

CIGNA Medicare Select Plus Rx® (HMO)

A Medicare Advantage HMO Medical Plan with Part D Prescription Drug Coverage

CIGNA Medicare Select Plus Rx® (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.

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.

CIGNA HealthCare of Arizona, Inc. is a Medicare Advantage Organization with a Medicare contract that offers various individual plans (including the CIGNA Medicare Select Plus Rx – Dual (HMO SNP) plan, which is a Coordinated Care plan offered without a contract with the Arizona Medicaid program).

This information is available in a different format, including Spanish and Braille. Please call Customer Service if you need plan information in another format or language.

Esta información está disponible en un formato diferente, incluso en español y braille. Si necesita información sobre el plan en otro formato o idioma, llame al Servicio de Atención al Cliente.



CIGNA

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What is the CIGNA Medicare Rx Select Plus Rx Formulary?

A formulary is a list of covered drugs selected by CIGNA Medicare Select Plus Rx 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. CIGNA Medicare Select Plus Rx will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a CIGNA Medicare Select Plus Rx network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

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

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of

the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2012. To get updated information about the drugs covered by CIGNA Medicare Select Plus Rx, please visit our website at www.cignamedicare.com or call Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

Our plan's printed formulary document will be updated for any mid-year, non maintenance changes via errata sheets in the event that we 1) remove a drug from our formulary, 2) increase the cost share of a formulary drug, or 3) add utilization management edits to a formulary drug **and** no new alternate drug is offered by our plan as a possible replacement for any of the previously described formulary changes. All affected members currently taking a formulary drug which will have one or more of the previously described formulary changes will be exempt from the formulary change(s) for the remainder of the coverage year.

How do I use the Formulary?

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

Medical Condition

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

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index 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?

CIGNA Medicare Select Plus Rx 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:** CIGNA Medicare Select Plus Rx requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from CIGNA Medicare Select Plus Rx before you fill your prescriptions. If you don't get approval, CIGNA Medicare Select Plus Rx may not cover the drug.
- **Quantity Limits:** For certain drugs, CIGNA Medicare Select Plus Rx limits the amount of the drug that CIGNA Medicare Select Plus Rx will cover. For example, CIGNA Medicare Select Plus Rx provides coverage for up to 1 tablet per day per prescription for Crestor 10 mg tablets. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, CIGNA Medicare Select Plus Rx 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, CIGNA Medicare Select Plus Rx may not cover Drug B unless you try Drug A first. If Drug A does not work for you, CIGNA Medicare Select Plus Rx 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 6. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.cignamedicare.com.

You can ask CIGNA Medicare Select Plus Rx to make an exception to these restrictions or limits. See the section, "How do I request an exception to the CIGNA Medicare Select Plus Rx formulary?" on page 2 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 formulary you should first contact Customer Service and confirm that your drug is not covered.

If you learn that CIGNA Medicare Select Plus Rx does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by CIGNA Medicare Select Plus Rx. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by CIGNA Medicare Select Plus Rx.
- You can ask CIGNA Medicare Select Plus Rx 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 CIGNA Medicare Select Plus Rx Formulary?

You can ask CIGNA Medicare Select Plus Rx 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, CIGNA Medicare Select Plus Rx limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Non-Preferred Brand Drugs Tier 3, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand Drugs Tier 2 instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Tier Drugs Tier 4.

Generally, CIGNA Medicare Select Plus Rx 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 physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's or 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 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 31-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 31-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 a prescription until we have provided you with a 102-day transition supply, consistent with dispensing increment (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

An extended transition process is provided to circumstances involving level of care changes in which a beneficiary is changing from one treatment setting to another. An override for refill too soon edit would be provided to allow appropriate coverage. Since there may exist some period of time in which beneficiaries with level of care changes have a temporary gap in coverage while going through a process, our transition policy would allow coverage for one fill with up to a 31-day supply of medication.

For more information

For more detailed information about your CIGNA Medicare Select Plus Rx prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about CIGNA Medicare Select Plus Rx, please call Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816. Or, visit www.cignamedicare.com.

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/seven days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

CIGNA Medicare Select Plus Rx's Formulary

The formulary that begins on page 6 provides coverage information about some of the drugs covered by CIGNA Medicare Select Plus Rx. If you have trouble finding your drug in the list, turn to the Index that begins on page 42.

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

The information in the Requirements/Limits column tells you if CIGNA Medicare Select Plus Rx has any special requirements for coverage of your drug.

2012 Comprehensive Formulary Copay/Coinsurance Tables

CIGNA Medicare Select Plus Rx[®] – Standard (HMO) CIGNA Medicare Select Plus Rx[®] – Premium (HMO)

State	Initial Coverage Level Copays/Coinsurance						
	Tiers	30-Day Retail	90-Day Retail	30-Day Preferred Mail Order	90-Day Preferred Mail Order	30-Day Out-of-Network	31-Day LTC
AZ	1*	\$5.00	\$15.00	\$5.00	\$12.50	\$5.00	\$5.00
	2	\$45.00	\$135.00	\$45.00	\$112.50	\$45.00	\$45.00
	3	\$75.00	\$225.00	\$75.00	\$187.50	\$75.00	\$75.00
	4	25%	25%	25%	25%	25%	25%

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

CIGNA Medicare Select Plus Rx[®] – Dual (HMO SNP)

State	Initial Coverage Level Copays						
	Tiers	30-Day Retail	90-Day Retail	30-Day Preferred Mail Order	90-Day Preferred Mail Order	30-Day Out-of-Network	31-Day LTC
AZ	1	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60
	2	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50
	3	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50
	4	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50

Cost-sharing is based on your level of Medicaid eligibility.

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Cost-Sharing Tier Description. Please refer to page 5 for applicable copay/cost-share amounts.

Tier 1: Generic Drugs. This grouping represents the lowest cost-sharing.

Tier 2: Preferred Brand Drugs.

Tier 3: Non-Preferred Brand Drugs.

Tier 4: Specialty Tier Drugs. This grouping represents the highest cost-sharing.

Symbol Key – Utilization Management Requirements/Limits

B vs D: Coverage determination for Part B or Part D required. Note: Inhalant solutions used in a nebulizer are only covered under Part D when the member is located in a long term care (LTC) setting.

GC: Gap coverage. 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.

HI: This prescription drug may be covered under our medical benefit. For more information, call Customer Service at 1-800-627-7534, seven days a week, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

PA: Prior authorization is required.

QL: Quantity limits apply.

RA : Restricted Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

ST: Step therapy is required.

Generally all medications on the formulary are available through mail order except when special circumstances or situations prohibit mailing a particular medication to your home.

Drug Name	Drug Tier	Requirements/ Limits
Analgesics		
<i>acetaminophen/codeine</i>	1	GC
<i>ascomp/codeine</i>	1	GC
<i>astramorph</i>	1	GC
AVINZA	3	QL (60 per 30 days)
BUPRENEX	3	
<i>buprenorphine hcl</i>	1	GC
<i>butalbital/acetaminophen/ caffeine/codeine</i>	1	GC
<i>butorphanol tartrate injection</i>	1	GC
<i>butorphanol tartrate nasal solution</i>	1	QL (5 per 30 days) GC
CAPITAL/CODEINE	2	

Drug Name	Drug Tier	Requirements/ Limits
<i>co-gesic</i>	1	GC
<i>codeine sulfate</i>	1	GC
DEMEROL INJECTION	3	
DILAUDID-5	3	
DILAUDID TABLET	3	
DURAMORPH	3	
EMBEDA	3	QL (60 per 30 days)
<i>endocet</i>	1	GC
<i>fentanyl citrate</i>	1	B vs D GC
<i>fentanyl citrate oral transmucosal 200mcg</i>	1	QL (120 per 30 days) PA GC
<i>fentanyl citrate oral transmucosal 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg</i>	4	QL (120 per 30 days) PA

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Drug Name	Drug Tier	Requirements/ Limits
<i>fentanyl patch</i>	1	QL (20 per 30 days) GC
HYCET	3	
<i>hydrocodone/ acetaminophen</i>	1	GC
<i>hydrocodone/ibuprofen</i>	1	GC
<i>hydromorphone hcl</i>	1	GC
INFUMORPH	3	
KADIAN	2	QL (60 per 30 days)
<i>levorphanol tartrate</i>	1	GC
<i>margesic-h</i>	1	GC
<i>maxidone</i>	1	GC
<i>meperidine hcl</i>	1	GC
<i>methadone hcl</i>	1	GC
<i>methadose</i>	1	GC
<i>morphine sulfate</i>	1	GC
<i>morphine sulfate er 15mg, 30mg</i>	1	QL (180 per 30 days) GC
<i>morphine sulfate er 60mg, 100mg, 200mg</i>	1	QL (120 per 30 days) GC
<i>nalbuphine hcl</i>	1	B vs D GC
ONSOLIS	4	QL (120 per 30 days) PA
OPANA	3	
OPANA ER 5MG, 10MG, 20MG, 30MG	2	QL (60 per 30 days)
OPANA ER 40MG	2	QL (120 per 30 days)
<i>oxycodone hcl</i>	1	GC
<i>oxycodone hcl/ acetaminophen</i>	1	GC
<i>oxycodone hcl/aspirin</i>	1	GC
<i>oxycodone hcl/ibuprofen</i>	1	GC
OXYCONTIN 10MG, 15MG, 20MG, 30MG, 40MG, 60MG	2	QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
OXYCONTIN 80MG	2	QL (120 per 30 days)
<i>oxymorphone hydrochloride</i>	1	GC
<i>pentazocine/acetaminophen</i>	1	GC
<i>pentazocine/naloxone hcl</i>	1	GC
<i>reprexain</i>	1	GC
<i>roxicet</i>	1	GC
ROXICODONE TABLET 15MG, 30MG	3	
STADOL	2	PA
<i>stagesic</i>	1	GC
SYNALGOS-DC	2	
TALWIN	3	B vs D
<i>tramadol hcl</i>	1	GC
<i>tramadol hcl er</i>	1	GC
<i>tramadol hcl/ acetaminophen</i>	1	GC
XODOL	3	
<i>zerlor</i>	1	GC
Anesthetics		
<i>lidocaine hcl</i>	1	GC
<i>lidocaine hcl jelly</i>	1	GC
<i>lidocaine hcl ointment 5%</i>	1	B vs D GC
<i>lidocaine hcl viscous</i>	1	GC
<i>lidocaine/prilocaine</i>	1	B vs D GC
LIDODERM	2	QL (90 per 30 days)
SYNERA	3	B vs D
Antibacterials		
AKNE-MYCIN	2	
ALTABAX	3	
<i>amikacin sulfate</i>	1	HI
<i>amoxicillin</i>	1	GC
<i>amoxicillin/potassium clavulanate</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>ampicillin</i>	1	GC
<i>ampicillin sodium</i>	1	GC
<i>ampicillin sodium/ sulbactam</i>	1	HI
AVELOX INJECTION	2	
AVELOX TABLET	2	QL (30 per 30 days)
AZACTAM	3	HI
AZACTAM IN ISO-OSMOTIC DEXTROSE 1GM	3	HI
AZACTAM IN ISO-OSMOTIC DEXTROSE 2GM	4	HI
<i>azithromycin injection, suspension</i>	1	GC
<i>azithromycin tablet 250mg</i>	1	QL (12 per 30 days) GC
<i>azithromycin tablet 500mg, 600mg</i>	1	GC
<i>aztreonam</i>	1	HI
<i>bacim</i>	1	GC
<i>bacitracin</i>	1	GC
<i>bactocill in dextrose</i>	1	HI
BICILLIN C-R	2	
BICILLIN L-A	3	
BLEPH-10	3	
CAYSTON	4	
CEDAX	3	
<i>cefaclor</i>	1	GC
<i>cefaclor er</i>	1	GC
<i>cefadroxil</i>	1	GC
<i>cefazolin sodium</i>	1	HI
<i>cefdinir</i>	1	GC
<i>cefepime</i>	1	HI
<i>cefotaxime sodium</i>	1	GC
<i>cefotetan</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>cefoxitin sodium</i>	1	GC
<i>cefpodoxime proxetil</i>	1	GC
<i>cefprozil</i>	1	GC
<i>ceftazidime</i>	1	GC
CEFTIN	3	
<i>ceftriaxone sodium</i>	1	GC
<i>cefuroxime axetil</i>	1	GC
<i>cefuroxime sodium</i>	1	GC
<i>cefuroxime/dextrose</i>	1	GC
<i>cephalexin</i>	1	GC
<i>chloramphenicol sodium succinate</i>	1	GC
CIPRO IV	3	
<i>ciprofloxacin</i>	1	GC
<i>ciprofloxacin er</i>	1	GC
<i>ciprofloxacin hcl</i>	1	GC
CLAFORAN	2	
<i>clarithromycin</i>	1	GC
<i>clarithromycin er</i>	1	GC
CLEOCIN CAPSULE 75MG	3	
CLEOCIN GALAXY	3	
CLEOCIN PEDIATRIC GRANULES	3	
CLEOCIN PHOSPHATE SOLUTION 900MG/6ML	3	
CLEOCIN SUPPOSITORY	3	
<i>clindamycin hcl</i>	1	GC
<i>clindamycin phosphate</i>	1	GC
<i>colistimethate sodium</i>	1	GC
COLY-MYCIN M	3	
CORTISPORIN CREAM, OINTMENT	2	
CUBICIN	4	HI

