

PATH TO HEALTH / CONNECT TO CARE

DRUG FORMULARY

Administered by MedImpact

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INTRODUCTION

Foreword

The below table describes Path to Health / Connect to Care prescription coverage:

Patient out-of-pocket cost	<ul style="list-style-type: none"> • \$5 copayment per prescription • No monthly share of cost requirement
Benefit maximums	<ul style="list-style-type: none"> • \$500 per prescription claim • \$1500 maximum benefit per enrollment period
Drug exclusions	<ul style="list-style-type: none"> • Specialty drugs and contraceptives are excluded

This document represents the efforts of MedImpact and Path to Health / Connect to Care to provide physicians and pharmacists with a method to evaluate the various drug products available under the Path to Health and Connect to Care Benefits. The medical treatment of patients is frequently related to the practical application of drug therapy. Due to the vast availability of medication treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the Path to Health and Connect to Care Formulary is to enhance the ability of physicians and pharmacists participating in Path to Health and Connect to Care to provide optimal cost effective drug therapy for Path to Health and Connect to Care members.

The development, maintenance, and improvement of the Path to Health / Connect to Care Formulary are evolutionary and require on-going oversight. This is accomplished by a pharmacy and therapeutics review process conducted by a panel of physicians and pharmacists. The Path to Health / Connect to Care Formulary is a continuously reviewed and revised list of drug products that reflects the consensus clinical opinion of the panel. Using this Formulary, you are encouraged to review the information and provide input and comments to Path to Health / Connect to Care.

Path to Health / Connect to Care uses the following criteria in the evaluation of product selection for the Path to Health / Connect to Care Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance, or prophylaxis of the medical condition.
- The drug product must demonstrate therapeutic marker outcomes accepted by the medical community.
- The drug product must be accepted for use by the medical community.
- The drug product should have a favorable cost ratio for the treatment of the medical condition.

How to Use the Drug Formulary

The Path to Health / Connect to Care Formulary is a list of covered and preferred drug agents for Path to Health and Connect to Care members. All products are listed by their generic names and most common proprietary (branded) name. The Path to Health / Connect to Care Formulary may be accessed by using the index, both by generic and proprietary

name (in small capital letters) and by therapeutic drug category. Any product not found in this Formulary listing shall be considered a Non-Formulary Drug.

Coverage Limitations

The Path to Health / Connect to Care Formulary does not provide information regarding the specific coverage or limitations an individual member may have. Path to Health and Connect to Care members may have specific limitations which are not reflected in this Drug Formulary. This Drug Formulary contains only FDA-approved outpatient drugs for eligible members and does not apply to non-FDA approved drugs or medications used in in-patient settings. If a Path to Health or Connect to Care member has any specific questions regarding coverage, they should contact Path to Health / Connect to Care at (916) 649-2631 for further explanation of benefits.

Path to Health and Connect to Care members are not eligible to receive prescription drug services outside of California and the designated border state areas of Oregon, Nevada and Arizona.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. The brand names listed are for reference use only and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by the Path to Health / Connect to Care pharmacy and therapeutics review process.

Path to Health / Connect to Care approves such multisource drugs for addition to the maximum allowable cost (MAC) list based on the following criteria:

- A minimum of one "A" rated source of the product.
- An FDA Rating for generic equivalency.
- Review by Path to Health / Connect to Care for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:
 - ◊ Coumadin
 - ◊ Dilantin
 - ◊ Lanoxin
 - ◊ Premarin
 - ◊ Synthroid

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

Experimental Drugs

The experimental nature or use of drug products will be determined by Path to Health / Connect to Care using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage.

Prior Authorization

Drug products that are listed as Prior Authorization (PA) required require approval when the member presents a prescription to a network pharmacy. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by Path to Health / Connect to Care, the request will be denied and alternative therapy may be recommended. Each request will be reviewed on individual patient need and approval may be given if a documented medical need exists.

Request Process for Non-Formulary Agents

Coverage for non-formulary agents may be requested in advance by physicians. When a Path to Health or Connect to Care member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist should notify the physician and member of the nonformulary status. The physician, pharmacist or member may then call MedImpact at (800) 788-2949 to initiate the medical exception process. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

The following general criteria are used for approval.

- 1) The use of Path to Health / Connect to Care Formulary Drug Products is contraindicated in the patient.
- 2) The patient has failed an appropriate trial of Formulary or related agents.
- 3) The choices available in the Path to Health / Connect to Care Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
- 4) The use of a Path to Health / Connect to Care Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

Path to Health / Connect to Care recognizes that not all medical needs can be met with agents listed in this document and encourages inquires about optional therapies.

Step Care Agents

Drug products defined as step care will undergo an electronic pre-authorization process per Path to Health / Connect to Care guidelines, which requires a trial of first-line drug(s) before a Step Care drug will be covered at the formulary brand level. If recommended guidelines for first-line therapy are not met, then the Step Care drug may be subject to review through the prior authorization process.

Quantity Limits

Limitations on quantity may be placed on certain products due to safety, therapeutic or cost-effectiveness considerations. Prescriptions for such agents exceeding the quantity limit (QL) will be subject to the prior authorization process.

Appeals Process

Prior authorization and medical exception requests are evaluated based on medical necessity and safety as described. In the event of denial, providers or Path to Health or Connect to Care members may request a formal appeal verbally or in writing within sixty (60) days of denial notification. To request an appeal, call (800) 788-2949 or send your written appeal request to the following address:

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court, San Diego, CA 92131
Attention: Appeals Coordinator
or
Fax (858) 790-6060

Formulary Process and Communication

The Path to Health / Connect to Care Formulary is a tool to promote cost-effective prescription drug use. While every attempt has been made to create a document that meets all therapeutic needs, the art of medicine makes this a formidable task. Path to Health / Connect to Care welcomes input on the formulary from physicians and pharmacists providing services to Path to Health and Connect to Care clients. Suggestions and comments should be submitted to the Path to Health / Connect to Care at the following address:

Path to Health / Connect to Care
ATTN: Pharmacy and Therapeutics Panel
1545 River Park Drive, Suite 435
Sacramento, CA 95815
(916) 649-2631

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CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

Aspirin	ASPIRIN
Aspirin EC	ECOTRIN
Celecoxib	CELEBREX
Diclofenac Sodium	VOLTAREN
Etodolac	LODINE
Ibuprofen	MOTRIN (INCLUDES OTC)
Indomethacin	INDOCIN
Ketoprofen	ORUVAIL, 200MG STRENGTH NON-FORMULARY
Indomethacin, Sustained Release	INDOCIN SR
Meloxicam Tablets	MOBIC (TABLETS ONLY), SUSPENSION NON-FORMULARY
Nabumetone	RELAFEN
Naproxen	NAPROSYN
Naproxen Sodium	ANAPROX ANAPROX DS
Salsalate	DISALCID
Sulindac	CLINORIL
Piroxicam	FELDENE

