



## **2011 Commercial Medication Formulary**

*Effective December 1, 2011*

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## Definitions

**Brand Medication** - A prescription medication that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer or a medication that is identified as a Brand medication by AvMed. AvMed delegates determination of Generic/Brand status to our Pharmacy Benefits Manager.

**Brand Additional Charge** - The additional charge that must be paid if you or your prescriber choose a brand medication when a generic equivalent is available. The charge is the difference between the cost of the brand medication and the generic medication. This charge must be paid in addition to the applicable non-Preferred brand copay.

**Cost-sharing Medications** - Medications, as designated by AvMed, designed to improve the quality of life by treating relatively minor, non-life threatening conditions. Such medications are subject to co-insurance and coverage is limited.

**Generic medication** - A prescription medication that has the same active ingredient as a brand medication or is identified as a generic medication by AvMed's Pharmacy Benefits Manager. FDA-approved generic products are just as effective and safe as the brand name products. Generic medications contain identical active ingredients, have the same indication for use, meet the same manufacturing standards, and are identical in strength and dosage form as brand name medications.

**Maintenance Medication** - A medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

**Participating Pharmacy** - A pharmacy (retail, mail order, or specialty pharmacy) that has entered into an agreement with AvMed to provide prescription drugs to AvMed members and has been designated by AvMed as a participating pharmacy.

**Preferred Medication List** - The listing of preferred medications as determined by AvMed's Pharmacy and Therapeutics Committee (P&T) based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes different levels of copay for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed's Pharmacy and Therapeutics Committee.

**Prescription Medication** - A medication that has been approved by the FDA and that can only be dispensed pursuant to a prescription according to state and federal law.

**Prior Authorization** - The process of obtaining approval for certain prescription drugs (prior to dispensing) according to AvMed's guidelines. The ordering prescriber must obtain approval from AvMed. The list of prescription drugs requiring prior authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring prior authorization are listed in this document on page VII. To initiate a prior authorization, please visit our website at [www.avmed.org](http://www.avmed.org) to obtain a Medication Exception Request Form (MER).

**Progressive Medication Program** – Medications included in this program require trial of a first-line medication in order for a second-line medication to be covered under your pharmacy benefit. (Coverage for a third-line medication requires trial of one or more first-line **AND** second-line medications.) If for medical reasons, you cannot use the first-line medication and require a second-line or third-line medication; your prescriber may request a prior authorization for you to have this medication covered. Certain medications may be grandfathered in for members who are controlled on a second-line or third-line medication. These medications are listed on page VIII along with the criteria.

**Self-Administered Injectable Medication** - A medication that has been approved by the FDA for self-injection and is administered by subcutaneous injection. Prior authorization is required for all self-administered injectable medications, except Insulin.

**Specialty Medications:** Your Specialty Medication coverage extends to many injectable and high cost oral medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a participating specialty pharmacy. The Co-payment levels for Specialty Medications apply regardless of provider. This means that you may be responsible for the appropriate Co-payment whether

you receive your Specialty Medication from the pharmacy, at the physician's office or during home health visits. Specialty Medications are limited to a 30-day supply.

**Quantity Limit** - Medications included in this program allow a maximum quantity per prescription and/or time period for one copay or coinsurance. Quantity limits are developed based upon FDA approved medication labeling and nationally recognized therapeutic clinical guidelines. If your prescription exceeds the quantity limit, a prior authorization will be required.

## Introduction

The AvMed Commercial Medication Formulary was developed to serve as a guide for prescribers, pharmacists, health care professionals and members in the selection of cost-effective medication therapy. AvMed recognizes that medication therapy is an integral part of effective health management. Due to the vast availability of medication options, a reasonable program for medication selection and use is warranted. The purpose of the AvMed Commercial Medication Formulary is to assist health care practitioners in providing and members in receiving optimal, cost-effective medication therapy.

This document reflects the expert opinion and effort of AvMed's Pharmacy and Therapeutics (P&T) Committee, which is comprised of practicing prescribers and pharmacists representing different specialties. The P&T Committee continually review new and existing medications to ensure this medication formulary remains responsive to the needs of our members and health care professionals. The criteria used by the P&T Committee to evaluate medication selection for the formulary includes, but is not limited to, medication safety profile, medication efficacy and effectiveness data, comparison of similar prescription or over-the counter (OTC) medications with equivalent indications and/or use while minimizing potential duplications and assessment of equitable cost of medication.

The medication formulary is a fluid document, which is continually reviewed and modified based on the current clinical opinion of AvMed's P&T Committee. This dynamic process does not allow this document to be completely accurate at all times. To accommodate regular changes, an updated electronic version of this formulary is available online at [www.avmed.org](http://www.avmed.org). AvMed welcomes your input and feedback on the information provided in this document.

## How to Read the Medication Formulary

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

**Medical Condition:** The formulary begins on page 1. The formulary is arranged into categories identifying groups of medications used to treat a specific condition or disease. For example, medications used to treat a heart condition are listed under the category, Cardiovascular Agents.

**Alphabetical Listing:** If you are not sure what category to look under, you should look for your medication in the Index, which is listed in the back of this document. The Index provides an alphabetical listing of all of the medications included in this document. Both brand name medications and generic medications are listed in the Index. Once you have found your medication in the Index, you will see the page number next to the medication where you can find coverage information. Once you have turned to that page listed in the Index, you will need to scan the first column (left hand-side) to find the name of your medication.

Sample Listing:

Medication Name	Copay Tier	Quantity Limit	Progressive Medication Program	Prior Authorization	Specialty Pharmacy	Comment
<b>Antidiabetic Agents: Oral</b>						
JANUMET	2	60/30 days				
JANUVIA	2	30/30 days				
KOMBIGLYZE XR	2	30/30 days				2.5/1000 mg strength- QL 60/30
<b>metformin hcl</b> (GLUCOPHAGE)	1	75/30 days				

Once the category or medication is located, the following items can be viewed in their respective columns:

**Medication Name:** This lists the generic name or brand name for the product. If the medication is available in generic form then it will be listed in lowercase **bold** print followed by the brand name medication (in parenthesis). Brand name products will be listed in capital letters.

**Copay Tier:** This section identifies if the product is a Tier 1 copay product (usually generic), Tier 2 copay product (preferred brand), Tier 3 copay product (non-preferred brand), Tier 4 copay product (self-administered injectable medication, excluding insulin), or Tier 5 copay product (cost-sharing medication) on the AvMed Commercial Medication Formulary. **Please note:** Tier 5 copay is not applicable to all plans.

**Quantity Limit:** Certain medications may be limited to specific quantities per prescription and/or time period for one copay or coinsurance.

**Progressive Medication Program (PMP):** Medications which require trial of one or more first-line medications prior to coverage of a second-line or third-line medication. Please refer to page VIII for a complete list of medications that are part of the PMP program.

**Prior Authorization:** Medications which require prior approval from AvMed before your medication will be covered by AvMed. Please refer to page VII for a complete list of medications that require prior authorization.

**Specialty Pharmacy:** Specialty medications are typically high cost, often injectable medications, used to treat complex, chronic diseases. They often require special handling, such as refrigeration or mixing. These medications will be required to be dispensed by CuraScript Pharmacy. These medications will be noted in this column.

## Benefit Coverage and Limitations

This printed medication formulary is for reference purposes only and does not guarantee nor define benefit coverage and limitations. Many members have specific benefit inclusions, exclusions, copayments, or a lack of coverage, which are not reflected in the AvMed Commercial Medication Formulary. You may contact AvMed's Member Services Department regarding any coverage questions by calling the number listed on the back of your card. Please note that the formulary process is dynamic and generally changes throughout the year. These changes typically occur due to, but not limited to, the following reasons: approval of new medications, availability of new approved generics, changes in clinical data, and medication safety concerns. AvMed is not held responsible for payment in the event that either a medication was omitted/included in error or that a medication was placed at an incorrect tier on this formulary. The following topics may or may not be applicable to individual members depending on member-specific benefit parameters.

## Coverage

Your prescription medication coverage includes medications that require a prescription, are filled by an AvMed network pharmacy, and are prescribed by your AvMed provider in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.

Your retail prescription medication coverage includes up to a 30-day supply of a medication for the listed copay. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease, and diabetes from the retail pharmacy for the applicable copay per 30-day supply. However, prior authorization may be required for certain covered medications.

Your mail order prescription medication coverage includes up to a 90-day supply of a routine maintenance medication for the listed copay per your prescription benefits. If the amount of medication is less than a 90-day supply, such as a 75-day supply, you will still be charged the listed mail order copay per your prescription benefits. Therefore, it is important that you only utilize this option for maintenance medications.

Your self-administered injectable medication coverage extends to many injectable medications approved by the FDA. These medications must be ordered by a prescriber and dispensed by a retail or specialty pharmacy. The copay levels for self-administered injectable medications apply regardless of provider. This means that you are responsible for the appropriate copay whether you receive your self-administered injectable medication from the pharmacy, at the prescriber's office or during home health visits. Self-administered injectable medications are limited to a 30-day supply.

If applicable to your specific prescription benefits, Tier 5 coverage is limited to itraconazole (Sporanox®), Aciphex, and Nexium.

Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid, clinical studies. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a member to experience an adverse event at higher doses.

## Tier Description

Each copay tier is assigned an established co-payment, which is the amount you pay when you fill a prescription. Consult your benefit documents to determine your specific co-payments, coinsurance, and/or deductibles that are part of your plan. You and your doctor decide which medication is most appropriate for you.

- **Tier 1 Copay (Lowest-Cost Option)** – These are typically generic medications and are the lowest out-of-pocket expense. You should always consider Tier 1 medications if you and your doctor decided they are appropriate to treat your condition.
- **Tier 2 Copay (Midrange-Cost Option)** – These are typically brand name medications and are in the middle range for out-of-pocket expense.
- **Tier 3 Copay (Higher-Cost Option)** – These are non-preferred brand name medications and are in the higher range for out-of-pocket expense. Sometimes there are alternatives available in Tier 1 or Tier 2 that may be appropriate to treat your condition. If you are currently taking a Tier 3 medication, ask your doctor whether there are lower co-payment alternatives that may be right for your treatment.
- **Tier 4 Copay (Self-Injectable Medications)** – These are generally self-injectable medications, excluding insulin, and are typically the highest out-of-pocket expense.
- **Tier 5 Copay (Cost-Sharing Medications)** - If applicable to your specific prescription benefits, this category is limited to Itraconazole (Sporanox®), Aciphex, and Nexium.

## **Common Medication Exclusions**

Due to employer chosen benefit design parameters; there could be certain medication classes that are excluded from your pharmacy benefit coverage. Prior authorization is generally not available for medications that are specifically excluded by benefit design. Commonly excluded products may include, but are not limited to:

- Over-the-counter, or OTC, medications or their equivalents unless otherwise specified in the Medication Formulary listing.
- Nicotine smoking cessation products (i.e. transdermal nicotine, nicotine gum, nicotine inhaler)
- Experimental medication products, or any medication product used in an experimental manner
- Foreign medications or medications not approved by the United States Food & Drug Administration (FDA)
- Replacement prescription drug products resulting from a lost, stolen, expired, broken, or destroyed prescription order or refill
- Diaphragms and other contraceptive devices
- Fertility drugs
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Dental-specific medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals except prenatal vitamins
- Nutritional supplements
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Compounded prescriptions, except pediatric preparations
- Pharmaceuticals that would be covered under the medical benefit. These may include, but are not limited to, immunizations; allergy serums; medical supplies, including therapeutic devices, dressings, appliances, and support garments; medications administered by the attending physician to treat an acute phase of an illness; and chemotherapy for cancer patients. Such benefits are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to copay or co-insurance and prior authorization requirements, as outlined on the Schedule of Benefits.

## **Mandated Generic Substitution**

AvMed advocates the use of cost-effective generic medications where FDA-labeled brand equivalent medications are available. A generic medication is approved by the FDA once the manufacturer has proven that it has the same active ingredient(s) as the brand name medication. Generally, generic medications cost less than brand name medications. If a member or prescriber requests a brand-name product in lieu of an approved generic, the member, based upon his/her coverage, will typically be required to pay the Non-Preferred Brand Copay plus the Brand Additional Charge.

## **Health Care Reform - Preventive Medications**

The Patient Protection and Affordable Care Act that was recently passed allow members to receive preventive evidence-based items and services at no cost to the member with certain stipulations. These items and services include, but are not limited to, certain medications including: fluoride products for members 5 years of age and under, aspirin for men ages 45-79 and for women ages 55-79, folic acid for women of childbearing age, and iron products for members 1 year of age and under.

Some of the limitations for receiving these medications at no cost to the member require that: (1) the member be part of a non-grandfathered plan using an in-network provider, (2) a prescription is required in which only the generic form of the medication will be covered, and (3) this coverage will only apply in a retail pharmacy. As new guidance continues to be released for coverage of preventive medications, the list and/or restrictions will be updated accordingly.

## Transition of Care

The Transition-of-Care Form has been developed for newly enrolled members with AvMed Health Plans who require assistance with transition of care from their previous insurance carrier and their providers. The information provided on this form will help allow for a smooth transition of your medical care to AvMed providers. If any of the medications listed on the Transition-of-Care Form are within our Progressive Medication Program or PA Program, AvMed will reach out to your provider/pharmacy to obtain the necessary information. If you have fulfilled the requirements of these programs, an authorization will be placed in the system to allow you to continue to get these medications.

## How Can I Save Money on Prescriptions

Always ask your doctor to consider choosing an appropriate medication from the formulary that is on the lower tier selections, such as the Tier 1 copay or Tier 2 copay. Medications within these tiers have the lowest out of pocket cost for you. If you are currently taking a Tier 3 medication, you may want to discuss with your doctor other medication alternatives that are on a lower copay tier.

## How Can I order a Free ACCU-CHEK® Diabetic Meter System

AvMed Members with Diabetes can call 1-888-355-4242 to directly place an order for an Accu-Chek® Aviva or Compact Plus Diabetic Meter System. Members are limited to one meter system per 365 days. A prescription is REQUIRED to order and receive the meter. AvMed Members will receive via Priority or Overnight Mail an ACCU-CHEK® PCS Card for a free Aviva or Compact Plus Diabetic Meter System (including a box of test strips, a lancet device and lancets, a box of control solution, and the new patient engagement tools). **The Member or representative should present the PCS card along with a prescription from their physician for an Aviva or Compact Plus Diabetic Meter System to a network pharmacy to redeem the meter.** *Note: If a member does not have a prescription from their physician, and it is an emergency situation, the member or representative should contact their provider for assistance.*

## Mail Order

AvMed offers mail order as a benefit option for maintenance medications, which are needed for chronic or long-term health conditions. Through our mail order vendor, Medco, prescriptions may be ordered for up to a 90-day supply of your medication, which will be delivered to your home. When using mail order for the first time, it is best to get a 30-day supply prescription filled at your retail pharmacy first and then ask your prescriber for an additional prescription for up to a 90-day supply. This can help to prevent you from running out of any medication prior to obtaining your mailed prescription. It can also help to reduce medication waste if you or your doctor decides the new medication is not the best choice due to intolerable side effects or ineffectiveness.