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Drug Name	Drug Tier	Requirements/ Limits
<i>demeclocycline hcl</i>	1	GC
<i>dicloxacillin sodium</i>	1	GC
DORIBAX	3	HI
DORYX	3	
<i>doxycycline hyclate</i>	1	GC
<i>doxycycline monohydrate</i>	1	GC
<i>e.e.s.</i>	1	GC
<i>ery</i>	1	GC
<i>ery-tab</i>	1	GC
ERYPED	2	
<i>erythrocin lactobionate</i>	1	GC
<i>erythrocin stearate</i>	1	GC
<i>erythromycin</i>	1	GC
<i>erythromycin base</i>	1	GC
<i>erythromycin ethylsuccinate</i>	1	GC
<i>erythromycin/sulfisoxazole</i>	1	GC
FACTIVE	3	QL (30 per 30 days)
FLAGYL ER	3	
FORTAZ	2	
FURADANTIN	2	
<i>gentamicin isotonic</i>	1	GC
<i>gentamicin sulfate</i>	1	GC
<i>gentamicin sulfate/sodium chloride</i>	1	GC
HELIDAC	3	
INVANZ	3	HI
<i>kanamycin sulfate</i>	1	GC
KETEK	3	
<i>levofloxacin</i>	1	QL (30 per 30 days) GC
LINCOCIN	2	
MACRODANTIN CAPSULE 25MG	3	

Drug Name	Drug Tier	Requirements/ Limits
<i>meropenem</i>	1	HI
MERREM	3	HI
<i>methenamine hippurate</i>	1	GC
METROGEL	2	
METROGEL-VAGINAL	3	
<i>metronidazole</i>	1	GC
<i>metronidazole vaginal</i>	1	GC
MINOCIN	3	
<i>minocycline hcl</i>	1	GC
MONUROL	3	
<i>nafcillin sodium</i>	1	HI
NALLPEN/DEXTROSE	2	HI
<i>neomycin sulfate</i>	1	GC
<i>neomycin sulfate/bacitracin/polymyxin</i>	1	GC
<i>neomycin sulfate/polymyxin b sulfates</i>	1	GC
<i>nitrofurantoin macrocrystalline</i>	1	GC
<i>nitrofurantoin monohydrate</i>	1	GC
<i>nitrofurantoin suspension</i>	1	GC
NOROXIN	3	
<i>ofloxacin</i>	1	GC
ORACEA	3	
<i>oxacillin sodium</i>	1	HI
<i>paromomycin sulfate</i>	1	GC
PCE	2	
<i>penicillin g potassium</i>	1	HI
<i>penicillin g procaine</i>	1	GC
<i>penicillin g sodium</i>	1	GC
<i>penicillin v potassium</i>	1	GC
<i>pfizerpen-g</i>	1	HI
PHISOHEX	3	

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Drug Name	Drug Tier	Requirements/ Limits
<i>piperacillin sodium</i>	1	GC
<i>piperacillin sodium/ tazobactam sodium</i>	1	HI
<i>polycin b</i>	1	GC
<i>polymyxin b sulfate</i>	1	GC
POLYTRIM	3	
PREVPAC	3	QL (28 per 30 days)
PRIMAXIN IM	3	
PRIMAXIN IV 250MG/250MG	2	HI
PRIMAXIN IV 500MG/500MG	3	HI
PRIMSOL	3	
SILVADENE	3	
<i>silver sulfadiazine</i>	1	GC
<i>sodium sulfacetamide</i>	1	GC
SPECTRACEF	3	
<i>ssd</i>	1	GC
<i>streptomycin sulfate</i>	1	GC
<i>sulfadiazine</i>	1	GC
<i>sulfamethoxazole/ trimethoprim</i>	1	GC
<i>sulfamethoxazole/ trimethoprim ds</i>	1	GC
SULFAMYLON	2	
SUPRAX	3	
SYNERCID	4	
<i>tazicef</i>	1	GC
TEFLARO	4	HI
<i>tetracycline hcl</i>	1	GC
<i>thermazene</i>	1	GC
TIMENTIN	3	HI
TOBI	4	B vs D
<i>tobramycin sulfate</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>tobramycin sulfate/sodium chloride</i>	1	GC
<i>trimethoprim</i>	1	GC
TYGACIL	3	HI
UNASYN	2	HI
VANOCIN HCL 125MG	4	QL (40 per 10 days)
VANOCIN HCL 250MG	4	QL (80 per 10 days)
<i>vancomycin hcl injection 500mg</i>	1	B vs D GC
<i>vancomycin hcl injection 1gm, 10gm</i>	1	HI
VANDAZOLE	3	
VIBATIV	3	HI
XIFAXAN 200MG	3	QL (90 per 30 days) PA
XIFAXAN 550MG	4	QL (60 per 30 days) PA
ZINACEF	2	
ZMAX	3	QL (120 per 30 days)
ZOSYN	2	HI
ZYMAR	3	ST
ZYVOX	4	PA
Anticonvulsants		
BANZEL SUSPENSION	3	
BANZEL TABLET 200MG	3	
BANZEL TABLET 400MG	4	
<i>carbamazepine</i>	1	GC
<i>carbamazepine er</i>	1	GC
CARBATROL	3	
CELONTIN	3	
DEPACON	2	
DILANTIN CAPSULE 30MG	2	
DILANTIN CAPSULE 100MG	3	
DILANTIN INFATABS	2	

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Drug Name	Drug Tier	Requirements/ Limits
DILANTIN SUSPENSION	3	
<i>divalproex sodium</i>	1	GC
<i>epitol</i>	1	GC
<i>ethosuximide</i>	1	GC
FELBATOL SUSPENSION	4	
FELBATOL TABLET	3	
<i>fosphenytoin sodium</i>	1	GC
<i>gabapentin</i>	1	GC
GABITRIL	3	
KEPPRA INJECTION	3	
LAMICTAL	2	
LAMICTAL CHEWABLE	2	
LAMICTAL ODT	2	
LAMICTAL STARTER KIT	2	
LAMICTAL XR	2	
<i>lamotrigine</i>	1	GC
<i>levetiracetam</i>	1	GC
LYRICA	2	QL (60 per 30 days)
NEURONTIN SOLUTION	3	
<i>oxcarbazepine</i>	1	GC
PEGANONE	2	
PHENYTEK	2	
<i>phenytoin</i>	1	GC
<i>phenytoin sodium</i>	1	GC
<i>phenytoin sodium extended</i>	1	GC
<i>primidone</i>	1	GC
SABRIL	4	
<i>topiramate</i>	1	GC
<i>valproate sodium</i>	1	GC
<i>valproic acid</i>	1	GC
VIMPAT	3	
<i>zonisamide</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
Antidementia Agents		
ARICEPT TABLET 23MG	2	QL (30 per 30 days)
<i>donepezil hcl</i>	1	QL (30 per 30 days) GC
<i>ergoloid mesylates</i>	1	GC
EXELON PATCH	2	QL (30 per 30 days)
EXELON SOLUTION	2	QL (180 per 30 days)
<i>galantamine hydrobromide capsule er</i>	1	QL (30 per 30 days) GC
<i>galantamine hydrobromide solution</i>	1	QL (180 per 30 days) GC
<i>galantamine hydrobromide tablet</i>	1	QL (60 per 30 days) GC
NAMENDA SOLUTION	2	QL (300 per 30 days)
NAMENDA TABLET	2	QL (60 per 30 days)
NAMENDA TITRATION PAK	2	QL (49 per 30 days)
<i>rivastigmine tartrate</i>	1	QL (60 per 30 days) GC
Antidepressants		
<i>amitriptyline hcl</i>	1	GC
<i>amoxapine</i>	1	GC
APLENZIN	3	QL (30 per 30 days)
<i>budeprion sr</i>	1	QL (60 per 30 days) GC
<i>budeprion xl</i>	1	QL (30 per 30 days) GC
<i>bupropion hcl</i>	1	GC
<i>bupropion hcl sr</i>	1	QL (60 per 30 days) GC
<i>chlordiazepoxide/ amitriptyline</i>	1	GC
<i>citalopram hydrobromide solution</i>	1	QL (900 per 30 days) GC
<i>citalopram hydrobromide tablet 10mg, 40mg</i>	1	QL (30 per 30 days) GC

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<i>citalopram hydrobromide tablet 20mg</i>	1	QL (90 per 30 days) GC
<i>clomipramine hcl</i>	1	GC
CYMBALTA	2	QL (60 per 30 days)
<i>desipramine hcl</i>	1	GC
<i>doxepin hcl</i>	1	GC
EMSAM	3	
<i>fluoxetine hcl</i>	1	GC
<i>fluvoxamine maleate</i>	1	GC
<i>imipramine hcl</i>	1	GC
<i>imipramine pamoate</i>	1	GC
LEXAPRO SOLUTION	3	QL (600 per 30 days)
LEXAPRO TABLET	3	QL (60 per 30 days)
<i>maprotiline hcl</i>	1	GC
MARPLAN	3	
<i>mirtazapine</i>	1	GC
<i>mirtazapine odt</i>	1	GC
NARDIL	3	
<i>nefazodone hcl</i>	1	GC
<i>nortriptyline hcl</i>	1	GC
PARNATE	3	
<i>paroxetine hcl suspension</i>	1	QL (900 per 30 days) GC
<i>paroxetine hcl tablet</i>	1	QL (30 per 30 days) GC
PAXIL SUSPENSION	3	QL (900 per 30 days)
<i>perphenazine/amitriptyline</i>	1	GC
<i>phenelzine sulfate</i>	1	GC
PRISTIQ	2	QL (30 per 30 days)
<i>protriptyline hcl</i>	1	GC
RAPIFLUX	3	
SAVELLA	2	QL (60 per 30 days)
SAVELLA TITRATION PACK	2	QL (55 per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>selfemra</i>	1	GC
<i>sertraline hcl concentrate</i>	1	QL (300 per 30 days) GC
<i>sertraline hcl tablet 25mg, 50mg</i>	1	QL (30 per 30 days) GC
<i>sertraline hcl tablet 100mg</i>	1	QL (60 per 30 days) GC
SURMONTIL	2	
<i>tranylcypromine sulfate</i>	1	GC
<i>trazodone hcl</i>	1	GC
<i>venlafaxine hcl</i>	1	GC
<i>venlafaxine hcl er capsule 37.5mg, 75mg</i>	1	QL (30 per 30 days) GC
<i>venlafaxine hcl er capsule 150mg</i>	1	QL (60 per 30 days) GC
VENLAFAXINE HCL ER TABLET	3	QL (30 per 30 days)
VIIBRYD	3	QL (30 per 30 days)
Antidotes, Deterrents, and Toxicologic Agents		
ANTABUSE	2	
ANTIZOL	4	
<i>buproban</i>	1	QL (60 per 30 days) GC
CAMPRAL	3	QL (180 per 30 days)
CHANTIX STARTING MONTH PAK	3	QL (106 per 365 days) ST
CHANTIX TABLET 0.5MG, 1MG	3	QL (336 per 365 days) ST
CHEMET	3	
<i>depade</i>	1	GC
EXJADE	4	
<i>fomepizole</i>	4	
<i>kionex</i>	1	GC
<i>naloxone hcl</i>	1	GC
<i>naltrexone hcl</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
NICOTROL INHALER	2	
NICOTROL NS	2	
RELISTOR	3	
REVIA	3	
<i>sodium polystyrene sulfonate</i>	1	GC
SUBOXONE	2	
SYPRINE	2	
VIVITROL	4	PA
Antiemetics		
ALOXI	3	B vs D
ANZEMET INJECTION	3	PA
ANZEMET TABLET	3	QL (5 per 30 days) B vs D
CESAMET	3	B vs D
<i>compro</i>	1	GC
<i>dronabinol 2.5mg, 5mg</i>	1	B vs D GC
<i>dronabinol 10mg</i>	4	B vs D
EMEND CAPSULE 40MG	2	QL (2 per 30 days) B vs D
EMEND CAPSULE 80MG	2	QL (8 per 30 days) B vs D
EMEND CAPSULE 125MG	2	QL (4 per 30 days) B vs D
EMEND TRIFOLD PACK	2	QL (12 per 30 days) B vs D
<i>granisetron hcl injection</i>	1	HI
<i>granisetron hcl tablet</i>	1	QL (60 per 30 days) B vs D GC
<i>granisol</i>	1	QL (300 per 30 days) B vs D GC
MARINOL 5MG, 10MG	4	B vs D
<i>meclizine hcl rx</i>	1	GC
<i>ondansetron hcl injection</i>	1	B vs D GC

