate</i>	1*	
<i>risperidone tab</i>	1*	QL
<i>thioridazine hcl</i>	1*	PA, HR
<i>thiothixene</i>	1*	
<i>trifluoperazine hcl</i>	1*	
<i>clozapine 100 mg, 200 mg tab</i>	2	QL
<i>fluphenazine decanoate</i>	2	
<i>haloperidol decanoate</i>	2	
INVEGA	2	QL
<i>risperidone dispersible tab; soln</i>	2	QL
SEROQUEL XR	2	QL
ZYPREXA TAB	2	QL
ZYPREXA ZYDIS	2	QL
ABILIFY	3	QL
ABILIFY DISCMELT	3	QL
FANAPT	3	QL, ST
FAZACLO	3	QL, ST
GEODON	3	QL
INVEGA SUSTENNA 39 MG/0.25ML, 78 MG/0.5ML SUSP	3	QL
LATUDA	3	QL
RISPERDAL CONSTA 12.5 MG, 25 MG, 37.5 MG SUSP	3	QL
SAPHRIS	3	QL, ST
SEROQUEL	3	QL
ZYPREXA INJ	3	QL

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
INVEGA SUSTENNA 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML SUSP	4	QL
RISPERDAL CONSTA 50 MG SUSP	4	QL
<b>HYPNOTICS</b>		
<i>zolpidem tartrate tab</i>	1*	QL
LUNESTA	2	QL
<b>DERMATOLOGICALS</b>		
<b>ACNE PRODUCTS</b>		
<i>clindamycin phosphate gel; lotion; soln; swab</i>	1*	
<i>erythromycin gel; soln</i>	1*	
<i>metronidazole cream; 0.75% gel; lotion</i>	1*	
AVITA CREAM	2	PA
<i>sulfacetamide sodium (acne)</i>	2	
<i>sulfacetamide sodium susp</i>	2	
<i>tretinoin</i>	2	PA
AVITA GEL	3	PA
<b>ANTIBIOTICS - TOPICAL</b>		
<i>gentamicin sulfate cream; 0.1% ointment</i>	1*	
<i>mupirocin 2% ointment</i>	1*	
<b>ANTIFUNGALS - TOPICAL</b>		
<i>clotrimazole cream; soln</i>	1*	
<i>clotrimazole- betamethasone cream</i>	1*	
<i>econazole nitrate</i>	1*	
<i>ketoconazole cream; shampoo</i>	1*	
<i>nystatin cream; ointment</i>	1*	
<i>nystatin-triamcinolone</i>	1*	
<i>ciclopirox olamine</i>	2	
<i>clotrimazole- betamethasone lotion</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>nyamyc</i>	2	
<i>nystatin powder</i>	2	
<i>nystop</i>	2	
<i>pedi-dri</i>	2	
<b>ANTIPSORIATICS</b>		
<i>calcipotriene soln</i>	2	QL
<i>calcipotriene ointment</i>	3	QL
<i>calcitrene</i>	3	QL
DOVONEX CREAM	3	QL
SORIATANE 10 MG CAP	3	ST
TAZORAC	3	PA
AMEVIVE	4	QL, PA, LA
OXSORALEN ULTRA	4	
SORIATANE 17.5 MG, 25 MG CAP	4	ST
<b>BURN PRODUCTS</b>		
SILVER SULFADIAZINE	1*	
SSD	1*	
THERMAZENE	1*	
SULFAMYLON	3	
<b>CORTICOSTEROIDS - TOPICAL</b>		
<i>alclometasone dipropionate</i>	1*	
<i>betamethasone dipropionate</i>	1*	
<i>betamethasone dipropionate aug cream</i>	1*	
<i>betamethasone valerate cream; ointment</i>	1*	
BETAMETHASONE VALERATE LOTION	1*	
<i>clobetasol propionate cream; gel; ointment; soln</i>	1*	
<i>cormax</i>	1*	
<i>desonide cream; ointment</i>	1*	
<i>fluocinolone acetonide</i>	1*	
<i>fluocinonide</i>	1*	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits
<i>fluticasone propionate ointment; cream</i>	1*	
<i>hydrocortisone ointment; 2.5% cream; lotion</i>	1*	
<i>mometasone furoate</i>	1*	
<i>proctocream hc</i>	1*	
<i>proctosol hc</i>	1*	
<i>proctozone-hc</i>	1*	
<i>triamcinolone acetonide cream; lotion; ointment</i>	1*	
<i>triderm</i>	1*	
<i>amcinonide</i>	2	
<i>betamethasone dipropionate aug gel; lotion; ointment</i>	2	
<i>colocort</i>	2	
<i>desonide lotion</i>	2	
<i>halobetasol propionate</i>	2	
<i>hydrocortisone enema</i>	2	
<i>hydrocortisone valerate</i>	2	
<i>lokara</i>	2	
CAPEX	3	
DERMA-SMOOTH/FS	3	
<b>MISCELLANEOUS - TOPICAL</b>		
<i>fluorouracil soln</i>	1*	
<i>selenium sulfide</i>	1*	
<i>ammonium lactate cream</i>	2	
FLUOROPLEX	2	
<i>fluorouracil cream</i>	2	
<i>laclotion</i>	2	
VOLTAREN GEL	2	QL
CARAC	3	
ELIDEL	3	QL, ST
<i>imiquimod</i>	3	
SOLARAZE	3	ST

Drug Name	Drug Tier	Requirements/ Limits
ZOVIRAX CREAM; OINTMENT	3	QL
TARGETIN GEL	4	QL, PA
<b>SCABICIDES AND PEDICULICIDES</b>		
<i>acticin</i>	1*	
<i>permethrin</i>	1*	
<i>malathion</i>	2	
EURAX	3	
<b>WOUND CARE PRODUCTS</b>		
SANTYL	3	
REGRANEX	4	QL, PA
<b>ENDOCRINE AND METABOLIC DRUGS</b>		
<b>ANDROGENS-ANABOLIC</b>		
ANDRODERM	2	QL
<i>androxy</i>	2	
<i>oxandrolone 2.5 mg tab</i>	2	PA
<i>testosterone cypionate</i>	2	
<i>testosterone enanthate</i>	2	
TESTIM	3	QL
ANADROL-50	4	PA
<i>oxandrolone 10 mg tab</i>	4	PA
<b>ANTIDIABETICS</b>		
<i>acarbose</i>	1*	QL
<i>glimepiride</i>	1*	QL
<i>glipizide</i>	1*	QL
<i>glipizide xl</i>	1*	QL
<i>glipizide-metformin hcl</i>	1*	QL
<i>glyburide 1.25 mg, 2.5 mg, 5 mg tab</i>	1*	QL
<i>glyburide micronized</i>	1*	QL
<i>glyburide-metformin</i>	1*	QL
<i>glycron 1.5 mg, 3 mg, 6 mg tab</i>	1*	QL
<i>metformin hcl</i>	1*	QL
<i>nateglinide</i>	1*	QL

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>tolazamide</i>	1*	QL
ACTOPLUS MET	2	QL
ACTOS	2	QL
DUETACT	2	QL
JANUMET	2	QL
JANUVIA	2	QL
KOMBIGLYZE XR	2	QL
ONGLYZA	2	QL
RIOMET	2	QL
VICTOZA	2	QL
BYETTA	3	QL
PRANDIN	3	QL
SYMLIN	3	QL, PA
SYMLINPEN 120	3	QL, PA
SYMLINPEN 60	3	QL, PA
<b>CALCIUM REGULATORS - MISC.</b>		
<i>alendronate sodium</i>	1*	QL
BONIVA	2	QL, PA
<i>calcitonin (salmon)</i>	2	QL
FORTICAL	2	QL
PROLIA	3	QL, ST
<b>CONTRACEPTIVES</b>		
<i>cryselle-28</i>	1*	QL
<i>cyclafem 1/35</i>	1*	QL
<i>low-ogestrel</i>	1*	QL
<i>medroxyprogesterone acetate susp</i>	1*	QL
<i>necon 0.5-35 mg-mcg, 1-35 mg-mcg tab</i>	1*	QL
<i>nortrel 0.5-35 mg-mcg, 1-35 mg-mcg tab</i>	1*	QL
<i>tri-previfem</i>	1*	QL
<i>tri-sprintec</i>	1*	QL
TRINESSA (28)	1*	QL
<i>azurette</i>	2	QL

Drug Name	Drug Tier	Requirements/Limits
<i>balziva</i>	2	QL
<i>briellyn</i>	2	QL
<i>kariva</i>	2	QL
<i>levonorgestrel</i>	2	
<i>next choice</i>	2	
<i>ogestrel</i>	2	QL
PLAN B	2	
<i>zenchent</i>	2	QL
<i>gianvi</i>	3	QL
<i>loryna</i>	3	QL
OCELLA 3-0.03 MG TAB	3	QL
ORTHO TRI-CYCLEN LO	3	QL
<b>CORTICOSTEROIDS</b>		
<i>baycadron</i>	1*	
<i>dexamethasone tab; elixir</i>	1*	
<i>fludrocortisone acetate</i>	1*	
<i>methylprednisolone</i>	1*	
<i>methylprednisolone (pak)</i>	1*	
<i>prednisone</i>	1*	
<i>prednisone intensol</i>	3	
ENTOCORT EC	4	ST
<b>DIABETIC OTHER</b>		
GLUCAGEN	2	
GLUCAGON EMERGENCY	2	
PROGLYCEM	4	
<b>ENDOCRINE AND METABOLIC AGENTS - MISC.</b>		
<i>calcitriol cap</i>	1*	PA
<i>cabergoline</i>	2	
<i>calcitriol 1 mcg/ml inj; soln</i>	2	PA
DESMOPRESSIN ACE RHINAL TUBE	2	
<i>desmopressin ace spray refrig</i>	2	
<i>desmopressin acetate spray</i>	2	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>desmopressin acetate tab</i>	2	
EVISTA	2	QL
<i>octreotide acetate 50 mcg/ml, 100 mcg/ml, 200 mcg/ml inj</i>	2	PA
HECTOROL CAP	3	PA, ST
SENSIPAR 30 MG TAB	3	QL
TEV-TROPIN	3	QL, PA
ZEMPLAR CAP	3	PA, ST
ALDURAZYME	4	LA
CYSTADANE	4	
<i>octreotide acetate 500 mcg/ml, 1000 mcg/ml inj</i>	4	PA
SANDOSTATIN LAR DEPOT	4	QL, PA
SENSIPAR 60 MG, 90 MG TAB	4	QL
SYNAREL	4	
<b>ESTROGENS</b>		
<i>estradiol patch</i>	1*	QL
<i>estradiol tab</i>	1*	
<i>estropipate</i>	1*	PA, HR
<i>ortho-est</i>	1*	PA, HR
ENJUVIA 0.3 MG, 0.9 MG, 0.45 MG, 0.625 MG TAB	2	QL, PA, HR
ENJUVIA 1.25 MG TAB	2	PA, HR
ALORA	3	QL
COMBIPATCH	3	QL
ESTRADERM	3	QL
PREMARIN 0.3 MG, 0.9 MG, 0.45 MG, 0.625 MG TAB	3	QL, PA, HR
PREMARIN 1.25 MG TAB	3	PA, HR
PREMPHASE	3	QL, PA, HR
PREMPRO	3	QL, PA, HR
VIVELLE-DOT	3	QL

Drug Name	Drug Tier	Requirements/Limits
<b>INSULIN</b>		
HUMULIN R U-500 (CONCENTRATED)	2*	PA
LANTUS	2*	
LEVEMIR	2*	
NOVOLIN 70/30	2*	
NOVOLIN N	2*	
NOVOLIN R	2*	
NOVOLOG	2*	
NOVOLOG MIX 70/30	2*	
<b>PROGESTINS</b>		
<i>medroxyprogesterone acetate tab</i>	1*	
<i>norethindrone acetate</i>	1*	
MEGACE ES	2	QL
<b>THYROID AGENTS</b>		
LEVOTHROID	1*	
<i>levothyroxine sodium tab</i>	1*	
LEVOXYL	1*	
<i>methimazole</i>	1*	
<i>propylthiouracil</i>	1*	
UNITHROID	1*	
SYNTHROID	3	
<b>GASTROINTESTINAL AGENTS</b>		
<b>ANTIEMETICS</b>		
<i>meclizine hcl</i>	1*	
<i>ondansetron hcl tab</i>	1*	PA
<i>dronabinol 2.5 mg, 5 mg cap</i>	2	QL, PA
EMEND 80 MG, 80 & 125 MG, 125 MG CAP	2	QL, PA
<i>ondansetron dispersible tab</i>	2	PA
<i>trimethobenzamide hcl cap</i>	2	PA, HR
<i>granisetron hcl tab</i>	3	PA
<i>granisol</i>	3	PA
<i>ondansetron hcl soln</i>	3	PA