Mail To: Medco Health Solutions of Fairfield  
P.O. BOX 747000  
Cincinnati, OH 45274-7000

## Contact Information

The AvMed Commercial Medication Formulary is designed to assist prescribers, members, and other health care professionals in the selection of cost-effective agents. AvMed encourages your input and feedback on how we can assist in improving this document and the formulary management process. You may contact AvMed's Member Services Department by calling the number listed on the back of your card.

For additional information, please visit our website at [www.avmed.org](http://www.avmed.org).



## Prior Authorization

The following medications require prior approval before coverage can be determined. Your prescriber may need to provide clinical information so that coverage may be considered. To initiate a Prior Authorization, please visit our website at [www.avmed.org](http://www.avmed.org) to obtain a Medication Exception Request Form (MER).

ABSTRAL	CRINONE	HEPSERA	PEG-INTRON	STELARA**
ACTEMRA**	DALIRESP	HUMIRA	PERFOROMIST	SOMATULINE DEPOT
<b>adapalene</b> (DIFFERIN)	DIFICID	INCIVEK	PROCHIEVE	STIMATE
ADCIRCA	<b>dihydroergotamine</b> (D.H.E 45)	INTRON-A	PROCRIT	<b>sumatriptan Injectable</b> (IMITREX STATDOSE)
AMPYRA	<b>dronabinol</b> (MARINOL)	<b>itraconazole</b> (SPORANOX)	PROMACTA	SUPPRELINLA**
<b>anastrozole</b> (ARIMIDEX)	ENBREL	IVIG**	PROVIGIL	SYLATRON
ANDRODERM	<b>enoxaparin sodium</b> (LOVENOX)	KINERET	QUALAQUIN	SYNAGIS**
ANDROGEL PUMP	EMEND	<b>letrozole</b> (FEMARA)	REGRANEX	TESTIM
ARANESP	EMSAM	LEUKINE	REMICADE**	<b>tretinoin</b> (RETIN-A)
ARIXTRA	ENDOMETRIN	LOTRONEX	RESTASIS	TYSABRI**
AXIRON	EPOGEN	LUPRON DEPOT**	RETIN-A MICRO	TYVASO
AVITA	<b>fentanyl citrate oral transmucosal</b> (ACTIQ)	LUPRON DEPOT-PED**	REVATIO	ULORIC
AVONEX	FENTORA	MUGARD	<b>ribavirin</b> (COPEGUS, REBETOL, <b>ribapak</b> , <b>ribasphere</b> )	VANCOCIN HCL
BETASERON	<b>fluoride</b>	NEUMEGA**	RITUXAN**	VENTAVIS
BROVANA	<b>folic acid</b>	NEUPOGEN	SABRIL	VICTRELIS
<b>budesonide</b> (PULMICORT RESPULES)	FORTEO	NPLATE**	SANCUSO	VIMPAT
<b>butorphanol tartrate</b> (STADOL)	FORTESTA	NUVIGIL	SELZENTRY	XOLAIR**
CAPHOSOL	FRAGMIN	OMNITROPE	SEROSTIM	XYREM
CELEBREX	FUZEON	ORENCIA**	SIMPONI	ZYTIGA
CIMZIA	GAMMAGARD INJ	<b>oxandrolone</b> (OXANDRIN)	SOLIRIS**	ZYVOX
CINRYZE**	GAMUNEX-C**	PEGASYS		
	GILENYA	PEGASYS PROCLICK		

\* This list of Prior Authorizations is subject to change.

\*\*These medications are designated by AvMed as prescription drugs that require administration by a medical professional (physician, nurse, etc.). Therefore, these medications will be covered under your medical benefits if you have applicable coverage and should not be covered through your prescription benefits. However, these products still require prior authorization prior to administration by a medical professional.

## Progressive Medication Program

For certain medications, coverage requires trial of one or more 1<sup>st</sup> line medications prior to coverage of a 2<sup>nd</sup> line medication. Coverage for 3<sup>rd</sup> line medications require a trial of one or more 1<sup>st</sup> line **AND** 2<sup>nd</sup> line medications. If for medical reasons, you cannot use the 1<sup>st</sup> line medication and require the 2<sup>nd</sup> or 3<sup>rd</sup> line medication; your prescriber may request an exception via the prior authorization process. Members who are already controlled on a 2<sup>nd</sup> or 3<sup>rd</sup> line medication in the medication categories noted with an (\*\*) will be grandfathered in.

Medication Category	1 <sup>st</sup> Line Meds (typically generics)	2 <sup>nd</sup> Line Meds	3 <sup>rd</sup> Line Meds
Antidiabetics	<b>metformin</b> , a sulfonylurea (e.g. <b>glyburide, glimiperide</b> ), and/or ACTOS		VICTOZA
Antidiabetics	Insulin	SYMLIN ( <i>must continue on 1<sup>st</sup> line medication</i> )	
Antihyperlipidemics** (Fibrates)	<b>fenofibrate</b> (LOFIBRA)	LIPOFEN, TRICOR, TRIGLIDE, TRILIPIX	
Antihypertensives** (ACEI/ARB)	<b>benazepril/-hct, captopril/-hct, enalapril/-hct, fosinopril/-hct, lisinopril/-hct, moexipril/-hct, quinapril/-hct, trandolapril/-hct</b>	<b>losartan/-hct</b> , DIOVAN/-HCT, EXFORGE, EXFORGE HCT, VALTURNA	ATACAND/-HCT, AVAPRO/AVALIDE, AZOR, BENICAR/-HCT, MICARDIS/-HCT, TEVETEN/-HCT, TRIBENZOR, EDARBI
Cholesterol** (Statins)	<b>lovastatin, pravastatin, simvastatin</b>	CRESTOR	LIPITOR, LESCOL XL, VYTORIN, CADUET
Heartburn/Ulcer** (Proton Pump Inhibitors)	<b>omeprazole Rx/OTC</b> (PRILOSEC), <b>lansoprazole, pantoprazole, omeprazole/sodium bicarbonate</b> (ZEGERID), PREVACID OTC, ZEGERID OTC	DEXILANT	NEXIUM, ACIPHEX
Osteoporosis** (Oral Bisphosphonate)	<b>alendronate</b> (FOSAMAX)	ACTONEL, ATELVIA, BONIVA, FOSAMAX PLUS D	

\*This list of Progressive Medication Programs is subject to change.

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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### Analgesics: Miscellaneous

ALAGESIC	3					
<b>anabar</b>	1	240/30 days				
<b>bupap</b> (SEDAPAP)	1	180/30 days				
<b>butalbital /acetaminophen /caffeine</b> (ESGIC-PLUS)	1	180/30 days				
<b>butalbital /apap /caffeine</b> (FIORICET)	1	180/30 days				
<b>butalbital/acetaminophen</b> (PHRENILIN)	1	180/30 days				
<b>butalbital/apap/caffeine</b> (ESGIC)	1	180/30 days				
<b>cafgesic</b> (DURABAC)	1	180/30 days				
DOLGIC LQ	3	480/30 days				
DOLGIC PLUS	3	150/30 days				
FRENADOL	2	180/30 days				
PHRENILIN FORTE	2	180/30 days				
RIDAURA	2	90/30 days				

### Analgesics: Nonsteroidal Anti-inflammatory Drugs

ARTHROTEC 50	3	120/30 days				
ARTHROTEC 75	3	90/30 days				
<b>butalbital /aspirin /caffeine</b> (FIORINAL)	1	180/30 days				
<b>butalbital/asa/caffeine</b> (FIORINAL)	1	180/30 days				
CAMBIA	3	9/30 days				
CELEBREX	3	60/30 days		Y		
<b>choline magnesium trisalicylate</b> (TRILISATE)	1					
<b>diclofenac potassium</b> (CATAFLAM)	1	120/30 days				
<b>diclofenac sodium</b> (VOLTAREN)	1	120/30 days				
<b>diclofenac sodium tab delayed release</b> (DICLOFENAC SODIUM EC)	1	120/30 days				
<b>diclofenac sodium er</b> (VOLTAREN-XR)	1	60/30 days				
<b>diflunisal</b>	1	90/30 days				
<b>etodolac tabs</b> (LODINE)	1	60/30 days				
<b>etodolac caps</b> (LODINE)	1	90/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
etodolac er (LODINE XL)	1	60/30 days				
fenoprofen calcium	1	150/30 days				
FLECTOR	3	60/30 days				
flurbiprofen (ANSAID)	1	90/30 days				
ibuprofen (MOTRIN)	1	120/30 days				
indomethacin caps	1	120/30 days				
INDOMETHACIN SUPP.	2	120/30 days				
indomethacin er (INDOCIN SR)	1	120/30 days				
ketoprofen	1					
KETOPROFEN ER	2					
ketorolac tromethamine (TORADOL)	1	20/30 days				
LEVACET	2	240/30 days				
MECLOFENAMATE SODIUM	3					
mefenamic acid (PONSTEL)	1	30/30 days				
meloxicam susp	1	300/30 days				
meloxicam tabs (MOBIC)	1	30/30 days				
mst 600 (NOVASAL)	1	180/30 days				
nabumetone (RELAFEN)	1	90/30 days				
NALFON	3	150/30 days				
NAPRELAN	3	60/30 days				
naproxen susp (NAPROSYN SUSP)	1	480/30 days				
naproxen tabs (NAPROSYN TABS)	1	90/30 days				
naproxen dr (EC-NAPROSYN)	1	60/30 days				
naproxen sodium (ANAPROX)	1	90/30 days				
naproxen sodium (ANAPROX DS)	1	90/30 days				
naproxen sodium (NAPRELAN)	1	60/30 days				
orphenadrine compound (NORGESIC)	1	120/30 days				
ORPHENADRINE COMPOUND DS	2	120/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>oxaprozin</b> (DAYPRO)	1	90/30 days				
PENNSAID	3	300/30 days				
<b>piroxicam</b> (FELDENE)	1					
<b>salsalate</b>	1					
<b>sulindac</b> (CLINORIL)	1					
<b>tolmetin sodium</b>	1					
<b>Analgesics: Opiate Agonists</b>						
ABSTRAL	3	120/30 days		Y		
<b>acetaminophen/caffeine/dihydrocodeine bitartrate</b> (PANLOR SS)	1	150/30 days				
<b>acetaminophen/codeine soln</b> (TYLENOL/CODEINE SOLN)	1	480/30 days				
<b>acetaminophen/codeine tabs</b> (TYLENOL/CODEINE TABS)	1	360/30 days				
<b>acetaminophen/codeine #3</b> (TYLENOL/CODEINE)	1	360/30 days				
<b>aspirin/codeine</b>	1	360/30 days				
AVINZA	2	30/30 days				
<b>butal /asa /caff /cod</b> (FIORINAL/CODEINE #3)	1	180/30 days				
<b>butalbital /apap /caffeine /codeine</b> (FIORICET/CODEINE)	1	180/30 days				
CAPITAL/CODEINE	2	180/30 days				
CODEINE PHOSPHATE	2					
<b>codeine sulfate</b>	1					
EMBEDA	3	60/30 days				
EXALGO	3	120/30 days				For the 8mg strength QL is 30/30 days
<b>fentanyl</b> (DURAGESIC)	1	10/30 days				
<b>fentanyl citrate oral transmucosal</b> (ACTIQ)	1	120/30 days		Y		
FENTORA	3	112/28 days		Y		
<b>hydrocet</b> (BANCAP-HC)	1	200/30 days				
<b>hydrocodone /acetaminophen</b> (ANEXSIA, LORCET LORTAB, VICODIN, XODOL)	1	200/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
hydrocodone /acetaminophen soln (LORTAB SOLN)	1	2700/30 days				
hydrocodone-acetaminophen soln 7.5-325 mg/15ml (HYCETSOLN)	1	540/30 days				
hydrocodone bitartrate/acetaminophen (MAXIDONE)	1	200/30 days				
hydrocodone/ibuprofen (VICOPROFEN)	1	200/30 days				
hydromorphone hcl (DILAUDID)	1					
MEPERIDINE HCL	2					
meperidine hcl (DEMEROL)	1					
meperidine/promethazine (MEPERGAN FORTIS)	1					
methadone hcl (DOLOPHINE)	1					
methadone hcl soln	1					
morphine sulfate	1					
morphine sulfate (RMS)	1					
morphine sulfate (ROXANOL)	1					
morphine sulfate cr (MS CONTIN)	1					
morphine sulfate er (MS CONTIN)	1					
morphine sulfate cap sr 24hr (KADIAN)	1	60/30 days				
ONSOLIS	3	120/30 days				
OPANA ER	2	60/30 days				
oxycodone hcl (OXYIR)	1					
oxycodone hcl (ROXICODONE)	1					
oxycodone hcl (ROXICODONE INTENSOL)	1	60/30 days				
oxycodone hcl er tabs(OXYCONTIN)	1	60/30 days				10MG, 20MG, 40MG, AND 80MG ONLY TIER 1
oxycodone/acetaminophen (TYLOX)	1	200/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>oxycodone /acetaminophen</b> (PERCOET)	1	200/30 days				
<b>oxycodone/aspirin</b> (PERCODAN)	1	360/30 days				
OXYCONTIN	2	60/30 days				
<b>oxymorphone hcl</b> (OPANA)	1	60/30 days				
ROXICET SOLN	3	480/30 days				
ROXICET TABS	3	200/30 days				
RYZOLT	3	30/30 days				
SYNALGOS-DC	3	300/30 days				
<b>tramadol hcl</b> (ULTRAM)	1	240/30 days				
<b>tramadol SR</b> (ULTRAM ER)	1	30/30 days				
<b>tramadol hydrochloride/acetaminophen</b> (ULTRACET)	1	240/30 days				
<b>trezix</b> (PANLOR DC)	3	300/30 days				
ZYDONE	3	200/30 days				
<b>Analgesics: Opiate Partial Agonists</b>						
<b>buprenorphine</b> (SUBUTEX)	1	90-180/30 days				
<b>butorphanol tartrate</b> (STADOL)	1	5/30 days		Y		
<b>pentazocine /acetaminophen</b> (TALACEN)	1	360/30 days				
<b>pentazocine/naloxone hcl</b> (TALWIN NX)	1	360/30 days				
SUBOXONE	3	90-180/30 days				QL 90/30 for 8-2 strength; QL 180/30 for 2-0.5 strength
<b>Antibacterials: Cephalosporins</b>						
CEDAX	3					
<b>cefaclor caps</b>	1					
CEFACLOR ER	2					
<b>cefadroxil</b> (DURICEF)	1					
<b>cefdinir</b> (OMNICEF)	1					
<b>cefepodoxime proxetil</b> (VANTIN)	1					
<b>cefprozil</b> (CEFZIL)	1					
<b>cefuroxime axetil</b> (CEFTIN)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
cephalexin (KEFLEX)	1					750mg strength Non Formulary
RANICLOR	3					
SPECTRACEF	3					
SUPRAX	3					
<b>Antibacterials: Macrolides</b>						
azithromycin pack	1	2/30 days				
azithromycin (ZITHROMAX)	1	12/30 days				
azithromycin susp (ZITHROMAX SUSP)	1					
clarithromycin (BIAXIN)	1					
clarithromycin er (BIAXIN XL)	1					
ERYPED	2					
ERY-TAB	2					
erythrocin stearate	1					
ERYTHROMYCIN	2					
erythromycin /sulfisoxazole (PEDIAZOLE)	1					
erythromycin base	2					
erythromycin ethylsuccinate	1					
KETEK	3					
PCE	2					
ZMAX	2	1/30 days				
<b>Antibacterials: Other</b>						
CAYSTON	2	84/30 days				
clindamycin hcl (CLEOCIN)	1					
clindamycin hcl solution (CLEOCIN PEDIATRIC GRANULES)	1					
DIFICID	3	20/30 days		Y		
neomycin sulfate	1					
TOBI	2	300/30 days				
VANCOCIN HCL	2	40/30 days		Y		
XIFAXAN	3	60/30 days				QL 200mg strength #9/30