Drug Name	Drug Tier	Requirements/ Limits
<i>ondansetron hcl oral solution</i>	1	QL (900 per 30 days) B vs D GC
<i>ondansetron hcl tablet 4mg</i>	1	QL (60 per 30 days) B vs D GC
<i>ondansetron hcl tablet 8mg</i>	1	QL (90 per 30 days) B vs D GC
<i>ondansetron hcl tablet 24mg</i>	1	QL (5 per 30 days) B vs D GC
<i>ondansetron odt tablet dispersible 4mg</i>	1	QL (60 per 30 days) B vs D GC
<i>ondansetron odt tablet dispersible 8mg</i>	1	QL (90 per 30 days) B vs D GC
<i>phenadoz</i>	1	GC
<i>prochlorperazine</i>	1	GC
<i>prochlorperazine edisylate</i>	1	GC
<i>prochlorperazine maleate</i>	1	GC
<i>promethazine hcl</i>	1	GC
<i>promethegan</i>	1	GC
SANCUSO	3	QL (4 per 30 days) PA
TIGAN INJECTION	2	
TRANSDERM-SCOP	2	
<i>trimethobenzamide hcl capsule</i>	1	B vs D GC
<i>trimethobenzamide hcl injection</i>	1	GC
Antifungals		
ABELCET	4	B vs D
AMBISOME	4	B vs D
AMPHOTEC	3	B vs D
<i>amphotericin b</i>	1	B vs D GC
ANCOBON	4	
CANCIDAS	4	HI
<i>ciclopirox gel</i>	1	GC
<i>ciclopirox nail lacquer</i>	1	PA GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>ciclopirox olamine</i>	1	GC
<i>clotrimazole rx</i>	1	GC
<i>clotrimazole/betamethasone dipropionate</i>	1	GC
DIFLUCAN IN NACL	3	
<i>econazole nitrate</i>	1	GC
ERAXIS	2	
ERTACZO	3	
EXELDERM	2	
<i>fluconazole</i>	1	GC
<i>fluconazole in dextrose</i>	1	HI
GRIFULVIN V	2	
GRIS-PEG	2	
<i>griseofulvin microsize</i>	1	GC
GYNAZOLE-1	3	
<i>itraconazole</i>	1	GC
<i>ketoconazole</i>	1	GC
LOPROX SHAMPOO	2	
<i>miconazole 3 rx</i>	1	GC
MYCAMINE	4	HI
NAFTIN	3	
NOXAFIL	4	
<i>nyamyc</i>	1	GC
<i>nystatin</i>	1	GC
<i>nystatin/triamcinolone</i>	1	GC
<i>nystop</i>	1	GC
OXISTAT	2	
<i>pedi-dri</i>	1	GC
PENLAC NAIL LACQUER	3	PA
<i>selenium sulfide rx</i>	1	GC
SELSUN SHAMPOO	3	
SPORANOX	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>terbinafine hcl tablet</i>	1	QL (90 per 270 days) GC
<i>terconazole</i>	1	GC
VFEND	4	
VFEND IV	3	
<i>voriconazole</i>	4	
<i>zazole</i>	1	GC
Antigout Agents		
<i>allopurinol</i>	1	GC
<i>allopurinol sodium</i>	1	GC
ALOPRIM	3	
COLCRYS	2	
<i>probenecid</i>	1	GC
<i>probenecid/colchicine</i>	1	GC
ULORIC	2	QL (30 per 30 days) ST
Anti-inflammatory Agents		
ARTHROTEC	3	
CELEBREX	2	QL (60 per 30 days)
<i>diclofenac potassium</i>	1	GC
<i>diclofenac sodium</i>	1	GC
<i>diclofenac sodium ec</i>	1	GC
<i>diclofenac sodium xr</i>	1	GC
<i>diflunisal</i>	1	GC
<i>etodolac</i>	1	GC
<i>etodolac er</i>	1	GC
<i>fenoprofen calcium</i>	1	GC
FLECTOR	3	
<i>flurbiprofen</i>	1	GC
<i>ibuprofen</i>	1	GC
<i>indomethacin</i>	1	GC
<i>indomethacin er</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>ketoprofen</i>	1	GC
<i>ketoprofen er</i>	1	GC
<i>ketorolac tromethamine injection</i>	1	PA GC
<i>ketorolac tromethamine tablet</i>	1	QL (20 per 30 days) GC
<i>meclofenamate sodium</i>	1	GC
<i>meloxicam</i>	1	GC
<i>nabumetone</i>	1	GC
<i>naproxen</i>	1	GC
<i>naproxen dr</i>	1	GC
<i>naproxen sodium</i>	1	GC
<i>oxaprozin</i>	1	GC
<i>piroxicam</i>	1	GC
<i>salsalate</i>	1	GC
<i>sulindac</i>	1	GC
<i>tolmetin sodium</i>	1	GC
VIMOVO	2	QL (60 per 30 days)
Antimigraine Agents		
AMERGE 1MG	3	QL (18 per 30 days) ST
AMERGE 2.5MG	3	QL (9 per 30 days) ST
AXERT 6.25MG	3	QL (18 per 30 days) ST
AXERT 12.5MG	3	QL (12 per 30 days) ST
CAFERGOT	3	
D.H.E. 45	4	
<i>dihydroergotamine mesylate</i>	1	GC
ERGOMAR	2	
<i>ergotamine tartrate/caffeine</i>	1	GC
FROVA	3	QL (18 per 30 days) ST

Drug Name	Drug Tier	Requirements/ Limits
MAXALT & MAXALT-MLT 5MG	2	QL (27 per 30 days)
MAXALT & MAXALT-MLT 10MG	2	QL (18 per 30 days)
<i>migergot</i>	1	GC
MIGRANAL	3	QL (8 per 30 days)
<i>naratriptan hcl 1mg</i>	1	QL (18 per 30 days) ST GC
<i>naratriptan hcl 2.5mg</i>	1	QL (9 per 30 days) ST GC
RELPAK 20MG	3	QL (12 per 30 days) ST
RELPAK 40MG	3	QL (6 per 30 days) ST
<i>sumatriptan succinate injection</i>	1	QL (4 per 30 days) GC
<i>sumatriptan succinate tablet 25mg</i>	1	QL (36 per 30 days) GC
<i>sumatriptan succinate tablet 50mg</i>	1	QL (18 per 30 days) GC
<i>sumatriptan succinate tablet 100mg</i>	1	QL (9 per 30 days) GC
TREXIMET	2	QL (9 per 30 days)
ZOMIG & ZOMIG ZMT 2.5MG	3	QL (12 per 30 days)
ZOMIG & ZOMIG ZMT 5MG	3	QL (6 per 30 days)
ZOMIG SOLUTION	3	QL (6 per 30 days)
Antimyasthenic Agents		
<i>bethanechol chloride</i>	1	GC
<i>guanidine hcl</i>	1	GC
MESTINON	2	
MESTINON TIMESPAN	2	
MYTELASE	2	
<i>pyridostigmine bromide</i>	1	GC
REGONOL	3	

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Drug Name	Drug Tier	Requirements/ Limits
Antimycobacterials		
CAPASTAT SULFATE	2	
<i>dapsone</i>	1	GC
<i>ethambutol hcl</i>	1	GC
<i>isonarif</i>	1	GC
<i>isoniazid</i>	1	GC
MYCOBUTIN	2	
PASER	3	
PRIFTIN	3	
<i>pyrazinamide</i>	1	GC
RIFADIN INJECTION	2	
RIFAMATE	2	
<i>rifampin</i>	1	GC
RIFATER	3	
SEROMYCIN	2	
TRECTOR	2	
Antineoplastics		
ABRAXANE	4	B vs D
ADRIAMYCIN	3	B vs D
AFINITOR	4	
ALIMTA	4	B vs D
ALKERAN	4	B vs D
<i>amifostine</i>	4	B vs D
<i>anastrozole</i>	1	QL (30 per 30 days) GC
ARIMIDEX	2	QL (30 per 30 days)
AROMASIN	3	
ARRANON	4	B vs D
ARZERRA	4	B vs D
AVASTIN	4	B vs D
BICNU	2	B vs D
<i>bleomycin sulfate</i>	1	B vs D GC

Drug Name	Drug Tier	Requirements/ Limits
BUSULFEX	2	B vs D
CAMPATH	4	B vs D
CAMPTOSAR	3	B vs D
<i>carboplatin</i>	1	B vs D GC
CEENU	2	
CERUBIDINE	3	B vs D
<i>cisplatin</i>	1	B vs D GC
<i>cladribine</i>	4	B vs D
CLOLAR	4	B vs D
COSMEGEN	4	B vs D
<i>cyclophosphamide</i>	1	B vs D GC
<i>cytarabine</i>	1	B vs D GC
<i>dacarbazine</i>	1	B vs D GC
DACOGEN	4	B vs D
<i>daunorubicin hcl</i>	1	B vs D GC
DAUNOXOME	3	B vs D
<i>dexrazoxane</i>	4	B vs D
<i>docetaxel</i>	4	B vs D
DOXIL	4	B vs D
<i>doxorubicin hcl</i>	1	B vs D GC
DROXIA	2	
ELITEK	4	
ELLEENCE	4	B vs D
ELOXATIN	4	B vs D
ELSPAR	2	B vs D
EMCYT	2	
<i>epirubicin hcl</i>	4	B vs D
ERBITUX	4	B vs D
ETHYOL	4	B vs D
ETOPOPHOS	4	B vs D
<i>etoposide</i>	1	B vs D GC
<i>exemestane</i>	1	GC

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FARESTON	3	
FASLODEX	4	B vs D
FEMARA	3	
FLUDARA	4	B vs D
<i>fludarabine phosphate</i>	4	B vs D
<i>fluorouracil</i>	1	B vs D GC
<i>gemcitabine hcl</i>	4	B vs D
GEMZAR	4	B vs D
GLEEVEC	4	
HALAVEN	4	
HERCEPTIN	4	B vs D
HEXALEN	4	
HYCANTIN	4	B vs D
HYDREA	3	
<i>hydroxyurea</i>	1	GC
IDAMYCIN PFS	4	B vs D
<i>idarubicin hcl</i>	4	B vs D
IFEX	3	B vs D
<i>ifosfamide</i>	1	B vs D GC
<i>ifosfamide/mesna</i>	4	B vs D
IRESSA	4	RA
<i>irinotecan</i>	4	B vs D
ISTODAX	4	B vs D
IXEMPRA	4	B vs D
JEVTANA	4	B vs D
<i>letrozole</i>	1	GC
LEUKERAN	2	
LEUSTATIN	2	B vs D
MATULANE	4	
<i>melfalan hydrochloride</i>	1	B vs D GC
<i>mercaptopurine</i>	1	GC
<i>mesna</i>	1	B vs D GC