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits
TRANSDERM-SCOP	3	QL, PA, HR
dronabinol 10 mg cap	4	QL, PA
<b>DIGESTIVE AIDS</b>		
CREON	2	
ZENPEP	2	
<b>GASTROINTESTINAL AGENTS - MISC.</b>		
diphenoxylate-atropine	1*	PA, HR
lactulose 10 gm/15ml, 20 gm/30ml soln	1*	
lonox	1*	PA, HR
loperamide hcl	1*	
metoclopramide hcl tab; soln	1*	
sulfasalazine	1*	
sulfazine	1*	
sulfazine ec	1*	
ursodiol cap	1*	
AMITIZA	2	QL, ST
APRISO	2	
balsalazide disodium	2	
CANASA	2	QL
mesalamine enema	2	
PENTASA	2	
PHOSLO	2	
RENVELA 0.8 GM PACKET	2	QL
RENVELA 2.4 GM PACKET; TAB	2	
ASACOL	3	
ASACOL HD	3	
calcium acetate	3	
DIPENTUM	3	
RELISTOR INJ	3	PA
LOTRONEX	4	QL, PA
REMICADE	4	PA
<b>LAXATIVES</b>		
constulose	1*	

Drug Name	Drug Tier	Requirements/ Limits
<i>gavilyte-c</i>	1*	
PEG 3350/ELECTROLYTES	1*	
<i>polyethylene glycol 3350</i>	1*	
<i>gavilyte-g</i>	2	
<i>gavilyte-n with flavor pack</i>	2	
GOLYTELY	2	
NULYTELY	2	
<i>peg 3350-kcl-na bicarb-nacl</i>	2	
<i>trilyte</i>	2	
<b>ULCER DRUGS</b>		
<i>dicyclomine hcl</i>	1*	PA, HR
<i>famotidine inj; tab</i>	1*	
<i>misoprostol</i>	1*	
<i>omeprazole</i>	1*	QL
<i>ranitidine hcl tab</i>	1*	
<i>sucralfate</i>	1*	
<i>glycopyrrolate tab</i>	2	
<i>methscopolamine bromide</i>	2	
NEXIUM	2	QL
<i>nizatidine cap</i>	2	
<i>ranitidine hcl syrup; 150 mg/6ml inj</i>	2	
CARAFATE SUSP	3	
DEXILANT	3	QL
NEXIUM I.V.	3	PA
<b>GENITOURINARY PRODUCTS</b>		
<b>GENITOURINARY AGENTS - MISC.</b>		
<i>nitrofurantoin macrocrystal 50 mg cap</i>	1*	HR
<i>nitrofurantoin monohyd macro</i>	1*	HR
<i>nitrofurantoin susp</i>	2	HR
CYSTAGON	3	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<b>GENITOURINARY AGENTS - PROSTATIC HYPERTROPHY AGENTS</b>		
<i>finasteride</i>	1*	QL
<i>tamsulosin hcl</i>	1*	QL
AVODART	2	QL
RAPAFLO	2	QL
<b>URINARY ANTISPASMODICS</b>		
<i>bethanechol chloride</i>	1*	
<i>oxybutynin chloride er tab</i>	1*	QL
<i>oxybutynin chloride tab; syrup</i>	1*	
DETROL	2	QL
DETROL LA	2	QL
<i>flavoxate hcl</i>	2	
TOVIAZ	2	QL
<i>tropium chloride</i>	3	QL, ST
<b>VAGINAL PRODUCTS</b>		
<i>clindamycin phosphate cream</i>	1*	
METRONIDAZOLE 0.75% GEL	1*	
<i>terconazole</i>	1*	
VANDAZOLE	1*	
<i>zazole 0.4% cream</i>	1*	
PREMARIN CREAM	2	
VAGIFEM	2	
ZAZOLE 0.8% CREAM	2	
<b>HEMATOLOGICAL AGENTS</b>		
<b>ANTICOAGULANTS</b>		
<i>jantoven</i>	1*	
<i>warfarin sodium</i>	1*	
ARIXTRA 2.5 MG/0.5ML INJ	2	QL
COUMADIN TAB	3	
<i>enoxaparin sodium 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml inj</i>	3	QL

Drug Name	Drug Tier	Requirements/Limits
ARIXTRA 10 MG/0.8ML, 5 MG/0.4ML, 7.5 MG/0.6ML INJ	4	QL
<i>enoxaparin sodium 100 mg/ml, 150 mg/ml, 120 mg/0.8ml inj</i>	4	QL
<b>HEMATOLOGICAL AGENTS - MISC.</b>		
<i>cilostazol</i>	1*	
<i>dipyridamole</i>	1*	HR
<i>pentopak</i>	1*	
<i>pentoxifylline cr</i>	1*	
PLAVIX 75 MG TAB	2	QL
AGGRENOX	3	QL, ST
<b>HEMATOPOIETIC AGENTS</b>		
ARANESP 25 MCG/0.42ML, 25 MCG/ML, 40 MCG/ML, 40 MCG/0.4ML, 60 MCG/0.3ML INJ	2	QL, PA
PROCRT 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 10000 UNIT/ML INJ	2	QL, PA
ARANESP 100 MCG/0.5ML, 60 MCG/ML, 100 MCG/ML, 200 MCG/ML, 300 MCG/ML, 500 MCG/ML, 150 MCG/0.3ML, 150 MCG/0.75ML, 200 MCG/0.4ML, 300 MCG/0.6ML INJ	4	QL, PA
CEREDASE	4	PA
LEUKINE 500 MCG/ML INJ	4	PA
NEULASTA	4	QL, PA
NEUPOGEN	4	QL, PA
PROCRT 20000 UNIT/ML, 40000 UNIT/ML INJ	4	QL, PA
PROMACTA	4	QL, PA, LA
ZAVESCA	4	PA, LA

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits
<b>MISCELLANEOUS PRODUCTS</b>		
<b>ANTIDOTES/CHELATING AGENTS</b>		
<i>depade</i>	1*	
<i>naltrexone hcl</i>	1*	
<i>kalexate</i>	2	
<i>kionex</i>	2	
<i>sodium polystyrene sulfonate</i>	2	
<i>sps</i>	2	
CUPRIMINE	3	
EXJADE 125 MG TAB	3	PA, LA
EXJADE 250 MG, 500 MG TAB	4	PA, LA
SYPRINE	4	
<b>IMMUNOMODULATORS</b>		
REVLIMID	4	QL, PA, LA
THALOMID	4	QL, PA
<b>IMMUNOSUPPRESSIVE AGENTS</b>		
<i>azathioprine tab</i>	1*	PA
<i>mycophenolate mofetil</i>	1*	PA
<i>cyclosporine cap</i>	2	PA
<i>cyclosporine modified 100 mg cap; soln</i>	2	PA
<i>engraf</i>	2	PA
NEORAL	2	PA
SANDIMMUNE CAP; SOLN	2	PA
<i>tacrolimus 0.5 mg, 1 mg cap</i>	2	PA
MYFORTIC 180 MG TAB	3	PA
PROGRAF INJ	3	PA
RAPAMUNE 0.5 MG TAB	3	PA
ZORTRESS 0.25 MG TAB	3	PA
CELLCEPT SUSP	4	PA
MYFORTIC 360 MG TAB	4	PA
RAPAMUNE 1 MG, 2 MG TAB; SOLN	4	PA

Drug Name	Drug Tier	Requirements/ Limits
<i>tacrolimus 5 mg cap</i>	4	PA
ZORTRESS 0.5 MG, 0.75 MG TAB	4	PA
<b>IRRIGATION SOLUTIONS</b>		
LACTATED RINGERS SOLN	1*	
STERILE WATER FOR IRRIGATION	1*	
<b>MEDICAL DEVICES</b>		
<i>bd insulin syringe</i>	1*	QL
<i>bd pen needle</i>	1*	QL
<i>alcohol prep pad</i>	2	QL
<i>alcohol prep swabs , 70%</i>	2	QL
<i>gauze pads 2"x2"</i>	2	QL
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<i>chlorhexidine gluconate</i>	1*	
<i>lidocaine viscous</i>	1*	
<i>nystatin susp</i>	1*	
<i>periogard</i>	1*	
<i>pilocarpine hcl tab</i>	1*	
<i>clotrimazole lozenge; troche</i>	2	
ORAVIG	2	QL
<b>NEUROMUSCULAR DRUGS</b>		
<b>ANTICONVULSANTS</b>		
<i>carbamazepine chew; susp; tab; er tab</i>	1*	
<i>divalproex sodium tab; er tab</i>	1*	
<i>epitol</i>	1*	
<i>gabapentin cap; tab</i>	1*	
<i>lamotrigine tab</i>	1*	
<i>levetiracetam soln; tab</i>	1*	QL
<i>phenytoin</i>	1*	
<i>phenytoin sodium extended</i>	1*	
<i>primidone</i>	1*	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>topiragen</i>	1*	QL
<i>topiramate tab</i>	1*	QL
<i>valproate sodium</i>	1*	
<i>valproic acid</i>	1*	
<i>zonisamide</i>	1*	
DILANTIN INFATABS	2	
<i>divalproex sodium cap</i>	2	
<i>lamotrigine chew</i>	2	
<i>levetiracetam inj</i>	2	
LYRICA	2	QL
<i>oxcarbazepine</i>	2	QL, ST
<i>phenytek</i>	2	
<i>topiramate cap</i>	2	
BANZEL 200 MG TAB; SUSP	3	QL, PA
CELONTIN	3	
DILANTIN 100 MG CAP; SUSP	3	
FELBATOL	3	
<i>gabapentin soln</i>	3	QL
GABITRIL	3	
PEGANONE	3	
TEGRETOL	3	
TEGRETOL XR	3	
VIMPAT	3	QL, PA
BANZEL 400 MG TAB	4	QL, PA
SABRIL	4	QL, PA, LA
<b>ANTIMYASTHENIC AGENTS</b>		
<i>pyridostigmine bromide</i>	1*	
GUANIDINE HCL	2	
MESTINON ER TAB; SYRUP	2	
<b>ANTIPARKINSON AGENTS</b>		
<i>amantadine hcl cap; syrup</i>	1*	
<i>benztropine mesylate tab</i>	1*	
<i>carbidopa-levodopa cr</i>	1*	
<i>carbidopa-levodopa tab</i>	1*	

Drug Name	Drug Tier	Requirements/Limits
<i>ropinirole hcl</i>	1*	
<i>selegiline hcl</i>	1*	
<i>trihexyphenidyl hcl</i>	1*	
AZILECT	2	QL
<i>bromocriptine mesylate</i>	2	
STALEVO	2	
COMTAN	3	QL
<b>MUSCULOSKELETAL THERAPY AGENTS</b>		
<i>baclofen</i>	1*	
<i>carisoprodol 350 mg tab</i>	1*	QL, PA, HR
<i>chlorzoxazone</i>	1*	PA, HR
<i>cyclobenzaprine hcl tab</i>	1*	QL, PA, HR
<i>dantrolene sodium</i>	1*	
<i>methocarbamol</i>	1*	PA, HR
<i>tizanidine hcl</i>	1*	
<i>orphenadrine citrate cr</i>	2	PA, HR
<i>orphenadrine compound-ds</i>	2	PA, HR
<i>orphenadrine-aspirin-caffeine</i>	2	PA, HR
RILUTEK	2	PA
<b>NUTRITIONAL PRODUCTS</b>		
<b>MINERALS AND ELECTROLYTES</b>		
<i>ed k+10</i>	1*	
KLOR-CON 10	1*	
KLOR-CON 8 ER TAB	1*	
<i>klor-con m10</i>	1*	
<i>klor-con m20</i>	1*	
<i>potassium chloride cr cap</i>	1*	
POTASSIUM CHLORIDE CR TAB	1*	
<i>potassium chloride crys cr</i>	1*	
<i>sodium fluoride 2.2 (1 f) mg tab</i>	1*	
<i>klor-con m15</i>	2	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<b>NUTRIENTS</b>		
DEXTROSE 5%, 10% INJ	1*	
INTRALIPID 20% EMULSION	2	PA
CLINISOL SF	3	PA
<b>VITAMINS</b>		
<i>niacor</i>	1*	
<i>prenatal vitamin/folic acid &gt; 0.8mg (generic)</i>	1*	
<b>OPHTHALMIC AGENTS</b>		
<b>ANTI-INFECTIVES</b>		
<i>ak-tob</i>	1*	
<i>ciprofloxacin hcl soln</i>	1*	
<i>erythromycin ointment</i>	1*	
<i>gentak</i>	1*	
<i>gentamicin sulfate 0.3% ointment</i>	1*	
<i>gentamicin sulfate 0.3% ointment; soln</i>	1*	
<i>gentasol</i>	1*	
<i>ilotycin</i>	1*	
<i>ofloxacin 0.3% soln</i>	1*	
<i>romycin</i>	1*	
<i>tobramycin sulfate soln</i>	1*	
<i>tobrasol</i>	1*	
AZASITE	2	
<i>bacitracin ointment</i>	2	
BESIVANCE	2	
CILOXAN OINTMENT	2	QL
IQUIX	2	
MOXEZA	2	
TOBEX OINTMENT	2	
<i>trifluridine</i>	2	
VIGAMOX	2	
ZYMAXID	2	