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ZYVOX SUSP	2	1680/28 days		Y		Prior authorization required; 3 days therapy allowed initially
ZYVOX TABS	2	56/28 days		Y		Prior authorization required; 3 days therapy allowed initially
<b>Antibacterials: Penicillins</b>						
<b>amoxicillin (AMOXIL)</b>	1					
<b>amoxicillin/clavulanate potassium (AUGMENTIN)</b>	1					
<b>amoxicillin/clavulanate potassium (AUGMENTIN ES-600)</b>	1					
<b>amoxicillin/clavulanate potassium sr (AUGMENTIN XR)</b>	1	40/30 days				
AMOXIL	2					Only 50MG/mL Tier 2
<b>ampicillin caps</b>	1					
AMPICILLIN SUSP	2					
AUGMENTIN CHEW	2					Only 250MG Chewable Tier 2
AUGMENTIN SUSP	2					Only 125Mg Tier 2
<b>dicloxacillin sodium</b>	1					
<b>penicillin v potassium</b>	1					
<b>Antibacterials: Quinolones</b>						
AVELOX	2	30/30 days				
CIPRO	2					
<b>ciprofloxacin er (CIPRO XR)</b>	1	30/30 days				
<b>ciprofloxacin hcl (CIPRO)</b>	1					
FACTIVE	3	10/30 days				
<b>levofloxacin (LEVAQUIN IV SOLN)</b>	1					
<b>levofloxacin (LEVAQUIN TABS)</b>	1	14/30 days				
<b>ofloxacin (FLOXIN)</b>	1					
<b>Antibacterials: Sulfonamides</b>						
GANTRISIN PEDIATRIC	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
SULFADIAZINE	2					
<b>sulfamethoxazole /trimethoprim (BACTRIM)</b>	1					
<b>sulfamethoxazole/trimethoprim ds (BACTRIM DS)</b>	1					
<b>sulfasalazine (AZULFIDINE EN-TABS)</b>	1					
<b>sulfazine (AZULFIDINE)</b>	1					
<b>Antibacterials: Tetracyclines</b>						
<b>demeclocycline hcl</b>	1					
<b>doxycycline hyclate (VIBRAMYCIN)</b>	1					Tier 1 applies to immediate release (IR) products only
<b>doxycycline monohydrate (ADOXA, MONODOX)</b>	1	30/30				Tier 1 does not apply to Adoxa 150m 75mg QL 60/30
<b>minocycline hcl (DYNACIN, MINOCIN)</b>	1	60/30 days				
<b>tetracycline hcl</b>	1					
<b>Antidiabetic Agents: Diabetic Meter Systems and Supplies</b>						
ACCU-CHEK <b>AVIVA</b> METER SYSTEM	Roche Pharma Free Meter Program	1/365 days				Call 1-888-355-4242 to place your order. A prescription is REQUIRED
ACCU-CHEK <b>COMPACT PLUS</b> METER SYSTEM	Roche Pharma Free Meter Program	1/365 days				Call 1-888-355-4242 to place your order. A prescription is REQUIRED
ACCU-CHEK SOFTCLIX LANCETS	2	200/30 days				For use with the ACCU-CHEK ACTIVE, ADVANTAGE, AND COMPACT PLUS meter systems
ACCU-CHEK SOFTCLIX LANCET DEVICE	2	1/365 days				For use with the ACCU-CHEK ACTIVE, ADVANTAGE, AND COMPACT PLUS meter systems
ACCU-CHEK SOFT TOUCH LANCETS	2	200/30 days				
ACCU-CHEK SOFT TOUCH LANCET DEVICE	2	200/30 days				
ACCU-CHEK MULTICLIX LANCETS	2	204/30 days				For use with ACCU-CHEK AVIVA meter system
ACCU-CHEK MULTICLIX LANCING DEVICE KIT	2	1/365 days				For use with ACCU-CHEK AVIVA meter system
BD ULTRA FINE LANCETS	2	204/30 days				
BD ULTRA-FINE 33 LANCETS	2	204/30 days				
ACCU-CHEK ACTIVE STRIPS	2	200/30 days				For use with ACCU-CHEK ACTIVE meter

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
						system
ACCU-CHEK COMFORT CURVE TEST STRIPS	2	200/30 days				For use with ACCU-CHEK ADVANTAGE meter system
ACCU-CHEK <b>ADVANTAGE</b> TEST STRIPS	2	200/30 days				For use with ACCU-CHEK Advantage meter system
ACCU-CHEK <b>AVIVA</b> TEST STRIPS	2	200/30 days				For use with ACCU-CHEK AVIVA meter system
ACCU-CHEK <b>COMPACT</b> STRIPS	2	204/30 days				For use with ACCU-CHEK COMPACT PLUS meter system
ACCU-CHEK <b>COMPACT</b> TEST DRUM	2	204/30 days				For use with ACCU-CHEK COMPACT PLUS meter system
ACCU-CHEK INSTANT GLUCOSE STRIPS	2	200/30 days				
ACCU-CHEK INSTANT PLUS STRIPS	2	200/30 days				
ACCU-CHEK <b>ACTIVE</b> GLUCOSE CONTROL SOLUTION	2					For use with ACCU-CHEK ACTIVE meter system
ACCU-CHEK COMFORT CURVE CONTROL SOLUTION	2					For use with ACCU-CHEK ADVANTAGE meter system
ACCU-CHEK <b>AVIVA</b> CONTROL SOLUTION	2					For use with ACCU-CHEK AVIVA meter system
ACCU-CHEK COMPACT GLUCOSE CONTROL SOLUTION	2					For use with ACCU-CHEK COMPACT PLUS meter system
ACCU-CHEK INSTANT GLUCOSE CONTROL SOLUTION	2					

### Antidiabetic Agents: Insulins and Supplies

APIDRA	2	45/30 days				
APIDRA SOLOSTAR	2	45/30 days				
HUMALOG	2	45/30 days				
HUMALOG KWIKPEN	2	45/30 days				
HUMALOG MIX 50/50	2	45/30 days				
HUMALOG MIX 50/50 KWIKPEN	2	45/30 days				
HUMALOG MIX 50/50 PEN	2	45/30 days				
HUMALOG MIX 75/25	2	45/30 days				
HUMALOG MIX 75/25 KWIKPEN	2	45/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
HUMALOG MIX 75/25 PEN	2	45/30 days				
HUMALOG PEN	2	45/30 days				
HUMULIN 50/50	2	45/30 days				
HUMULIN 70/30	2	45/30 days				
HUMULIN 70/30 PEN	2	45/30 days				
HUMULIN N	2	45/30 days				
HUMULIN N U-100 PEN	2	45/30 days				
HUMULIN R	2	45/30 days				
HUMULIN R U-500 (CONCENTRATED)	2	45/30 days				
LANTUS	2	45/30 days				
LANTUS FOR OPTICLIK	2	45/30 days				
LANTUS SOLOSTAR	2	45/30 days				
LEVEMIR	2	45/30 days				
LEVEMIR FLEXPEN	2	45/30 days				
NOVOLIN 70/30	2	45/30 days				
NOVOLIN N	2	45/30 days				
NOVOLIN R	2	45/30 days				
NOVOLOG	2	45/30 days				
NOVOLOG FLEXPEN	2	45/30 days				
NOVOLOG MIX 70/30	2	45/30 days				
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	2	45/30 days				
NOVOLOG PENFILL	2	45/30 days				
RELION 70/30	2	45/30 days				
RELION 70/30 INNOLET	2	45/30 days				
RELION N	2	45/30 days				
RELION N INNOLET	2	45/30 days				
RELION R	2	45/30 days				
BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2"	2	120/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
BD INSULIN SYRINGE SAFETYGLIDE/U-100/0.3ML/31G X 5/16"	2	120/30 days				
BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2"	2	120/30 days				
BD ULTRAFINE III MINI PEN NEEDLES/31G X 5MM	2	120/30 days				
BD ULTRAFINE III SHORT PEN NEEDLES/31G X 5/16"	2	120/30 days				
BD ULTRA-FINE ORIGINAL PEN NEEDLES/29G X 12.7MM	2	120/30 days				
INSULIN SYRINGE/0.3ML/29G X 1/2"	2	120/30 days				
INSULIN SYRINGE/0.5ML/29G X 1/2"	2	120/30 days				
INSULIN SYRINGE/1ML/29G X 1/2"	2	120/30 days				
INSULIN SYRINGE/1ML/31G X 5/16"	2	120/30 days				
<b>Antidiabetic Agents: Miscellaneous</b>						
BYETTA	2	2.4/30 days				
SYMLIN SOLN	2	10/30 days	Y			Progressive Medication Program Therapy with insulin required <i>Must continue on 1<sup>st</sup> line medication.</i>
SYMLINPEN 120	2	11/30 days	Y			Progressive Medication Program Therapy with insulin required <i>Must continue on 1<sup>st</sup> line medication.</i>
SYMLINPEN 60	2	6/30 days	Y			Progressive Medication Program Therapy with insulin required <i>Must continue on 1<sup>st</sup> line medication.</i>
VICTOZA	3	9/30 days	Y			Progressive Medication Program therapy with metformin, sulfonylureas, and/or thiazolidinedione.
<b>Antidiabetic Agents: Oral</b>						
<b>acarbose (PRECOSE)</b>	1	90/30 days				
ACTOPLUS MET	2	90/30 days				
ACTOPLUS MET XR	2	30/30 days				
ACTOS	2	30/30 days				
AVANDAMET	2	60/30 days				
AVANDARYL	2	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
AVANDIA	2	30/30 days				
<b>chlorpropamide (DIABINESE)</b>	1					
DUETACT	2	30/30 days				
<b>glimepiride (AMARYL)</b>	1					
<b>glipizide (GLUCOTROL)</b>	1					
<b>glipizide xl (GLUCOTROL XL)</b>	1					
<b>glipizide/metformin hcl (METAGLIP)</b>	1					
GLUMETZA	3	60/30 days				
<b>glyburide (MICRONASE)</b>	1					
<b>glyburide micronized (GLYNASE)</b>	1					
<b>glyburide/metformin hcl (GLUCOVANCE)</b>	1					
GLYCRON	2					
GLYSET	2	90/30 days				
JANUMET	2	60/30 days				
JANUVIA	2	30/30 days				
KOMBIGLYZE XR	2	30/30 days				2.5/1000 mg strength- QL 60/30
<b>metformin hcl (GLUCOPHAGE)</b>	1	75/30 days				
<b>metformin hcl er (GLUCOPHAGE XR)</b>	1	90/30 days				
<b>natelinide (STARLIX)</b>	1	90/30 days				
ONGLYZA	2	30/30 days				
PRANDIN	2	120/30 days				
<b>tolazamide</b>	1					

## Antifungals

ANCOBON	2					
<b>fluconazole susp (DIFLUCAN SUSP)</b>	1					
<b>fluconazole tabs(DIFLUCAN TABS)</b>	1	4/30 days				
GRIFULVIN V	2					
<b>griseofulvin microsize (GRIFULVIN V)</b>	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
GRIS-PEG	2					
<b>itraconazole</b> (SPORANOX)	1/5			Y		For 5 Tier benefit, PA not required. Copay Tier 5 applies.
<b>ketoconazole</b> (NIZORAL)	1	60/30 days				
NOXAFIL	2					
<b>nystatin</b>	1					
<b>terbinafine hcl</b> (LAMISIL)	1					
VFEND SUSP	3	150/30 days				
VFEND TABS	3	60/30 days				
<b>Antigout Agents</b>						
<b>probenecid</b>	1					
<b>probenecid/colchicine</b>	1					
<b>Antihelmintics</b>						
ALBENZA	3					
BILTRICIDE	3					
<b>mebendazole</b>	1					
<b>Antihistamines: 1<sup>st</sup> Generation</b>						
ACUFLEX	3					
ACCUHIST PDX	3					
ALLERX	2					
ALPAIN	2					
BROFED	2					
<b>bromhist pediatric</b>	1					
<b>brompheniramine sr</b> (RESPA-B)	1					
<b>brompheniramine/dextromethorphan/phenylephrine</b> (ALAHIST DM)	1					
CARBAPHEN 12 PED	3					
<b>carbinoxamine maleate</b> (CARBINOXAMINE MALEATE)	1					
<b>chlorpheniramine /phenyltoloxamine /phenylephrine</b> (NALEX-A)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>chlorpheniramine/phenylephrine hcl</b>	1					
<b>chlorpheniramine/pseudoephedrine cr</b> (DECONAMINE SR)	1					
<b>chlorpheniramine/pseudoephedrine la</b> (BIOHIST LA)	1					
COMHIST	2					
<b>cpm 8/pse 90/msc 2.5</b>	1					
<b>cyproheptadine hcl</b>	1					
DESPEC-PDC	3					
DEXCHLORPHENIRAMINE MALEATE	2					
DEXCHLORPHENIRAMINE MALEATE CR	2					
<b>diphenhydramine/phenylephrine</b> (ALAHIST LQ)	1					
<b>d-hist d</b> (DURAHIST D)	1					
<b>dologen</b>	1					
DOLOGESIC	2					
DRYMAX	3					
DUOTAN PD	2					
ED-CHLOR-TAN	2					
HISTEX SR	3					
<b>k-tan</b> (RYNA-12)	1					
<b>k-tan 4</b> (RYNA-12 S)	1					
<b>lohist-pd</b> (ACCUHIST)	1					
NALEX-A 12	3					
PALGIC	2					
<b>phenyl chlor-tan</b> (RYNATAN PEDIATRIC)	1					
<b>phenylephrine cm</b> (RESCON-MX)	1					
PROLEX DMX	3					
<b>promethazine hcl supp</b>	1	12/30 days				
<b>promethazine hcl tabs</b>	1					
<b>promethazine hcl plain syrup</b>	1					
PROTID	2					
<b>pseudo cm</b>	1					
RELAGESIC	3					