Drug Name	Drug Tier	Requirements/ Limits
MESNEX INJECTION	4	B vs D
MESNEX TABLET	4	
<i>mitomycin</i>	1	B vs D GC
<i>mitoxantrone hcl</i>	1	B vs D GC
MUSTARGEN	2	B vs D
NEXAVAR	4	RA
NIPENT	4	B vs D
NOVANTRONE	4	B vs D
ONCASPAR	4	B vs D
ONTAK	4	B vs D
<i>oxaliplatin</i>	4	B vs D
<i>paclitaxel</i>	1	B vs D GC
PANRETIN	4	
<i>pentostatin</i>	4	B vs D
PHOTOFRIN	4	B vs D
PROLEUKIN	4	
PURINETHOL	3	
REVLIMID	4	RA
RITUXAN	4	PA
SPRYCEL	4	
SUTENT	4	
<i>tabloid</i>	1	GC
<i>tamoxifen citrate</i>	1	GC
TARCEVA	4	
TARGRETIN	4	
TASIGNA	4	
TAXOTERE	4	B vs D
THALOMID	4	
<i>thiotepa</i>	1	B vs D GC
<i>toposar</i>	1	B vs D GC
<i>topotecan hcl</i>	4	B vs D
TORISEL	4	B vs D

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TREANDA	4	B vs D
<i>tretinoin - oral</i>	4	
TRISENOX	3	B vs D
TYKERB	4	
VANDETANIB	4	
VECTIBIX	4	B vs D
VELCADE	4	B vs D
VIDAZA	2	
<i>vinblastine sulfate</i>	1	B vs D GC
<i>vincasar pfs</i>	1	B vs D GC
<i>vincristine sulfate</i>	1	B vs D GC
<i>vinorelbine tartrate</i>	1	B vs D GC
VOTRIENT	4	
ZANOSAR	4	B vs D
ZINECARD	4	B vs D
ZOLINZA	4	
ZYTIGA	4	
Antiparasitics		
<i>acticin</i>	1	GC
ALBENZA	2	
ALINIA	3	
BILTRICIDE	2	
<i>chloroquine phosphate</i>	1	GC
COARTEM	3	QL (24 per 30 days)
DARAPRIM	2	
EURAX	3	
<i>hydroxychloroquine sulfate</i>	1	GC
<i>lindane</i>	1	GC
MALARONE	3	
<i>malathion</i>	1	GC
<i>mebendazole</i>	1	GC
<i>mefloquine hcl</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
MEPRON	4	
OVIDE	3	
PENTAM 300	3	
<i>permethrin</i>	1	GC
PRIMAQUINE PHOSPHATE	3	
QUALAQUIN	2	PA
STROMEKTOL	2	
Antiparkinson Agents		
<i>amantadine hcl</i>	1	GC
APOKYN	4	
AZILECT	2	QL (30 per 30 days)
<i>benztropine mesylate</i>	1	GC
<i>bromocriptine mesylate</i>	1	GC
<i>carbidopa/levodopa</i>	1	GC
<i>carbidopa/levodopa odt</i>	1	GC
<i>carbidopa/levodopa sr</i>	1	GC
COMTAN	3	
LODOSYN	2	
MIRAPEX ER	2	
PARCOPA	3	
<i>pramipexole dihydrochloride</i>	1	GC
REQUIP XL	2	
<i>ropinirole hcl</i>	1	GC
<i>selegiline hcl</i>	1	GC
STALEVO	2	
TASMAR	2	
<i>trihexyphenidyl hcl</i>	1	GC
ZELAPAR	3	
Antipsychotics		
ABILIFY DISCMELT 10MG	3	QL (60 per 30 days)
ABILIFY DISCMELT 15MG	4	QL (60 per 30 days)
ABILIFY INJECTION	3	

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Drug Name	Drug Tier	Requirements/ Limits
ABILIFY ORAL SOLUTION	3	QL (900 per 30 days)
ABILIFY TABLET 2MG, 5MG, 10MG, 15MG	3	QL (30 per 30 days)
ABILIFY TABLET 20MG, 30MG	4	QL (30 per 30 days)
<i>chlorpromazine hcl</i>	1	GC
<i>clozapine</i>	1	GC
FANAPT	3	QL (60 per 30 days)
FANAPT TITRATION PACK	3	QL (16 per 30 days)
FAZACLO	3	
<i>fluphenazine decanoate</i>	1	GC
<i>fluphenazine hcl</i>	1	GC
GEODON CAPSULE	2	QL (60 per 30 days)
GEODON INJECTION	2	
<i>haloperidol</i>	1	GC
<i>haloperidol decanoate</i>	1	GC
<i>haloperidol lactate</i>	1	GC
INVEGA SUSTENNA 39MG/0.25ML, 78MG/0.5ML	3	
INVEGA SUSTENNA 117MG/0.75ML, 156MG/ ML, 234MG/1.5ML	4	
INVEGA TABLET 1.5MG, 3MG	3	QL (30 per 30 days)
INVEGA TABLET 6MG	3	QL (60 per 30 days)
INVEGA TABLET 9MG	4	QL (30 per 30 days)
LATUDA	3	QL (30 per 30 days)
<i>loxapine succinate</i>	1	GC
ORAP	3	
<i>perphenazine</i>	1	GC
RISPERDAL CONSTA 12.5MG, 25MG	3	QL (4 per 28 days)
RISPERDAL CONSTA 37.5MG, 50MG	4	QL (4 per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>risperidone odt 0.25mg, 0.5mg, 1mg, 2mg, 3mg</i>	1	QL (60 per 30 days) GC
<i>risperidone odt 4mg</i>	1	QL (120 per 30 days) GC
<i>risperidone solution</i>	1	QL (240 per 30 days) GC
<i>risperidone tablet 0.25mg, 0.5mg, 1mg, 2mg, 3mg</i>	1	QL (60 per 30 days) GC
<i>risperidone tablet 4mg</i>	1	QL (120 per 30 days) GC
SAPHRIS	3	
SEROQUEL 25MG, 50MG, 100MG, 200MG	3	QL (120 per 30 days)
SEROQUEL 300MG, 400MG	3	QL (60 per 30 days)
SEROQUEL XR 50MG, 300MG, 400MG	2	QL (60 per 30 days)
SEROQUEL XR 150MG, 200MG	2	QL (30 per 30 days)
SYMBYAX	3	QL (30 per 30 days)
<i>thioridazine hcl</i>	1	GC
<i>thiothixene</i>	1	GC
<i>trifluoperazine hcl</i>	1	GC
ZYPREXA 2.5MG, 5MG, 7.5MG, 10MG	2	QL (30 per 30 days)
ZYPREXA 15MG, 20MG	4	QL (30 per 30 days)
ZYPREXA INJECTION	2	
ZYPREXA ZYDIS 5MG, 10MG	2	QL (30 per 30 days)
ZYPREXA ZYDIS 15MG, 20MG	4	QL (30 per 30 days)
Antispasticity Agents		
<i>baclofen</i>	1	GC
<i>dantrolene sodium</i>	1	GC
<i>tizanidine hcl</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
Antivirals		
<i>acyclovir</i>	1	GC
<i>acyclovir sodium</i>	1	B vs D GC
APTIVUS	4	
ATRIPLA	4	
BARACLUDE SOLUTION	3	
BARACLUDE TABLET	4	
COMBIVIR	4	
COPEGUS	4	
CRIXIVAN	2	
CYTOVENE	3	B vs D
DENAVIR	2	
<i>didanosine</i>	1	GC
EDURANT	4	
EMTRIVA	3	
EPIVIR	2	
EPIVIR HBV	2	
EPZICOM	4	
<i>famciclovir</i>	1	GC
FLUMADINE	3	
<i>foscarnet sodium</i>	1	B vs D GC
FUZEON	4	
<i>ganciclovir capsule 250mg</i>	1	GC
<i>ganciclovir capsule 500mg</i>	4	
<i>ganciclovir injection</i>	1	B vs D GC
HEPSERA	4	
INTELENCE	4	
INVIRASE CAPSULE	3	
INVIRASE TABLET	4	
ISENTRESS	4	
KALETRA SOLUTION	4	

Drug Name	Drug Tier	Requirements/ Limits
KALETRA TABLET 100MG/25MG	3	
KALETRA TABLET 200MG/50MG	4	
LEXIVA SUSPENSION	3	
LEXIVA TABLET	4	
NORVIR	3	
PREZISTA 75MG, 150MG	3	
PREZISTA 400MG, 600MG	4	
REBETOL CAPSULE	4	
REBETOL SOLUTION	2	
RELENZA DISKHALER	3	QL (120 per 365 days)
RESCRIPTOR	2	
RETROVIR IV INFUSION	3	
REYATAZ 100MG	3	
REYATAZ 150MG, 200MG, 300MG	4	
<i>ribapak</i>	4	
<i>ribasphere capsule 200mg</i>	1	GC
<i>ribasphere tablet 200mg</i>	1	GC
<i>ribasphere tablet 400mg, 600mg</i>	4	
<i>ribavirin 200mg</i>	1	GC
<i>rimantadine hcl</i>	1	GC
SELZENTRY	2	
<i>stavudine</i>	1	GC
SUSTIVA	3	
TAMIFLU CAPSULE 30MG	2	QL (120 per 365 days)
TAMIFLU CAPSULE 45MG	2	QL (60 per 365 days)
TAMIFLU CAPSULE 75MG	2	QL (56 per 365 days)
TAMIFLU SUSPENSION	2	
TRIZIVIR	4	

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Drug Name	Drug Tier	Requirements/ Limits
TRUVADA	4	
TYZEKA	4	
<i>valacyclovir hcl</i>	1	GC
VALCYTE	4	
VICTRELIS	4	PA
VIDEX EC	2	
VIDEX PEDIATRIC	2	
VIRACEPT	2	
VIRAMUNE	2	
VIRAMUNE XR	2	
VIRAZOLE	4	B vs D
VIREAD	4	
VISTIDE	4	
ZERIT	2	
ZIAGEN	2	
<i>zidovudine</i>	1	GC
ZOVIRAX CREAM, OINTMENT	3	
Anxiolytics		
<i>buspirone hcl</i>	1	GC
LEXAPRO SOLUTION	3	QL (600 per 30 days)
LEXAPRO TABLET	3	QL (60 per 30 days)
<i>meprobamate</i>	1	GC
Bipolar Agents		
<i>divalproex sodium er</i>	1	GC
EQUETRO	3	
<i>lithium carbonate</i>	1	GC
<i>lithium carbonate er</i>	1	GC
<i>lithium citrate</i>	1	GC
LITHOBID	3	

Drug Name	Drug Tier	Requirements/ Limits
Blood Glucose Regulators		
<i>acarbose</i>	1	GC
ACTOPLUS MET	2	QL (90 per 30 days)
ACTOS	2	QL (30 per 30 days)
ALCOHOL PREP PADS	2	
APIDRA	2	
AVANDAMET	3	QL (60 per 30 days)
AVANDARYL 1MG/4MG, 2MG/4MG, 4MG/4MG	3	QL (60 per 30 days)
AVANDARYL 2MG/8MG, 4MG/8MG	3	QL (30 per 30 days)
AVANDIA 2MG, 4MG	3	QL (60 per 30 days)
AVANDIA 8MG	3	QL (30 per 30 days)
BYETTA	2	QL (3 per 30 days)
<i>chlorpropamide</i>	1	GC
DUETACT	2	QL (30 per 30 days)
GAUZE PADS 2"X2"	2	
<i>glimepiride</i>	1	GC
<i>glipizide</i>	1	GC
<i>glipizide er</i>	1	GC
<i>glipizide/metformin hcl</i>	1	GC
GLUCAGEN HYPOKIT	2	QL (2 per 1 day)
GLUCAGON EMERGENCY KIT	2	QL (2 per 1 day)
<i>glyburide</i>	1	GC
<i>glyburide micronized</i>	1	GC
<i>glyburide/metformin hcl</i>	1	GC
GLYSET	3	
HUMALOG	3	ST
HUMULIN	3	ST
HUMULIN R U-500 (CONCENTRATED)	2	

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Drug Name	Drug Tier	Requirements/ Limits
INSULIN SYRINGES & NEEDLES	2	
JANUMET	2	QL (60 per 30 days)
JANUVIA	2	QL (30 per 30 days)
KOMBIGLYZE XR 500MG/5MG, 1000MG/5MG	2	QL (30 per 30 days)
KOMBIGLYZE XR 1000MG/2.5MG	2	QL (60 per 30 days)
LANTUS	2	
LEVEMIR	2	
<i>metformin hcl</i>	1	GC
<i>metformin hcl er</i>	1	GC
<i>nateglinide</i>	1	GC
NOVOLIN	2	
NOVOLOG	2	
ONGLYZA	2	QL (30 per 30 days)
PROGLYCEM	2	
RIOMET	3	
SYMLIN	3	QL (20 per 30 days)
SYMLINPEN 60	3	QL (12 per 30 days)
SYMLINPEN 120	3	QL (10.8 per 30 days)
<i>tolazamide</i>	1	GC
<i>tolbutamide</i>	1	GC
VICTOZA	2	QL (9 per 30 days)
Blood Products/Modifiers/Volume Expanders		
AGGRENOX	2	QL (60 per 30 days)
<i>aminocaproic acid</i>	1	GC
ARANESP 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML, 60MCG/0.3ML, 60MCG/ML	2	PA