SECOND LINE AGENTS

SE	Etodolac Extended Release	LODINE XL, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
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Miscellaneous Arthritis Agents

Leflunomide	ARAVA
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Migraine Agents

	APAP/Dichloralphenazone/Isomethep	MIDRIN
	Butalbital/APAP/Caffeine	ESGIC ESGIC PLUS FIORICET
	Butalbital/Aspirin/Caffeine (Tablets Only)	FIORINAL
QL	Ergotamine/Caffeine	CAFERGOT
QL	Naratriptan	AMERGE, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Rizatriptan	MAXALT, MAXALT MLT, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Sumatriptan	IMITREX, LIMITED TO 4 INJECTIONS, 9 TABLETS, OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH, SUMAVEL NON-FORMULARY
SE, QL	Eletriptan	RELPAK, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
SE, QL	Zolmitriptan	ZOMIG, ZOMIG ZMT STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
PA, QL	Dihydroergotamine	MIGRANAL, PA REQ , LIMITED TO 1 KIT (4 TREATMENTS) PER MONTH

Opiate Agonists

QL	Acetaminophen/Codeine	TYLENOL #2, #3, #4, LIMITED TO #240/MONTH OR 960ML/MONTH ; ORAL SUSPENSION AND VOPAC NON-FORMULARY
QL	Acetaminophen/Hydrocodone	NORCO 5/325, LIMITED TO #240/MONTH
QL		NORCO 7.5/325, LIMITED TO #180/MONTH
QL		NORCO 10/325, LIMITED TO #150/MONTH
		ALL OTHER HYDROCODONE/APAP STRENGTHS NON-FORMULARY
QL	Butalbital/APAP/Caffeine/Codeine	FIORICET/CODEINE, LIMITED TO #180/MONTH
QL	Butalbital/Aspirin/Caffeine/Codeine	FIORINAL/CODEINE, LIMITED TO #180/MONTH
QL	Codeine/Aspirin	EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH
QL	Hydromorphone	DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine	MSIR, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine SR	MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH
QL	Oxycodone	OXYIR, LIMITED TO #240/MONTH
QL	Oxycodone	OXYFAST, LIMITED TO #960ML/MONTH
QL	Oxycodone/Acetaminophen	PERCOCET, LIMITED TO #240/MONTH; MAGNACET AND PRIMALEV NON-FORMULARY
QL		TYLOX, LIMITED TO #240/MONTH
QL	Oxycodone/Aspirin	PERCODAN, LIMITED TO #240/MONTH
PA, QL	Oxycodone	OXYCONTIN, PA REQ , LIMITED TO #60/MONTH
	Narcotic Withdrawal Therapy Agents	
	Naloxone Spray and Syringes	NARCAN; EVZIO NON-FORMULARY
	Opiate Antagonists	
	Naltrexone	REVIA
	Miscellaneous Analgesics	
	Acetaminophen	TYLENOL
	Tramadol	ULTRAM ; ULTRAM ER NON-FORMULARY
PA, QL	Butorphanol NS	STADOL NS, PA REQ , LIMITED TO 2 BOTTLES/MONTH
	Miscellaneous Central Nervous System Agents	
	Donepezil	ARICEPT
	Anticonvulsant Agents	
	Barbiturate Anticonvulsants	
	Mephobarbital	MEBARAL
	Phenobarbital	PHENOBARBITAL
	Primidone	MYSOLINE
	Benzodiazepine Anticonvulsants	
QL	Clonazepam	KLONOPIN, LIMITED TO #90/MONTH; RAPDIS TABLETS NON-FORMULARY
	Hydantoin Anticonvulsants	
	Phenytoin	DILANTIN, PHENYTEK
	Miscellaneous Anticonvulsants	
	Carbamazepine	TEGRETOL; EQUETRO NON-FORMULARY
	Carbamazepine Extended Release	TEGRETOL XR
	Divalproex Sodium	DEPAKOTE
	Divalproex Sodium Extended Release	DEPAKOTE ER
	Gabapentin	NEURONTIN
	Levetiracetam	KEPPRA
	Oxcarbazepine	TRILEPTAL
	Tiagabine	GABITRIL
	Valproic Acid	DEPAKENE
	Zonisamide	ZONEGRAN
QL	Lamotrigine	LAMICTAL, LIMITED TO #60/MONTH FOR 100MG AND 150MG, #180/MONTH FOR 25MG

QL	Topiramate	TOPAMAX, LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS
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Antiparkinsonian Agents

Amantadine Benztropine Mesylate Bromocriptine Carbidopa/Levodopa Carbidopa/Levodopa CR Pramipexole Ropinirole Selegiline Trihexyphenidyl	SYMMETREL COGENTIN PARLODEL SINEMET; PARCOPA NON-FORMULARY SINEMET CR MIRAPEX REQUIP; REQUIP XL NON-FORMULARY SELEGILINE, ZELAPAR AND EMSAM NON-FORMULARY ARTANE
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Muscle Relaxant Agents

Skeletal Muscle Relaxants

QL	Baclofen Carisoprodol Chlorzoxazone Cyclobenzaprine Dantrolene Sodium Methocarbamol Orphenadrine Citrate Orphenadrine/Aspirin/Caffeine	LIORESAL SOMA, LIMITED TO #120/MONTH; 250 STRENGTH NON-FORMULARY PARAFON DSC FLEXERIL DANTRIUUM ROBAXIN NORFLEX NORGESIC
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Psychotherapeutic Agents

Tricyclic Antidepressant Agents

Amitriptyline Amoxapine Desipramine Doxepin Imipramine Maprotiline Nortriptyline Protriptyline	ELAVIL ASENDIN NORPRAMIN SINEQUAN TOFRANIL, TOFRANIL PM NON-FORMULARY LUDIOMIL PAMELOR VIVACTIL
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S.S.R.I. Agents

Citalopram Fluoxetine Capsules Fluvoxamine Paroxetine Sertraline	CELEXA PROZAC CAPSULES (10MG, 20MG ONLY), TABLETS NON-FORMULARY LUVOX PAXIL ZOLOFT
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S.N.R.I. Agents