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
RELHIST	3					
RESCON	3					
RESCON-JR	3					
<b>rhinoflex</b>	1					
<b>rhinoflex-650 (RELAGESIC)</b>	1					
<b>r-tanna (RYNATAN)</b>	1					
RYNATAN PEDIATRIC	3	480/30 days				
RYDEX	3					
SYMPAK	3					
SYMPAK II	3					
SYMPAK PDX	3					
<b>triotann pediatric</b>	1					
<b>ultrabrom</b>	1					
<b>ultrabrom pd</b>	1					
VAZOTAB	3	60/30 days				
V-COF	3					
V-HIST	3					
<b>Anti-HIV Agents: Fusion Inhibitors</b>						
FUZEON	4			Y	Y	Curascript Only
SELZENTRY	2			Y		
<b>Anti-HIV Agents: Integrase Inhibitors</b>						
ISENTRESS	2	60/30 days				
ATRIPLA	2	30/30 days				
<b>Anti-HIV Agents: Nonnucleoside RTIs</b>						
INTELENCE	2	60/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
RESCRIPTOR	2	180/30 days				
SUSTIVA	2	30/30 days				
VIRAMUNE SUSP	2					
VIRAMUNE TABS	2	60/30 days				
VIRAMUNE XR TABLET	2	30/30 days				
<b>Anti-HIV Agents: Nucleoside/Nucleotide RTIs</b>						
COMBIVIR	2					
COMPLERA	2	30/30 days				
<b>didanosine</b> (VIDEX EC)	1					
EDURANT	3	30/30 days				
EMTRIVA CAPS	2	30/30 days				
EMTRIVA SOLN	2	75/30 days				
EPIVIR SOLN	2					
EPIVIR TABS	2	60/30 days				
EPIVIR HBV	2					
EPIVIR HBV	2	90/30 days				
EPZICOM	2	30/30 days				
<b>stavudine</b> (ZERIT)	1	60/30 days				
TRIZIVIR	2	60/30 days				
TRUVADA	2	30/30 days				
VIDEX EC	3					
VIDEX PEDIATRIC	2					
VIREAD	2	30/30 days				
ZIAGEN SOLN	2	900/30 days				
ZIAGEN TABS	2	60/30 days				
<b>zidovudine</b> (RETROVIR)	1					
<b>Anti-HIV Agents: Protease Inhibitors</b>						
APTIVUS	2	120/30 days				
CRIXIVAN	2	150/30 days				
INVIRASE CAPS	2	270/30 days				
INVIRASE TABS	2	210/30 days				
KALETRA TABS/CAPS	2	120/30 days				
KALETRA SOLN	2	600/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
LEXIVA	2	120/30 days				
NORVIR	2					
PREZISTA	2	60/30 days				
REYATAZ	2	30/30 days				
VIRACEPT POWD	2					
VIRACEPT TABS	2	120/30 days				
<b>Antihypoglycemics</b>						
GLUCAGEN HYPOKIT	2	2/365 days				
<b>Anti-infectives: Miscellaneous</b>						
HELIDAC	3	56/30 days				
PYLERA	3	120/30 days				
<b>Anti-infectives: Urinary</b>						
MACRODANTIN	2					
<b>methenamine/hyosc/meth blue/benz acid/phenyl sol</b> (PROSED D/S)	1					
<b>methenamine/hyosc/meth blue/benz acid/phenyl tab</b> (PROSED D/S)	1					
<b>methenamine hippurate</b> (HIPREX)	1					
MONUROL	2					
<b>nitrofurantoin susp</b> (FURADANTIN)	1					
<b>nitrofurantoin macrocrystalline</b> (MACRODANTIN)	1					
<b>nitrofurantoin monohydrate</b> (MACROBID)	1					
PRIMSOL	2					
<b>trimethoprim</b> (PROLOPRIM)	1					
URETRON D/S	2					
<b>urimar t</b>	1					
<b>urogesic-blue</b>	1					
UTA	2					
<b>visqid a/a</b> (UROQID #2)	1					
<b>Antimigraine Agents</b>						
AXERT	3	6/30 days				
<b>dihydroergotamine mesylate</b> (D.H.E. 45)	1			Y		
ERGOMAR	2					
<b>ergotamine tartrate/caffeine</b> (CAFERGOT)	1					
FROVA	3	9/30 days				
<b>isometh/apap</b> (MIDRIN CAPS)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
MAXALT	2	12/30 days				
MAXALT-MLT	2	12/30 days				
MIGERGOT	2	20/30 days				
MIGRAL	3					
MIGRANAL	3	8/30 days				
<b>naratriptan tab (AMERGE)</b>	1	9/30 days				
RELPAK	2	9/30 days				
<b>sumatriptan soln (IMITREX SOLN)</b>	1	6/30 days				
<b>sumatriptan succinate refill (IMITREX STATDOSE REFILL)</b>	1			Y		
<b>sumatriptan succinate (IMITREX STATDOSE SYSTEM)</b>	1			Y		
<b>sumatriptan tabs (IMITREX TABS)</b>	1	9/30 days				
ZOMIG	3	6/30 days				
ZOMIG ZMT	3	6/30 days				

## Antimycobacterials

<b>cycloserine (SEROMYCIN)</b>	3					
DAPSONE	2					
<b>ethambutol hcl</b>	1					
<b>isonarif (RIFAMATE)</b>	1					
ISONIAZID SYRP	2					
<b>isoniazid tabs</b>	1					
MYCOBUTIN	2					
PASER	2					
PRIFTIN	2					
<b>pyrazinamide</b>	1					
<b>rifampin (RIFADIN)</b>	1					
RIFATER	2					
TRECTOR	2					

## Antineoplastics

AFINITOR	2	30/30 days			Y	Curascript Only
ALKERAN	2					
<b>anastrozole (ARIMIDEX)</b>	1			Y		
<b>bicalutamide (CASODEX)</b>	1	30/30 days				
CEENU	2	3/30 days				
CAPRELSA	2					
CYCLOPHOSPHAMIDE	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
DROXIA	2					
EMCYTE	2					
<b>etoposide</b> (VEPESID)	1					
exemestane (AROMASIN)	1					
FARESTON	2	30/30 days				
<b>flutamide</b>	1	180/30 days				
GLEEVEC	2	60/30 days			Y	Curascript Only
HEXALEN	2					
HYCAMPTIN	2				Y	Curascript Only
<b>hydroxyurea</b> (HYDREA)	1					
INTRON-A	4			Y	Y	Curascript Only
INTRON-A W/DILUENT	4			Y	Y	Curascript Only
IRESSA	2	30/30 days			Y	Curascript Only
<b>letrozole</b> (FEMARA)	1	30/30 days		Y		
LEUKERAN	2					
LYSODREN	2					
MATULANE	2					
<b>megestrol acetate</b> (MEGACE)	1					
<b>mercaptopurine</b> (PURINETHOL)	1					
<b>methotrexate</b>	1					
MYLERAN	2					
NEXAVAR	2	120/30 days			Y	Curascript Only
NILANDRON	2					
OFORTA	2					
SOLTAMOX	2	300/30 days				
SPRYCEL	2	60/30 days			Y	Curascript Only; QL 30/30 - 80MG AND 140MG
SUTENT	2	30/30 days			Y	Curascript Only
SYLATRON INJ KIT	4				Y	Curascript Only
TABLOID	2					
<b>tamoxifen citrate</b>	1	60/30 days				
TARCEVA	2	30/30 days			Y	Curascript Only
TARGRETIN	2					
TASIGNA 150 MG	2	120/30 days			Y	Curascript Only

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
TASIGNA 200 MG	2	112/28 days			Y	Curascript Only
TEMODAR	2				Y	Curascript Only
TESLAC	2					
<b>tretinoin</b> (VESANOID)	1					
TYKERB	2	150/30 days			Y	Curascript Only
VOTRIENT	2	60/30 days				
XELODA	2				Y	Curascript Only
ZOLINZA	2	120/30 days			Y	Curascript Only
ZYTIGA	2	120/30 days			Y	Requires prior trial of docetaxel; Curascript Only

## Antiparkinsonian Agents

AMANTADINE HCL TABS	2					
<b>amantadine hcl</b> (SYMMETREL)	1					
APOKYN	4	18/30 days			Y	Curascript Only
AZILECT	2	30/30 days				
<b>benztropine mesylate</b> (COGENTIN)	1					
<b>bromocriptine mesylate</b> (PARLODEL)	1					
<b>cabergoline</b> (DOSTINEX)	1					
<b>carbidopa/levodopa</b> (SINEMET)	1					
<b>carbidopa/levodopa er</b> (SINEMET CR)	1					
COMTAN	2					
EMSAM	3	30/30 days		Y		
KEMADRIN	2					
LODOSYN	2					
MIRAPEX ER	3	30/30 days				
NEUPRO	2	30/30 days				
PARCOPA	2					
<b>pramipexole</b> (MIRAPEX)	1	135/30				
REQUIP XL	2					
<b>ropinirole hcl</b> (REQUIP)	1					
<b>selegiline hcl</b> (ELDEPRYL)	1					
STALEVO	2					
TASMAR	2					
<b>trihexyphenidyl hcl</b> (ARTANE)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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## Antiprotozoals

ALINIA TAB	3	6/30 days				
ALINIA SUS	3	180/30 days				
<b>chloroquine phosphate tabs (ARALEN)</b>	1	5/365 days				
COARTEM	2	24/30 days				
FLAGYL ER	3					
MALARONE	3	12/365 days				
MEFLOQUINE HCL TABS	1	5/365 days				
MEPRON	2					
<b>metronidazole (FLAGYL)</b>	1					
NEBUPENT	3					
QUALAQUIN	2			Y		
TINDAMAX	2					
YODOXIN	2					

## Antivirals

<b>acyclovir (ZOVIRAX)</b>	1					
BARACLUDE SOLN	2	180/30 days				
BARACLUDE TABS	2	30/30 days				
<b>famciclovir (FAMVIR)</b>	1	90/30 days				
GANCICLOVIR	2					
HEPSERA	2	30/30 days		Y		
INCIVEK	4			Y	Y	Curascript Only
INFERGEN	4	2/28 days			Y	Curascript Only
PEGASYS	4			Y	Y	Curascript Only; Pegasys is preferred product
PEGASYS PROCLICK	4			Y	Y	Curascript Only; Pegasys is preferred product
PEG-INTRON	4			Y	Y	Curascript Only; Pegasys is preferred product
PEG-INTRON REDIPEN PAK 4	4			Y	Y	Curascript Only; Pegasys is preferred product
RELENZA DISKHALER	3	20/30 days				
<b>ribapak</b>	1			Y	Y	Curascript Only
<b>ribasphere</b>	1			Y	Y	Curascript Only
<b>ribavirin (COPEGUS)</b>	1			Y	Y	Curascript Only
<b>ribavirin (REBETOL)</b>	1			Y	Y	Curascript Only
<b>rimantadine hcl (FLUMADINE)</b>	1	15/30 days				
TAMIFLU CAPS	3	10/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
TAMIFLU SUSP	3	75/30 days				
TYZKA	2	30/30 days				
<b>valacyclovir (VALTREX)</b>	1	60/30 days				
VALCYTE	2					
VICTRELIS	4			Y	Y	Curascript Only; Incivek preferred
XERESE	3	5/30 days				
<b>Autonomic Drugs</b>						
ADRENACLICK	2					
ATROVENT HFA	3	40/30 days				
CANTIL	2					
<b>chlordiazepoxide /clidinium (LIBRAX)</b>	1					
COLYTROL	2					
COLYTROL PEDIATRIC	2					
CUVPOSA	3					
<b>dicyclomine hcl (BENTYL)</b>	1					
EPIPEN 2-PAK	2	1/365 days				
EPIPEN-JR 2-PAK	2	1/365 days				
<b>ergoloid mesylates</b>	1					
<b>glycopyrrolate (ROBINUL)</b>	1					
<b>glycopyrrolate forte (ROBINUL FORTE)</b>	1					
<b>hyomax-dt (SYMAX DUOTAB)</b>	1					
<b>hyoscyamine</b>	1					
<b>hyoscyamine sulfate (ANASPAZ)</b>	1					
<b>hyoscyamine sulfate (LEVSIN)</b>	1					
<b>hyoscyamine sulfate (LEVSIN/SL)</b>	1					
<b>hyoscyamine sulfate er (LEVBID)</b>	1					
<b>hyoscyamine sulfate er (LEVSINEX)</b>	1					
<b>ipratropium bromide</b>	1	360/30 days				
<b>methscopolamine bromide (PAMINE)</b>	1					
<b>methscopolamine bromide (PAMINE FORTE)</b>	1					



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>midodrine hcl</b> (PROAMATINE)	1					
PROPANTHELINE BROMIDE	2					
SAL-TROPINE	2					
SPIRIVA HANDIHALER	2	30/30 days				
<b>symax fastabs</b> (NULEV)	1					
TWINJECT	2	2/365 days				

### Autonomic Drugs: Cholinergics

ARICEPT	2	30/30 days				23 mg strength
<b>bethanechol chloride</b> (URECHOLINE)	1					
COGNEX	3	120/30 days				
<b>donepezil</b> (ARICEPT)	1	30/30 days				
<b>donepezil odt</b> (ARICEPT ODT)	1	30/30 days				
EVOXAC	2	90/30 days				
EXELON PATCH	2	30/30 days				
EXELON SOLN	2	600/30 days				
<b>galantamine</b> (RAZADYNE)	1	60/30 days				
<b>galantamine er</b> (RAZADYNE ER)	1	30/30 days				
GUANIDINE HCL	2					
MESTINON	3					
MESTINON TIMESPAN	3					
MYTELASE	3					
<b>pilocarpine hcl</b> (SALAGEN)	1					
PROSTIGMIN	2					
<b>pyridostigmine bromide</b> (MESTINON)	1					
<b>rivastigmine cap</b> (EXELON)	1	60/30 days				
RAZADYNE SOLUTION	2					

### Blood Regulators: Anticoagulants

<b>jantoven</b> (COUMADIN)	1					
<b>warfarin sodium</b> (COUMADIN)	1					
XARELTO	2	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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### Blood Regulators: Antithrombotics

AGGRENOX	2	60/30 days				
<b>anagrelide hydrochloride</b> (AGRYLIN)	1					
<b>cilostazol</b> (PLETAL)	1	60/30 days				
EFFIENT	2	35/30 days				
<b>enoxaparin sodium</b> (LOVENOX)	1	21/60 days		Y		Prior authorization required >21 day supply in 60 days
FRAGMIN	3	21/60 days		Y		Prior authorization required >21 day supply in 60 days
<b>fondaparinux sodium</b> (ARIXTRA)	1	21/60 days		Y		Prior authorization required >21 day supply in 60 days
<b>heparin sodium</b>	1					
HEPARIN SODIUM	2					
<b>heparin sodium dcu</b>	1					
LOVENOX	2	21/60 days		Y		Prior authorization required >21 day supply in 60 days; Brand available in 300mg/3ml strength only
PLAVIX	2	33/30 days				
PRADAXA	2	60/30 days				
<b>ticlopidine hcl</b> (TICLID)	1					