Drug Name	Drug Tier	Requirements/ Limits
ARANESP 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML	4	PA
ARIXTRA 2.5MG/0.5ML	2	QL (32 per 365 days)
ARIXTRA 5MG/0.4ML	4	QL (12 per 365 days)
ARIXTRA 7.5MG/0.6ML	4	QL (18 per 365 days)
ARIXTRA 10MG/0.8ML	4	QL (24 per 365 days)
<i>cilostazol</i>	1	GC
COUMADIN	3	
CYKLOKAPRON	2	
<i>dipyridamole</i>	1	GC
EFFIENT 5MG	2	QL (42 per 30 days)
EFFIENT 10MG	2	QL (36 per 30 days)
<i>enoxaparin sodium 30mg/0.3ml</i>	1	QL (18 per 365 days) GC
<i>enoxaparin sodium 40mg/0.4ml</i>	1	QL (24 per 365 days) GC
<i>enoxaparin sodium 60mg/0.6ml</i>	1	QL (36 per 365 days) GC
<i>enoxaparin sodium 80mg/0.8ml</i>	1	QL (48 per 365 days) GC
<i>enoxaparin sodium 100mg/ml, 150mg/ml</i>	4	QL (60 per 365 days)
<i>enoxaparin sodium 120mg/0.8ml</i>	4	QL (48 per 365 days)
EPOGEN 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	QL (12 per 28 days) PA
EPOGEN 10000UNIT/ML, 20000UNIT/ML	4	PA
FRAGMIN INJECTION 2500UNIT/0.2ML, 5000UNIT/0.2ML	3	QL (6 per 365 days) ST

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Drug Name	Drug Tier	Requirements/ Limits
FRAGMIN 2500UNIT/0.2ML, 5000UNIT/0.2ML	4	QL (54 per 365 days) ST
FRAGMIN 7500UNIT/0.3ML	4	QL (180 per 365 days) ST
FRAGMIN 10000UNIT/ML	4	QL (15 per 365 days) ST
FRAGMIN 12500UNIT/0.5ML	4	QL (18 per 365 days) ST
FRAGMIN 15000UNIT/0.6ML	4	QL (21.6 per 365 days) ST
FRAGMIN 18000UNT/0.72ML	3	QL (133 per 365 days) ST
<i>heparin sodium/d5w</i>	1	GC
<i>heparin sodium/nacl</i>	1	GC
<i>heparin sodium 1000unit/ml</i>	1	B vs D GC
<i>heparin sodium 2000unit/ ml, 2500unit/ml, 5000unit/ ml, 10000unit/ml, 20000unit/ml</i>	1	GC
<i>jantoven</i>	1	GC
LEUKINE	4	
MOZOBIL	4	
NEULASTA	4	
NEUMEGA	4	PA
NEUPOGEN	4	
<i>pentopak</i>	1	GC
<i>pentoxifylline er</i>	1	GC
PLAVIX TABLET 75MG	2	
PRADAXA	2	QL (60 per 30 days)
PROCRIT 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	2	QL (12 per 28 days) PA
PROCRIT 10000UNIT/ML	2	PA
PROCRIT 20000UNIT/ML, 40000UNIT/ML	4	PA

Drug Name	Drug Tier	Requirements/ Limits
PROMACTA	4	
<i>ticlopidine hcl</i>	1	GC
<i>warfarin sodium</i>	1	GC
Cardiovascular Agents		
<i>acebutolol hcl</i>	1	GC
<i>acetazolamide sodium</i>	1	GC
ADVICOR	3	QL (30 per 30 days)
<i>afeditab cr</i>	1	GC
<i>amiloride hcl</i>	1	GC
<i>amiloride hcl/ hydrochlorothiazide</i>	1	GC
<i>amiodarone hcl</i>	1	GC
<i>amlodipine besylate</i>	1	QL (30 per 30 days) GC
<i>amlodipine besylate/ benazepril hcl</i>	1	QL (30 per 30 days) GC
AMTURNIDE	3	QL (30 per 30 days)
ATACAND/ATACAND HCT	3	QL (30 per 30 days) ST
<i>atenolol</i>	1	GC
<i>atenolol/chlorthalidone</i>	1	GC
AVALIDE	3	QL (30 per 30 days) ST
AVAPRO	3	QL (30 per 30 days) ST
<i>benazepril hcl</i>	1	GC
<i>benazepril hcl/ hydrochlorothiazide</i>	1	GC
BENICAR/BENICAR HCT	3	QL (30 per 30 days)
<i>betaxolol hcl</i>	1	GC
BIDIL	3	
<i>bisoprolol fumarate</i>	1	GC
<i>bisoprolol fumarate/ hydrochlorothiazide</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>bumetanide</i>	1	GC
BYSTOLIC 2.5MG, 5MG	2	QL (90 per 30 days)
BYSTOLIC 10MG	2	QL (120 per 30 days)
BYSTOLIC 20MG	2	QL (60 per 30 days)
<i>captopril</i>	1	GC
<i>captopril/ hydrochlorothiazide</i>	1	GC
<i>cartia xt</i>	1	GC
<i>carvedilol</i>	1	GC
CATAPRES-TTS-1	3	QL (4 per 28 days)
CATAPRES-TTS-2	3	QL (4 per 28 days)
CATAPRES-TTS-3	3	QL (8 per 28 days)
<i>chlorothiazide</i>	1	GC
<i>chlorothiazide sodium</i>	1	GC
<i>chlorthalidone</i>	1	GC
<i>cholestyramine light</i>	1	GC
<i>clonidine hcl tablet</i>	1	GC
<i>clonidine hcl patch 0.1mg/24hr, 0.2mg/24hr</i>	1	QL (4 per 28 days) GC
<i>clonidine hcl patch 0.3mg/24hr</i>	1	QL (8 per 28 days) GC
<i>clorpres</i>	1	GC
<i>colestipol hcl</i>	1	GC
COREG CR	2	QL (30 per 30 days)
CORZIDE	3	
CRESTOR	2	QL (30 per 30 days)
DEMSER	2	
DIBENZYLIN	2	
<i>digoxin</i>	1	GC
<i>dilt-cd</i>	1	GC
<i>dilt-xr</i>	1	GC
<i>diltiazem cd</i>	1	GC
<i>diltiazem hcl</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>diltiazem hcl er</i>	1	GC
<i>diltzac</i>	1	GC
DIOVAN/DIOVAN HCT	2	QL (30 per 30 days)
<i>disopyramide phosphate</i>	1	GC
DIURIL	2	
DIURIL IV	3	
DYNACIRC CR	3	
DYRENIUM	2	
EDECRIN	2	
<i>enalapril maleate</i>	1	GC
<i>enalapril maleate/ hydrochlorothiazide</i>	1	GC
<i>eplerenone</i>	1	GC
EXFORGE/EXFORGE HCT	2	QL (30 per 30 days)
<i>felodipine er</i>	1	QL (30 per 30 days) GC
<i>fenofibrate micronized</i>	1	QL (30 per 30 days) GC
<i>fenofibrate tablet 54mg</i>	1	QL (60 per 30 days) GC
<i>fenofibrate tablet 160mg</i>	1	QL (30 per 30 days) GC
<i>flecainide acetate</i>	1	GC
<i>fosinopril sodium</i>	1	GC
<i>fosinopril sodium/ hydrochlorothiazide</i>	1	GC
<i>furosemide</i>	1	GC
<i>gemfibrozil</i>	1	GC
<i>guanabenz acetate</i>	1	GC
<i>guanfacine hcl</i>	1	GC
<i>hydralazine hcl</i>	1	GC
<i>hydrochlorothiazide</i>	1	GC
<i>indapamide</i>	1	GC
INNOPRAN XL	3	

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Drug Name	Drug Tier	Requirements/ Limits
<i>isosorbide dinitrate</i>	1	GC
<i>isosorbide dinitrate er</i>	1	GC
<i>isosorbide mononitrate</i>	1	GC
<i>isosorbide mononitrate er</i>	1	GC
<i>isradipine</i>	1	GC
<i>labetalol hcl</i>	1	GC
LANOXIN	2	
LESCOL 20MG	2	QL (30 per 30 days)
LESCOL 40MG	2	QL (60 per 30 days)
LESCOL XL 80MG	2	QL (30 per 30 days)
LIPITOR	1	QL (30 per 30 days) GC
LIPOFEN 50MG	3	QL (90 per 30 days) ST
LIPOFEN 150MG	3	QL (30 per 30 days) ST
<i>lisinopril</i>	1	GC
<i>lisinopril/ hydrochlorothiazide</i>	1	GC
LOFIBRA CAPSULE	3	QL (30 per 30 days) ST
LOFIBRA TABLET 54MG	3	QL (60 per 30 days) ST
LOFIBRA TABLET 160MG	3	QL (30 per 30 days) ST
<i>losartan potassium</i>	1	QL (30 per 30 days) GC
<i>losartan potassium/ hydrochlorothiazide</i>	1	QL (30 per 30 days) GC
<i>lovastatin 10mg, 20mg</i>	1	QL (30 per 30 days) GC
<i>lovastatin 40mg</i>	1	QL (60 per 30 days) GC
LOVAZA	2	
<i>methyclothiazide</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>methyldopa</i>	1	GC
<i>methyldopa/ hydrochlorothiazide</i>	1	GC
<i>methyldopate hcl</i>	1	GC
<i>metolazone</i>	1	GC
<i>metoprolol succinate er 25mg, 50mg, 100mg</i>	1	QL (90 per 30 days) GC
<i>metoprolol succinate er 200mg</i>	1	QL (60 per 30 days) GC
<i>metoprolol tartrate</i>	1	GC
<i>metoprolol tartrate/ hydrochlorothiazide</i>	1	GC
<i>mexiletine hcl</i>	1	GC
MICARDIS/MICARDIS HCT	2	QL (30 per 30 days)
<i>midodrine hcl</i>	1	GC
<i>minitran</i>	1	GC
<i>minoxidil</i>	1	GC
<i>moexipril hcl</i>	1	GC
<i>moexipril hcl/ hydrochlorothiazide</i>	1	GC
MONOKET	3	
MULTAQ	2	QL (60 per 30 days)
<i>nadolol</i>	1	GC
<i>nadolol/ bendroflumethiazide</i>	1	GC
NIACOR	3	
NIASPAN 500MG	2	QL (30 per 30 days)
NIASPAN 750MG, 1000MG	2	QL (60 per 30 days)
<i>nicardipine hcl</i>	1	GC
<i>nifediac cc</i>	1	GC
<i>nifedical xl</i>	1	GC
<i>nifedipine</i>	1	GC
<i>nifedipine er</i>	1	GC
<i>nimodipine</i>	4	

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Drug Name	Drug Tier	Requirements/ Limits
<i>nisoldipine er 20mg, 30mg, 40mg</i>	1	QL (30 per 30 days) GC
NITRO-BID	3	
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	3	
<i>nitroglycerin</i>	1	GC
<i>nitroglycerin patch</i>	1	GC
NITROLINGUAL PUMPSPRAY	2	
NITROSTAT	2	
NORPACE CR	3	
<i>pacerone</i>	1	GC
<i>perindopril erbumine</i>	1	GC
<i>pindolol</i>	1	GC
<i>pravastatin sodium</i>	1	QL (30 per 30 days) GC
<i>prazosin hcl</i>	1	GC
<i>prevalite</i>	1	GC
<i>procainamide hcl</i>	1	GC
<i>propafenone hcl</i>	1	GC
<i>propafenone hcl er</i>	1	GC
<i>propranolol hcl</i>	1	GC
<i>propranolol hcl er</i>	1	GC
<i>propranolol hcl/ hydrochlorothiazide</i>	1	GC
<i>quinapril hcl</i>	1	GC
<i>quinapril hcl/ hydrochlorothiazide</i>	1	GC
<i>quinidine gluconate</i>	1	GC
<i>quinidine gluconate er</i>	1	GC
<i>quinidine sulfate</i>	1	GC
<i>quinidine sulfate er</i>	1	GC
<i>ramipril</i>	1	QL (60 per 30 days) GC