QL	Duloxetine	CYMBALTA , LIMITED TO #60/MONTH
QL	Venlafaxine	EFFEXOR, LIMITED TO #60/MONTH IF DOSE ≤ 200MG/DAY, LIMITED TO #90/MONTH OF DOSE > 200MG/DAY
QL	Venlafaxine Extended Release	EFFEXOR XR, LIMITED TO #30/MONTH VENLAFAXINE EXTENDED RELEASE TABLETS NON-FORMULARY

M.A.O. Inhibitor Agents

Phenelzine Tranylcypromine	NARDIL PARNATE
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Miscellaneous Antidepressant Agents

	Bupropion	WELLBUTRIN, APLENZIN NON-FORMULARY
	Bupropion SR	WELLBUTRIN SR, APLENZIN NON-FORMULARY
	Bupropion XL	WELLBUTRIN XL, APLENZIN NON-FORMULARY
	Clomipramine	ANAFRANIL
	Mirtazapine	REMERON TAB, SOLTABS AND 7.5MG TABLETS NON-FORMULARY
	Trazodone	DESYREL
MD, QL	Nefazodone	SERZONE, RESTRICTED TO PSYCHIATRY, LIMITED TO #60/MONTH

Antimanic Agents

Lithium Carbonate

ESKALITH
LITHOBID

Benzodiazepines

QL	Alprazolam	XANAX, LIMITED TO #90/MONTH; XANAX XR, NIRAVAM, AND ALPRAZOLAM INTENSOL NON-FORMULARY
QL	Clorazepate	TRANXENE, LIMITED TO #90/MONTH
QL	Chlordiazepoxide	LIBRIUM, LIMITED TO #90/MONTH
QL	Diazepam	VALIUM, LIMITED TO #90/MONTH, DIASTAT NON-FORMULARY
QL	Flurazepam	DALMANE, LIMITED TO #30/MONTH
QL	Lorazepam	ATIVAN, LIMITED TO #90/MONTH; LORAZEPAM ORAL CONCENTRATE NON-FORMULARY
QL	Temazepam	RESTORIL, LIMITED TO #30/MONTH; 22.5MG STRENGTH NON-FORMULARY
QL	Triazolam	HALCION, LIMITED TO #30/MONTH

Antipsychotic Agents

QL	Asenapine	SAPHRIS, LIMITED TO #60 PER MONTH
QL	Aripiprazole	ABILIFY, LIMITED TO #30 PER MONTH DISCMELTS NON-FORMULARY
	Chlorpromazine	THORAZINE
	Clozapine	CLOZARIL
	Fluphenazine	PROLIXIN
	Haloperidol	HALDOL, HALDOL DECANOATE-VIALS ONLY
	Loxapine	LOXITANE
	Molindone	MOBAN
QL	Olanzapine	ZYPREXA, LIMITED TO #60/MONTH
QL		ZYPREXA ZYDIS, LIMITED TO #60/MONTH
		ZYPREXA INJECTION
		ZYPREXA RELPREVV

	Perphenazine	TRILAFON
	Pimozide	ORAP
QL	Quetiapine	SEROQUEL, LIMITED TO #90/MONTH, 25MG STRENGTH NON-FORMULARY. 25MG STRENGTH NOT COVERED FOR INSOMNIA, SUBMIT PA FOR OTHER INDICATIONS.
QL	Risperidone	RISPERDAL, LIMITED TO #60/MONTH
	Thioridazine	MELLARIL
	Thiothixene	NAVANE
	Trifluoperazine	STELAZINE
QL	Ziprasidone	GEODON, LIMITED TO #60/MONTH

Antipsychotic/SSRI Combination Agents

QL	Olanzapine/Fluoxetine HCl	SYMBYAX, LIMITED TO #30/MONTH
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Miscellaneous Anxiolytics, Sedatives, and Hypnotics

	Buspirone	BUSPAR 7.5MG STRENGTH NON-FORMULARY
	Chloral Hydrate	NOCTEC
	Hydroxyzine	ATARAX

QL	Hydroxyzine Pamoate Promethazine Zolpidem	VISTARIL PHENERGAN AMBIEN, LIMITED TO #14/MONTH, AMBIEN CR AND EDLUAR NON-FORMULARY
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CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

Antidysrhythmic Drug Agents

Amiodarone	CORDARONE; 100MG STRENGTH NON-FORMULARY
Disopyramide	NORPACE
Disopyramide CR	NORPACE CR
Flecainide	TAMBOCOR
Mexiletine	MEXITIL
Procainamide	PRONESTYL
Procainamide SR	PROCAN SR
	PROCANBID
Propafenone	RYTHMOL
Quinidine Gluconate	QUINAGLUTE
Quinidine Polygalacturonate	CARDIOQUIN
Quinidine Sulfate	CIN-QUIN
Quinidine Sulfate SR	QUINIDEX
Sotalol	BETAPACE

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

Reserpine	SERPASIL
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Beta-Adrenergic Antagonist Agents

Atenolol	TENORMIN
Metoprolol Succinate	TOPROL XL
Metoprolol Tartrate	LOPRESSOR
Nadolol	CORGARD
Pindolol	VISKEN
Propranolol	INDERAL
Propranolol LA	INDERAL LA

Combination Alpha-Beta Antagonist Agents

Carvedilol	COREG; COREG CR NON-FORMULARY
Labetalol	NORMODYNE
	TRANDATE

Angiotensin Converting Enzyme Inhibitor Agents

Benazepril	LOTENSIN
Captopril	CAPOTEN
Enalapril	VASOTEC
Lisinopril	PRINIVIL
	ZESTRIL

Angiotensin Receptor Blocker Agents

	Irbesartan	AVAPRO
	Losartan	COZAAR
	Telmisartan	MICARDIS
SE, QL	Olmesartan	BENICAR, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS
SE, QL	Valsartan	DIOVAN, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Calcium Channel Blocking Agents

Amlodipine	NORVASC, LIMITED TO #30/MONTH
Diltiazem	CARDIZEM
Diltiazem SR	CARDIZEM SR; CARDIZEM LA NON-FORMULARY
Diltiazem CD	CARTIA XT
Felodipine	PLENDIL, LIMITED TO #30/MONTH
Nifedipine, Sustained Release	ADALAT CC
Verapamil	CALAN
Verapamil LA Tablets	CALAN SR; COVERA-HS NON-FORMULARY
Verapamil SR Capsules	VERELAN