### Blood Regulators: Hematopoietics

ARANESP ALBUMIN FREE	4			Y	Y	PA requires trial with Procrit; Curascript Only
ARANESP ALBUMIN FREE SURECLICK	4			Y	Y	PA requires trial with Procrit; Curascript Only
EPOGEN	4			Y	Y	Curascript Only
LEUKINE	4			Y	Y	Curascript Only
NEUPOGEN	4			Y	Y	Curascript Only
PROCRIT	4			Y	Y	Curascript Only

### Blood Regulators: Miscellaneous

AMICAR	2					
<b>aminocaproic acid</b> (AMICAR)	1					
LYSTEDA	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
pentoxifylline er (TRENTAL)	1					
PROMACTA	3			Y	Y	Curascript Only
<b>Cardiovascular Agents: a-Adrenergic Blockers</b>						
CARDURA XL	3	30/30 days				
doxazosin mesylate (CARDURA)	1					
prazosin hcl (MINIPRESS)	1					
terazosin hcl (HYTRIN)	1					
<b>Cardiovascular Agents: ACE Inhibitors</b>						
benazepril hcl (LOTENSIN)	1					
benazepril hcl/hydrochlorothiazide (LOTENSIN HCT)	1					
captopril (CAPOTEN)	1					
captopril /hydrochlorothiazide (CAPOZIDE)	1					
enalapril maleate (VASOTEC)	1					
enalapril maleate/hydrochlorothiazide (VASERETIC)	1					
fosinopril sodium (MONOPRIL)	1					
fosinopril sodium/hydrochlorothiazide (MONOPRIL HCT)	1					
lisinopril (ZESTRIL)	1					
lisinopril /hydrochlorothiazide (PRINZIDE)	1					
moexipril /hydrochlorothiazide (UNIRETIC)	1					
moexipril hcl (UNIVASC)	1					
perinodopril (ACEON)	1	30/30 days				
quinapril hcl (ACCUPRIL)	1					
quinaretic (ACCURETIC)	1					
ramipril (ALTACE)	1	30/30 days				
trandolapril (MAVIK)	1					
<b>Cardiovascular Agents: Aldosterone Receptor Agonists</b>						

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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<b>eplerenone</b> (INSPRA )	1	60/30 days				
<b>spironolactone</b> (ALDACTONE)	1					
<b>spironolactone /hydrochlorothiazide</b> (ALDACTAZIDE)	1					

### Cardiovascular Agents: Alpha-adrenergic Agonists

<b>clonidine hcl</b> (CATAPRES)	1					
<b>clonidine- tts</b> (CATAPRES-TTS)	1	4-8/28 days				
GUANABENZ ACETATE	2					
<b>guanfacine hcl</b> (TENEX)	1					
<b>methyldopa</b> (ALDOMET)	1					
METHYLDOPA /HYDROCHLOROTHIAZIDE	2					

### Cardiovascular Agents: Antiarrhythmics

<b>amiodarone hcl</b> (CORDARONE)	1	60/30 days				
<b>amiodarone hcl</b> (PACERONE)	1	60/30 days				
<b>disopyramide phosphate</b> (NORPACE)	1					
<b>disopyramide phosphate er</b> (NORPACE CR)	1					
<b>flecainide acetate</b> (TAMBOCOR)	1					
MEXILETINE HCL	2					
MULTAQ	2	60/30 days				
NORPACE CR	2					
PRONESTYL	2					
PRONESTYL SR	2					
<b>propafenone hcl</b> (RYTHMOL)	1					
<b>propafenone hcl sr</b> (RYTHMOL SR)	1					
<b>quinidine gluconate cr</b>	1					
<b>quinidine sulfate</b>	1					
<b>quinidine sulfate er</b>	1					
TIKOSYN	2	60/30 days				

### Cardiovascular Agents: ARBs

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ATACAND	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan AND Diovan required
ATACAND HCT	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan/hct AND Diovan HCT required
AVALIDE	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan/hct AND Diovan HCT required
AVAPRO	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan AND Diovan required
BENICAR	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan AND Diovan required
BENICAR HCT	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan/hct AND Diovan HCT required
DIOVAN	2	30/30 days	Y			Progressive Medication Program with ACE Inhibitor required
DIOVAN HCT	2	30/30 days	Y			Progressive Medication Program with ACE Inhibitor combo required
EDARBI TAB	3	30/30	Y			Progressive Medication Program with ACE Inhibitor AND losartan AND Diovan required
<b>losartan (COZAAR)</b>	1	30/30 days	Y			Progressive Medication Program with ACE Inhibitor required
<b>losartan/hctz (HYZAAR)</b>	1	30/30 days	Y			Progressive Medication Program with ACE Inhibitor combo required
MICARDIS	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan AND Diovan required
MICARDIS HCT	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan/hct AND Diovan HCT required
TEVETEN	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan AND Diovan required

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
TEVETEN HCT	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan/hct AND Diovan HCT required
TRIBENZOR	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND losartan/hct AND Diovan HCT required

### Cardiovascular Agents: Calcium-Channel Blockers

<b>amlodipine besylate</b> (NORVASC)	1	30/30 days				
<b>amlodipine besylate/benazepril hydrochloride</b> (LOTREL)	1	30/30 days				
AZOR	3	30/30 days	Y			
CADUET	3	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin AND Crestor required
CARDENE SR	3	30/30 days				
COVERA-HS	3	30/30 days				
<b>diltiazem cd</b> (CARDIZEM CD)	1					
<b>diltiazem hcl</b> (CARDIZEM)	1					
<b>diltiazem hcl</b> (TIAZAC)	1					
<b>diltiazem hcl er</b> (DILACOR XR)	1					
<b>diltiazem hcl er</b> (TIAZAC)	1					
<b>diltiazem hcl sr</b> (CARDIZEM LA)	1					
<b>diltiazem xr</b> (DILACOR XR)	1					
DYNACIRC CR	2	60/30 days				
EXFORGE	2	30/30 days	Y			Progressive Medication Program with ACE Inhibitor required
EXFORGE HCT	2	30/30 days	Y			Progressive Medication Program with ACE Inhibitor combo required
<b>felodipine er</b> (PLENDIL)	1					
<b>isradipine</b> (DYNACIRC)	1	120/30 days				
LEXXEL	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>nicardipine hcl</b> (CARDENE)	1					
<b>nifediac cc</b> (ADALAT CC)	1					
<b>nifedical xl</b> (PROCARDIA XL)	1					
NIFEDIPINE 20mg	2					
<b>nifedipine</b> (PROCARDIA)	1					
<b>nifedipine er</b> (PROCARDIA XL)	1					
<b>nisoldipine sr</b> (SULAR)	1	30/30 days				
TARKA	3	30/30 days				Generic no longer available
<b>verapamil hcl</b> (CALAN)	1					
<b>verapamil hcl er</b> (CALAN SR)	1					
<b>verapamil hcl er</b> (VERELAN)	1					
<b>verapamil hcl er</b> (VERELAN PM)	1					
<b>verapamil hcl sr</b> (VERELAN)	1					
<b>Cardiovascular Agents: Diuretics</b>						
<b>acetazolamide</b>	1					
<b>amiloride /hydrochlorothiazide</b> (MODURETIC 5-50)	1					
AMILORIDE HCL	2					
<b>bumetanide</b> (BUMEX)	1					
<b>chlorothiazide</b>	1					
<b>chlorthalidone</b>	1					
CHLORTHALIDONE 100mg	2					
DIURIL	3					
DYRENIUM	2					
EDECIN	3					
FUROSEMIDE SOLN	2					
<b>furosemide</b> (LASIX)	1					
<b>hydrochlorothiazide</b>	1					
<b>hydrochlorothiazide</b> (MICROZIDE)	1					
<b>indapamide</b> (LOZOL)	1					
<b>methazolamide</b>	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
METHYCLOTHIAZIDE	2					
<b>metolazone</b> (ZAROXOLYN)	1					
THALITONE	2					
<b>torseamide</b> (DEMADEX)	1					
<b>triamterene /hydrochlorothiazide</b>	1					
<b>triamterene /hydrochlorothiazide</b> (MAXZIDE)	1					
<b>triamterene /hydrochlorothiazide</b> (MAXZIDE-25)	1					

### Cardiovascular Agents: Dyslipidemics

ADVICOR	2	30/30 days				
<b>atorvastatin</b> (LIPITOR)	1	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin AND Crestor required
<b>cholestyramine</b> (QUESTRAN)	1					
<b>cholestyramine light</b> (QUESTRAN LIGHT)	1					
<b>colestipol hcl</b> (COLESTID)	1					
<b>colestipol hcl for oral suspension</b> (COLESTID)	1					
CRESTOR	2	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin required
<b>fenofibrate</b> (LOFIBRA)	1	30/30 days				
<b>gemfibrozil</b> (LOPID)	1	60/30 days				
LESCOL	3	30/30 days				
LESCOL XL	3	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin AND Crestor required
LIPITOR	3	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin AND Crestor required
LIPOFEN	3	30/30 days	Y			Progressive Medication Program with generic fenofibrate required



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>lovastatin (MEVACOR)</b>	1	30/30 days				
LOVAZA	2	120/30 days				
NIASPAN	2	60/30 days				
<b>pravastatin sodium (PRAVACHOL)</b>	1	30/30 days				
SIMCOR	2	60/30 days				
SLO-NIACIN	1					
<b>simvastatin (ZOCOR)</b>	1	30/30 days				
TRICOR	3	30/30 days	Y			Progressive Medication Program with generic fenofibrate required
TRIGLIDE	3	60/30 days	Y			Progressive Medication Program with generic fenofibrate required
TRILIPIX	3	30/30 days	Y			Progressive Medication Program with generic fenofibrate required
VYTORIN	3	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin AND Crestor required
WELCHOL	2	30-210/30 days				
ZETIA	3	30/30 days				

### Cardiovascular Agents: Hypotensives, Misc

AMTURNIDE	2	30/30 days				
RESERPINE	3					
TEKAMLO	2	30/30 days				
TEKTURNA	2	30/30 days				
TEKTURNA HCT	2	30/30 days				
VALTURNA	2	30/30 days	Y			Progressive Medication Program with ACE Inhibitor required

### Cardiovascular Agents: Other

<b>aspirin</b>	1					Preventive Medication: \$0 copay; men 45-79, women 55-79; only generic covered with retail Rx
DIGOXIN SOLN	2					
<b>digoxin (LANOXIN)</b>	1					
RANEXA	2	60/30 days				

### Cardiovascular Agents: $\beta$ -Adrenergic Blockers

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
acebutolol hcl (SECTRAL)	1					
atenolol (TENORMIN)	1					
atenolol/chlorthalidone (TENORETIC 100)	1					
atenolol/chlorthalidone (TENORETIC 50)	1					
betaxolol hcl (KERLONE)	1	30/30 days				
bisoprolol fumarate (ZEBETA)	1					
bisoprolol fumarate/hydrochlorothiazide (ZIAC)	1					
BYSTOLIC	2	120/30 days				
carvedilol (COREG)	1	60/30 days				
COREG CR	2	30/30 days				
INNOPRAN XL	2					
labetalol hcl (TRANDATE)	1					
LEVATOL	3					
metoprolol /hydrochlorothiazide (LOPRESSOR HCT)	1					
metoprolol succinate er (TOPROL XL)	1					
metoprolol tartrate (LOPRESSOR)	1					
nadolol (CORGARD)	1					
nadolol /bendroflumethiazide (CORZIDE)	1					
PINDOLOL	2					
PROPRANOLOL /HYDROCHLOROTHIAZIDE 25/80mg	2					
propranolol /hydrochlorothiazide (INDERIDE)	1					
PROPRANOLOL HCL SOLN	2					
propranolol hcl (INDERAL)	1					
propranolol hcl er (INDERAL LA)	1	30/30 days				
sorine (BETAPACE)	1					
sotalol hcl (BETAPACE)	1					
TIMOLOL MALEATE	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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### Cardiovascular Agents: Vasodilators

ADCIRCA	3	60/30 days		Y	Y	Curascript Only
BIDIL	3	180/30 days				
DILATRATE SR	2					
<b>dipyridamole (PERSANTINE)</b>	1					
HYDRALAZINE /HYDROCHLOROTHIAZIDE	2					
<b>hydralazine hcl</b>	1					
ISORDIL TITRADOSE	3					
<b>isosorbide dinitrate (ISORDIL)</b>	1					
<b>isosorbide dinitrate er (ISORDIL)</b>	1					
<b>isosorbide mononitrate (ISMO)</b>	1					
<b>isosorbide mononitrate (MONOKET)</b>	1					
<b>isosorbide mononitrate er (IMDUR)</b>	1					
<b>isoxsuprine hcl (VASODILAN)</b>	1					
LETAIRIS	2	30/30 days			Y	Curascript Only
<b>minoxidil</b>	1					
NITRO-BID	2	120/30 days				
NITRO-DUR	3	30/30 days				
NITROMIST	2					
<b>nitroglycerin (NITROSTAT)</b>	1					
<b>nitroglycerin cr</b>	1					
<b>nitroglycerin er</b>	1					
<b>nitroglycerin transdermal (NITRO-DUR)</b>	1	30/30 days				
NITROLINGUAL PUMPSPRAY	2					
<b>papaverine hcl</b>	1					
<b>papaverine hcl cr</b>	1					
PROGLYCEM	3					
REVATIO	3			Y	Y	Curascript Only
TRACLEER	2	60/30 days			Y	Curascript Only
TYVASO	3	28/28 days		Y		
VENTAVIS	3			Y		

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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### Central Nervous System Agents: Antipsychotics: Atypical

ABILIFY SOLN	3	300/30 days				
ABILIFY TABS	3	30/30 days				
ABILIFY DISCMELT	3	30/30 days				
<b>clozapine (CLOZARIL)</b>	1					
FAZACLO	3	90/30 days				QL 90/30- 12.5mg; QL 120/30 25mg, 100mg, & 200mg; QL 180/30-150 mg
GEODON	2	60/30 days				
INVEGA	3	30/30 days				
LATUDA	3	30/30 days				
<b>olanzapine tab (ZYPREXA)</b>	1	30/30 days				
<b>olanzapine orally disintegrating tab (ZYPREXA ZYDIS)</b>	1	30/30 days				
<b>risperidone soln (RISPERDAL SOLN)</b>	1	240/30 days				
<b>risperidone tabs (RISPERDAL TABS)</b>	1	60/30 days				
<b>risperidone odt (RISPERDAL M-TABS)</b>	1	60/30 days				
SEROQUEL	2	90/30 days				200mg QL 120/30 300mg QL 60/30 400MG QL 60/30
SEROQUEL XR	2	30/30 days				