Drug Name	Drug Tier	Requirements/Limits
<b>ANTIALLERGIC</b>		
<i>azelastine hcl 0.05% soln</i>	1*	QL
<i>cromolyn sodium soln</i>	1*	
BEPREVE	2	QL
PATADAY	2	QL
PATANOL	3	QL
<b>ANTIGLAUCOMA</b>		
BETAXOLOL HCL SOLN	1*	QL
<i>brimonidine tartrate 0.2% soln</i>	1*	QL
<i>carteolol hcl</i>	1*	
<i>dorzolamide hcl</i>	1*	QL
<i>dorzolamide hcl-timolol mal</i>	1*	QL
<i>latanoprost</i>	1*	QL
LEVOBUNOLOL HCL 0.25% SOLN	1*	
<i>levobunolol hcl 0.5% soln</i>	1*	
TIMOLOL MALEATE GEL SOLUTION	1*	QL
<i>timolol maleate soln</i>	1*	
ALPHAGAN P	2	QL
AZOPT	2	QL
COMBIGAN	2	QL
ISTALOL	2	QL
TRAVATAN Z	2	QL
BETOPTIC-S	3	QL
<b>MISCELLANEOUS</b>		
<i>ak-con</i>	1*	
RESTASIS	2	QL
LACRISERT	3	
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS</b>		
<i>diclofenac sodium soln</i>	1*	QL
<i>flurbiprofen sodium</i>	1*	QL
<i>ketorolac soln</i>	1*	QL

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
BROMDAY	2	QL
NEVANAC	3	QL
<b>OPHTHALMIC STEROIDS</b>		
<i>dexamethasone sodium phosphate soln</i>	1*	
FLUOROMETHOLONE	1*	
PREDNISOLONE ACETATE	1*	
<i>prednisolone sodium phosphate 1% soln</i>	1*	
ALREX	2	
BLEPHAMIDE	2	
<i>blephamide s.o.p.</i>	2	
LOTEMAX	2	
<i>tobramycin-dexamethasone</i>	2	
ZYLET	2	
DUREZOL	3	
MAXIDEX	3	
TOBRADEX OINTMENT	3	
<b>OTIC AGENTS</b>		
<b>OTIC AGENTS</b>		
<i>acetic acid 2% soln</i>	1*	
<i>cortomycin</i>	1*	
<i>neomycin-polymyxin-hc soln; 3.5-10000-1 susp</i>	1*	
<i>ofloxacin 0.3% soln</i>	1*	
CIPRO HC	3	
CIPRODEX	3	QL
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISCELLANEOUS</b>		
<b>ANTIDEMENTIA AGENTS</b>		
ARICEPT 23 MG TAB	2	QL, ST
<i>donepezil hcl</i>	2	QL
NAMENDA	2	QL
NAMENDA TITRATION PAK	2	QL

Drug Name	Drug Tier	Requirements/Limits
EXELON SOLN; PATCH	3	QL
<i>galantamine hydrobromide</i>	3	QL, ST
<i>rivastigmine tartrate</i>	3	QL, ST
<b>MULTIPLE SCLEROSIS AGENTS</b>		
AMPYRA	4	QL, PA, LA
AVONEX	4	QL, PA
COPAXONE	4	QL, PA
EXTAVIA 0.3 MG INJ	4	QL, PA
GILENYA	4	QL, PA
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
<i>bupropion 150 mg er tab 12 hr</i>	1*	
<i>perphenazine-amitriptyline</i>	1*	HR
SAVELLA	2	QL
SAVELLA TITRATION PACK	2	QL
ORAP	3	ST
XENAZINE	4	QL, PA, LA
<b>SMOKING DETERRENTS</b>		
<i>buproban</i>	1*	
<i>bupropion hcl (smoking deter)</i>	1*	
CHANTIX	3	QL
CHANTIX CONTINUING MONTH PAK	3	QL
CHANTIX STARTING MONTH PAK	3	QL
NICOTROL	3	QL
NICOTROL NS	3	QL
<b>RESPIRATORY AGENTS</b>		
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS</b>		
<i>albuterol sulfate nebulizer</i>	1*	QL, PA
<i>albuterol sulfate tab; syrup; er tab</i>	1*	

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk  
 \*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/Limits
<i>ipratropium bromide 0.02% soln</i>	1*	QL, PA
<i>ipratropium-albuterol</i>	1*	QL, PA
<i>terbutaline sulfate tab</i>	1*	
<i>theochron</i>	1*	
<i>theophylline cr</i>	1*	
ADVAIR DISKUS	2	QL
ADVAIR HFA	2	QL
ASMANEX 120 METERED DOSES	2	QL
ASMANEX 14 METERED DOSES	2	QL
ASMANEX 30 METERED DOSES	2	QL
ASMANEX 60 METERED DOSES	2	QL
ASMANEX 7 METERED DOSES	2	QL
<i>cromolyn sodium nebulizer</i>	2	PA
FLOVENT DISKUS	2	QL
FLOVENT HFA	2	QL
FORADIL AEROLIZER	2	QL
PERFOROMIST	2	QL, PA
PROAIR HFA	2	QL
QVAR	2	QL
SEREVENT DISKUS	2	QL
SINGULAIR	2	QL
SPIRIVA HANDIHALER	2	QL
SYMBICORT 80-4.5 MCG/ACT, 160-4.5 MCG/ACT AEROSOL	2	QL
<i>theophylline er tab</i>	2	
XOPENEX HFA	2	QL
ALVESCO	3	QL
ATROVENT HFA	3	QL
BROVANA	3	QL, PA

Drug Name	Drug Tier	Requirements/Limits
<i>budesonide susp</i>	3	QL, PA
COMBIVENT	3	QL, ST
DULERA	3	QL
<i>theo-24</i>	3	
<i>zafirlukast</i>	3	QL, ST
<i>terbutaline sulfate inj</i>	4	
<b>ANTIHISTAMINES</b>		
<i>clemastine fumarate</i>	1*	
<i>cyproheptadine hcl</i>	1*	PA, HR
<i>diphenhydramine hcl inj</i>	1*	
<i>promethazine hcl tab; soln; syrup</i>	1*	PA, HR
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL</b>		
<i>flunisolide 0.025% soln</i>	1*	QL
<i>fluticasone propionate susp</i>	1*	QL
<i>ipratropium bromide 0.03%, 0.06% soln</i>	1*	QL
ASTEPRO	2	
<i>azelastine hcl 137 mcg/spray soln</i>	2	
NASONEX	2	QL
VERAMYST	2	QL
PATANASE	3	QL
<b>RESPIRATORY AGENTS - MISC.</b>		
<i>acetylcysteine</i>	1*	PA
GLASSIA	4	PA, LA
PULMOZYME	4	PA

PA = Prior Authorization, QL = Quantity Limit, ST = Step Therapy, LA = Limited Access, HR = High Risk

\*We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

## Appendix A — Quantity Limits

Drug Name	Quantity Limit
ABILIFY DISCMELT 10 MG DISPERSIBLE TAB	30 tablets per 30 days
ABILIFY DISCMELT 15 MG DISPERSIBLE TAB	60 tablets per 30 days
ABILIFY INJ	3.9 mL (3 vials) per day
ABILIFY SOLN	900 mL per 30 days
ABILIFY TAB	30 tablets per 30 days
<i>acarbose</i>	90 tablets per 30 days
<i>acetaminophen-codeine #2, #3, #4</i>	400 tablets per 30 days
<i>acetaminophen-codeine soln</i>	5000 ml per 30 days
ACTEMRA	40 mL per 28 days
ACTOPLUS MET	90 tablets per 30 days
ACTOS	30 tablets per 30 days
ADCIRCA	60 tablets per 30 days
ADRENACLICK	2 devices per 30 days
ADVAIR DISKUS	60 doses (1 inhaler) per 30 days
ADVAIR HFA	12 gm (1 inhaler) per 30 days
<i>afeditab cr</i>	30 tablets per 30 days
AFINITOR	30 tablets per 30 days
AGGRENOX	60 capsules per 30 days
<i>albuterol sulfate (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml nebulizer</i>	450 mL per 30 days
<i>albuterol sulfate (5 mg/ml) 0.5% nebulizer</i>	100 mL per 30 days
<i>alcohol prep pad</i>	200 pads per 30 days
<i>alcohol prep swabs , 70%</i>	200 pads per 30 days
<i>alendronate sodium 35 mg, 70 mg tab</i>	4 tablets per 28 days

Drug Name	Quantity Limit
<i>alendronate sodium 5 mg, 10 mg, 40 mg tab</i>	30 tablets per 30 days
ALORA	8 patches per 28 days
ALPHAGAN P	10 mL per 30 days
ALVESCO	12.2 gm (2 inhalers) per 30 days
AMEVIVE	4 vials per 28 days
AMITIZA	60 capsules per 30 days
<i>amlodipine besylate 10 mg tab</i>	30 tablets per 30 days
<i>amlodipine besylate 2.5 mg, 5 mg tab</i>	45 tablets per 30 days
<i>amlodipine-benazepril</i>	30 capsules per 30 days
AMPYRA	60 tablets per 30 days
AMTURNIDE	30 tablets per 30 days
<i>anastrozole</i>	30 tablets per 30 days
ANDRODERM	30 patches per 30 days
ANTARA 130 MG CAP	30 capsules per 30 days
ANTARA 43 MG CAP	60 capsules per 30 days
ARANESP 100 MCG/0.5ML INJ	4 mL (8 syringes) per 28 days
ARANESP 150 MCG/0.3ML INJ	2.4 mL (8 syringes) per 28 days
ARANESP 150 MCG/0.3ML, 300 MCG/0.6ML INJ	2.4 mL (4 syringes) per 28 days
ARANESP 150 MCG/0.75ML INJ	6 mL (8 vials) per 28 days
ARANESP 200 MCG/0.4ML INJ	3.2 mL (8 syringes) per 28 days
ARANESP 25 MCG/0.42ML INJ	3.36 mL (8 syringes) per 28 days

Drug Name	Quantity Limit
ARANESP 25 MCG/ML, 40 MCG/ML INJ	8 mL (8 vials) per 28 days
ARANESP 300 MCG/ML INJ	4 mL (4 vials) per 28 days
ARANESP 40 MCG/0.4ML INJ	3.2 mL (8 syringes) per 28 days
ARANESP 500 MCG/ML INJ	4 mL (4 syringes) per 28 days
ARANESP 60 MCG/0.3ML INJ	2.4 mL (8 syringes) per 28 days
ARANESP 60 MCG/ML, 100 MCG/ML, 200 MCG/ML INJ	8 mL (8 vials) per 28 days
ARICEPT 23 MG TAB	30 tablets per 30 days
ARIXTRA 10 MG/0.8ML INJ	24 mL (30 syringes) per 30 days
ARIXTRA 2.5 MG/0.5ML INJ	15 mL (30 syringes) per 30 days
ARIXTRA 5 MG/0.4ML INJ	12 mL (30 syringes) per 30 days
ARIXTRA 7.5 MG/0.6ML INJ	18 mL (30 syringes) per 30 days
ASMANEX 120 METERED DOSES	0.24 gm (1 inhaler) per 30 days
ASMANEX 14 METERED DOSES	0.24 gm (1 inhaler) per 14 days
ASMANEX 30 METERED DOSES 110 MCG/INH AEROSOL	0.135 gm (1 inhaler) per 30 days
ASMANEX 30 METERED DOSES 220 MCG/INH AEROSOL	0.24 gm (1 inhaler) per 30 days
ASMANEX 60 METERED DOSES	0.24 gm (1 inhaler) per 30 days
ASMANEX 7 METERED DOSES	0.135 gm (1 inhaler) per 30 days
ATRIPLA	30 tablets per 30 days
ATROVENT HFA	25.8 gm (2 inhalers) per 30 days
AVINZA 120 MG CAP	300 capsules per 30 days

Drug Name	Quantity Limit
AVINZA 30 MG, 45 MG, 60 MG, 75 MG, 90 MG CAP	30 capsules per 30 days
AVODART	30 capsules per 30 days
AVONEX 30 MCG KIT	4 vials (1 kit) per 28 days
AVONEX 30 MCG/0.5ML KIT	4 syringes per 28 days
<i>azelastine hcl 0.05% soln</i>	6 mL per 30 days
AZILECT	30 tablets per 30 days
AZOPT	10 mL per 30 days
AZOR	30 tablets per 30 days
<i>azurette</i>	28 tablets per 28 days
<i>balziva</i>	28 tablets per 28 days
BANZEL 200 MG TAB	240 tablets per 30 days
BANZEL 400 MG TAB	240 tablets per 30 days
BANZEL SUSP	2760 mL per 30 days
<i>bd insulin syringe</i>	200 syringes per 30 days
<i>bd pen needle</i>	200 needles per 30 days
BENICAR	30 tablets per 30 days
BENICAR HCT	30 tablets per 30 days
BEPREVE	10 mL per 30 days
BETAXOLOL HCL SOLN	15 mL per 30 days
BETOPTIC-S	15 mL per 30 days
BONIVA KIT	1 kit per 90 days
BONIVA TAB	1 tablet per 30 days
<i>briellyn</i>	28 tablets per 28 days
<i>brimonidine tartrate 0.2% soln</i>	10 mL per 30 days
BROMDAY	1.7 mL per 30 days
BROVANA	120 mL per 30 days