Centrally Acting Antihypertensive Agents

Clonidine	CATAPRES
Guanfacine	TENEX
Methyldopa	ALDOMET

Combination Antihypertensive Agents

	Atenolol/Chlorthalidone	TENORETIC
	Benazepril/HCTZ	LOTENSIN HCT
	Bisoprolol/HCTZ	ZIAC
	Captopril/HCTZ	CAPOZIDE
	Enalapril/HCTZ	VASORETIC
	Lisinopril/HCTZ	ZESTORETIC
	Losartan/HCTZ	PRINZIDE
SE, QL	Olmesartan/HCTZ	HYZAAR, BENICAR HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS
SE, QL	Valsartan/HCTZ	DIOVAN HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Drugs for Pheochromocytoma

PA	Phenoxybenzamine	DIBENZYLINE, PA REQUIRED
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Potassium-Sparing Diuretics

	Spironolactone	ALDACTONE
	Spironolactone/HCTZ	ALDACTAZIDE
	Triamterene	DYRENIUM
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50

Loop Diuretics

	Bumetanide	BUMEX
	Furosemide	LASIX

Thiazide and Related Diuretics

	Chlorthalidone	HYGROTON
	Hydrochlorothiazide (HCTZ)	HYDRODIURIL
	Indapamide	LOZOL
	Metolazone	ZAROXOLYN

Vasodilator Antihypertensive Agents

	Doxazosin Mesylate	CARDURA; CARDURAL XL NON-FORMULARY
	Hydralazine	APRESOLINE
	Minoxidil	LONITEN
	Prazosin	MINIPRESS
	Terazosin	HYTRIN

Antilipemic Agents

Atorvastatin	LIPITOR
Cholestyramine/Aspartame	QUESTRAN LIGHT
Cholestyramine/Sucrose	QUESTRAN
Gemfibrozil	LOPID
Lovastatin	MEVACOR
Niacin	NIACIN
Pravastatin	PRAVACHOL
Niacin, Delayed Release	NIASPAN
Niacin/Lovastatin	ADVICOR
Simvastatin	ZOCOR, 80MG STRENGTH RESTRICTED TO PRIOR USE OF 80MG DUE TO MYOPATHY RISK; ALL OTHER STRENGTHS FORMULARY

Blood Agents

Coagulants and Anticoagulants

QL	Enoxaparin	LOVENOX, LIMITED TO #20/FILL TIMES 3
	Warfarin Sodium	COUMADIN

Hemorheologic Agents

Pentoxifylline	TRENTAL
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Cardiac Glycoside Agents

Digoxin	LANOXIN; LANOXICAPS NON-FORMULARY
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Antiplatelet Agents

Cilostazole	PLETAL
Clopidogrel	PLAVIX
Dipyridamole	PERSANTINE
Pasugrel	EFFIENT

Vasodilating Agents

Isosorbide Dinitrate	ISORDIL; CHEW TABLETS NON-FORMULARY
Isosorbide Dinitrate SR	DILATRATE SR
Isosorbide Mononitrate	ISOSORBIDE MONONITRATE
Isosorbide Dinitrate ER	ISOSORBIDE MONONITRATE
Nitroglycerin Ointment	NITROL
Nitroglycerin Patches	NITRO-DUR
Nitroglycerin Spray	NITROLINGUAL SPRAY
Nitroglycerin Sublingual	NITROSTAT SL
SE	IMDUR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ISOSORBIDE DINITRATE OR ISOSORBIDE DINITRATE SR IN THE PAST 90 DAYS

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

Attapulgite	PAREPECTOLIN
Bismuth Subsalicylate	PEPTO BISMOL

Diphenoxylate/Atropine
Kaolin/Pectin

LOMOTIL
KAOPECTATE

Loperamide

IMODIUM

Antiemetic Agents

Meclizine
Metoclopramide
Ondansetron ODT Tablets
Ondansetron Tablets
Ondansetron Solution
Prochlorperazine Maleate

ANTIVERT
REGLAN
ZOFTRAN ODT
ZOFTRAN TABLETS
ZOFTRAN SOLUTION
COMPAZINE
COMPAZINE SPANSULES NOT COVERED
PHENERGAN
TIGAN

Promethazine
Trimethobenzamide

Antimuscarinic/Antispasmodic Agents

Belladonna/Phenobarbital
(Extentabs, Capsules Not Covered)
Chlordiazepoxide/Clidinium
Dicyclomine
Hyoscyamine Sulfate

DONNATAL

CHLORDIAZEPOXIDE/CLIDINIUM
BENTYL
LEVBID
LEVSIN
LEVSIN SL

Antiulcer/Antipeptic Agents

Antacid Mg OH/Al OH
Antacid Mg OH/Al OH/Simethicone
Lansoprazole 15mg OTC

MAALOX, TC
MYLANTA I, II
PREVACID 24HR,
LEGEND LANSOPRAZOLE NON-FORMULARY
CYTOTEC
PRILOSEC 20MG AND 40MG, OTHER STRENGTHS NON-FORMULARY
PRILOSEC OTC
PROTONIX
MYLICON
CARAFATE

Misoprostol
Omeprazole 20mg and 40mg

Omeprazole Magnesium
Pantoprazole Tablets
Simethicone
Sucralfate

Bowel Evacuant Agents

QL Bowel Evacuation Prep Kits

FLEET PREP KIT 1, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
FLEET PREP KIT 2, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
FLEET PREP KIT 3, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR

QL Enema

FLEET ENEMA, LIMITED TO #2 ENEMAS/MONTH AND 4 FILLS PER YEAR

QL Oral Colon Lavage Solution
Oral Saline Laxative

COLYTE
FLEET PHOSPHO-SODA, LIMITED TO #2 BOTTLES/MONTH AND 4 FILLS PER YEAR

Digestive Enzymes

Amylase/Lipase/Protease
Amylase/Lipase/Protease

PANCRELIPASE 5,000
CREON

Amylase/Lipase/Protease

PANCREAZE

Gallstone Solubilizing Agents

Ursodiol

ACTIGALL

Gastrointestinal Stimulant Agents

Metoclopramide

REGLAN

H₂ Antagonist Agents

Cimetidine

TAGAMET

Famotidine

PEPCID

Ranitidine

ZANTAC (TABLETS ONLY)

Laxative Agents

QL

Bisacodyl Suppositories

DULCOLAX, LIMITED TO #30/MONTH

Docusate Sodium Capsules

COLACE

QL

Lactulose

CEPHULAC, LIMITED TO 4L/MONTH

QL

Sennosides

CHRONULAC, LIMITED TO 4L/MONTH

SENNA

Miscellaneous Gastrointestinal Supplies

Ostomy Supplies

Miscellaneous Gastrointestinal Agents

Mesalamine

DELZICOL

ROWASA

Olsalazine

DIPENTUM

Sulfasalazine

AZULFIDINE

PA

Budesonide

ENTOCORT EC, PA REQ

ANTI-INFECTIVE AGENTS

Amebicides

Metronidazole

FLAGYL; FLAGYL ER NON-FORMULARY

Iodoquinol (Diiodohydroxyquin)