Drug Name	Drug Tier	Requirements/ Limits
RANEXA	2	
<i>reserpine</i>	1	GC
RYTHMOL SR	3	
SAMSCA 15MG	4	QL (30 per 30 days)
SAMSCA 30MG	4	QL (60 per 30 days)
SIMCOR 500MG/20MG, 500MG/40MG, 1000MG/40MG	2	QL (30 per 30 days)
SIMCOR 750MG/20MG, 1000MG/20MG	2	QL (60 per 30 days)
<i>simvastatin 5mg, 10mg, 20mg</i>	1	QL (90 per 30 days) GC
<i>simvastatin 40mg</i>	1	QL (45 per 30 days) GC
<i>simvastatin 80mg</i>	1	QL (30 per 30 days) GC
SODIUM EDECIN	2	
<i>sorine</i>	1	GC
<i>sotalol hcl</i>	1	GC
<i>spironolactone</i>	1	GC
<i>spironolactone/ hydrochlorothiazide</i>	1	GC
TARKA 1MG/240MG, 2MG/180MG, 2MG/240MG	3	QL (30 per 30 days)
TARKA 4MG/240MG	3	QL (60 per 30 days)
<i>taztia xt</i>	1	GC
TEKAMLO	3	QL (30 per 30 days)
TEKTURNA/TEKTURNA HCT	3	QL (30 per 30 days)
TEVETEN/TEVETEN HCT	3	QL (30 per 30 days) ST
THALITONE	2	
TIKOSYN	2	
<i>timolol maleate</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
TOPROL XL 25MG, 50MG, 100MG	3	QL (90 per 30 days)
TOPROL XL 200MG	3	QL (60 per 30 days)
<i>toremide</i>	1	GC
<i>trandolapril</i>	1	GC
<i>triamterene/ hydrochlorothiazide</i>	1	GC
TRICOR 48MG	3	QL (60 per 30 days)
TRICOR 145MG	3	QL (30 per 30 days)
TRIGLIDE 50MG	3	QL (60 per 30 days) ST
TRIGLIDE 160MG	3	QL (30 per 30 days) ST
TRILIPIX 45MG	2	QL (60 per 30 days)
TRILIPIX 135MG	2	QL (30 per 30 days)
TWYNSTA	2	QL (30 per 30 days)
VALTURNA	3	QL (30 per 30 days)
<i>verapamil hcl</i>	1	GC
<i>verapamil hcl er</i>	1	GC
VYTORIN	2	QL (30 per 30 days)
WELCHOL PACKET	2	QL (30 per 30 days)
WELCHOL TABLET	2	
ZETIA	2	QL (30 per 30 days)
Central Nervous System Agents		
ADDERALL XR 5MG, 10MG, 15MG	3	QL (30 per 30 days)
ADDERALL XR 20MG, 25MG, 30MG	3	QL (60 per 30 days)
<i>amphetamine/ dextroamphetamine tablet</i>	1	GC
AMPYRA	4	QL (60 per 30 days) PA
CONCERTA	3	QL (30 per 30 days)
DAYTRANA	3	

Drug Name	Drug Tier	Requirements/ Limits
DESOXYN	3	PA
<i>dexmethylphenidate hcl</i>	1	GC
<i>dextroamphetamine sulfate</i>	1	GC
<i>dextroamphetamine sulfate er</i>	1	GC
METADATE ER	2	
<i>methamphetamine hcl</i>	1	PA GC
METHYLIN CHEWABLE TABLET, SOLUTION	3	
<i>methylin er</i>	1	GC
<i>methylin tablet</i>	1	GC
<i>methylphenidate hcl</i>	1	GC
<i>methylphenidate hcl sr</i>	1	GC
NUEDEXTA	3	QL (60 per 30 days) PA
PROVIGIL 100MG	3	QL (30 per 30 days) PA
PROVIGIL 200MG	3	QL (60 per 30 days) PA
RILUTEK	2	
STRATTERA 10MG, 18MG, 25MG, 40MG	2	QL (60 per 30 days)
STRATTERA 60MG, 80MG, 100MG	2	QL (30 per 30 days)
XYREM	4	RA
Dental and Oral Agents		
<i>chlorhexidine gluconate</i>	1	GC
EVOXAC	3	
KEPIVANCE	4	
<i>perio gard</i>	1	GC
<i>pilocarpine hcl</i>	1	GC
<i>triamcinolone in orabase</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
Dermatological Agents		
8-MOP	2	
<i>adapalene</i>	1	GC
<i>ala scalp</i>	1	GC
<i>ala-cort</i>	1	GC
<i>alclometasone dipropionate</i>	1	GC
ALDARA	3	
<i>amcinonide</i>	1	GC
AMEVIVE	4	PA
<i>ammonium lactate rx</i>	1	GC
<i>amnesteem</i>	1	GC
<i>augmented betamethasone dipropionate</i>	1	GC
AVITA	3	PA
AZELEX	2	
BENZACLIN	2	
<i>betamethasone dipropionate</i>	1	GC
<i>betamethasone valerate</i>	1	GC
<i>calcipotriene</i>	1	GC
CARAC	3	
<i>claravis</i>	1	GC
CLINDAGEL	3	
<i>clindamycin phosphate</i>	1	GC
<i>clindamycin phosphate/ benzoyl peroxide</i>	1	GC
<i>clobetasol propionate</i>	1	GC
<i>clobetasol propionate e</i>	1	GC
CLOBEX	3	
CLODERM	2	
CONDYLOX	3	
CORDRAN	2	
CORDRAN SP	2	

Drug Name	Drug Tier	Requirements/ Limits
CORDRAN TAPE	2	
CUTIVATE LOTION	3	
DERMA-SMOOTHIE/FS	2	
DESONATE	3	
<i>desonide</i>	1	GC
<i>desoximetasone</i>	1	GC
DIFFERIN	2	
<i>diflorasone diacetate</i>	1	GC
DOVONEX CREAM	3	
EFUDEX	3	
ELIDEL	3	
<i>erythromycin/benzoyl peroxide</i>	1	GC
EVOCLIN	3	
FINACEA	2	
<i>fluocinolone acetonide</i>	1	GC
<i>fluocinonide</i>	1	GC
<i>fluocinonide e</i>	1	GC
FLUOROPLEX	2	
<i>fluorouracil</i>	1	GC
<i>fluticasone propionate</i>	1	GC
<i>halobetasol propionate</i>	1	GC
<i>hydrocortisone</i>	1	GC
<i>hydrocortisone butyrate</i>	1	GC
<i>hydrocortisone valerate</i>	1	GC
<i>imiquimod</i>	1	GC
KENALOG	3	
<i>laclotion</i>	1	GC
<i>lokara</i>	1	GC
LUXIQ	3	
<i>mometasone furoate</i>	1	GC
<i>mupirocin</i>	1	GC
OLUX-E	3	

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Drug Name	Drug Tier	Requirements/ Limits
OXSORALEN	3	
OXSORALEN ULTRA	2	
PANDEL	2	
<i>podofilox</i>	1	GC
<i>prednicarbate</i>	1	GC
<i>procto-pak</i>	1	GC
PROCTOCORT	3	
<i>proctocream hc</i>	1	GC
<i>proctosol hc</i>	1	GC
<i>proctozone-hc</i>	1	GC
PROTOPIC	3	PA
REGRANEX	4	QL (30 per 30 days) PA
RETIN-A MICRO	3	PA
SANTYL	2	
SOLARAZE	2	
SORIATANE	4	
<i>sotret</i>	1	GC
TAZORAC	3	
<i>tretinoin - topical</i>	1	PA GC
<i>triamcinolone acetonide</i>	1	GC
<i>triderm</i>	1	GC
<i>u-cort</i>	1	GC
UVADEX	2	B vs D
VANOS	3	
VERDESO	3	
ZIANA	3	
ZONALON	2	
ZYCLARA	3	
Enzyme Replacements/ Modifiers		
ADAGEN	4	
ALDURAZYME	4	

Drug Name	Drug Tier	Requirements/ Limits
BUPHENYL	2	
CEREDASE	4	
CEREZYME	4	
CREON	2	
CYSTADANE	4	
CYSTAGON	2	
ELAPRASE	4	
FABRAZYME	4	
KUVAN	4	
MYOZYME	4	
NAGLAZYME	4	
ORFADIN	4	
VPRIV	4	B vs D
ZAVESCA	4	
ZENPEP	2	
Gastrointestinal Agents		
ACIPHEX	3	QL (60 per 30 days)
AMITIZA	2	QL (60 per 30 days)
<i>atropine sulfate</i>	1	GC
CANTIL	2	
CARAFATE	3	
<i>cimetidine</i>	1	GC
<i>cimetidine hcl</i>	1	GC
<i>constulose</i>	1	GC
DEXILANT	3	QL (60 per 30 days)
<i>dicyclomine hcl</i>	1	GC
<i>diphenoxylate/atropine</i>	1	GC
<i>enulose</i>	1	GC
<i>famotidine injection, tablet</i>	1	GC
GASTROCROM	2	
<i>gavilyte-c</i>	1	GC
<i>gavilyte-g</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>gavilyte-n</i>	1	GC
<i>generlac</i>	1	GC
<i>glycopyrrolate</i>	1	GC
GOLYTELY	2	
HALFLYTELY	2	
KRISTALOSE	3	
<i>lactulose</i>	1	GC
<i>lansoprazole</i>	1	QL (60 per 30 days) GC
<i>lansoprazole odt</i>	1	QL (60 per 30 days) GC
<i>loperamide hcl rx</i>	1	GC
LOTRONEX	2	PA
<i>methscopolamine bromide</i>	1	GC
<i>metoclopramide hcl</i>	1	GC
<i>misoprostol</i>	1	GC
MOTOFEN	2	
MOVIPREP	3	
NEXIUM	2	QL (60 per 30 days)
NEXIUM I.V.	2	
<i>nizatidine capsule</i>	1	GC
NULYTELY	2	
<i>omeprazole</i>	1	QL (60 per 30 days) GC
<i>omeprazole/sodium bicarbonate</i>	1	QL (60 per 30 days) ST GC
<i>pantoprazole sodium</i>	1	QL (60 per 30 days) GC
<i>polyethylene glycol 3350</i>	1	GC
<i>propantheline bromide</i>	1	GC
<i>ranitidine hcl</i>	1	GC
ROBINUL INJECTION	2	
<i>sucralfate</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>trilyte</i>	1	GC
URSO 250	3	
URSO FORTE	3	
<i>ursodiol</i>	1	GC
VISICOL	3	
ZEGERID	3	QL (60 per 30 days) ST
Genitourinary Agents		
<i>alfuzosin hcl er</i>	1	QL (30 per 30 days) GC
AVODART	2	QL (30 per 30 days)
<i>calcium acetate</i>	1	GC
CLINDESSE	3	
DETROL	2	QL (60 per 30 days)
DETROL LA	2	QL (30 per 30 days)
<i>doxazosin mesylate</i>	1	GC
ELMIRON	2	
ENABLEX	3	QL (30 per 30 days)
<i>finasteride</i>	1	QL (30 per 30 days) GC
<i>flavoxate hcl</i>	1	GC
FOSRENOL	2	
GELNIQUE	2	QL (30 per 30 days)
JALYN	2	QL (30 per 30 days)
<i>oxybutynin chloride</i>	1	GC
<i>oxybutynin chloride er 5mg</i>	1	QL (30 per 30 days) GC
<i>oxybutynin chloride er 10mg, 15mg</i>	1	QL (60 per 30 days) GC
PHOSLO	2	
RAPAFLO	2	QL (30 per 30 days) ST
RELAGARD	3	
RENVELA	2	