Drug Name	Quantity Limit
<i>budeprion xl 150 mg er tab 24 hr</i>	90 tablets per 30 days
<i>budeprion xl 300 mg er tab 24 hr</i>	30 tablets per 30 days
<i>budesonide susp</i>	120 mL per 30 days
<i>bupropion 150 mg er tab 24 hr</i>	90 tablets per 30 days
<i>bupropion 300 mg er tab 24 hr</i>	30 tablets per 30 days
<i>butorphanol tartrate soln</i>	10 mL per 30 days
BYETTA 10 MCG/0.04ML INJ	2.4 mL (1 pen) per 30 days
BYETTA 5 MCG/0.02ML INJ	1.2 mL (1 pen) per 30 days
BYSTOLIC 10 MG TAB	120 tablets per 30 days
BYSTOLIC 2.5 MG, 5 MG TAB	30 tablets per 30 days
BYSTOLIC 20 MG TAB	60 tablets per 30 days
<i>calcipotriene ointment</i>	120 gm per 30 days
<i>calcipotriene soln</i>	120 mL per 30 days
<i>calcitonin (salmon)</i>	3.7 mL (1 bottle) per 30 days
<i>calcitrene</i>	120 gm per 30 days
CANASA	30 suppositories per 30 days
<i>carisoprodol 350 mg tab</i>	120 tablets per 30 days
<i>cartia xt 120 mg, 300 mg cap</i>	30 capsules per 30 days
<i>cartia xt 180 mg, 240 mg cap</i>	60 capsules per 30 days
<i>carvedilol 25 mg tab</i>	120 tablets per 30 days
<i>carvedilol 3.125 mg, 6.25 mg, 12.5 mg tab</i>	90 tablets per 30 days
CELEBREX 100 MG, 200 MG, 400 MG CAP	60 capsules per 30 days
CHANTIX	336 tablets per year

Drug Name	Quantity Limit
CHANTIX CONTINUING MONTH PAK	336 tablets per year
CHANTIX STARTING MONTH PAK	106 tablets (2 paks) per year
CILOXAN OINTMENT	3.5 gm per 30 days
CIPRODEX	7.5 mL per 30 days
<i>citalopram hydrobromide soln</i>	900 mL per 30 days
<i>citalopram hydrobromide tab</i>	45 tablets per 30 days
<i>clozapine 100 mg tab</i>	270 tablets per 30 days
<i>clozapine 200 mg tab</i>	135 tablets per 30 days
<i>clozapine 25 mg tab</i>	120 tablets per 30 days
<i>clozapine 50 mg tab</i>	135 tablets per 30 days
<i>co-gesic</i>	240 tablets per 30 days
COLCRYS	60 tablets per 30 days
COMBIGAN	10 mL per 30 days
COMBIPATCH	8 patches per 28 days
COMBIVENT	29.4 gm (2 inhalers) per 30 days
COMTAN	240 tablets per 30 days
COPAXONE	1 kit (30 mL) per 30 days
COREG CR	30 capsules per 30 days
CRESTOR	30 tablets per 30 days
<i>cryselle-28</i>	28 tablets per 28 days
<i>cyclafem 1/35</i>	28 tablets per 28 days
<i>cyclobenzaprine hcl tab</i>	90 tablets per 30 days
CYMBALTA	60 capsules per 30 days
DETROL	60 tablets per 30 days

Drug Name	Quantity Limit
DETROL LA	30 capsules per 30 days
DEXILANT	30 capsules per 30 days
DEXMETHYLPHE-NIDATE HCL	60 tablets per 30 days
<i>diclofenac sodium soln</i>	5 mL per 30 days
<i>dilt-cd 120 mg, 300 mg cap</i>	30 capsules per 30 days
<i>dilt-cd 180 mg, 240 mg cap</i>	60 capsules per 30 days
<i>dilt-xr 120 mg cap</i>	30 capsules per 30 days
<i>dilt-xr 180 mg, 240 mg cap</i>	60 capsules per 30 days
<i>diltiazem cd 120 mg, 300 mg, 360 mg cap</i>	30 capsules per 30 days
<i>diltiazem cd 180 mg, 240 mg cap</i>	60 capsules per 30 days
DILTIAZEM CD 420 MG CAP	30 capsules per 30 days
<i>diltiazem hcl cr 120 mg cap</i>	30 capsules per 30 days
<i>diltiazem hcl cr 180 mg, 240 mg cap</i>	60 capsules per 30 days
<i>diltzac 120 mg, 300 mg, 360 mg cap</i>	30 capsules per 30 days
<i>diltzac 180 mg, 240 mg cap</i>	60 capsules per 30 days
DIOVAN	30 tablets per 30 days
DIOVAN HCT	30 tablets per 30 days
<i>donepezil hcl</i>	30 tablets per 30 days
<i>dorzolamide hcl</i>	10 mL per 30 days
<i>dorzolamide hcl-timolol mal</i>	10 mL per 30 days
DOVONEX CREAM	120 gm per 30 days
<i>doxazosin mesylate 1 mg, 2 mg, 4 mg tab</i>	30 tablets per 30 days
<i>doxazosin mesylate 8 mg tab</i>	60 tablets per 30 days

Drug Name	Quantity Limit
<i>dronabinol 10 mg cap</i>	60 capsules per 30 days
<i>dronabinol 2.5 mg, 5 mg cap</i>	90 capsules per 30 days
DUETACT	30 tablets per 30 days
DULERA	13 gm (1 inhaler) per 30 days
ELIDEL	60 gm per 30 days
EMEND 80 MG, 80 & 125 MG, 125 MG CAP	6 capsules per 30 days
EMSAM	30 patches per 30 days
ENBREL 25 MG/0.5ML INJ	4.08 mL (8 syringes) per 28 days
ENBREL 50 MG/ML INJ	7.84 mL (8 syringes) per 28 days
ENBREL KIT	16 injections (4 kits) per 28 days
<i>endocet 10-650 mg tab</i>	180 tablets per 30 days
<i>endocet 5-325 mg, 7.5-325 mg, 10-325 mg tab</i>	360 tablets per 30 days
<i>endocet 7.5-500 mg tab</i>	240 tablets per 30 days
ENJUVIA 0.3 MG, 0.9 MG, 0.45 MG, 0.625 MG TAB	30 tablets per 30 days
<i>enoxaparin sodium 100 mg/ml, 150 mg/ml inj</i>	30 mL (30 syringes) per 30 days
<i>enoxaparin sodium 120 mg/0.8ml inj</i>	24 mL (30 syringes) per 30 days
<i>enoxaparin sodium 30 mg/0.3ml inj</i>	9 mL (30 syringes) per 30 days
<i>enoxaparin sodium 40 mg/0.4ml inj</i>	12 mL (30 syringes) per 30 days
<i>enoxaparin sodium 60 mg/0.6ml inj</i>	18 mL (30 syringes) per 30 days
<i>enoxaparin sodium 80 mg/0.8ml inj</i>	24 mL (30 syringes) per 30 days
EPINEPHRINE	2 devices per 30 days

Drug Name	Quantity Limit
EPIPEN	2 devices per 30 days
EPIPEN JR	2 devices per 30 days
ESTRADERM	8 patches per 28 days
<i>estradiol patch</i>	4 patches per 28 days
EVISTA	30 tablets per 30 days
EXALGO	120 tablets per 30 days
EXELON PATCH	30 patches per 30 days
EXELON SOLN	180 mL per 30 days
EXFORGE	30 tablets per 30 days
EXFORGE HCT	30 tablets per 30 days
EXTAVIA 0.3 MG INJ	15 vials per 30 days
<i>famciclovir 125 mg, 250 mg tab</i>	60 tablets per 30 days
<i>famciclovir 500 mg tab</i>	21 tablets per 30 days
FANAPT 1 & 2 & 4 & 6 MG TAB	1 pack per 365 days
FANAPT 1 MG, 2 MG, 4 MG, 6 MG, 8 MG, 10 MG, 12 MG TAB	60 tablets per 30 days
FASLODEX	5 mL per 28 days
FAZACLO 100 MG DISPERSIBLE TAB	270 tablets per 30 days
FAZACLO 12.5 MG, 25 MG DISPERSIBLE TAB	120 tablets per 30 days
FAZACLO 150 MG DISPERSIBLE TAB	180 tablets per 30 days
FAZACLO 200 MG DISPERSIBLE TAB	135 tablets per 30 days
<i>felodipine 2.5 mg, 10 mg er tab</i>	30 tablets per 30 days
<i>felodipine 5 mg er tab</i>	60 tablets per 30 days
<i>fenofibrate 160 mg tab</i>	30 tablets per 30 days
<i>fenofibrate 54 mg tab</i>	60 tablets per 30 days
<i>fenofibrate micronized</i>	30 capsules per 30 days
<i>fentanyl citrate 200 mcg lollipop</i>	120 lollipops per 30 days

Drug Name	Quantity Limit
<i>fentanyl citrate 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg lollipop</i>	120 lollipops per 30 days
<i>fentanyl patch</i>	16 patches per 30 days
<i>finasteride</i>	30 tablets per 30 days
FLOVENT DISKUS 250 MCG/BLIST AEROSOL	240 gm (4 inhalers) per 30 days
FLOVENT DISKUS 50 MCG/BLIST, 100 MCG/BLIST AEROSOL	120 gm (2 inhalers) per 30 days
FLOVENT HFA 110 MCG/ACT, 220 MCG/ACT AEROSOL	24 gm (2 inhalers) per 30 days
FLOVENT HFA 44 MCG/ACT AEROSOL	21.2 gm (2 inhalers) per 30 days
<i>fluconazole 150 mg tab</i>	4 tablets per 28 days
<i>flunisolide 0.025% soln</i>	75 mL (3 bottles) per 30 days
<i>fluoxetine hcl 10 mg cap</i>	240 capsules per 30 days
<i>fluoxetine hcl 10 mg tab</i>	240 tablets per 30 days
<i>fluoxetine hcl 20 mg cap</i>	120 capsules per 30 days
<i>fluoxetine hcl 20 mg tab</i>	120 tablets per 30 days
<i>fluoxetine hcl 40 mg cap</i>	60 capsules per 30 days
<i>fluoxetine hcl soln</i>	600 mL per 30 days
<i>flurbiprofen sodium</i>	2.5 mL per 30 days
<i>fluticasone propionate susp</i>	32 gm (2 bottles) per 30 days
FORADIL AEROLIZER	60 capsules (1 inhaler) per 30 days
FORTICAL	3.7 mL (1 bottle) per 30 days
FUZEON	1 kit per 30 days
<i>gabapentin soln</i>	2160 mL per 30 days

Drug Name	Quantity Limit
<i>galantamine hydrobromide cap</i>	30 capsules per 30 days
<i>galantamine hydrobromide soln</i>	180 mL per 30 days
<i>galantamine hydrobromide tab</i>	60 tablets per 30 days
<i>gauze pads 2"x2"</i>	200 pads per 30 days
<i>gemfibrozil</i>	60 tablets per 30 days
GEODON 20 MG, 40 MG, 60 MG CAP	60 capsules per 30 days
GEODON 80 MG CAP	90 capsules per 30 days
GEODON INJ	3 mL per 3 days
<i>gianvi</i>	28 tablets per 28 days
GILENYA	30 capsules per 30 days
GLEEVEC 100 MG TAB	90 tablets per 30 days
GLEEVEC 400 MG TAB	60 tablets per 30 days
<i>glimepiride 1 mg tab</i>	240 tablets per 30 days
<i>glimepiride 2 mg tab</i>	120 tablets per 30 days
<i>glimepiride 4 mg tab</i>	60 tablets per 30 days
<i>glipizide 10 mg er tab</i>	60 tablets per 30 days
<i>glipizide 10 mg tab; 5 mg er tab</i>	120 tablets per 30 days
<i>glipizide 2.5 mg er tab; 5 mg tab</i>	240 tablets per 30 days
<i>glipizide xl 10 mg er tab</i>	60 tablets per 30 days
<i>glipizide xl 2.5 mg er tab</i>	240 tablets per 30 days
<i>glipizide xl 5 mg er tab</i>	120 tablets per 30 days
<i>glipizide-metformin hcl 2.5-250 mg tab</i>	240 tablets per 30 days
<i>glipizide-metformin hcl 2.5-500 mg, 5-500 mg tab</i>	120 tablets per 30 days