YODOXIN

Antihelmintic Agents

Albendazole

ALBENZA

Furazolidone

FUROXONE

Mebendazole

VERMOX

Praziquantel

BILTRICIDE

Antibiotic Agents

Aminoglycosides

Neomycin Sulfate

MYCIFRADIN

Cephalosporins

Cefaclor

CECLOR

	Cefadroxil	DURICEF
	Cefdinir	OMNICEF
QL	Cefixime	SUPRAX, LIMITED TO #1 X 400MG/FILL
	Cefuroxime Tablets	CEFTIN
	Cephalexin	KEFLEX; 750MG STRENGTH NON-FORMULARY
	Macrolide Antibiotic Agents	
QL	Azithromycin	ZITHROMAX, LIMITED TO A 5-DAY SUPPLY; ZMAX NON-FORMULARY
	Erythromycin Base	ERY-TAB
	Erythromycin Stearate	PCE
	Erythromycin Ethylsuccinate	ERYPED SUSPENSION
	Erythromycin/Sulfisoxazole	ERYTHROCIN
PA	Clarithromycin	EES
	Miscellaneous Antibiotic Agents	PEDIAZOLE
	Clindamycin	BIAXIN, PA REQ
	Metronidazole	CLEOCIN
	Penicillins	FLAGYL
	Amoxicillin	AMOXIL
	Amoxicillin/Potassium Clavulanate	TRIMOX
	Ampicillin	AUGMENTIN
	Dicloxacillin	PRINCIPEN
	Penicillin VK (125mg Tablets Not Covered)	DYNAPEN
	Quinolones	PEN VK
QL	Ciprofloxacin tablets	CIPRO TABLETS ONLY, LIMITED TO 21-DAY SUPPLY; CIPRO XR AND PROQUIN XR NONFORMULARY
QL	Moxifloxacin	AVELOX, LIMITED TO 21-DAY SUPPLY
	Sulfonamide Agents	
	Erythromycin/Sulfisoxazole	PEDIAZOLE
	Sulfamethoxazole/Trimethoprim (SMZ/TMP)	BACTRIM
	Sulfisoxazole	SEPTRA
	Sulfadiazine	GANTRISIN
	Trimethoprim	SULFADIAZINE
	Tetracyclines	TRIMPEX
	Doxycycline	VIBRAMYCIN
	Minocycline	VIBRA-TABS
	Tetracycline	DORYX, PERIOSTAT, AND ORACEA NON-FORMULARY
	Antifungal Agents	MINOCIN
	Clotrimazole	ACHROMYCIN V
	Fluconazole	SUMYCIN
	Griseofulvin Ultramicrosized	MYCELEX TROCHE
	Ketoconazole	DIFLUCAN
	Nystatin (Oral Powder Not Covered)	GRIS-PEG
	Terbinafine Tablets	FULVICIN P/G
		NIZORAL
		MYCOSTATIN
		LAMISIL TABLETS

Antimalarial Agents

Atovaquone/Proguanil	MALARONE
Chloroquine Phosphate	CHLOROQUINE PHOSPHATE
Hydroxychloroquine	PLAQUENIL
Iodoquinol	YODOXIN
Mefloquine	LARIAM
Primaquine	PRIMAQUINE
Pyrimethamine	DARAPRIM
Quinine (260mg Not Covered)	QUININE

Antituberculosis Agents

Ethambutol	MYAMBUTOL
Isoniazid	ISONIAZID
Pyrazinamide	PYRAZINAMIDE
Rifabutin	MYCOBUTIN
Rifampin	RIFADIN

Anti-Ulcer Eradication Agents

QL	Amoxicillin/Clarithromycin/Lansoprazole	PREVPAC, LIMITED TO 14-DAY SUPPLY/YEAR
QL	Tetracycline/Bismuth/Metronidazole	HELIDAC, LIMITED TO 14-DAY SUPPLY/YEAR

Other Antiviral Agents

	Amantadine	SYMMETREL
	Acyclovir Oral	ZOVIRAX ORAL
	Oseltamivir	TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS
	Rimantadine	FLUMADINE
	Zanamivir	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS
	Valacyclovir	VALTREX
SE	Famciclovir	FAMVIR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS

Leprostatic Agents

Clofazimine	LAMPRENE
Dapsone	DAPSONE; ACZONE NON-FORMULARY

RESPIRATORY/EENT AGENTS

Antihistamine Agents

Single Entity Alkylamine Agents

Chlorpheniramine	CHLORTRIMETON
Dexchlorpheniramine	POLARAMINE

Single Entity Ethanolamine Agents

Cyproheptadine	PERIACTIN
Diphenhydramine	BENADRYL

Non-Sedating Single Entity Agents

Cetirizine, OTC	CETIRIZINE, OTC
Fexofenadine	FEXOFENADINE
Loratadine, OTC	LORATADINE, OTC

Miscellaneous Antihistamine Agents

Hydroxyzine	ATARAX
Hydroxyzine Pamoate	VISTARIL
Promethazine	PHENERGAN

Antihistamine/Decongestant Combination Agents

Antihistamine/Decongestant Agents

Bromphen/Pseudoephedrine	BROMFED BROMFED PD
Guaifenesin/Pseudoephedrine	GUAIFED-PD
Pseudoephedrine/Chlorpheniramine	DECONAMINE SR

Antitussive Agents

Non-Narcotic Antitussive Agents

Benzonatate	TESSALON
Dextromethorphan	TUSSIN PEDIATRIC
Promethazine/Dextromethorphan	PHENERGAN W/DEXTROMETHORPHAN

Narcotic Antitussive Agents

Codeine/Chlorpheniramine/ Pseudoephedrine	NOVAHISTINE DH
Guaifenesin/Codeine	ROBITUSSIN A-C
Guaifenesin/Codeine/Pseudoephedrine	NOVAHISTINE EXPECTORANT ROBITUSSIN DAC
Phenylephrine/Hydrocodone/ Chlorpheniramine	HISTUSSIN HC
Promethazine/Codeine	ENDAL-HD
Promethazine/Phenylephrine/Codeine	PHENERGAN/CODEINE
Terpin Hydrate/Codeine	PHENERGAN VC/CODEINE
Triprolidine/Pseudoephedrine/Codeine	TERPIN HYDRATE/CODEINE ACTIFED/CODEINE

Decongestants

Pseudoephedrine	SUDAFED
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Asthma/COPD Agents