### Central Nervous System Agents: Anitpsychotics: Conventional

<b>chlorpromazine hcl (THORAZINE)</b>	1					
<b>compro</b>	1					
<b>fluphenazine hcl (PROLIXIN)</b>	1					
<b>haloperidol</b>	1					
<b>loxapine succinate (LOXITANE)</b>	1					
MOBAN	2					
NAVANE	2					
ORAP	2					
<b>perphenazine</b>	1					
<b>prochlorperazine maleate</b>	1					
<b>thioridazine hcl</b>	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
thiothixene (NAVANE)	1					
trifluoperazine hcl	1					
<b>Central Nervous System Agents: Anticonvulsants</b>						
BANZEL	3	240/30 days				
BANZEL SUS	3	2400mL/30 days				
carbamazepine (TEGRETOL)	1					
carbamazepine er (CARBATROL)	1					
carbamazepine XR (TEGRETOL-XR)	1					
CELONTIN	2					
clonazepam (KLONOPIN)	1					
clonazepam orally disintegrating (KLONOPIN WAFERS)	1					
DIASTAT ACUDIAL	3	10/30 days				
DIASTAT PEDIATRIC	3	10/30 days				
DILANTIN	2					Only 30mg caps at Tier 2
DILANTIN INFATABS	2					
divalproex (DEPAKOTE )	1					
divalproex er (DEPAKOTE ER)	1					
divalproex sprinkles (DEPAKOTE SPRINKLES)	1					
epitol (TEGRETOL)	1					
ethosuximide (ZARONTIN)	1					
felbamate (FELBATOL)	1					
gabapentin (NEURONTIN)	1					
gabapentin solution (NEURONTIN SOLN)	1	1080mL/30 days				
GABITRIL	2					
KEPPRA SOLN	3	900/30				
lamotrigine (LAMICTAL)	1					
lamotrigine chewable dispersible (LAMICTAL CHEWABLE DISPERSIBLE)	1					
levetiracetam (KEPPRA)	1	90/30 days				
levetiracetam er (KEPPRA XR)	1	180/30 days				750MG limited to 120/30 days
LYRICA	3					300mg QL 60/30
oxcarbazepine (TRILEPTAL)	1					Suspension QL

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
						1200ML/30 days
PEGANONE	2					
<b>phenytoin</b> (DILANTIN, PHENYTEK)	1					
<b>phenytoin sodium extended</b> (DILANTIN)	1					
<b>primidone</b> (MYSOLINE)	1					
SABRIL	2	180/30 days		Y		QL for packets: 150/30 days; PA required > 2 yoa
<b>topiramate</b> (TOPAMAX)	1	240/30 days				
<b>topiramate sprinkles</b> (TOPAMAX SPRINKLES)	1					
<b>valproic acid</b> (DEPAKENE)	1					
VIMPAT	3	60/30 days		Y		QL for oral solution is 1200ml/30 days
<b>zonisamide</b> (ZONEGRAN)	1					

**Central Nervous System Agents: Antidepressants: NRIs and TCAs**

<b>amitriptyline hcl</b>	1					
AMOXAPINE	2					
<b>chlordiazepoxide /amitriptyline</b> (LIMBITROL)	1					
<b>chlordiazepoxide /amitriptyline</b> (LIMBITROL DS)	1					
<b>clomipramine hcl</b> (ANAFRANIL)	1					
<b>desipramine hcl</b> (NORPRAMIN)	1					
<b>doxepin hcl</b>	1					
<b>imipramine hcl</b> (TOFRANIL)	1					
IMIPRAMINE PAMOATE	3					
MAPROTILINE HCL	2					
<b>nortriptyline hcl</b> (PAMELOR)	1					
PERPHENAZINE /AMITRIPTYLINE	2					
SURMONTIL	2					
<b>trimipramine maleate</b> (SURMONTIL)	1					
VIVACTIL	2					

**Central Nervous System Agents: Antidepressants: Other**

<b>budeprion sr</b> (WELLBUTRIN SR)	1	60/30 days				
<b>budeprion xl</b> (WELLBUTRIN XL)	1	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
bupropion hcl (WELLBUTRIN)	1					
bupropion hcl (WELLBUTRIN XL)	1	30/30 days				
bupropion hcl sr (WELLBUTRIN SR)	1	60/30 days				
mirtazapine (REMERON)	1	30/30 days				
mirtazapine (REMERON SOLTAB)	1	30/30 days				
nefazodone hcl	1	60/30 days				
OLEPTRO	3	30-75/30 days				300mg QL-30/30; 150mg QL-75/30
trazodone hcl	1					
<b>Central Nervous System Agents: Antidepressants: Selective Serotonin and Norepinephrine-reuptake Inhibitors</b>						
CYMBALTA	3	30/30 days				
PRISTIQ	3	30/30 days				
SAVELLA	2	60/30 days				* Titration pack qty limit = 55/28 days
venlafaxine hcl (EFFEXOR)	1	30/30 days				
venlafaxine hcl sr cap (EFFEXOR XR)	1	30/30 days				
venlafaxine hcl er tab (VENLAFAXINE ER)	1	30/30 days				225mg -Tier 2
<b>Central Nervous System Agents: Antidepressants: SSRIs</b>						
citalopram hydrobromide (CELEXA)	1	Maximum daily dose 40mg per day				Maximum of total daily dose of 40mg/day regardless of tablet strength. PA is required for total daily dose greater than 40mg.
fluoxetine hcl (PROZAC)	1					
fluoxetine hcl dr (PROZAC WEEKLY)	1	4/28 days				
fluvoxamine maleate	1					
LEXAPRO SOLN	3	300/30 days				
LEXAPRO TABS	3	30/30 days				
paroxetine hcl susp(PAXIL SUSP)	1	600/30 days				
paroxetine hcl tabs (PAXIL TABS)	1					
paroxetine hcl (PAXIL CR)	1	30/30 days				
sertraline hcl (ZOLOFT)	1					
SYMBYAX	2	30/30 days				
<b>Central Nervous System Agents: Antimanics</b>						
lithium carbonate (LITHIUM CARBONATE)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>lithium carbonate er</b> (LITHOBID)	1					
<b>lithium citrate</b>	1					
<b>Central Nervous System Agents: Barbiturates</b>						
<b>mephobarbital</b> (MEBARAL)	1					
SECONAL	2					
<b>Central Nervous System Agents: Benzodiazepines</b>						
<b>alprazolam</b> (XANAX)	1					
<b>alprazolam xr</b> (XANAX XR)	1	30/30 days				
<b>chlordiazepoxide hcl</b> (LIBRIUM)	1					
<b>clorazepate dipotassium</b> (TRANXENE T)	1					
<b>diazepam</b> (VALIUM)	1					
DORAL	3					
<b>estazolam</b> (PROSOM)	1					
<b>flurazepam hcl</b> (DALMANE)	1					
<b>lorazepam</b> (ATIVAN)	1					
LORAZEPAM INTENSOL	3	60/30 days				
<b>oxazepam</b> (SERAX)	1					
<b>temazepam</b> (RESTORIL)	1	30/30 days				
<b>triazolam</b> (HALCION)	1					
<b>Central Nervous System Agents: MAO Inhibitors</b>						
MARPLAN	3					
<b>phenelzine sulfate</b> (NARDIL)	1					
<b>tranylcypromine sulfate</b> (PARNATE)	1					
<b>Central Nervous System Agents: Miscellaneous</b>						
NAMENDA	2	60/30 days				
NAMENDA TITRATION PAK	2	49/30 days				
RILUTEK	2	60/30 days				
STRATTERA	3	30/30 days				



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
XENAZINE	2	90/30 days				
XYREM	2			Y		
<b>Central Nervous System Agents: Sedatives/Hypnotics</b>						
<b>bupirone hcl (BUSPAR)</b>	1					
CHLORAL HYDRATE SUPP	2					
<b>chloral hydrate syrup</b>	1					
EQUAGESIC	2					
<b>hydroxyzine hcl (ATARAX)</b>	1					
<b>hydroxyzine pamoate (VISTARIL)</b>	1					
LUNESTA	3	30/30 days				
<b>meprobamate (MEPROBAMATE)</b>	1					
ROZEREM	2	30/30 days				
SOMNOTE	2					
<b>zaleplon (SONATA )</b>	1	30/30 days				
<b>zolpidem tartrate (AMBIEN)</b>	1	30/30 days				
<b>zoldipem tartrate er (AMBIEN CR)</b>	1	30/30 days				
<b>Central Nervous System Stimulating Agents</b>						
ADDERALL XR	3	60/30 days				
<b>amphetamine/dextroamphetamine sr (ADDERALL XR)</b>	2	60/30 days				
<b>amphetamine/dextroamphetamine (ADDERALL)</b>	1	60/30 days				
CONCERTA	3	60/30 days				
DAYTRANA	3	30/30 days				
<b>dexmethylphenidate hcl (FOCALIN)</b>	1	60/30 days				
<b>dextroamphetamine sulfate (DEXTROSTAT)</b>	1	180/30 days				
<b>dextroamphetamine sulfate cap sr 24hr (DEXEDRINE)</b>	1	90/30 days				
FOCALIN XR	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
INTUNIV	3	30/30 days				
METADATE CD	3	30/30 days				
<b>methamphetamine hcl</b> (DESOXYN)	1					
<b>methylin er</b> (METADATE ER)	1	60/30 days				
<b>methylphenidate hcl</b> (RITALIN)	1	90/30 days				
<b>methylphenidate hcl</b> (RITALIN SR)	1	60/30 days				
<b>methylphenidate hcl soln</b> (METHYLIN SOLN)	1	450/30 days				
NUVIGIL	3	30/30 days		Y		
PROCENTRA	3	600ml/30 days				
PROVIGIL	3	60/30 days		Y		
RITALIN LA	3	30/30 days				
VYVANSE	3	30/30 days				
<b>Dermatological Agents: Antibacterials</b>						
AKNE-MYCIN	3					
ALTABAX	3	15/30 days				
BACTROBAN	2	30/30 days				
BENZACLIN	3	50/30 days				Copay per 25 grams
CLEOCIN	2	6/30 days				
CLINDAGEL	3					
<b>clindamax</b> (CLEOCIN)	1					
<b>clindamycin phosphate</b> (CLEOCIN-T)	1					
<b>clindamycin phosphate foam</b> (EVOCLIN)	1	100/30 days				
<b>clindamycin/benzoyl peroxide gel</b>	1	50/30 days				Copay per 25 grams
CLINDESSE	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
DUAC CS	3	1/30 days				
<b>erythromycin</b>	1					
<b>erythromycin</b> (ERYGEL)	1					
<b>erythromycin/benzoyl peroxide</b> (BENZAMYCIN)	1	46.6/30 days				Copay per 25 grams
<b>gentamicin sulfate</b>	1					
METROGEL	2	60/30 days				
METROGEL 1% KIT	2	1/30 days				
<b>metronidazole</b> (METROCREAM)	1	45/30 days				
<b>metronidazole</b> (METROGEL)	1	60/30 days				
<b>metronidazole</b> (METROLOTION)	1	60/30 days				
<b>metronidazole vaginal</b> (METROGEL VAGINAL)	1					
<b>mexar wash</b> (OVACE WASH)	1					
<b>mupirocin</b> (BACTROBAN)	1	44/30 days				
NORITATE	2					
<b>seb-prev wash</b> (OVACE WASH)	1	360/30 days				
<b>sulfacetamide sodium-urea pad</b> (SOD SULFACET PAD)	1					
<b>sulfacetamide sodium</b> (KLARON)	1	336/30 days				
<b>Dermatological Agents: Antifungals</b>						
<b>ciclopirox</b> (LOPROX)	1					
<b>ciclopirox nail lacquer</b> (PENLAC NAIL LACQUER)	1					
<b>clotrimazole</b> (MYCELEX)	1					
<b>clotrimazole/betamethasone dipropionate</b> (LOTRISONE)	1					
<b>econazole nitrate</b> (SPECTAZOLE)	1					
ERTACZO	3	60gm/30 days				
EXELDERM	2					
GYNAZOLE-1	2					
<b>ketconazole</b> (NIZORAL)	1	120/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>ketoconazole</b> (NIZORAL)	1	240/30 days				
LOPROX SHAMPOO	3	240/30 days				
NAFTIN	2					
NAFTIN-MP	2					
<b>nystatin</b> (MYCOSTATIN)	1					
NYSTATIN VAGINAL	2					
<b>nystop</b> (MYCOSTATIN)	1					
OXISTAT	2	60/30 days				
<b>terconazole cream</b> (TERAZOL 3 CREAM)	1	40/30 days				
<b>terconazole supp</b> (TERAZOL 3 SUPP)	1	6/30 days				
<b>terconazole</b> (TERAZOL 7)	1	90/30 days				
<b>zazole</b> (TERAZOL 3)	1	40/30 days				
<b>zazole</b> (TERAZOL 7)	1	90/30 days				
<b>Dermatological Agents: Anti-inflammatories</b>						
ALA-SCALP	3					
<b>alclometasone dipropionate</b> (ACLOVATE)	1					
AMCINONIDE LOTN	2					
<b>amcinonide cream</b> (CYCLOCORT CREAM)	1					
<b>apexicon e</b> (PSORCON E)	1	60/30 days				
<b>augmented betamethasone dipropionate</b> (DIPROLENE)	1					
<b>augmented betamethasone dipropionate</b> (DIPROLENE AF)	1					
<b>betamethasone dipropionate</b>	1					
<b>betamethasone valerate</b>	1					
<b>beta-val</b>	1					
CAPEX	3					
<b>clobetasol propionate foam</b>	1	100/30 days				Copay per 50 grams
<b>clobetasol propionate</b> (TEMOVATE)	1					
<b>clobetasol propionate e</b> (TEMOVATE E)	1					
CLOBEX LIQD	3	118/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
CLOBEX LOTN/SHAMP	3	236/30 days				
CLODERM PUMP	3					
CORDRAN	2					
CORDRAN SP	2					
CORDRAN TAPE	2					
<b>cormax</b> (TEMOVATE)	1					
CORTIFOAM	2					
CORTISPORIN	2					
CUTIVATE	3					
DERMA-SMOOTH/FS BODY OIL	2					
DERMA-SMOOTH/FS SCALP OIL	2					
<b>desonide</b> (DESOWEN)	1					
<b>desoximetasone</b> (TOPICORT)	1					
<b>desoximetasone</b> (TOPICORT LP)	1					
<b>diflorasone diacetate</b>	1					
EPIFOAM	2					
<b>fluocinolone acetonide</b>	1					
<b>fluocinolone acetonide</b> (SYNALAR)	1					
<b>fluocinonide</b> (LIDEX)	1					
<b>fluocinonide emollient base</b> (LIDEX-E)	1					
<b>fluticasone propionate</b> (CUTIVATE)	1					
<b>halobetasol propionate</b> (ULTRAVATE)	1					
HALOG	2					
<b>hemril-30</b> (PROCTOCORT)	1	12/30 days				
<b>hydrocortisone</b>	1					
<b>hydrocortisone</b> (HYTONE)	1					
<b>hydrocortisone acetate</b> (ANUSOL-HC)	1	12/30 days				
<b>hydrocortisone butyrate</b> (LOCOID)	1					
<b>hydrocortisone valerate</b> (WESTCORT)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
KENALOG	3					
<b>lidocaine hcl/hydrocortisone acetate (LIDAMANTLE HC)</b>	1	177/30 days				
LOCOID LIPOCREAM	2					
LUXIQ	3	100/30 days				Copay per 50 grams
<b>mometasone furoate (ELOCON)</b>	1					
NOVACORT	2					
<b>nystatin/triamcinolone</b>	1					
<b>nystatin/triamcinolone (MYCOLOG II)</b>	1					
OLUX-E	3	100/30 days				Copay per 50 grams
PANDEL	3	80/30 days				
<b>prednicarbate (DERMATOP)</b>	1					
<b>proctocream-hc (ANUSOL-HC)</b>	1	30/30 days				
PROCTOFOAM HC	2					
<b>proctosol hc</b>	1	30/30 days				
<b>proctozone hc</b>	1	30/30 days				
TACLONEX	3	100/30 days				
TACLONEX SCALP	3	240/30 days				
TEXACORT	3					
<b>triamcinolone acetonide (KENALOG)</b>	1					
<b>triamcinolone in orabase (KENALOG IN ORABASE)</b>	1					
VANOS	3	120/ 23 days				
VOLTAREN GEL	3					
<b>Dermatological Agents: Antivirals</b>						
DENAVIR	3	5/30days				
ZOVIRAX CREAM	2	5/30 days				
ZOVIRAX OINT	2	30/30 days				
<b>Dermatological Agents: Miscellaneous</b>						
ACCUZYME SE	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ACID JELLY	2					
<b>acticin</b> (ELIMITE)	1					
<b>adapalene cream</b> (DIFFERIN CREAM)	1	45/30 days		Y		PA required >26 years of age
<b>adapalene gel</b> (DIFFERIN GEL)	1	45/30 days		Y		PA required >26 years of age
ALCORTIN A	3					
<b>amnesteem</b> (ACCUTANE)	1					
ANACAINE	2					
<b>anthralin</b> (DRITHO-CRÈME HP)	1	50/30 days				
ATOPICLAIR	2	200/30 days				Copay per 100 grams
AVAR	3					
<b>avita</b> (RETIN-A)	1			Y		PA required >26 years of age
AZELEX	2					
CALCIPOTRIENE OINT	2	60/30 days				
<b>calcipotriene</b> (DOVONEX)	1	60/30 days				
CARAC	2	30/30 days				
<b>claravis</b> (ACCUTANE)	1					
CONDYLOX	3	3.5/30 days				
<b>dermazene</b> (VYTONE)	1					
DIFFERIN LOTION	2	59/30 days		Y		PA required >26 years of age
DOVONEX	2	120/30 days				
DRITHO-SCALP	2	50/30 days				
ELIDEL	2	120/30 days				Copay per 60 grams
EURAX	3					
FEM PH	2					
FINACEA	2	50/30 days				
FLUOROPLEX	2	30/30 days				
<b>fluorouracil cream</b> (EFUDEX CREAM)	1	40/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
fluorouracil soln (EFUDEX SOLN)	1	10/30 days				
hydrocortisone acetate/pramoxine (ANALPRAM-HC)	1					
hypercare (DRYSOL)	1					
imiquimod (ALDARA)	1	12/30 days				
kovia (ACCUZYME)	1					
kovia 6.5	1	60/30 days				
lidazone hc (ANAMANTLE HC)	1	98/30 days				
lidocaine	1					
lidocaine (LIDAMANTLE)	1	177/30 days				
lidocaine hcl jelly (XYLOCAINE JELLY)	1					
lidocaine/prilocaine (EMLA)	1					
LIDODERM	3	60/30 days				
lindane	1					
malathion (OVIDE)	1					
OXSORALEN ULTRA	2					
PANAFIL SE	2	34/30 days				
PANRETIN	2	60/30 days				
phenazopyridine hcl (PYRIDIUM)	1					
phenazopyridine plus (PYRIDIUM PLUS)	1					
PHISOHEX	3	296/30 days				
podofilox (CONDYLOX W/APPLICATORS)	1					
pramoxine-hc (PRAMOSONE)	1					
prascion fc (PLEXION CLEANSING CLOTH)	1	60/30 days				
PROCORT CREAM	3					
PROTOPIC	2	120/30 days				Copay per 60 grams
prudoxin (ZONALON)	1					
REGANEX	3			Y		
RETIN-A MICRO	3	50/30 days		Y		PA required >26 years of age