Drug Name	Quantity Limit
<i>glyburide 1.25 mg tab</i>	480 tablets per 30 days
<i>glyburide 2.5 mg tab</i>	240 tablets per 30 days
<i>glyburide 5 mg tab</i>	120 tablets per 30 days
<i>glyburide micronized 1.5 mg tab</i>	240 tablets per 30 days
<i>glyburide micronized 3 mg tab</i>	120 tablets per 30 days
<i>glyburide micronized 6 mg tab</i>	60 tablets per 30 days
<i>glyburide-metformin 1.25-250 mg tab</i>	240 tablets per 30 days
<i>glyburide-metformin 2.5-500 mg, 5-500 mg tab</i>	120 tablets per 30 days
<i>glycron 1.5 mg tab</i>	240 tablets per 30 days
<i>glycron 3 mg tab</i>	120 tablets per 30 days
<i>glycron 6 mg tab</i>	60 tablets per 30 days
HEPSERA	30 tablets per 30 days
HUMIRA 20 MG/0.4ML KIT	2 syringes or pens (1 kit) per 28 days
HUMIRA 40 MG/0.8ML KIT	6 pens (1 kit) per year
<i>hydrocodone-acetaminophen 10-660 mg tab</i>	181 tablets per 30 days
<i>hydrocodone-acetaminophen 2.5-500 mg, 5-500 mg, 7.5-500 mg, 10-500 mg tab</i>	240 tablets per 30 days
<i>hydrocodone-acetaminophen 5-325 mg, 7.5-325 mg, 10-325 mg tab</i>	360 tablets per 30 days
<i>hydrocodone-acetaminophen 7.5-500 mg/15ml soln</i>	3600 mL per 30 days

Drug Name	Quantity Limit
<i>hydrocodone-acetaminophen 7.5-650 mg, 10-650 mg tab</i>	185 tablets per 30 days
<i>hydrocodone-acetaminophen 7.5-750 mg, 10-750 mg tab</i>	160 tablets per 30 days
<i>hydromorphone hcl tab</i>	240 tablets per 30 days
INFERGEN 15 MCG/0.5ML INJ	15 mL per 28 days
INFERGEN 9 MCG/0.3ML INJ	3.6 mL per 28 days
INNOPRAN XL	30 capsules per 30 days
INTELENCE 100 MG TAB	120 tablets per 30 days
INTELENCE 200 MG TAB	60 tablets per 30 days
INVEGA 1.5 MG, 3 MG, 9 MG ER TAB	30 tablets per 30 days
INVEGA 6 MG ER TAB	60 tablets per 30 days
INVEGA SUSTENNA 117 MG/0.75ML SUSP	0.75 mL (1 syringe) per 28 days
INVEGA SUSTENNA 156 MG/ML SUSP	1 mL (1 syringe) per 28 days
INVEGA SUSTENNA 234 MG/1.5ML SUSP	1.5 mL (1 syringe) per 28 days
INVEGA SUSTENNA 39 MG/0.25ML SUSP	0.25 mL (1 syringe) per 28 days
INVEGA SUSTENNA 78 MG/0.5ML SUSP	0.5 mL (1 syringe) per 28 days
<i>ipratropium bromide 0.02% soln</i>	312.5 mL per 30 days
<i>ipratropium bromide 0.03% soln</i>	30 mL (1 inhaler) per 30 days
<i>ipratropium bromide 0.06% soln</i>	30 mL (2 inhalers) per 30 days
<i>ipratropium-albuterol</i>	360 mL per 30 days
ISENTRESS	60 tablets per 30 days
ISTALOL	5 mL per 30 days

Drug Name	Quantity Limit
<i>itraconazole</i>	120 capsules per 30 days
JANUMET	60 tablets per 30 days
JANUVIA	30 tablets per 30 days
KADIAN 10 MG, 20 MG, 30 MG, 50 MG, 60 MG, 80 MG CAP	60 capsules per 30 days
KADIAN 100 MG CAP	90 capsules per 30 days
KADIAN 200 MG CAP	180 capsules per 30 days
KALETRA 100-25 MG TAB	240 tablets per 30 days
<i>kariva</i>	28 tablets per 28 days
<i>ketorolac 15 mg/ml, 30 mg/ml inj</i>	20 mL per 30 days
<i>ketorolac soln</i>	10 mL per 30 days
<i>ketorolac tab</i>	20 tablets per 30 days
KINERET	18.76 mL (28 syringes) per 28 days
KOMBIGLYZE XR 2.5-1000 MG TAB	60 tablets per 30 days
KOMBIGLYZE XR 5-500 MG, 5-1000 MG TAB	30 tablets per 30 days
<i>latanoprost</i>	2.5 mL per 30 days
LATUDA	30 tablets per 30 days
LETAIRIS	30 tablets per 30 days
<i>letrozole</i>	30 tablets per 30 days
<i>levetiracetam 250 mg, 1000 mg tab</i>	90 tablets per 30 days
<i>levetiracetam 500 mg tab</i>	180 tablets per 30 days
<i>levetiracetam 750 mg tab</i>	120 tablets per 30 days
<i>levetiracetam soln</i>	900 mL per 30 days
LEXAPRO 10 MG TAB	45 tablets per 30 days
LEXAPRO 5 MG, 20 MG TAB	30 tablets per 30 days
LEXAPRO SOLN	600 mL per 30 days

Drug Name	Quantity Limit
LIDODERM	3 patches per day
LIPITOR	30 tablets per 30 days
<i>loryna</i>	28 tablets per 28 days
<i>losartan potassium</i>	30 tablets per 30 days
<i>losartan potassium-hctz</i>	30 tablets per 30 days
LOTRONEX	60 tablets per 30 days
<i>lovastatin 10 mg tab</i>	30 tablets per 30 days
<i>lovastatin 20 mg, 40 mg tab</i>	60 tablets per 30 days
LOVAZA	120 capsules per 30 days
<i>low-ogestrel</i>	28 tablets per 28 days
LUNESTA	30 tablets per 30 days
LUPRON DEPOT 11.25 MG KIT	1 kit per 84 days
LUPRON DEPOT 3.75 MG KIT	1 kit per 30 days
LYRICA	90 capsules per 30 days
MAXALT	12 tablets per 30 days
MAXALT-MLT	12 tablets per 30 days
<i>medroxyprogesterone acetate susp</i>	1 vial per 90 days
MEGACE ES	150 mL per 30 days
<i>metformin hcl 1000 mg tab</i>	75 tablets per 30 days
<i>metformin hcl 500 mg er tab</i>	120 tablets per 30 days
<i>metformin hcl 500 mg tab</i>	150 tablets per 30 days
<i>metformin hcl 750 mg er tab</i>	60 tablets per 30 days
<i>metformin hcl 850 mg tab</i>	90 tablets per 30 days
<i>methadone hcl 5 mg, 10 mg tab</i>	600 tablets per 30 days
<i>methadone hcl 5 mg/5ml, 10 mg/5ml soln</i>	3000 mL per 30 days

Drug Name	Quantity Limit
<i>methadone hcl conc</i>	600 mL per 30 days
<i>methadose 5 mg, 10 mg tab</i>	600 tablets per 30 days
<i>methadose conc</i>	600 mL per 30 days
<i>methadose sugar-free</i>	600 mL per 30 days
<i>metoprolol succinate 200 mg er tab</i>	60 tablets per 30 days
<i>metoprolol succinate 25 mg, 50 mg, 100 mg er tab</i>	45 tablets per 30 days
<i>moexipril hcl 15 mg tab</i>	120 tablets per 30 days
<i>moexipril hcl 7.5 mg tab</i>	60 tablets per 30 days
<i>moexipril-hctz 15-12.5 mg, 15-25 mg tab</i>	60 tablets per 30 days
<i>moexipril-hctz 7.5-12.5 mg tab</i>	30 tablets per 30 days
<i>morphine sulfate 15 mg tab</i>	180 tablets per 30 days
MORPHINE SULFATE 30 MG TAB	180 tablets per 30 days
<i>morphine sulfate cr 15 mg, 30 mg, 100 mg tab</i>	90 tablets per 30 days
<i>morphine sulfate cr 200 mg tab</i>	180 tablets per 30 days
<i>morphine sulfate cr 60 mg tab</i>	120 tablets per 30 days
MULTAQ	60 tablets per 30 days
NAMENDA SOLN	360 mL per 30 days
NAMENDA TAB	60 tablets per 30 days
NAMENDA TITRATION PAK	49 tablets (1 pak) per year
<i>naratriptan hcl</i>	12 tablets per 30 days
NASONEX	34 gm (2 bottles) per 30 days
<i>nateglinide</i>	90 tablets per 30 days
<i>necon 0.5-35 mg-mcg, 1-35 mg-mcg tab</i>	28 tablets per 28 days

Drug Name	Quantity Limit
NEULASTA	1.2 mL (2 syringes) per 28 days
NEUPOGEN 300 MCG/0.5ML INJ	7 mL (14 syringes) per 21 days
NEUPOGEN 300 MCG/ML INJ	14 mL (14 vials) per 21 days
NEUPOGEN 480 MCG/0.8ML INJ	11.2 mL (14 syringes) per 21 days
NEUPOGEN 480 MCG/1.6ML INJ	22.4 mL (14 vials) per 21 days
NEVANAC	3 mL per 30 days
NEXAVAR	120 tablets per 30 days
NEXIUM CAP	30 capsules per 30 days
NEXIUM PACKET	30 packets per 30 days
NIASPAN 500 MG ER TAB	90 tablets per 30 days
NIASPAN 750 MG, 1000 MG ER TAB	60 tablets per 30 days
NICOTROL	2688 cartridges per year
NICOTROL NS	360 mL (36 bottles) per year
<i>nifediac cc 30 mg, 60 mg er tab</i>	30 tablets per 30 days
<i>nifedical xl</i>	30 tablets per 30 days
<i>nifedipine 30 mg, 60 mg er tab</i>	30 tablets per 30 days
<i>nifedipine cr osmotic 30 mg, 60 mg er tab</i>	30 tablets per 30 days
<i>nortrel 0.5-35 mg-mcg, 1-35 mg-mcg tab</i>	28 tablets per 28 days
NOXAFIL	600 mL per 30 days
OCELLA 3-0.03 MG TAB	28 tablets per 28 days
<i>ogestrel</i>	28 tablets per 28 days
<i>omeprazole 10 mg, 40 mg cap</i>	30 capsules per 30 days

Drug Name	Quantity Limit
<i>omeprazole 20 mg cap</i>	60 capsules per 30 days
ONGLYZA	30 tablets per 30 days
OPANA ER	90 tablets per 30 days
ORAVIG	14 tablets per 14 days
ORTHO TRI-CYCLEN LO	28 tablets per 28 days
<i>oxcarbazepine susp</i>	1200 mL per 30 days
<i>oxcarbazepine tab</i>	120 tablets per 30 days
<i>oxybutynin chloride 10 mg, 15 mg er tab</i>	60 tablets per 30 days
<i>oxybutynin chloride 5 mg er tab</i>	30 tablets per 30 days
<i>oxycodone hcl 15 mg, 30 mg tab</i>	180 tablets per 30 days
<i>oxycodone hcl 5 mg, 10 mg tab</i>	360 tablets per 30 days
<i>oxycodone hcl cap</i>	360 capsules per 30 days
<i>oxycodone-acetaminophen 10-650 mg tab</i>	180 tablets per 30 days
<i>oxycodone-acetaminophen 5-325 mg, 7.5-325 mg, 10-325 mg tab</i>	360 tablets per 30 days
<i>oxycodone-acetaminophen 7.5-500 mg tab</i>	240 tablets per 30 days
<i>oxycodone-acetaminophen cap</i>	240 capsules per 30 days
OXYCONTIN 10 MG, 15 MG, 20 MG, 30 MG, 40 MG ER TAB	90 tablets per 30 days
OXYCONTIN 60 MG, 80 MG ER TAB	120 tablets per 30 days
<i>paroxetine hcl susp</i>	900 mL per 30 days
<i>paroxetine hcl tab</i>	45 tablets per 30 days
PATADAY	5 mL per 30 days

Drug Name	Quantity Limit
PATANASE	30.5 gm (1 bottle) per 30 days
PATANOL	10 mL per 30 days
PEG-INTRON 50 MCG/0.5ML KIT	4 injections (1 kit) per 28 days
PEG-INTRON 80 MCG/0.5ML, 120 MCG/0.5ML, 150 MCG/0.5ML KIT	4 injections per 28 days
PEGASYS INJ	4 mL (4 vials) per 28 days
PEGASYS KIT	1 kit per 28 days
PERFOROMIST	120 mL per 30 days
PLAVIX 75 MG TAB	30 tablets per 30 days
PRANDIN 0.5 MG, 1 MG TAB	120 tablets per 30 days
PRANDIN 2 MG TAB	240 tablets per 30 days
<i>pravastatin sodium</i>	30 tablets per 30 days
PREMARIN 0.3 MG, 0.9 MG, 0.45 MG, 0.625 MG TAB	30 tablets per 30 days
PREMPHASE	28 tablets per 28 days
PREMPRO	28 tablets per 28 days
PREZISTA 150 MG TAB	180 tablets per 30 days
PREZISTA 400 MG, 600 MG TAB	60 tablets per 30 days
PREZISTA 75 MG TAB	360 tablets per 30 days
PRISTIQ	30 tablets per 30 days
PROAIR HFA	34 gm (4 inhalers) per 30 days
PROCRIT 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 10000 UNIT/ML INJ	12 mL (12 vials) per 28 days
PROCRIT 20000 UNIT/ML, 40000 UNIT/ML INJ	12 mL (12 vials) per 28 days