Inhaled Sympathomimetic (Adrenergic) Agents

QL	Albuterol HFA	PROVENTIL HFA , LIMITED TO #2 INHALERS/MONTH, PROAIR HFA, VENTOLIN HFA, AND XOPENEX HFA NON-FORMULARY.
QL	Albuterol/Ipratropium	COMBIVENT RESPIMAT, LIMITED TO #1 INHALER/MONTH
QL	Formoterol	FORADIL, LIMITED TO #60/MONTH
QL	Ipratropium	ATROVENT HFA
QL	Pirbuterol Acetate	MAXAIR, LIMITED TO #2 INHALERS/MONTH MAXAIR AUTOHALER, LIMITED TO #2 INHALERS/MONTH
QL	Salmeterol	SEREVENT, LIMITED TO #1 INHALER/MONTH OR #60 BLISTERS/MONTH
SE, QL	Mometasone/Formoterol	DULERA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA), ANTICHOLINERGIC, OR ANTICHOLINERGIC/LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH
SE, QL	Salmeterol/Fluticasone	ADVAIR DISKUS 250/50 STRENGTH ONLY, STEP THERAPY , RESTRICTED TO COPD AFTER A TRIAL ANTICHOLINERGIC OR LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH

Oral Sympathomimetic (Adrenergic) Agents

Albuterol	PROVENTIL
Albuterol E.R.	PROVENTIL REPETABS
	VOLMAX

Metaproterenol Oral	ALUPENT
Terbutaline Sulfate	BRETHINE BRICANYL

Inhaled Oral Corticosteroid Agents

QL	Beclomethasone Inhaler	QVAR REDIHALER, LIMITED TO #2 INHALERS/MONTH
QL	Mometasone Inhaler	ASMANEX, LIMITED TO #2 INHALERS/MONTH

Leukotriene Receptor Antagonists

QL	Montelukast	SINGULAIR, LIMITED TO #30/MONTH
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Respiratory Smooth Muscle Relaxant Agents

Aminophylline 150mg/5ml	
Aminophylline Suppositories	
Theophylline, 80mg/15cc (Alcohol Free)	SLO-PHYLLIN 80
Theophylline	SLO-PHYLLIN
Theophylline, Sustained Release	THEO-DUR, SLO-BID, UNIPHYL

Expectorant Agents

Guaifenesin	ROBITUSSIN
Guaifenesin/Dextromethorphan	ROBITUSSIN DM
Guaifenesin/Phenylephrine	ENDAL
Guaifenesin/Pseudoephedrine	ZEPHREX LA
Phenylephrine/Promethazine	PHENERGAN VC
Phenylephrine/Guaifenesin	RESCON GC
Potassium Iodide	SSKI

Mucolytic Agents

Acetylcysteine	MUCOMYST
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Eye, Ear, Nose and Throat (EENT) Preparations

Ophthalmic Antibiotic Agents

Bacitracin	BACITRACIN
Dexamethasone/Polymyxin/Neomycin	MAXITROL
Erythromycin Base	ILOTYCIN
Gentamicin	GARAMYCIN
Gentamicin/Prednisolone	PRED-G
Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN OPHTHALMIC
Neomycin/Gramicidin/Polymyxin	NEOSPORIN OPHTHALMIC
Ofloxacin	OCUFLOX
Polymixin B Sulfate/TMP	POLYTRIM
Tobramycin	TOBREX

Ophthalmic Anti-Inflammatory Agents, Corticosteroid

Fluorometholone	EFLONE FML FML FORTE
Prednisolone Acetate	PRED MILD OPHTHALMIC PRED FORTE
Prednisolone Phosphate	INFLAMASE INFLAMASE FORTE

Ophthalmic Anti-Inflammatory Agents, NSAIDs

Flurbiprofen Sodium	OCUFEN
Diclofenac Sodium	VOLTAREN
Ketorolac Tromethamine	ACULAR

Ophthalmic Antiviral Agents

Trifluridine Ophthalmic Solution	VIROPTIC
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Ophthalmic Beta Blockers

Levobunolol
Timolol

Ophthalmic Miotic Agents

Brimonidine

Dorzolamide
Dorzolamide/Timolol
Echothiophate Iodide
Pilocarpine

Ophthalmic Mydriatic Agents

Atropine Sulfate
Dipivefrin
Tropicamide

Ophthalmic Sulfonamide Agents

Sulfacetamide

Sulfacetamide 10%/Prednisolone 0.2%
Sulfacetamide 10%/Prednisolone 0.5%

Miscellaneous Ophthalmic Agents

Ketotifen
Latanoprost
Naphazoline
Naphazoline/Pheniramine

Otic Anti-Infective Agents

Acetic Acid
Acetic Acid 2%
Acetic Acid 2%/Hydrocortisone 1%
Hydrocortisone/Neomycin/Polymyxin
Ofloxacin

Miscellaneous Otic Agents

Benzocaine/Antipyrine
Carbamide Peroxide/Glycerin

BETAGAN
TIMOPTIC

ALPHAGAN
ALPHAGAN P
TRUSOPT
COSOPT
PHOSPHOLINE IODIDE
PILOCAR
OCUSERT NOT COVERED

ISOPTO ATROPINE
PROPINE
MYDRIACYL

BLEPH-10
SODIUM SULAMYD
BLEPHAMIDE
METIMYD

ZADITOR OTC, ALAWAY
XALATAN
ALBALON
NAPHCON-A

VOSOL
DOMEBORO
VOSOL HC
CORTISPORIN
FLOXIN OTIC

AURALGAN
DEBROX

Inhaled/Oral EENT Agents

Inhaled Nasal Agents

Fluticasone, Nasal
Triamcinolone, Nasal
Ipratropium, Nasal

QL

Carbonic Anhydrase Inhibitor Agents

Acetazolamide
Acetazolamide SA
Methazolamide

Local Anesthetic Agents

Benzocaine/Antipyrine Otic
Lidocaine Solution
Lidocaine, Viscous
Triamcinolone 0.1% in Orabase

FLONASE
NASACORT
ATROVENT, LIMITED TO #2 DEVICES/MONTH

DIAMOX
DIAMOX SEQUELS
NEPTAZANE

AURALGAN
XYLOCAINE
VISCIOUS XYLOCAINE
KENALOG IN ORABASE

Miscellaneous EENT Agents

Carbachol
Chlorhexidine Gluconate
Cromolyn Ophthalmic Solution
Epinephrine Injection
Optichamber