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
RETIN-A MICRO PUMP	3	50/30 days		Y		PA required >26 years of age
SANTYL	2					
selenium sulfide (SELSUN SHAMPOO)	1					
silver sulfadiazine (SILVADENE)	1					
sodium hyaluronate	1	340/30 days				
sodium sulfacetamide/sulfur (PLEXION TS)	1	341/30 days				
SOLARAZE	2	100/30				
sulfacetamide sodium/sulfur cleanser	1	341/30 days				
SULFAMYLON	2					
sulfatol cleanser (ROSULA)	1	355/30 days				
SYNERA	2	2/30 days				
TAZORAC	2	30/30 days				
tbc (GRANULEX)	1					
tretinoin (RETIN-A)	1	50/30 days		Y		PA required >26 years of age
XCLAIR	2	150/30 days				
XERAC AC	2	60/30 days				
ziox (PANAFIL)	1	60/30 days				
ziox 405 (PANAFIL)	1	60/30 days				
<b>Electrolyte and Fluid Maintenance</b>						
acetic acid 0.25%	1					
calcium acetate (PHOSLO)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
CARBAGLU TAB	2					
<b>effervescent potassium/chloride (K-LYTE/CL)</b>	1					
FOSRENOL	2	90/30 days				
GALZIN	2					
<b>klor-con (K-LOR)</b>	1					
<b>klor-con 8</b>	1					
KLOR-CON M15	2					
<b>klor-con m20 (K-DUR)</b>	1					
<b>klotrix (K-TABS)</b>	1					
K-PHOS	2					
K-PHOS MF	2					
K-PHOS NO 2	2					
<b>lactulose</b>	1	2880/30 days				
LITHOSTAT	2					
MICRO-K	2					
ORACIT	2					
<b>potassium bicarbonate (K-LYTE)</b>	1					
<b>potassium chloride</b>	1					
<b>potassium chloride powder packet (KLOR-CON 25)</b>	1					
<b>potassium chloride er (K-DUR)</b>	1					
<b>potassium chloride er (MICRO-K)</b>	1					
<b>potassium citrate (UROCIT-K 5)</b>	1					
<b>potassium citrate extended-release (UROCIT-K 10)</b>	1					
RENAGEL	2	360/30 days				
REVELA	2	525/30 days				
<b>sodium polystyrene sulfonate</b>	1	480/30 days				
<b>sodium polystyrene sulfonate (KAYEXALATE)</b>	1	480/30 days				
<b>sps</b>	1	480/30 days				
UROCIT-K 15	3					
<b>vis-phos n (K-PHOS NEUTRAL)</b>	1					
<b>Enzyme Replacement</b>						
PULMOZYME	2					
SUCRAID	2					
<b>Eyes, Ears, Nose, and Throat Agents: Anesthetics</b>						
AKTEN	3	5/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
altacaine	1					
antipyrine/benzocaine	1					
auroguard	1					
benzotic	1					
bromfenac (XIBROM)	1					
CAPHOSOL	3	120/30 days		Y		
ear-gesic (TYMPAGESIC DROPS)	1					
MUGARD	3	120/30 days		Y		
oticaine otic	1					
otogesic (TYMPAGESIC DROPS)	1					
proparacaine hcl (ALCAINE)	1	15/30 days				
<b>Eyes, Ears, Nose, and Throat Agents: Anti-infectives</b>						
AZASITE	3	5/30 days				
bacitracin	1					
bacitracin /neomycin /polymyxin	1	4/30 days				
bacitracin/polymyxin b	1	4/30 days				
BESIVANCE	3	5/30 days				
chlorhexadine gluconate oral rinse (PERIDEX ORAL RINSE)	1	960/30 days				
CILOXAN	2	4/30 days				
ciprofloxacin hcl (CILOXAN)	1	10/30 days				
IQUIX	3	10/30 days				
levofloxacin (QUIXIN)	1	10/30 days				
MOXEZA	2	3/30 days				
NATACYN	3	15/30 days				
neomycin /polymyxin /gramicidin (NEOSPORIN)	1					
ofloxacin (FLOXIN OTIC)	1	20/30 days				
ofloxacin (OCUFLOX)	1	10/30 days				
pramoxine/chloroxylenol (PRAMOTIC)	1	10/30 days				
sodium sulfacetamide (BLEPH-10)	1					
tobrasol (TOBREX)	1	10/30 days				
TOBREX	2	4/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>trifluridine (VIROPTIC)</b>	1	8/30 days				
<b>trimethoprim sulfate/polymyxin b sulfate (POLYTRIM)</b>	1	10/30 days				
VIGAMOX	2	3/30 days				
ZIRGAN	3	5/30 days				
ZYMAR	2	5/30 days				
ZYMAXID	2	2.5/30 days				

### Eyes, Ears, Nose, and Throat Agents: Anti-inflammatories

ACULAR	3	5/30 days				
ACULAR LS	3	5/30 days				
ACULAR PF	3	5/30 days				
BROMDAY SOL 0.09%	3	1.7ml/30 days				
<b>diclofenac sodium (VOLTAREN)</b>	1	5/30 days				
<b>flurbiprofen sodium (OCUFEN)</b>	1	2.5/30 days				

### Eyes, Ears, Nose, and Throat Agents: Corticosteroids

<b>acetic acid/hydrocortisone</b>	1					
ALREX	3	5/30 days				
<b>bac /poly /neomy /hc</b>	1	4/30 days				
BECONASE AQ	3	25/30 days				
BLEPHAMIDE	2	10/30 days				
BLEPHAMIDE S.O.P.	2	4/30 days				
CIPRO HC	3	10/30 days				
CIPRODEX	2	7.5/30 days				
<b>cortisporin-tc</b>	2					
<b>cortomycin (CORTISPORIN)</b>	1					
<b>dexamethasone sodium phosphate</b>	1					
DUREZOL	3	10/30 days				
FLAREX	3	10/30 days				
<b>flunisolide (NASALIDE)</b>	1	25/30 days				
<b>fluorometholone (FML LIQUIFILM)</b>	1	10/30 days				
<b>fluticasone propionate (FLONASE)</b>	1	16/30 days				
FML FORTE	2	10/30 days				
FML S.O.P.	2	4/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
LOTEMAX SUSP	3	5/30 days				
LOTEMAX OINTMENT	3	3.5/30 days				
MAXIDEX	3					
<b>methadex</b> (MAXITROL)	1					
NASONEX	2	34/30 days				
<b>neo /poly /bac /hc</b>	1					
<b>neomycin /polymyxin /dexamethasone</b> (MAXITROL)	1					
<b>neomycin /polymyxin /hydrocortisone otic soln</b> (CORTISPORIN)	1					
<b>neomycin /polymyxin /hydrocortisone oph susp</b>	3					
OMNARIS SPR	3	12.5ml/30 days				
<b>otomar</b> (CORTANE-B-OTIC)	1					
POLY-PRED	2	15/30 days				
PRED MILD	2	5/30 days				
PRED-G	3	5/30 days				
PRED-G S.O.P.	3	4/30 days				
PREDNISOLONE SODIUM PHOSPHATE	2	15/30 days				
RHINOCORT AQUA	3	8.6/30 days				
<b>sulfacetamide sodium/prednisolone sodium phosphate</b>	1	15/30 days				
TOBRADEX OINT	3	4/30 days				
<b>tobramycin/ dexamethasone</b> (TOBRADEX SUSP)	1	10/30 days				
<b>triamcinolone acetonide</b> (NASACORT AQ)	1	16.5/30 days				
VERAMYST	3	10/30 days				
VEXOL	3	5/30 days				
ZYLET	3	5/30 days				
<b>Eyes, Ears, Nose, and Throat Agents: Miscellaneous</b>						
<b>acetic acid</b>	1					
<b>acetic acid/aluminum acetate</b>	1					
<b>apraclonidine</b> (IOPIDINE)	1	15/30 days				*ONLY 0.5% at tier 1
ASTEPRO	2	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
azelastine (ASTELIN)	1	30/30 days				
cromolyn sodium (NASALCROM)	1	26/30 days				
FIRST-BXN MOUTHWASH	3	473/30 days				
FIRST-DUKES MOUTHWASH	3	474/30 days				
FIRST-MARYS MOUTHWASH	3	474/30 days				
IOPIDINE	3	15/30 days				
LACRISERT	2					
PATANASE	3	30.5/30 days				
RESTASIS	2	64/30 days		Y		
TYZINE PEDIATRIC	2					

### Gastrointestinal Agents: Antiemetics

ANZEMET	3	4-8/30 days				
CESAMET	3	6/30 days				
dronabinol (MARINOL)	1			Y		
EMEND	2	4-12/30 days		Y		
granisetron hcl (KYTRIL)	1	2/30 days				
maldemar (SCOPACE)	1					
ondansetron hcl (ZOFTRAN)	1	6-12/30 days				
ondansetron odt (ZOFTRAN ODT)	1	6-12/30 days				
SANCUSO	3	4/28 days		Y		
trimethobenzamide hcl (TIGAN)	1					

### Gastrointestinal Agents: Anti-inflammatories

APRISO	2	120/30 days				
ASACOL	2	360/30 days				
ASACOL-HD	2	180/30 days				
balsalazide disodium (COLAZAL)	1	270/30 days				
CANASA	2	60/30 days				
DIPENTUM	2	120/30 days				
hydrocortisone (CORTENEMA)	1					
LIALDA	3	120/30 days				
mesalamine (ROWASA)	1	3600/30 days				
PENTASA	2	240/30 days				

### Gastrointestinal Agents: Enzyme Replacement

CREON	2					
CREON 5	2					
CREON 10	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
CREON 20	2					
CREON 30	2					
DYGASE	2					
ENZYMAL	2					
GASTRINEX	2					
LIPRAM 4500	3					
LIPRAM-PN10	2					
LIPRAM-PN16	2					
LIPRAM-PN20	2					
LIPRAM-UL12	3					
LIPRAM-UL18	3					
LIPRAM-UL20	3					
PANCREASE MT 10	3					
PANCREASE MT 16	3					
PANCREASE MT 20	3					
PANCREASE MT 4	2					
PANCREATIN	2					
PANCREAZE	2	300/30				
PANCRECARB MS-16	2					
PANCRECARB MS-4	2					
PANCRECARB MS-8	2					
PANCRELIPASE	2					
PANGESTYME CN 10	2					
PANGESTYME CN 20	2					
PANGESTYME EC	2					
PANGESTYME MT 16	2					
PANGESTYME UL 12	2					
PANGESTYME UL 18	2					
PANGESTYME UL 20	2					
<b>plaretase 8000</b>	1					
PLARETASE 8000	2					
ULTRASE	2					
ULTRASE MT 12	2					
ULTRASE MT 18	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ULTRASE MT 20	2					
VIOKASE	2					
VIOKASE 16	2					
VIOKASE 8	2					
ZENPEP	3					