Drug Name	Quantity Limit
PROLIA	1 mL per 180 days
PROMACTA 25 MG TAB	60 tablets per 30 days
PROMACTA 50 MG TAB	45 tablets per 30 days
PROMACTA 75 MG TAB	30 tablets per 30 days
<i>propranolol hcl cr 120 mg, 160 mg cap</i>	60 capsules per 30 days
<i>propranolol hcl cr 60 mg, 80 mg cap</i>	30 capsules per 30 days
PROVIGIL	30 tablets per 30 days
QVAR 40 MCG/ACT AEROSOL	17.4 gm (2 inhalers) per 30 days
QVAR 80 MCG/ACT AEROSOL	26.1 gm (3 inhalers) per 30 days
<i>ramipril</i>	60 capsules per 30 days
RANEXA 1000 MG ER TAB	60 tablets per 30 days
RANEXA 500 MG ER TAB	90 tablets per 30 days
RAPAFLO	30 capsules per 30 days
REGRANEX	15 gm per 30 days
REVELA 0.8 GM PACKET	90 packets per 30 days
RESTASIS	64 mL per 30 days
REVATIO TAB	90 tablets per 30 days
REVLIMID 25 MG CAP	21 capsules per 28 days
REVLIMID 5 MG, 10 MG, 15 MG CAP	30 capsules per 30 days
RIOMET	765 mL 30 days
RISPERDAL CONSTA 12.5 MG, 25 MG, 37.5 MG SUSP	2 injections per 28 days
RISPERDAL CONSTA 50 MG SUSP	2 injections per 28 days

Drug Name	Quantity Limit
<i>risperidone 0.5 mg, 0.25 mg dispersible tab</i>	90 tablets per 30 days
<i>risperidone 0.5 mg, 0.25 mg tab</i>	90 tablets per 30 days
<i>risperidone 1 mg, 2 mg, 3 mg, 4 mg dispersible tab</i>	60 tablets per 30 days
<i>risperidone 1 mg, 2 mg, 3 mg, 4 mg tab</i>	60 tablets per 30 days
<i>risperidone soln</i>	240 mL per 30 days
<i>rivastigmine tartrate</i>	60 capsules per 30 days
<i>roxicot 5-325 mg tab</i>	360 tablets per 30 days
SABRIL PACKET	180 packets per 30 days
SABRIL TAB	180 tablets per 30 days
SANDOSTATIN LAR DEPOT 10 MG, 30 MG KIT	1 kit per 28 days
SANDOSTATIN LAR DEPOT 20 MG KIT	2 kits per 28 days
SAPHRIS	60 tablets per 30 days
SAVELLA	60 tablets per 30 days
SAVELLA TITRATION PACK	55 tablets (1 pack) per year
SELZENTRY 150 MG TAB	60 tablets per 30 days
SELZENTRY 300 MG TAB	120 tablets per 30 days
SENSIPAR 30 MG TAB	60 tablets per 30 days
SENSIPAR 60 MG TAB	60 tablets per 30 days
SENSIPAR 90 MG TAB	120 tablets per 30 days
SEREVENT DISKUS	60 doses (1 inhaler) per 30 days
SEROQUEL	90 tablets per 30 days
SEROQUEL XR 150 MG, 200 MG TAB	30 tablets per 30 days

Drug Name	Quantity Limit
SEROQUEL XR 50 MG, 300 MG, 400 MG TAB	60 tablets per 30 days
<i>sertraline hcl 25 mg tab</i>	30 tablets per 30 days
<i>sertraline hcl 50 mg tab</i>	45 tablets per 30 days
<i>sertraline hcl conc</i>	300 mL per 30 days
SIMCOR 500-20 MG, 750-20 MG, 1000-20 MG ER TAB	60 tablets per 30 days
SIMCOR 500-40 MG, 1000-40 MG ER TAB	30 tablets per 30 days
<i>simvastatin</i>	30 tablets per 30 days
SINGULAIR PACKET	30 packets per 30 days
SINGULAIR TAB; CHEW	30 tablets per 30 days
SPIRIVA HANDIHALER	30 caps for inhalation per 30 days
SPRYCEL 20 MG, 50 MG, 70 MG TAB	60 tablets per 30 days
SPRYCEL 80 MG, 100 MG, 140 MG TAB	30 tablets per 30 days
STRATTERA 10 MG, 18 MG, 25 MG, 40 MG, 60 MG CAP	60 capsules per 30 days
STRATTERA 80 MG, 100 MG CAP	30 capsules per 30 days
SUBOXONE SUBLINGUAL TABLET	90 tablets per 30 days
<i>sumatriptan succinate inj</i>	4 mL (8 vials or syringes) per 30 days
<i>sumatriptan succinate tab</i>	12 tablets per 30 days
SUTENT 12.5 MG CAP	112 capsules per 28 days
SUTENT 25 MG CAP	56 capsules per 28 days
SUTENT 50 MG CAP	28 capsules per 28 days

Drug Name	Quantity Limit
SYMBICORT 80-4.5 MCG/ACT, 160-4.5 MCG/ACT AEROSOL	10.2 gm (1 inhaler) per 30 days
SYMLIN	20 mL per 30 days
SYMLINPEN 120	10.8 mL (4 pens) per 30 days
SYMLINPEN 60	12 mL (8 pens) per 30 days
TAMIFLU 30 MG CAP	60 capsules per 30 days
TAMIFLU 45 MG, 75 MG CAP	30 capsules per 30 days
TAMIFLU SUSP	200 mL per 30 days
<i>tamsulosin hcl</i>	60 capsules per 30 days
TARCEVA 100 MG, 150 MG TAB	30 tablets per 30 days
TARCEVA 25 MG TAB	90 tablets per 30 days
TARGRETIN GEL	60 gm per 30 days
TASIGNA	120 capsules per 30 days
<i>taztia xt 120 mg, 300 mg, 360 mg cap</i>	30 capsules per 30 days
<i>taztia xt 180 mg, 240 mg cap</i>	60 capsules per 30 days
TEKAMLO	30 tablets per 30 days
TEKTURNA	30 tablets per 30 days
TEKTURNA HCT	30 tablets per 30 days
<i>terazosin hcl 1 mg, 5 mg cap</i>	30 capsules per 30 days
<i>terazosin hcl 2 mg, 10 mg cap</i>	60 capsules per 30 days
<i>terbinafine hcl</i>	90 tablets per year
TESTIM	300 gm per 30 days
TEV-TROPIN	17 vials per 28 days
THALOMID	28 capsules per 28 days
TIMOLOL MALEATE GEL SOLUTION	5 mL per 30 days

Drug Name	Quantity Limit
<i>tolazamide 250 mg tab</i>	120 tablets per 30 days
<i>tolazamide 500 mg tab</i>	60 tablets per 30 days
<i>topiragen 200 mg tab</i>	240 tablets per 30 days
<i>topiragen 25 mg, 50 mg, 100 mg tab</i>	60 tablets per 30 days
<i>topiramate 200 mg tab</i>	240 tablets per 30 days
<i>topiramate 25 mg, 50 mg, 100 mg tab</i>	60 tablets per 30 days
TOVIAZ	30 tablets per 30 days
TRACLEER	60 tablets per 30 days
<i>tramadol hcl tab</i>	240 tablets per 30 days
<i>tramadol-acetaminophen</i>	360 tablets per 30 days
TRANSDERM-SCOP	10 patches per 30 days
TRAVATAN Z	2.5 mL per 30 days
TRELSTAR DEPOT	1 vial per 28 days
TRELSTAR LA	1 vial per 84 days
<i>tri-previfem</i>	28 tablets per 28 days
<i>tri-sprintec</i>	28 tablets per 28 days
TRIBENZOR	30 tablets per 30 days
TRICOR 145 MG TAB	30 tablets per 30 days
TRICOR 48 MG TAB	90 tablets per 30 days
TRILIPIX 135 MG CAP	30 capsules per 30 days
TRILIPIX 45 MG CAP	90 capsules per 30 days
TRINESSA (28)	28 tablets per 28 days
<i>tropium chloride</i>	60 tablets per 30 days
TWINJECT	2 devices per 30 days
TYKERB	180 tablets per 30 days
<i>valacyclovir hcl</i>	30 tablets per 30 days
VALTURNA	30 tablets per 30 days

Drug Name	Quantity Limit
<i>venlafaxine hcl</i> 150 mg cap	60 capsules per 30 days
<i>venlafaxine hcl</i> 37.5 mg, 75 mg cap	30 capsules per 30 days
VERAMYST	20 gm (2 bottles) per 30 days
VFEND SUSP	450 mL per 30 days
VICTOZA	One 2 syringe pack (6mL) or 3 syringe pack (9mL) per 30 days
VIMPAT SOLN; INJ	1200 mL per 30 days
VIMPAT TAB	60 tablets per 30 days
VIVELLE-DOT	8 patches per 28 days
VOLTAREN GEL	500 gm per 30 days
VOTRIENT	120 tablets per 30 days
XENAZINE 12.5 MG TAB	240 tablets per 30 days
XENAZINE 25 MG TAB	120 tablets per 30 days
XOPENEX HFA	60 gm (4 inhalers) per 30 days
<i>zafirlukast</i>	60 tablets per 30 days
<i>zenchent</i>	28 tablets per 28 days
ZETIA	30 tablets per 30 days
ZOLINZA	120 capsules per 30 days
<i>zolpidem tartrate tab</i>	30 tablets per 30 days
ZOSTAVAX	1 vaccine per year
ZOVIRAX CREAM	5 gm per 30 days
ZOVIRAX OINTMENT	30 gm per 30 days
ZYPREXA 10 MG TAB	120 tablets per 30 days
ZYPREXA 15 MG, 20 MG TAB	60 tablets per 30 days
ZYPREXA 2.5 MG, 5 MG, 7.5 MG TAB	30 tablets per 30 days
ZYPREXA INJ	3 mL per 3 days

Drug Name	Quantity Limit
ZYPREXA ZYDIS 10 MG DISPERSIBLE TAB	120 tablets per 30 days
ZYPREXA ZYDIS 15 MG, 20 MG DISPERSIBLE TAB	60 tablets per 30 days
ZYPREXA ZYDIS 5 MG DISPERSIBLE TAB	30 tablets per 30 days
ZYVOX SUSP	1680 mL per 28 days
ZYVOX TAB	56 tablets per 28 days

# Index of Drugs

## Symbols

---

A	
ABILIFY	17
ABILIFY DISCMELT	17
acarbose	19
acebutolol hcl	15
acetaminophen-codeine #2, #3, #4	9
acetaminophen-codeine soln	9
acetazolamide	16
acetic acid	27
acetylcysteine	28
ACTEMRA	9
acticin	19
ACTOPLUS MET	20
ACTOS	20
acyclovir	12
ADACEL	14
ADCIRCA	16
ADRENALICK	16
ADVAIR DISKUS	28
ADVAIR HFA	28
afeditab cr	15
AFINITOR	13
AGGRENOX	23
ak-con	26
ak-tob	26
ALBENZA	11
albuterol sulfate	27
alclometasone dipropionate	18
alcohol prep pad	24
alcohol prep swabs	24
ALDURAZYME	21
alendronate sodium	20
ALINIA	11
allopurinol	10
ALORA	21
ALPHAGAN P	26
ALREX	27
ALVESCO	28
amantadine hcl	25
amcinonide	19
AMEVIVE	18
amifostine	13
amikacin sulfate	10
amiloride hcl	16
amiloride-hctz	16
amiodarone hcl	14
AMITIZA	22
amitriptyline hcl	16
amlodipine-benazepril	15
amlodipine besylate	15
ammonium lactate	19
amoxicillin	13
amoxicillin-pot clavulanate	13
amphetamine-dextroamphetamine	9
amphotericin b	11
AMPYRA	27
AMTURNIDE	15
ANADROL-50	19
anastrozole	13
ANCOBON	11
ANDRODERM	19
androxy	19
ANTARA	14
APRISO	22
ARANESP	23
ARICEPT	27
ARIXTRA	23
ASACOL	22
ASACOL HD	22
ASMANEX 7 METERED DOSES	28
ASMANEX 14 METERED DOSES	28
ASMANEX 30 METERED DOSES	28
ASMANEX 60 METERED DOSES	28
ASMANEX 120 METERED DOSES	28
ASTEPRO	28
atenolol	15
atenolol-chlorthalidone	15
ATRIPLA	11
ATROVENT HFA	28
AVASTIN	14
AVINZA	10
AVITA	18
AVODART	23
AVONEX	27
AZASITE	26
azathioprine	24
azelastine hcl	26,28

AZILECT.....	25
azithromycin .....	12
AZOPT.....	26
AZOR.....	15
azurette .....	20