QL

ISOPTO CARBACHOL
PERIDEX
CROLOM
EPIPEN
OPTICHAMBER, LIMITED TO #2/YEAR

Sodium Chloride for Inhalation
Triethanolamine

GENERIC
CERUMENEX

DIABETES AND THYROID AGENTS

Oral Diabetes Agents

Sulfonylureas

Glipizide
Glipizide L.A.
Glyburide

GLUCOTROL
GLUCOTROL XL
DIABETA, GLYNASE
MICRONASE
AMARYL
DIABINESE
TOLINASE
ORINASE

Glimepiride
Chlorpropamide
Tolazamide
Tolbutamide

Non-Sulfonylureas

Acarbose
Metformin
Metformin ER
Pioglitazone
Alogliptin

PRECOSE
GLUCOPHAGE
GLUCOPHAGE XR
ACTOS

SE, QL

NESINA, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH

SE, QL

Sitagliptin

JANUVIA, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH

Combination Diabetes Agents

Glipizide/Metformin
Glyburide/Metformin
Alogliptin/Metformin

SE, QL

METAGLIP
GLUCOVANCE
KAZANO, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR ALOGLIPTIN IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH

SE, QL

Sitagliptin/Metformin

JANUMET, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH

SE, QL

Sitagliptin/Metformin Extended Release

JANUMET XR, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 30 TABLETS/MONTH EXCEPT JANUMET XR 50-1000, WHICH IS LIMITED TO 60 TABLETS/MONTH

Insulin Agents

Insulin
Insulin Lispro
Insulin Glargine

ALL LILLY INSULINS, VIALS ONLY
HUMALOG, HUMALOG MIX, VIALS AND PENS
LANTUS, VIALS ONLY

Miscellaneous Diabetes Agents

Glucagon

GLUCAGON

Thyroid Agents

Levothyroxine
Liotrix
Liothyronine

LEVOTHROID
THYROLAR
CYTOMEL

Thyroid, Desiccated

ARMOUR THYROID
LEVOXYL
SYNTHROID

Antithyroid Agents

Methimazole
Propylthiouracil

TAPAZOLE
PROPYLTHIOURACIL

HORMONE AGENTS

Oral Adrenal Corticosteroid Agents

Cortisone Acetate
Dexamethasone
Fludrocortisone Acetate
Hydrocortisone Oral
Methylprednisolone
Prednisone

CORTONE
DECADRON
FLORINEF
CORTEF
MEDROL
DELTASONE
ORASONE
MEDROL DOSEPAK
PEDIAPRED
PRELONE

Prednisolone

Androgen Agents

Danazol
Fluoxymesterone
Methyltestosterone

DANOCRINE
HALOTESTIN
ANDROID
METANDREN

Bone Resorption Inhibitors

QL Alendronate

FOSAMAX,
70MG AND 35MG LIMITED TO #4/MONTH;
5MG, 10MG, AND 40MG LIMITED TO #30/MONTH;
SOLUTION LIMITED TO #300ML/MONTH
FOSAMAX PLUS D NONFORMULARY
MIACALCIN NS, **PA REQ**

PA Calcitonin

Parathyroid Hormone

PA, QL Teriparatide

FORTEO, **PA REQ**, LIMITED TO 1 PEN/MONTH

Estrogen Agents

Conjugated Estrogens
Conjugated Estrogens, Vaginal
Estradiol
Estradiol Patches

PREMARIN
PREMARIN VAGINAL CREAM
ESTRACE
ALORA
CLIMARA
ESTRADERM
VIVELLE
VIVELLE DOT
PREMPRO, PREMPRO LOW DOSE
PREMPHASE

Estrogen/Medroxyprogesterone

ESTRATEST, ESTRATEST HS
ESTRING, **STEP THERAPY**, RESTRICTED TO USE AFTER A
TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS

SE Esterified Estrogens/ Methyltestosterone
Estradiol/Vaginal Ring

Estrogen Agonist-Antagonists

Raloxifene	EVISTA
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Contraceptives

Contraceptives are not a covered benefit.

Oxytocic Agents

Ergonovine Maleate	ERGOTRATE
Methylergonovine Maleate	METHERGINE

Pituitary Agents

Desmopressin	DDAVP
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Progestin Agents

Medroxyprogesterone	CYCRIN
	PROVERA
Norethindrone Acetate	AYGESTIN
	NORLUTATE

GENITOURINARY AGENTS

Urinary Anti-Infective Agents

Meth/Me Blue/PA/Salol/ATP/Hyos	URISED
Nitrofurantoin (Tablets, Suspension Only)	FURADANTIN
Trimethoprim	TRIMPEX

Urinary Anti-Spasmotic Agents

Pentosan	ELMIRON
Phenazopyridine	PYRIDIUM

Genitourinary Smooth Muscle Relaxant Agents

	Belladonna/Methylene Blue	URISED
	Oxybutynin	DITROPAN
		DITROPAN XL NOT COVERED
ST, QL	Tolterodine	DETROL, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS
ST, QL		DETROL LA, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS