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Drug Name	Drug Tier	Requirements/ Limits
<i>tamsulosin hcl</i>	1	QL (60 per 30 days) GC
<i>terazosin hcl</i>	1	GC
TOVIAZ	2	QL (30 per 30 days)
<i>tropium chloride</i>	1	QL (60 per 30 days) GC
VESICARE	3	QL (30 per 30 days)
Hormonal Agents – Stimulant/Replacement/ Modifying (Adrenal)		
<i>a-hydrocort</i>	1	B vs D GC
<i>a-methapred</i>	1	B vs D GC
CELESTONE	2	
CORTEF 5MG, 20MG	2	B vs D
CORTEF 10MG	2	
<i>cortisone acetate</i>	1	GC
DEPO-MEDROL	3	B vs D
<i>dexamethasone</i>	1	GC
<i>dexamethasone intensol</i>	1	GC
<i>dexamethasone sodium phosphate</i>	1	B vs D GC
<i>fludrocortisone acetate</i>	1	GC
<i>methylprednisolone acetate</i>	1	B vs D GC
<i>methylprednisolone sodium succinate 40mg, 125mg</i>	1	B vs D GC
<i>methylprednisolone sodium succinate 1000mg</i>	1	HI
<i>methylprednisolone tablet 4mg</i>	1	GC
<i>methylprednisolone tablet 8mg, 16mg, 32mg</i>	1	B vs D GC
ORAPRED ODT	3	
<i>prednisolone sodium phosphate</i>	1	GC
<i>prednisone</i>	1	B vs D GC

Drug Name	Drug Tier	Requirements/ Limits
<i>prednisone intensol</i>	1	B vs D GC
SOLU-CORTEF	2	B vs D
SOLU-MEDROL 40MG, 125MG, 500MG	2	B vs D
SOLU-MEDROL 2GM	2	HI
Hormonal Agents – Stimulant/Replacement/ Modifying (Pituitary)		
DDAVP 0.01% NASAL SPRAY	3	
<i>desmopressin acetate</i>	1	GC
EGRIFTA	4	QL (60 per 30 days) PA
GENOTROPIN	4	PA
GENOTROPIN MINIQUICK 0.2MG	3	PA
GENOTROPIN MINIQUICK 0.4MG, 0.6MG, 0.8MG, 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 2MG	4	PA
HUMATROPE	4	PA
INCRELEX	4	PA
METHERGINE	3	
NORDITROPIN	4	PA
NUTROPIN	4	PA
NUTROPIN AQ	4	PA
OMNITROPE 5MG/1.5ML, 10MG/1.5ML	3	PA
OMNITROPE 5.8MG	4	PA
SAIZEN	4	PA
SEROSTIM	4	PA
STIMATE	2	
TEV-TROPIN	3	PA
ZORBTIVE	4	PA

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Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents – Stimulant/Replacement/ Modifying (Sex Hormones/Modifiers)		
ACTIVELLA	3	
ALORA	2	QL (8 per 28 days)
ANADROL-50	4	
ANDRODERM	2	
ANDROGEL	2	
ANDROXY	3	
ANGELIQ	3	
<i>apri</i>	1	GC
<i>aranelle</i>	1	GC
<i>aviane</i>	1	GC
<i>balziva</i>	1	GC
<i>camila</i>	1	GC
CENESTIN	3	
<i>cesia</i>	1	GC
CLIMARA PRO	3	QL (4 per 28 days)
COMBIPATCH	3	
<i>cryselle</i>	1	GC
<i>cyclafem</i>	1	GC
CYCLESSA	3	
DEPO-ESTRADIOL	2	
DEPO-PROVERA	2	
DEPO-SUB Q PROVERA 104	2	
DIVIGEL	3	
ELLA	2	
ENJUVIA	2	
<i>enpresse</i>	1	GC
<i>errin</i>	1	GC
ESTRACE CREAM	3	
<i>estradiol</i>	1	GC
<i>estradiol/norethindrone acetate</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
ESTRASORB	3	QL (97.44 per 28 days)
ESTRING	3	
<i>estropipate</i>	1	GC
ESTROSTEP FE	3	
EVISTA	2	QL (30 per 30 days)
FEMCON FE	3	
FEMHRT 1/5	3	
FEMHRT LOW DOSE	3	
FEMRING	3	QL (1 per 90 days)
FEMTRACE	3	
<i>gianvi</i>	1	GC
<i>jinteli</i>	1	GC
<i>jolivette</i>	1	GC
<i>junel/junel fe</i>	1	GC
<i>kariva</i>	1	GC
<i>kelnor</i>	1	GC
<i>leena</i>	1	GC
<i>lessina</i>	1	GC
<i>levora</i>	1	GC
LOESTRIN 24 FE	3	
LOSEASONIQUE	3	
<i>low-ogestrel</i>	1	GC
<i>lutera</i>	1	GC
LYBREL	3	
<i>medroxyprogesterone acetate</i>	1	GC
MEGACE ES	2	
MEGACE ORAL	3	
<i>megestrol acetate</i>	1	GC
MENOSTAR	3	QL (4 per 28 days)
<i>methitest</i>	1	GC
<i>microgestin/microgestin fe</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>mononessa</i>	1	GC
<i>necon</i>	1	GC
<i>next choice</i>	1	GC
NOR-QD	3	
<i>nora-be</i>	1	GC
<i>norethindrone acetate</i>	1	GC
<i>nortrel</i>	1	GC
NUVARING	3	
<i>ocella</i>	1	GC
<i>ogestrel</i>	1	GC
ORTHO EVRA	3	
ORTHO TRI-CYCLEN LO	3	
<i>ortho-est</i>	1	GC
OXANDRIN	4	
<i>oxandrolone 2.5mg</i>	1	GC
<i>oxandrolone 10mg</i>	4	
<i>portia</i>	1	GC
PREFEST	3	
PREMARIN CREAM	2	
PREMARIN INJECTION	3	
PREMARIN TABLET	3	QL (30 per 30 days)
PREMPHASE	3	
PREMPRO	3	QL (28 per 28 days)
<i>previfem</i>	1	GC
PROMETRIUM	2	
<i>quasense</i>	1	GC
<i>reclipsen</i>	1	GC
SEASONIQUE	3	
<i>solia</i>	1	GC
<i>sprintec</i>	1	GC
<i>sronyx</i>	1	GC
STRIANT	3	

Drug Name	Drug Tier	Requirements/ Limits
TESTIM	2	
<i>testosterone cypionate</i>	1	PA GC
<i>testosterone enanthate</i>	1	PA GC
<i>tri-legest fe</i>	1	GC
<i>tri-previfem</i>	1	GC
<i>tri-sprintec</i>	1	GC
<i>trinessa</i>	1	GC
<i>trivora</i>	1	GC
VAGIFEM	3	
<i>velivet</i>	1	GC
VIVELLE-DOT	2	QL (8 per 28 days)
YAZ	3	
<i>zeosa</i>	1	GC
<i>zovia</i>	1	GC
Hormonal Agents – Stimulant/Replacement/ Modifying (Thyroid)		
ARMOUR THYROID	2	
CYTOMEL	3	
LEVOTHROID	2	
<i>levothyroxine sodium</i>	1	GC
LEVOXYL	2	
<i>liothyronine sodium</i>	1	GC
SYNTHROID	3	
THYROLAR	3	
UNITHROID	2	
Hormonal Agents – Suppressant (Adrenal)		
LYSODREN	2	
Hormonal Agents – Suppressant (Parathyroid)		
SENSIPAR 30MG	2	QL (60 per 30 days)
SENSIPAR 60MG	4	QL (60 per 30 days)
SENSIPAR 90MG	4	QL (120 per 30 days)

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Hormonal Agents – Suppressant (Pituitary)		
<i>cabergoline</i>	1	GC
ELIGARD	3	PA
FIRMAGON	3	B vs D
<i>leuprolide acetate</i>	1	PA GC
LUPRON DEPOT	4	PA
LUPRON DEPOT-PED	4	PA
<i>octreotide acetate 50mcg/ml, 100mcg/ml, 200mcg/ml</i>	1	GC
<i>octreotide acetate 500mcg/ml, 1000mcg/ml</i>	4	
SANDOSTATIN	4	
SANDOSTATIN LAR DEPOT	4	
SOMATULINE DEPOT	4	
SOMAVERT	4	
SYNAREL	4	PA
TRELSTAR	2	PA
Hormonal Agents – Suppressant (Sex Hormones/Modifiers)		
<i>bicalutamide</i>	1	GC
CASODEX	3	
<i>flutamide</i>	1	GC
NILANDRON	2	
Hormonal Agents – Suppressant (Thyroid)		
<i>methimazole</i>	1	GC
<i>propylthiouracil</i>	1	GC
Immunological Agents		
ACTEMRA	4	PA
ACTHIB	2	
ACTIMMUNE	4	
ADACEL	2	
ARAVA	3	

Drug Name	Drug Tier	Requirements/ Limits
ARCALYST	4	PA RA
ATGAM	4	
AVONEX	4	PA
AZASAN	2	B vs D
<i>azathioprine</i>	1	B vs D GC
<i>azathioprine sodium</i>	1	B vs D GC
BETASERON	4	PA
BOOSTRIX	2	
CARIMUNE	4	PA
CELLCEPT CAPSULE	3	B vs D
CELLCEPT IV	3	B vs D
CELLCEPT SUSPENSION, TABLET	4	B vs D
CERVARIX	2	
COMVAX	2	
COPAXONE	4	PA
CUPRIMINE	2	
<i>cyclosporine</i>	1	B vs D GC
<i>cyclosporine modified</i>	1	B vs D GC
DAPTACEL	2	
DECAVAC	2	
DEPEN TITRATABS	2	
DIPHThERIA/TETANUS TOXOID PEDIATRIC	1	GC
ENBREL	4	PA
ENGERIX-B	2	B vs D
GAMASTAN S/D	2	PA
GAMMAGARD	4	PA
GAMMAPLEX	4	PA
GAMUNEX	4	PA
GARDASIL	2	
<i>gengraf</i>	1	B vs D GC

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Drug Name	Drug Tier	Requirements/ Limits
GILENYA	4	QL (30 per 30 days) PA
HAVRIX	2	
HIZENTRA	4	PA
HUMIRA	4	PA
IMOVAX RABIES VACCINE	2	
INFANRIX	2	
INFERGEN	4	PA
INTRON-A PEN 3MU/0.2ML, 6MUNIT/ML	2	
INTRON-A PEN 5MU/0.2ML, 10MU/0.2ML	4	
INTRON-A VIAL	4	
IPOL	2	
IXIARO	2	
JE-VAX	2	
<i>leflunomide</i>	1	GC
M-M-R II	2	
MENACTRA	2	
MENOMUNE-A/C/Y/W-135	2	
MENVEO	2	
<i>methotrexate</i>	1	B vs D GC
<i>methotrexate sodium</i>	1	B vs D GC
<i>mycophenolate mofetil</i>	1	B vs D GC
MYFORTIC	2	B vs D
NEORAL	3	B vs D
ORENCIA	4	PA
ORTHOCLONE OKT3	4	B vs D
PEDIARIX	2	
PEDVAX HIB	2	
PEG-INTRON	4	PA
PRIVIGEN	4	PA

Drug Name	Drug Tier	Requirements/ Limits
PROGRAF CAPSULE 0.5MG, 1MG	3	B vs D
PROGRAF CAPSULE 5MG	4	B vs D
PROGRAF INJECTION	3	B vs D
PROQUAD	2	
RABAVERT	2	
RAPAMUNE SOLUTION	4	B vs D
RAPAMUNE TABLET 0.5MG	3	B vs D
RAPAMUNE TABLET 1MG, 2MG	4	B vs D
REBIF	4	PA
RECOMBIVAX HB	2	B vs D
REMICADE	4	PA
RHEUMATREX	2	
RIDAURA	2	
ROTATEQ	2	
SANDIMMUNE	2	B vs D
SIMULECT	4	B vs D
SYNAGIS	4	PA
<i>tacrolimus</i>	1	B vs D GC
TETANUS TOXOID ADSORBED	2	
TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT	1	GC
THYMOGLOBULIN	4	
TREXALL	3	B vs D
TRIHIBIT	2	
TRIPEDIA	2	
TWINRIX	2	
TYPHIM VI	3	
TYSABRI	4	PA RA
VAQTA	2	