## B

bacitracin.....	26
baclofen .....	25
balsalazide disodium .....	22
balziva .....	20
BANZEL .....	25
BARACLUDE.....	12
baycadron .....	20
bd insulin syringe.....	24
bd pen needle .....	24
benazepril hcl .....	14
benazepril-hctz.....	15
BENICAR .....	14
BENICAR HCT .....	15
benztropine mesylate.....	25
BEPREVE.....	26
BESIVANCE.....	26
betamethasone dipropionate.....	18
betamethasone dipropionate aug .....	18,19
betamethasone valerate .....	18
BETAMETHASONE VALERATE .....	18
BETAXOLOL HCL .....	26
bethanechol chloride .....	23
BETOPTIC-S .....	26
BIDIL.....	16
BILTRICIDE.....	10
bisoprolol fumarate.....	15
bisoprolol-hctz .....	15
bleomycin sulfate.....	13
BLEPHAMIDE .....	27
blephamide s.o.p.....	27
BONIVA .....	20
briellyn.....	20
brimonidine tartrate.....	26
BROMDAY .....	27
bromocriptine mesylate .....	25
BROVANA .....	28
budeprion sr .....	16
budeprion xl.....	17

budesonide .....	28
bumetanide .....	16
buproban.....	27
bupropion.....	16,17,27
bupropion hcl (smoking deter).....	27
buspiron hcl.....	16
butorphanol tartrate.....	10
BYETTA .....	20
BYSTOLIC .....	15

## C

cabergoline.....	20
calcipotriene .....	18
calcitonin (salmon) .....	20
calcitrene.....	18
calcitriol.....	20
calcium acetate.....	22
CANASA .....	22
CAPEX.....	19
captopril .....	14
captopril-hctz .....	15
CARAC.....	19
CARAFATE.....	22
carbamazepine .....	24
carbidopa-levodopa .....	25
carbidopa-levodopa cr.....	25
carisoprodol.....	25
carteolol hcl .....	26
cartia xt .....	15
carvedilol.....	15
cefaclor.....	12
cefazolin sodium.....	12
cefdinir.....	12
cefepime hcl.....	12
cefotaxime sodium.....	12
cefepodoxime.....	12
cefprozil.....	12
ceftriaxone sodium .....	12
cefuroxime axetil .....	12
cefuroxime sodium .....	12
CELEBREX.....	9
CELLCEPT .....	24
CELONTIN.....	25
cephalexin.....	12
CEREDASE.....	23
CHANTIX.....	27

CHANTIX CONTINUING MONTH PAK.....	27	cryselle-28 .....	20
CHANTIX STARTING MONTH PAK.....	27	CUPRIMINE .....	24
chlorhexidine gluconate .....	24	cyclafem 1/35 .....	20
chlorpromazine hcl .....	17	cyclobenzaprine hcl.....	25
chlorthalidone.....	16	cyclophosphamide.....	13
chlorzoxazone .....	25	cyclosporine.....	24
ciclopirox olamine .....	18	cyclosporine modified .....	24
cilostazol .....	23	CYMBALTA .....	17
CILOXAN .....	26	cyproheptadine hcl .....	28
CIPRO .....	12	CYSTADANE .....	21
CIPRODEX.....	27	CYSTAGON.....	22
ciprofloxacin hcl .....	12,26		
CIPRO HC.....	27	<b>D</b>	
citalopram hydrobromide.....	16	dantrolene sodium.....	25
clarithromycin.....	12	dapsone .....	11
clemastine fumarate .....	28	demeclocycline hcl.....	13
clindamycin hcl.....	10	depade .....	24
clindamycin phosphate .....	18,23	DERMA-SMOOTH/FS.....	19
CLINISOL SF .....	26	desipramine hcl .....	16
clobetasol propionate.....	18	DESMOPRESSIN ACE RHINAL TUBE.....	20
clomipramine hcl .....	16	desmopressin ace spray refrig .....	20
clonidine hcl.....	15	desmopressin acetate.....	21
clotrimazole .....	18,24	desmopressin acetate spray.....	20
clotrimazole-betamethasone.....	18	desonide .....	18,19
clozapine .....	17	DETROL.....	23
co-gesic .....	9	DETROL LA.....	23
colchicine-probenecid .....	10	dexamethasone.....	20
COLCRYS .....	10	dexamethasone sodium phosphate.....	27
colestipol hcl .....	14	DEXILANT.....	22
colistimethate sodium .....	11	DEXMETHYLPHENIDATE HCL .....	9
colocort .....	19	dextroamphetamine sulfate.....	9
COMBIGAN .....	26	dextroamphetamine sulfate cr .....	9
COMBIPATCH.....	21	DEXTROSE .....	26
COMBIVENT.....	28	DIBENZYLINE .....	15
COMBIVIR.....	11	diclofenac potassium .....	9
compro.....	17	diclofenac sodium .....	9,26
COMTAN .....	25	diclofenac sodium cr.....	9
constulose.....	22	dicloxacillin sodium.....	13
COPAXONE .....	27	dicyclomine hcl.....	22
COREG CR .....	15	didanosine .....	11
cormax .....	18	diflunisal .....	9
cortomycin .....	27	digoxin .....	16
COUMADIN .....	23	DIGOXIN.....	16
CREON .....	22	dihydroergotamine .....	10
CRESTOR.....	14	DILANTIN .....	25
CRIXIVAN.....	11	DILANTIN INFATABS.....	25
cromolyn sodium .....	26,28	dilt-cd .....	15
		diltiazem cd .....	15

DILTIAZEM CD.....	15
diltiazem hcl.....	15
diltiazem hcl cr.....	15
dilt-xr.....	15
diltzac.....	15
DIOVAN.....	14
DIOVAN HCT.....	15
DIPENTUM.....	22
diphenhydramine hcl.....	28
diphenoxylate-atropine.....	22
DIPHThERIA-TETANUS TOXOIDS.....	14
dipyridamole.....	23
disopyramide phosphate.....	14
divalproex sodium.....	24,25
donepezil hcl.....	27
DORIBAX.....	11
dorzolamide hcl.....	26
dorzolamide hcl-timolol mal.....	26
DOVONEX.....	18
doxazosin mesylate.....	15
doxepin hcl.....	16
doxycycline hyclate.....	13
dronabinol.....	21,22
DUETACT.....	20
DULERA.....	28
DUREZOL.....	27

## E

econazole nitrate.....	18
EDECRIN.....	16
ed k+10.....	25
e.e.s. 400.....	12
E.E.S. GRANULES.....	12
ELIDEL.....	19
EMEND.....	21
EMSAM.....	17
EMTRIVA.....	11
enalapril-hctz.....	15
enalapril maleate.....	14
ENBREL.....	9
endocet.....	9
ENJUVA.....	21
enoxaparin sodium.....	23
ENTOCORT EC.....	20
EPINEPHRINE.....	16
EPIPEN.....	16
EPIPEN JR.....	16

epitol.....	24
EPIVIR.....	11
EPIVIR HBV.....	12
EPZICOM.....	11
ERAXIS.....	11
ergomar.....	10
ery-tab.....	12
erythrocin stearate.....	12
erythromycin.....	18,26
erythromycin base.....	12
erythromycin ethylsuccinate.....	12
ESTRADERM.....	21
estradiol.....	21
estropipate.....	21
ethambutol hcl.....	11
etodolac.....	9
etodolac cr.....	9
EURAX.....	19
EVISTA.....	21
EXALGO.....	10
EXELON.....	27
exemestane.....	13
EXFORGE.....	15
EXFORGE HCT.....	15
EXJADE.....	24
EXTAVIA.....	27

## F

famciclovir.....	12
famotidine.....	22
FANAPT.....	17
FASLODEX.....	13
FAZACLO.....	17
FELBATOL.....	25
felodipine.....	15
fenofibrate.....	14
fenofibrate micronized.....	14
fentanyl citrate.....	10
fentanyl patch.....	10
finasteride.....	23
flavoxate hcl.....	23
flecainide acetate.....	14
FLOVENT DISKUS.....	28
FLOVENT HFA.....	28
fluconazole.....	11
fludrocortisone acetate.....	20
flunisolide.....	28

fluocinolone acetonide.....	18
fluocinonide.....	18
FLUOROMETHOLONE.....	27
FLUOROPLEX.....	19
fluorouracil.....	19
fluoxetine hcl.....	17
fluphenazine decanoate.....	17
fluphenazine hcl.....	17
flurbiprofen sodium.....	26
fluticasone propionate.....	19,28
fluvoxamine maleate.....	17
FORADIL AEROLIZER.....	28
FORTICAL.....	20
fosinopril-hctz.....	15
fosinopril sodium.....	14
furosemide.....	16
FUZEON.....	12

## G

gabapentin.....	24,25
GABITRIL.....	25
galantamine hydrobromide.....	27
ganciclovir.....	12
gauze pads.....	24
gavilyte-c.....	22
gavilyte-g.....	22
gavilyte-n with flavor pack.....	22
gemfibrozil.....	14
gengraf.....	24
gentak.....	26
gentamicin sulfate.....	10,18,26
gentamicin sulfate 0.3%.....	26
gentasol.....	26
GEODON.....	17
gianvi.....	20
GILENYA.....	27
GLASSIA.....	28
GLEEVEC.....	13
glimepiride.....	19
glipizide.....	19
glipizide-metformin hcl.....	19
glipizide xl.....	19
GLUCAGEN.....	20
GLUCAGON EMERGENCY.....	20
glyburide.....	19
glyburide-metformin.....	19

glyburide micronized.....	19
glycopyrrolate.....	22
glycron.....	19
GOLYTELY.....	22
granisetron hcl.....	21
granisol.....	21
grifulvin v.....	11
griseofulvin microsize.....	11
GRIS-PEG.....	11
guanfacine hcl.....	15
GUANIDINE HCL.....	25

## H

halobetasol propionate.....	19
haloperidol.....	17
haloperidol decanoate.....	17
HECTOROL.....	21
HEPSERA.....	12
HEXALEN.....	13
HUMIRA.....	9
HUMULIN R U-500 (CONCENTRATED).....	21
hydralazine hcl.....	15
hydrochlorothiazide.....	16
hydrocodone-acetaminophen.....	9
hydrocortisone.....	19
hydrocortisone valerate.....	19
hydromorphone hcl.....	9,10
hydroxychloroquine sulfate.....	11
hydroxyurea.....	13
hydroxyzine hcl.....	16
hydroxyzine pamoate.....	16

## I

ibuprofen.....	9
ilotycin.....	26
imipramine hcl.....	17
imiquimod.....	19
indomethacin.....	9
indomethacin cr.....	9
INFERGEN.....	12
INNOPRAN XL.....	15
INTELENCE.....	12
INTRALIPID.....	26
INTRON-A.....	13
INVANZ.....	11
INVEGA.....	17
INVEGA SUSTENNA.....	17,18

INVIRASE.....	11,12
ipratropium-albuterol .....	28
ipratropium bromide .....	28
IQUIX.....	26
ISENTRESS .....	12
isoniazid .....	11
isosorbide dinitrate.....	14
isosorbide mononitrate.....	14
ISTALOL.....	26
itraconazole .....	11

## J

jantoven.....	23
JANUMET.....	20
JANUVIA.....	20

## K

KADIAN .....	10
KALETRA.....	11,12
kalexate .....	24
kariva .....	20
ketoconazole .....	11,18
ketoprofen cr .....	9
ketorolac .....	9,26
KINERET .....	9
kionex.....	24
KLOR-CON 8.....	25
KLOR-CON 10.....	25
klor-con m10.....	25
klor-con m15.....	25
klor-con m20.....	25
KOMBIGLYZE XR.....	20

## L

labetalol hcl .....	15
laclotion.....	19
LACRISERT.....	26
LACTATED RINGERS.....	24
lactulose.....	22
lamotrigine.....	24,25
LANOXIN.....	16
LANTUS.....	21
latanoprost.....	26
LATUDA.....	17
leflunomide .....	9
LETAIRIS.....	16
letrozole.....	13

LEUKERAN .....	13
LEUKINE .....	23
leuprolide acetate .....	13
LEVEMIR.....	21
levetiracetam.....	24,25
levobunolol hcl .....	26
LEVOBUNOLOL HCL .....	26
levonorgestrel.....	20
LEVOTHROID.....	21
levothyroxine sodium.....	21
LEVOXYL.....	21
LEXAPRO.....	17
LEXIVA .....	11
lidocaine hcl.....	10
lidocaine-prilocaine .....	10
lidocaine viscous .....	24
LIDODERM .....	10
LIPITOR.....	14
lisinopril .....	14
lisinopril-hctz .....	15
lithium carbonate.....	17
LITHIUM CITRATE.....	17
lokara .....	19
lonox.....	22
loperamide hcl.....	22
loryna.....	20
losartan potassium .....	14
losartan potassium-hctz .....	15
LOTEMAX .....	27
LOTRONEX .....	22
lovastatin.....	14
LOVAZA .....	14
low-ogestrel .....	20
loxapine succinate .....	17
LUNESTA.....	18
LUPRON DEPOT .....	13
LYRICA .....	25
LYSODREN.....	13