Parasympathomimetic (Cholinergic) Agents

Bethanechol	URECHOLINE
Neostigmine	PROSTIGMIN
Pyridostigmine	MESTINON

TOPICAL/MUCOUS MEMBRANE AGENTS

Keratolytic Agents

Anthralin

DRITHOCREME

Podofilox

DRITHO-SCALP

CONDYLOX

Miscellaneous Skin/Mucous Membrane Agents

Aluminum Acetate

BURROWS SOLUTION

Aluminum Chloride Hexahydrate

DRYSOL

Benzoyl Peroxide, OTC Generic

BENZOYL PEROXIDE, OTC GENERIC

Calamine

CALAMINE LOTION

Calcipotriene

DOVONEX

Fluorouracil

EFUDEX

Hydrocortisone 1% Rectal

PROCTOCORT

Masoprocol

ACTINEX

PA

Becaplermin

REGRANEX, **PA REQ**

PA

Isotretinoin

AC CUTANE, **PA REQ**

Topical Antibiotic Agents

Bacitracin

BACITRACIN

Bacitracin/Polymixin/Neomycin

NEOSPORIN

Clindamycin Solution

CLEOCIN T

Erythromycin Topical

ERYGEL

EMGEL

T-STAT

Erythromycin/Benzoyl Peroxide

BENZAMYCIN

Gentamicin Sulfate

GARAMYCIN

Mupirocin

BACTROBAN

Silver Sulfadiazine

SILVADENE

Topical Antifungal Agents

Clotrimazole

LOTRIMIN

Clotrimazole/Betamethasone

LOTRISONE

Ciclopirox

LOPROX

Ketoconazole

NIZORAL

Miconazole Nitrate

MONISTAT-DERM

Nystatin

MYCOSTATIN

Terbinafine

LAMISIL

Tolnaftate

TINACTIN

Triamcinolone/Nystatin

MYCOLOG II

Vaginal Antifungal Agents

Butoconazole

FEMSTAT

Clotrimazole Cream/Vaginal Tablets

MYCELEX

MYCELEX G

Nystatin

MYCOSTATIN

Miconazole Cream/Vaginal Tablets

MONISTAT

MONISTAT 3

Triple Sulfa Cream

SULTRIN

Tioconazole

VAGISTAT-1

Vaginal Anti-Infective Agents

Metronidazole

METROGEL-VAGINAL

Topical Anti-Inflammatory Agents

LOW POTENCY

Fluocinolone 0.025%

Desonide

Hydrocortisone

Hydrocortisone Enema

Hydrocortisone Acetate

Hydrocortisone/Pramoxine

SYNALAR

TRIDESILON

HYTONE

CORTENEMA

CORTIFOAM

PROCTOCREAM-HC

MEDIUM POTENCY

Betamethasone Dipropionate

Betamethasone Valerate 0.01%

Betamethasone Valerate 0.1%

Desoximetasone Cream/Gel 0.05%

Flurandrenolide

Hydrocortisone Valerate

Mometasone Furoate Cream

Triamcinolone

DIPROSONE

MAXIVATE

VALISONE REDUCED STRENGTH

VALISONE

TOPICORT LP

CORDRAN

WESTCORT

ELOCON

ARISTOCORT

ARISTOCORT A NOT COVERED

KENALOG

HIGH POTENCY

Betamethasone Dipropionate

Desoximetasone 0.25%

Fluocinonide

Fluocinolone Acetonide 0.2%

VERY HIGH POTENCY

Augmented Betamethasone

Dipropionate

Clobetasol Cream, Gel, Solution,
Ointment

Diflorasone Diacetate

DIPROLENE

TOPICORT

LIDEX

LIDEX E

SYNALAR

DIPROLENE AF

TEMOVATE

FLORONE

FLORONE-E

PSORCON

Topical Antipruritic and Local Anesthetic Agents

Lidocaine (Viscous and Spray Only)

Pramoxine/Hydrocortisone

Pramoxine

Pimecrolimus

Tacrolimus

XYLOCAINE

PROCTOFOAM HC

EPIFOAM

ELIDEL, **PA REQ**

PROTOPIC, **PA REQ**

PA

PA

Topical Antiviral Agents

Acyclovir Topical

ZOVIRAX OINTMENT

Topical Miscellaneous Anti-Infective Agents

Selenium Sulfide 2.5%

Sulfacetamide Lotion

EXSEL

SELSUN

SEBIZON

Scabicide/Pediculicide Agents

Crotamiton
Malathion
Permethrin

EURAX
OVIDE
ELIMITE
NIX

MISCELLANEOUS/UNCLASSIFIED AGENTS

Electrolyte Agents

Miscellaneous Agents

Calcium Acetate
Calcium Carbonate
Magnesium Oxide, OTC Generic

PHOS LO
TUMS
MAGNESIUM OXIDE, OTC GENERIC

Potassium Agents

Potassium Chloride 8mEq
Potassium Chloride
Potassium Chloride 10mEq
Potassium Chloride

MICRO-K

KAON-CL 10
K-DUR
MICRO-K 10

Potassium Chloride 20mEq
Potassium Chloride

K-DUR

<i>Potassium Chloride Effervescent Tablets</i>	
Potassium Chloride Tablets	K-LYTE
Potassium Chloride Tablets	K-LYTE CL DS
<i>Potassium Chloride Powders</i>	
Potassium Chloride Powder	K-LOR
<i>Potassium Chloride Liquids</i>	
Potassium Chloride Liquid	KAON-CL
<i>Potassium-Removing Resins</i>	
Sodium Polystyrene Sulfonate	KAYEXALATE

Heavy Metal Antagonist Agents

Penicillamine	CUPRIMINE
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Vitamin Agents

Vitamin B-Complex Agents

Cyanocobalamin	VITAMIN B ₁₂ (ORAL FORMULATIONS ONLY)
Folic Acid	FOLIC ACID
Niacin	NIACIN
Pyridoxine	VITAMIN B ₆
Thiamine	VITAMIN B ₁

Vitamin D

Calcitriol	ROCALTROL
Ergocalciferol	DRISDOL

Vitamin K Activity Agents

Phytonadione	MEPHYTON
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Iron Agents

Ferrous Sulfate (Tablets, Liquid, Drops)	FEOSOL
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Diagnostic Testing

Blood Glucose Supplies

QL	Alcohol Swabs	LIMITED TO 200/MONTH
	Blood Glucose Monitoring Control Solution	BLOOD GLUCOSE MONITORING CONTROL SOLUTION, ROCHE PRODUCTS (E.G., ACCU-CHEK) ONLY
QL	Blood Glucose Test Strips	BLOOD GLUCOSE TEST STRIPS, ROCHE STRIPS (E.G., ACCU-CHEK) ONLY , LIMITED TO 100 STRIPS/MONTH FOR MEMBERS THAT ARE DIET-CONTROLLED OR ON ORAL AGENTS. MEMBERS ON INSULIN LIMITED TO 150 STRIPS/MONTH. LARGER QUANTITIES AVAILABLE VIA PRIOR AUTHORIZATION
	Glucometers	GLUCOMETERS, ROCHE METERS (E.G., ACCU-CHEK) ONLY
	Lancets	

Alcohol And Smoking Deterrent Agents

PA	Bupropion SR	ZYBAN, PA REQ
	Disulfiram	ANTABUSE
PA	Nicotine	NICORETTE GUM, PA REQ
PA		NICOTINE PATCH, PA REQ (OTC PATCHES ONLY)
PA		NICOTROL NASAL SPRAY, PA REQ

Gout Agents

Allopurinol	ZYLOPRIM
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QL	Colchicine	COLCRYS, LIMITED TO 1 TABLET/DAY. PATIENTS WHO FAIL 1 TABLET/DAY MAY RECEIVE 2 TABLETS/DAY.
	Probenecid	BENEMID

Other Medical Supplies

Limited medical supplies are available through the pharmacy benefit. For additional information, contact MedImpact at (800) 788-2949. The following exceptions should be noted:

- Durable medical equipment (e.g., wheelchairs, walkers, canes, crutches) are filled through the medical benefit. Path to Health / Connect to Care does not provide coverage for contraceptive medical supplies (e.g., diaphragms, cervical caps, condoms).

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