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Drug Name	Drug Tier	Requirements/ Limits
VARIVAX	2	
VIVAGLOBIN	4	PA
YF-VAX	2	
ZORTRESS 0.25MG	3	B vs D
ZORTRESS 0.5MG, 0.75MG	4	B vs D
ZOSTAVAX	2	
Inflammatory Bowel Disease Agents		
APRISO	3	
ASACOL	3	ST
ASACOL HD	3	ST
<i>balsalazide disodium</i>	1	GC
CANASA	2	
<i>colocort</i>	1	GC
CORTIFOAM	3	
DIPENTUM	2	
ENTOCORT EC	4	
<i>hydrocortisone enema</i>	1	GC
LIALDA	2	
<i>mesalamine enema</i>	1	GC
PENTASA	2	
<i>sulfasalazine</i>	1	GC
<i>sulfazine ec</i>	1	GC
Metabolic Bone Disease Agents		
ACTONEL 5MG, 30MG	3	QL (30 per 30 days) ST
ACTONEL 35MG	3	QL (4 per 28 days) ST
ACTONEL 150MG	3	QL (1 per 30 days) ST
<i>alendronate sodium 5mg, 10mg, 40mg</i>	1	QL (30 per 30 days) GC
<i>alendronate sodium 35mg, 70mg</i>	1	QL (4 per 28 days) GC
BONIVA INJECTION	2	QL (3 per 90 days) B vs D

Drug Name	Drug Tier	Requirements/ Limits
BONIVA TABLET	2	QL (1 per 30 days)
CALCIJEX	2	B vs D
<i>calcitonin-salmon</i>	1	GC
<i>calcitriol</i>	1	B vs D GC
<i>etidronate disodium</i>	1	GC
FORTEO	4	
FORTICAL	1	GC
FOSAMAX PLUS D	3	QL (4 per 28 days) ST
FOSAMAX SOLUTION	3	QL (300 per 28 days)
HECTOROL	3	ST B vs D
MIACALCIN INJECTION	3	B vs D
MIACALCIN NASAL SOLUTION	3	
<i>pamidronate disodium</i>	1	B vs D GC
SKELID	3	
XGEVA	4	PA
ZEMPLAR	2	B vs D
ZOMETA	4	PA
Miscellaneous Therapeutic Agents		
<i>anagrelide hydrochloride</i>	1	GC
BOTOX	3	PA
<i>levocarnitine</i>	1	B vs D GC
<i>sterile water irrigation</i>	1	GC
XENAZINE	4	RA
XEOMIN	3	PA
Ophthalmic Agents		
<i>acetazolamide</i>	1	GC
<i>ak-con</i>	1	GC
<i>ak-tob</i>	1	GC
ALAMAST	3	
ALOCRIL	3	
ALOMIDE	3	

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Drug Name	Drug Tier	Requirements/ Limits
ALPHAGAN P	2	
ALREX	3	
<i>apraclonidine</i>	1	GC
AZASITE	2	
<i>azelastine hcl</i>	1	GC
AZOPT	2	
<i>bacitracin</i>	1	GC
<i>bacitracin/polymyxin b</i>	1	GC
<i>betaxolol hcl</i>	1	GC
BETIMOL	2	
BETOPTIC-S	2	
BLEPHAMIDE	2	
BLEPHAMIDE S.O.P.	2	
<i>brimonidine tartrate</i>	1	GC
<i>bromfenac</i>	1	GC
<i>carteolol hcl</i>	1	GC
CILOXAN	2	
COMBIGAN	2	
COSOPT	3	
<i>cromolyn sodium</i>	1	GC
<i>dexamethasone sodium phosphate</i>	1	GC
DIAMOX	2	
<i>diclofenac sodium</i>	1	GC
<i>dorzolamide hcl</i>	1	GC
<i>dorzolamide hcl/timolol maleate</i>	1	GC
DUREZOL	3	
ELESTAT	3	
EMADINE	3	
<i>epinastine hcl</i>	1	GC
FLAREX	2	
<i>fluorometholone</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>flurbiprofen sodium</i>	1	GC
FML	2	
FML FORTE	2	
<i>gentak</i>	1	GC
<i>gentamicin sulfate</i>	1	GC
<i>gentasol</i>	1	GC
IOPIDINE	3	
IQUIX	2	
ISTALOL	3	
<i>ketorolac tromethamine</i>	1	GC
LACRISERT	2	
<i>latanoprost</i>	1	GC
<i>levobunolol hcl</i>	1	GC
<i>levofloxacin</i>	1	GC
LOTEMAX	3	
LUMIGAN	2	QL (2.5 per 30 days)
MAXIDEX	2	
<i>methazolamide</i>	1	GC
<i>metipranolol</i>	1	GC
MOXEZA	2	
<i>mydral</i>	1	GC
NATACYN	3	
<i>neomycin/polymyxin/bacitracin/hydrocortisone</i>	1	GC
<i>neomycin/polymyxin/dexamethasone</i>	1	GC
<i>neomycin/polymyxin/gramicidin</i>	1	GC
<i>neomycin/polymyxin/hydrocortisone</i>	1	GC
NEVANAC	2	
OCUFEN	3	
<i>ofloxacin</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
OPTIPRANOLOL	3	
OPTIVAR	3	
<i>parcaine</i>	1	GC
PATADAY	2	
PATANOL	2	
PHOSPHOLINE IODIDE	3	
PILOPINE HS	3	
<i>poly-dex</i>	1	GC
POLY-PRED	2	
PRED MILD	2	
PRED-G	2	
PRED-G S.O.P.	2	
<i>prednisolone acetate</i>	1	GC
<i>prednisolone sodium phosphate</i>	1	GC
<i>proparacaine hcl</i>	1	GC
QUIXIN	3	ST
RESTASIS	2	
<i>romycin</i>	1	GC
<i>sulfacetamide sodium/ prednisolone sodium phosphate</i>	1	GC
<i>timolol maleate</i>	1	GC
TOBRADEX OINTMENT	3	
TOBRADEX ST	3	
<i>tobramycin sulfate</i>	1	GC
<i>tobramycin sulfate/ dexamethasone</i>	1	GC
<i>tobrasol</i>	1	GC
TOBREX OINTMENT	2	
TRAVATAN Z	2	QL (2.5 per 30 days)
<i>trifluridine</i>	1	GC
<i>trimethoprim sulfate/ polymyxin b sulfate</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>tropicamide</i>	1	GC
TRUSOPT	3	
VEXOL	2	
VIGAMOX	2	
VOLTAREN	3	
ZIRGAN	3	
ZYLET	3	
Otic Agents		
<i>acetazol hc</i>	1	GC
<i>acetic acid</i>	1	GC
CIPRO HC	2	
CIPRODEX	2	
COLY-MYCIN S	3	
CORTISPORIN-TC	2	
<i>cortomycin</i>	1	GC
DERMOTIC	3	
<i>hydrocortisone/acetic acid</i>	1	GC
<i>neomycin/polymyxin/ hydrocortisone</i>	1	GC
<i>ofloxacin</i>	1	GC
Respiratory Tract Agents		
<i>acetylcysteine</i>	1	B vs D GC
ADCIRCA	4	QL (60 per 30 days) PA
ADVAIR DISKUS/HFA	2	
<i>albuterol sulfate er</i>	1	GC
<i>albuterol sulfate inhalation solution</i>	1	B vs D GC
<i>albuterol sulfate syrup, tablet</i>	1	GC
ALVESCO	3	
<i>aminophylline</i>	1	GC
ARALAST NP	4	PA

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Drug Name	Drug Tier	Requirements/ Limits
ASMANEX	2	
ASTEPRO	2	
ATROVENT HFA	3	ST
<i>azelastine hcl</i>	1	GC
BROVANA	3	B vs D
<i>budesonide</i>	1	B vs D GC
<i>carbinoxamine maleate</i>	1	GC
CLARINEX REDITABS	3	QL (30 per 30 days)
CLARINEX SYRUP	3	QL (300 per 30 days)
CLARINEX TABLET	3	QL (30 per 30 days)
CLARINEX-D 12 HOUR	3	QL (60 per 30 days)
CLARINEX-D 24 HOUR	3	QL (30 per 30 days)
<i>clemastine fumarate</i>	1	GC
COMBIVENT	3	
<i>cromolyn sodium</i>	1	B vs D GC
<i>cyproheptadine hcl</i>	1	GC
DALIRESP	3	PA
<i>dexchlorpheniramine maleate</i>	1	GC
<i>diphenhydramine hcl rx</i>	1	GC
ELIXOPHYLLIN	3	
<i>epinephrine hcl</i>	1	GC
EPIPEN	2	QL (2 per 1 day)
EPIPEN-JR	2	QL (2 per 1 day)
<i>fexofenadine hcl tablet 30mg, 60mg</i>	1	QL (60 per 30 days) GC
<i>fexofenadine hcl tablet 180mg</i>	1	QL (30 per 30 days) GC
FLONASE	3	ST
FLOVENT DISKUS/HFA	2	
<i>flunisolide</i>	1	GC
<i>fluticasone propionate</i>	1	GC
FORADIL AEROLIZER	2	

Drug Name	Drug Tier	Requirements/ Limits
GLASSIA	4	PA
<i>hydroxyzine hcl</i>	1	GC
<i>hydroxyzine pamoate</i>	1	GC
<i>ipratropium bromide/ albuterol sulfate</i>	1	B vs D GC
<i>ipratropium bromide inhalation solution</i>	1	B vs D GC
<i>ipratropium bromide nasal solution</i>	1	GC
LETAIRIS	4	
<i>levalbuterol inhalation solution</i>	1	B vs D GC
LUFYLLIN	3	
MAXAIR	3	QL (14 per 30 days)
<i>metaproterenol sulfate</i>	1	GC
NASACORT AQ	3	ST
NASONEX	3	ST
OMNARIS	3	
<i>palgic liquid</i>	1	GC
PERFOROMIST	3	B vs D
PROAIR HFA	2	
PROLASTIN	4	PA
PROLASTIN-C	4	PA
<i>promethazine vc</i>	1	GC
PROVENTIL HFA	3	
PULMICORT	3	B vs D
PULMICORT FLEXHALER	3	ST
PULMOZYME	4	B vs D
QVAR	2	
REMODULIN	4	B vs D
REVATIO	4	PA
SEMPREX-D	3	
SEREVENT DISKUS	2	

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Drug Name	Drug Tier	Requirements/ Limits
SINGULAIR	2	
SPIRIVA	2	
SYMBICORT	2	
<i>terbutaline sulfate</i>	1	GC
THEO-24	2	
<i>theochron</i>	1	GC
<i>theophylline er</i>	1	GC
TRACLEER	4	RA
TWINJECT	2	QL (2 per 1 day)
TYZINE	2	
TYZINE PEDIATRIC	2	
VENTAVIS	4	PA
VENTOLIN HFA	2	
VERAMYST	2	
VOSPIRE ER	2	
XOLAIR	4	PA
XOPENEX	3	B vs D
XOPENEX HFA	3	
<i>zafirlukast</i>	1	QL (60 per 30 days) GC
ZEMAIRA	4	PA
ZYFLO CR	2	
Sedatives/Hypnotics		
LUNESTA	3	QL (30 per 30 days)
ROZEREM	3	QL (30 per 30 days) ST
<i>zaleplon</i>	1	QL (30 per 30 days) GC
<i>zolpidem tartrate</i>	1	QL (30 per 30 days) GC
Skeletal Muscle Relaxants		
<i>carisoprodol 350mg</i>	1	GC
<i>carisoprodol/aspirin</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>carisoprodol/aspirin/codeine</i>	1	GC
<i>chlorzoxazone</i>	1	GC
<i>cyclobenzaprine hcl</i>	1	GC
<i>metaxalone</i>	1	ST GC
<i>methocarbamol</i>	1	GC
<i>orphenadrine citrate</i>	1	GC
<i>orphenadrine citrate er</i>	1	GC
<i>orphenadrine compound ds</i>	1	GC
<i>orphenadrine/asa/caffeine</i>	1	GC
ROBAXIN INJECTION	3	
SKELAXIN	3	ST
Therapeutic Nutrients/Minerals/Electrolytes		
AMINOSYN	2	B vs D
<i>ammonium chloride</i>	1	GC
CLINIMIX	2	B vs D
CLINIMIX E	2	B vs D
CLINISOL SF 15%	2	B vs D
<i>dextrose</i>	1	B vs D GC
<i>dextrose/electrolyte #48</i>	1	B vs D GC
<i>dextrose/nacl</i>	1	B vs D GC
<i>dextrose/potassium chloride</i>	1	B vs D GC
<i>ed k+10</i>	1	GC
<i>eliphos</i>	1	GC
FREAMINE	2	B vs D
HEPATAMINE	2	B vs D
HEPATASOL	2	B vs D
INTRALIPID	2	B vs D
IONOSOL	2	B vs D
ISOLYTE	2	B vs D
K-TABS	1	GC
KCL/D5W/LR	2	B vs D
KCL/D5W/NACL	2	B vs D

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