## M

malathion .....	19
MARPLAN .....	17
MAXALT.....	10
MAXALT-MLT .....	10
MAXIDEX.....	27
mebendazole .....	10

meclizine hcl	21
medroxyprogesterone acetate	20,21
mefloquine hcl	11
MEGACE ES	21
megestrol acetate	13
meloxicam	9
MEPRON	11
mercaptopurine	13
meropenem	11
mesalamine enema	22
MESTINON	25
metadate er	9
metformin hcl	19
methadone hcl	9,10
methadose	9
methadose sugar-free	10
methimazole	21
methocarbamol	25
methotrexate	13
methscopolamine bromide	22
methyl dopa	15
methyl dopa-hctz	15
methylin	9
methylin er	9
methylphenidate hcl	9
methylphenidate hcl cr	9
methylprednisolone	20
methylprednisolone (pak)	20
metoclopramide hcl	22
metolazone	16
metoprolol-hctz	15
metoprolol succinate	15
metoprolol tartrate	15
metronidazole	10,18
METRONIDAZOLE	23
mexiletine hcl	14
midodrine hcl	16
minocycline hcl	13
minoxidil	15
mirtazapine	17
misoprostol	22
moexipril hcl	14
moexipril-hctz	15
mometasone furoate	19
morphine sulfate	10
MORPHINE SULFATE	10
morphine sulfate cr	10

MOXEZA	26
MULTAQ	14
mupirocin	18
mycophenolate mofetil	24
MYFORTIC	24

## N

nabumetone	9
nadolol	15
naltrexone hcl	24
NAMENDA	27
NAMENDA TITRATION PAK	27
naproxen	9
naproxen sodium	9
naratriptan hcl	10
NASONEX	28
nateglinide	19
NEBUPENT	11
necon	20
neomycin-polymyxin-hc	27
neomycin sulfate	10
NEORAL	24
NEULASTA	23
NEUPOGEN	23
NEVANAC	27
NEXAVAR	13
NEXIUM	22
NEXIUM I.V.	22
next choice	20
niacor	26
NIASPAN	14
NICOTROL	27
NICOTROL NS	27
nifediac cc	16
nifedical xl	16
nifedipine	16
nifedipine cr osmotic	16
nimodipine	16
NITRO-DUR	14
nitrofurantoin macrocrystal	22
nitrofurantoin monohyd macro	22
nitrofurantoin susp	22
nitroglycerin	14
NITROSTAT	14
nizatidine	22
norethindrone acetate	21
NORPACE CR	14

nortrel	20	pedi-dri	18
nortriptyline hcl	17	PEG 3350/ELECTROLYTES	22
NORVIR	11	peg 3350-kcl-na bicarb-nacl	22
NOVOLIN 70/30	21	PEGANONE	25
NOVOLIN N	21	PEGASYS	12
NOVOLIN R	21	PEG-INTRON	12
NOVOLOG	21	penicillin v potassium	13
NOVOLOG MIX 70/30	21	PENTAM	11
NOXAFIL	11	PENTASA	22
NULYTELY	22	pentopak	23
nyamyc	18	pentoxifylline cr	23
nystatin	11,18,24	PERFOROMIST	28
nystatin-triamcinolone	18	periogard	24
nystop	18	permethrin	19
<b>O</b>		perphenazine	17
OCELLA	20	perphenazine-amitriptyline	27
octreotide acetate	21	phenelzine sulfate	17
ofloxacin	12,26,27	phenytek	25
ogestrel	20	phenytoin	24
omeprazole	22	phenytoin sodium extended	24
ondansetron dispersible tab	21	PHOSLO	22
ondansetron hcl	21	pilocarpine hcl	24
ONGLYZA	20	PLAN B	20
OPANA ER	10	PLAVIX	23
ORAP	27	polyethylene glycol 3350	22
ORAVIG	24	potassium chloride cr	25
orphenadrine-aspirin-caffeine	25	POTASSIUM CHLORIDE CR	25
orphenadrine citrate cr	25	potassium chloride crys cr	25
orphenadrine compound-ds	25	PRANDIN	20
ortho-est	21	pravastatin sodium	14
ORTHO TRI-CYCLEN LO	20	prazosin hcl	15
oxandrolone	19	PREDNISOLONE ACETATE	27
oxaprozin	9	prednisolone sodium phosphate	27
oxcarbazepine	25	prednisone	20
OXSORALEN ULTRA	18	prednisone intensol	20
oxybutynin chloride	23	PREMARIN	21,23
oxycodone-acetaminophen	10	PREMPHASE	21
oxycodone hcl	10	PREMPRO	21
OXYCONTIN	10	prenatal vitamin/folic acid > 0.8mg (generic)	26
<b>P</b>		PREZISTA	11,12
pacerone	14	PRIMAXIN IM	11
paroxetine hcl	17	primaxin iv	11
PATADAY	26	primidone	24
PATANASE	28	PRISTIQ	17
PATANOL	26	PROAIR HFA	28
		probenecid	10
		prochlorperazine	17

prochlorperazine maleate.....	17
PROCRIT .....	23
proctocream hc.....	19
proctosol hc .....	19
proctozone-hc.....	19
PROGLYCEM.....	20
PROGRAF.....	24
PROLIA.....	20
PROMACTA.....	23
promethazine hcl.....	28
propafenone hcl.....	14
propranolol hcl.....	15
propranolol hcl cr.....	15
propranolol-hctz.....	15
propylthiouracil.....	21
protriptyline hcl.....	17
PROVIGIL.....	9
PULMOZYME.....	28
pyridostigmine bromide.....	25

## Q

quinapril hcl.....	14
quinapril-hctz.....	15
quinidine sulfate.....	14
QVAR.....	28

## R

ramipril.....	14
RANEXA.....	14
ranitidine hcl.....	22
RAPAFLO.....	23
RAPAMUNE.....	24
REBETOL.....	12
REGRANEX.....	19
RELISTOR.....	22
REMICADE.....	22
REMODULIN.....	16
REVELA.....	22
RESCRIPTOR.....	11
RESTASIS.....	26
REVATIO.....	16
REVLIMID.....	24
REYATAZ.....	11
ribasphere.....	12
ribavirin.....	12
RIDAURA.....	9
rifampin.....	11

RILUTEK.....	25
rimantadine hcl.....	12
RIOMET.....	20
RISPERDAL CONSTA.....	17,18
risperidone.....	17
RITUXAN.....	14
rivastigmine tartrate.....	27
romycin.....	26
ropinirole hcl.....	25
roxicot.....	10

## S

SABRIL.....	25
SANDIMMUNE.....	24
SANDOSTATIN LAR DEPOT.....	21
SANTYL.....	19
SAPHRIS.....	17
SAVELLA.....	27
SAVELLA TITRATION PACK.....	27
selegiline hcl.....	25
selenium sulfide.....	19
SELZENTRY.....	12
SENSIPAR.....	21
SEREVENT DISKUS.....	28
SEROQUEL.....	17
SEROQUEL XR.....	17
sertraline hcl.....	17
SILVER SULFADIAZINE.....	18
SIMCOR.....	14
simvastatin.....	14
SINGULAIR.....	28
sodium fluoride.....	25
sodium polystyrene sulfonate.....	24
SOLARAZE.....	19
SORIATANE.....	18
sorine.....	15
sotalol hcl.....	15
SPIRIVA HANDIHALER.....	28
spironolactone.....	16
spironolactone-hctz.....	16
SPRYCEL.....	13
sps.....	24
SSD.....	18
STALEVO.....	25
stavudine.....	11
STERILE WATER FOR IRRIGATION.....	24
STRATTERA.....	9

SUBOXONE	10	THALOMID	24
sucralfate	22	theo-24	28
sulfacetamide sodium	18	theochron	28
sulfacetamide sodium (acne)	18	theophylline	28
sulfamethoxazole-tmp ds	10	theophylline cr	28
sulfamethoxazole-trimethoprim	10	THERMAZENE	18
SULFAMYLON	18	thioridazine hcl	17
sulfasalazine	22	thiothixene	17
sulfazine	22	TIKOSYN	14
sulfazine ec	22	timolol maleate	26
sulindac	9	TIMOLOL MALEATE	26
sumatriptan succinate	10	tizanidine hcl	25
SURMONTIL	17	TOBI	10
SUSTIVA	11	TOBRADEX	27
SUTENT	13	tobramycin-dexamethasone	27
SYMBICORT	28	tobramycin sulfate	10,26
SYMLIN	20	tobramycin sulfate in saline	10
SYMLINPEN 60	20	tobrasol	26
SYMLINPEN 120	20	TOBEX	26
SYNAREL	21	tolazamide	20
SYNTHROID	21	topiragen	25
SYPRINE	24	topiramate	25
<b>T</b>			
tacrolimus	24	torsemide	16
TAMIFLU	12	TOVIAZ	23
tamoxifen citrate	13	TRACLEER	16
tamsulosin hcl	23	tramadol-acetaminophen	10
TARCEVA	13	tramadol hcl	10
TARGRETIN	19	TRANSDERM-SCOP	22
TASIGNA	13	tranylcypromine sulfate	17
TAZORAC	18	TRAVATAN Z	26
taztia xt	16	trazodone hcl	17
TEGRETOL	25	TRELSTAR DEPOT	13
TEGRETOL XR	25	TRELSTAR LA	13
TEKAMLO	15	tretinoin	18
TEKTURNA	15	tretinoin (chemotherapy)	13
TEKTURNA HCT	15	trexall	13
terazosin hcl	15	triamcinolone acetonide	19
terbinafine hcl	11	triamterene-hctz	16
terbutaline sulfate	28	TRIBENZOR	15
terconazole	23	TRICOR	14
TESTIM	19	triderm	19
testosterone cypionate	19	trifluoperazine hcl	17
testosterone enanthate	19	trifluridine	26
tetracycline hcl	13	trihexyphenidyl hcl	25
TEV-TROPIN	21	TRILIPIX	14
		trilyte	22
		trimethobenzamide hcl	21

trimethoprim.....	10
TRINESSA (28).....	20
tri-previfem.....	20
tri-sprintec.....	20
TRIZIVIR.....	11
tropium chloride.....	23
TRUVADA.....	12
TWINJECT.....	16
TYGACIL.....	11
TYKERB.....	13
TYZEKA.....	12

## U

ULORIC.....	10
UNITHROID.....	21
ursodiol.....	22

## V

VAGIFEM.....	23
valacyclovir hcl.....	12
VALCYTE.....	12
valproate sodium.....	25
valproic acid.....	25
VALTURNA.....	15
VANCOCIN HCL CAP.....	11
vancomycin hcl.....	11
VANDAZOLE.....	23
VAQTA.....	14
VELCADE.....	13
venlafaxine hcl.....	17
VERAMYST.....	28
verapamil hcl.....	16
verapamil hcl cr.....	16
VERAPAMIL HCL CR.....	16
VFEND.....	11
VICTOZA.....	20
VIDEX.....	11
VIGAMOX.....	26
VIMPAT.....	25
VIRACEPT.....	12
VIRAMUNE.....	11
VIREAD.....	11
VIVELLE-DOT.....	21
VOLTAREN.....	19
VOTRIENT.....	13

## W

warfarin sodium.....	23
WELCHOL.....	14

## X

XENAZINE.....	27
XOPENEX HFA.....	28

## Y

## Z

zafirlukast.....	28
ZAVESCA.....	23
zazole.....	23
ZAZOLE.....	23
ZEMPLAR.....	21
zenchent.....	20
ZENPEP.....	22
ZETIA.....	14
ZIAGEN.....	11
zidovudine.....	11
ZMAX.....	13
ZOLINZA.....	13
zolpidem tartrate.....	18
zonisamide.....	25
ZORTRESS.....	24
ZOSTAVAX.....	14
ZOVIRAX.....	19
ZYLET.....	27
ZYMAXID.....	26
ZYPREXA.....	17
ZYPREXA ZYDIS.....	17
ZYVOX.....	11



# Generations Healthcare HMO

*Medicare Advantage Health Plans*

## Member Services

**1-866-547-3060**

(TTY users call **1-800-958-2692**)

8:00 a.m. to 8:00 p.m. in your local time zone, 7 days a week.

**[www.GenerationsHealthcare.cc](http://www.GenerationsHealthcare.cc)**

This information is available for free in other languages. Please contact our customer service number at 1-866-547-3060, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 1-800-958-2692) 7 days a week for additional information.

Esta información está disponible sin cargo en otros idiomas. Para obtener más información, comuníquese con el Servicio de Atención al Cliente al número 1-866-547-3060, de 8:00 a. m. a 8:00 p. m. en su zona horaria local (los usuarios de TTY deben llamar al 1-800-958-2692) los 7 días de la semana.

Generations Healthcare HMO is a Medicare-approved HMO plan offered through the following organization that contracts with the Federal government: Today's Options of Oklahoma®, Inc., a member of the Universal American family of companies.

UNIVERSAL  
AMERICAN

A Healthy Collaboration®