### Gastrointestinal Agents: H2 Antagonists

<b>cimetidine</b> (TAGAMET)	1					
<b>famotidine</b> (PEPCID)	1					
<b>famotidine susp.</b> (PEPCID SUSP)	3	150/30 days				Excluded from coverage >12 years of age
<b>nizatadine</b> (AXID)	1	30-480/30 days				Solution: Excluded from coverage >12 years of age
<b>ranitidine hcl</b> (ZANTAC)	1					

### Gastrointestinal Agents: Other

AMITIZA	2	60/30 days				
<b>belladonna alkaloids/phenobarbital cr</b> (DONNATAL EXTENTAB)	1					
COLYTE-FLAVOR PACKS	3					
DIGEX NF	3					
<b>diphenoxylate/atropine</b> (LOMOTIL)	1					
HALFLYTELY BOWEL PREP	2					
<b>hyoscyamine/ phenyltoloxamine</b> (DIGEX NF)	1					
<b>loperamide hcl</b>	1					
LOTRONEX	2			Y		
<b>metoclopramide hcl</b> (REGLAN)	1					
MOVIPREP	2					
OSMOPREP	2					
<b>paregoric</b>	1					
<b>peg 3350/electrolytes</b> (COLYTE)	1					
<b>polyethylene glycol 3350</b> (MIRALAX)	1					
<b>se-donna pb hyos</b> (DONNATAL ELX)	1					
<b>ursodiol</b> (ACTIGALL)	1					
<b>ursodiol 250</b> (URSO 250)	1					
<b>ursodiol</b> (URSO FORTE)	1					
VISICOL	2					



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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### Gastrointestinal Agents: PPIs

ACIPHEX	3/5	30/30 days	Y			Progressive Medication Program with omeprazole AND pantoprazole AND lansoprazole AND Dexilant required; For 5 Tier benefit, Copay Tier 5 applies.
DEXILANT	2	30/30 days	Y			Progressive Medication Program with omeprazole, lansoprazol pantoprazole, Prevacid OTC, or Zegerid OTC required.
<b>lansoprazole (PREVACID)</b>	1	30/30 days				
<b>lansoprazole odt (PREVACID SOLUTAB)</b>	1	30/30 days				
NEXIUM	3/5	30/30 days	Y			Progressive Medication Program with omeprazole AND pantoprazole AND lansoprazole AND Dexilant required; For 5 Tier benefit, Copay Tier 5 applies.
<b>omeprazole (PRILOSEC)</b>	1	60/30 days				QL- 30/30 days for 40 mg strength
<b>omeprazole otc (PRILOSEC OTC)</b>	1	56/28 days				
<b>omeprazole/sodium bicarbonate cap (ZEGERID)</b>	1	30/30 days				
<b>pantoprazole sodium (PROTONIX)</b>	1	30/30 days				
PREVACID OTC	1	56/28 days				
PREVPAC	3	14/30 days				
PRILOSEC PACKETS	3	30/30 days	Y			Progressive Medication Program with generic omeprazole required.
PROTONIX PACK	3	30/30 days	Y			Progressive Medication Program with generic pantoprazole required.
ZEGERID OTC	1	28/28 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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### Gastrointestinal Agents: Protectants

CARAFATE SUSP	2	480/30 days				
<b>misoprostol</b> (CYTOTEC)	1	120/30 days				
<b>sucralfate tabs</b> (CARAFATE TABS)	1	120/30 days				

### Genitourinary Agents

DETROL	2	60/30 days				
DETROL LA	2	30/30 days				
ENABLEX	3	30/30 days				
GELNIQUE	3	30/30 days				
<b>flavoxate hcl</b> (URISPAS)	1	240/30 days				
<b>oxybutynin chloride</b> (DITROPAN)	1	480/30 days				
<b>oxybutynin chloride er</b> (DITROPAN XL)	1	30/30 days				
SANCTURA XR	3	30/30 days				
TOVIAZ	3	30/30 days				
<b>tropium chloride</b> (SANCTURA)	1	60/30 days				
VESICARE	2	30/30 days				

### Hormonal Agents: Androgens

ANDRODERM	3	30/30 days		Y		
ANDROGEL PUMP	2	300/30 days		Y		
ANDROGEL GEL 1.62%	2	150gm/30 days		Y		
AXIRON SOL 30MG/ACT	3	180gm/30 days		Y		
FORTESTA GEL 10MG/ACT	2	120gm/day		Y		
<b>danazol</b>	1					
<b>oxandrolone</b> (OXANDRIN)	1			Y		
TESTIM	3	300/30 days		Y		

### Hormonal Agents: Contraceptives

<b>apri</b> (DESOGEN)	1	28/28 days				
<b>aviane</b> (ALESSE-28)	1	28/28 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
BEYAZ	2	28/28 days				
<b>cesia</b> (CYCLESSA)	1	28/28 days				
<b>cryselle-28</b> (LO/OVRAL-28)	1	28/28 days				
<b>drospirenone/ethinyl estradiol 3/0.02</b> (YAZ)	2	28/28 days				
ELLA TAB	3	1/28 days				
<b>enpresse-28</b> (TRI-LEVLEN)	1	28/28 days				
<b>errin</b> (NOR-QD)	1	28/28 days				
GENERESS FE CHEWABLE	2	28/28 days				
<b>jolessa</b> (SEASONALE)	1	91/91 days				
<b>junel 1.5/30</b> (LOESTRIN 1.5/30-21)	1	28/28 days				
<b>kariva</b> (MIRCETTE)	1	28/28 days				
<b>kelnor 1/35</b> (DEMULEN 1/35-28)	1	28/28 days				
<b>leena</b> (TRI-NORINYL 28)	1	28/28 days				
<b>levonorgestrel-ethinyl estradiol (continuous) tab</b> (LYBREL)	1	28/28 days				
LO LOESTRIN FE	2	28/28 days				
LOESTRIN 24 FE	2	28/28 days				
LOSEASONIQUE	2	91/91 days				
<b>microgestin 1/20</b> (LOESTRIN 1/20-21)	1	28/28 days				
<b>microgestin fe</b> (LOESTRIN FE 1/20)	1	28/28 days				
<b>microgestin fe 1.5/30</b> (LOESTRIN FE 1.5/30)	1	28/28 days				
<b>mononessa</b> (ORTHO-CYCLEN-28)	1	28/28 days				
NATAZIA	2	28/28 days				
NECON 10/11-28	2	28/28 days				
<b>next choice</b> (PLAN B)	1	2/30 days				Excluded for members >16 years old
<b>norethindrone &amp; ethinyl estradiol-fe chew tab</b> (FEMCON FE CHW)	1	28/28 days				
<b>nortrel 0.5/35 (28)</b> (BREVICON-28)	1	28/28 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>nortrel 1/35 (28)</b> (NORINYL 1+35)	1	28/28 days				
<b>nortrel 7/7/7</b> (ORTHO-NOVUM 7/7/7-28)	1	28/28 days				
NUVARING	3	1/28 days				
<b>ocella</b> (YASMIN-28)	1	28/28 days				
OGESTREL	2	28/28 days				
ORTHO EVRA	2	3/28 days				
ORTHO TRI-CYCLEN LO	2	28/28 days				
OVCON-50 28	2	28/28 days				
SAFYRAL	2	28/28 days				
<b>levonorg-eth est tab 0.15-0.03mg(84) &amp; eth est tab 0.01mg(7)</b> (SEASONIQUE)	1	91/91 days				
<b>tri-legest fe</b> (ESTROSTEP FE)	1	28/28 days				
<b>tri-sprintec</b> (ORTHO TRI-CYCLEN)	1	28/28 days				
<b>zenchent</b> (OVCON-35)	1	28/28 days				
<b>zovia 1/50e</b> (DEMULEN 1/50-28)	1	28/28 days				

### Hormonal Agents: Corticosteroids

ADVAIR DISKUS	2	60/30 days				
ADVAIR HFA	2	12/30 days				
AEROBID	3	21/30 days				
ALVESCO	3	6.1/30 days				
ASMANEX 120 METERED DOSES	2	1/30 days				
ASMANEX 30 METERED DOSES	2	1/30 days				
ASMANEX 60 METERED DOSES	2	1/30 days				
budesonide (PULMICORT)	1	2/30 days		Y		Only 0.25 and 0.5mg strengths tier 1; Prior authorization required >8 yrs of age
<b>budesonide cap sr 24hr</b> (ENTOCORT EC)	1	90/30 days				
CELESTONE	3					
<b>cortisone acetate</b>	1					
DEXAMETHASONE ELIX	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>dexamethasone tabs</b>	1					
DEXPAK	3					
DULERA	2	13/30 days				
FLOVENT DISKUS	2	60/30 days				
FLOVENT HFA	2	21.2/30 days				
<b>fludrocortisone acetate (FLORINEF)</b>	1					
<b>hydrocortisone (CORTEF)</b>	1					
<b>methylprednisolone (MEDROL)</b>	1					
<b>methylprednisolone (MEDROL DOSEPAK)</b>	1					
PREDNISOLONE TABS	2					
<b>prednisolone (PRELONE)</b>	1					
<b>prednisolone sodium phosphate (ORAPRED)</b>	1					
<b>prednisolone sodium phosphate (PEDIAPRED)</b>	1					
<b>prednisone (DELTASONE)</b>	1					
<b>prednisone (STERAPRED DS)</b>	1					
PULMICORT FLEXHALER	3	2/30 days				
PULMICORT RESPULES	3	60/30 days		Y		Prior authorization required >8 yrs of age
QVAR	2	24/30 days				
SYMBICORT	2	10.2/30 days				
<b>Hormonal Agents: Estrogen Agonists</b>						
<b>alora</b>	1	8/28 days				
ANGELIQ	3	28/28 days				
CENESTIN	2					
CLIMARA PRO	3	4/28 days				
COMBIPATCH	2	8/28 days				
<b>covaryx (ESTRATEST)</b>	1					
<b>covaryx hs (ESTRATEST H.S.)</b>	1					
<b>essian (ESTRATEST)</b>	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>essian h.s.</b> (ESTRATEST H.S.)	1					
ESTRACE	2					
ESTRADERM	2					
<b>estradiol</b> (CLIMARA)	1	4/28 days				
<b>estradiol</b> (ESTRACE)	1					
<b>estradiol/norethindrone acetate</b> (ACTIVELLA)	1	28/28 days				
DIVIGEL	3					
ELESTRIN GEL 0.06%	3	26gm pump/30 days				
ENJUVIA	3					
ESTRADIOL & NORETHINDRONE ACETATE TAB 1-0.5 MG (ACTIVELLA)						
ESTRASORB	3	98/30 days				
ESTRING	3	1/84 days				Covered for 3 copays
ESTROGEL	3	100/30 days				Copay per 50 grams
<b>estropipate</b> (OGEN)	1					
EVAMIST SPRAY	3					
EVISTA	2	30/30 days				
FEMHRT LOW DOSE	2					
FEMRING	3	1/84 days				Covered for 3 copays
FEMTRACE	2					
MENEST	2					
MENOSTAR	3					
<b>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</b> (FEMHRT 1/5)	1					
PREFEST	2					
PREMARIN	2					
PREMARIN W/APPLICATOR	2	86/30 days				
PREMPHASE	2	28/28 days				
PREMPRO	2	28/28 days				
VAGIFEM	3	18/28 days				
VIVELLE-DOT	3	8/28 days				
<b>Hormonal Agents: Growth Hormone</b>						
INCRELEX	4				Y	Curascript Only
IPLX	4				Y	Curascript Only
OMNITROPE	4			Y	Y	Exclusive Somatropin agent covered;

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
						Curascript only
SEROSTIM	4			Y	Y	Curascript Only
<b>Hormonal Agents: Miscellaneous</b>						
<b>calcitonin nasal spray</b> (FORTICAL, MIACALCIN)	1	3.7/28 days				
FORTEO	4	3/28 days		Y	Y	Curascript Only
<b>methylergonovine maleate</b> (METHERGINE)	1					
MIACALCIN INJ SOLN	4				Y	Curascript Only
<b>Hormonal Agents: Pituitary</b>						
<b>desmopressin acetate</b> (DDAVP)	1					
STIMATE	3			Y		
<b>Hormonal Agents: Progestins</b>						
CRINONE	3			Y		
ENDOMETRIN	3			Y		
<b>medroxyprogesterone acetate</b> (DEPO-PROVERA CONTRACEPTIVE)	1	1/84 days				\$30 copay
<b>medroxyprogesterone acetate</b> (PROVERA)	1					
MEGACE ES	3	150/30 days				
<b>norethindrone acetate</b> (AYGESTIN)	1					
PROCHIEVE	3			Y		
PROMETRIUM	2					
<b>Hormonal Agents: Thyroid Agents</b>						
ARMOUR THYROID	2					Brand available in 15, 120, 180, 240, and 300mg strengths
<b>levothroid</b>	1					
<b>levothyroxine sodium</b>	1					
<b>levoxyl</b>	1					
<b>liothyronine</b> (CYTOMEL)	1					
<b>methimazole</b> (TAPAZOLE)	1					
NATURE-THROID	3					
<b>propylthiouracil</b>	1					
SYNTHROID	2					
<b>thyroid tab</b> (ARMOUR THYROID)	1					
THYROLAR-1	2					
THYROLAR-1/2	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
THYROLAR-1/4	2					
THYROLAR-2	2					
THYROLAR-3	2					
TIROSINT	2					
<b>unithroid direct</b>	1					
<b>Miscellaneous Agents</b>						
ACTONEL	3	1-30/30 days	Y			Progressive Medication Program with alendronate required.
ACTONEL WITH CALCIUM	3	28/28 days	Y			Progressive Medication Program with alendronate required.
<b>alendronate sodium (FOSAMAX)</b>	1	4-30/30 days				
<b>alfuzosin hcl er (UROXATRAL)</b>	1	30/30 days				
<b>allopurinol (ZYLOPRIM)</b>	1					
AMPYRA	3	60/30 days		Y		
ATELVIA	3	4/30 days	Y			Progressive Medication Program with alendronate required.
AVODART	2	30/30 days				
AVONEX	4	4/30 days		Y	Y	Curascript Only; Copaxone and Rebif are preferred products
<b>azathioprine (IMURAN)</b>	1					
BETASERON	4	15/30 days		Y	Y	Curascript Only; Copaxone and Rebif are preferred products
BONIVA	3	1-30/30 days	Y			Progressive Medication Program with alendronate required.
CELLCEPT SUSP	2					
CIMZIA	4	1/28 days		Y	Y	Humira and Enbrel required first; Curascript Only
CIMZIA STARTER KIT	4	1/28 days		Y	Y	Humira and Enbrel required first; Curascript Only
COLCRYS	3	60/30 days				
COPAXONE	4	30/30 days			Y	Curascript Only; Copaxone and Rebif are preferred products
<b>cyclosporine (SANDIMMUNE)</b>	1					



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
CYCLOSPORINE MODIFIED CAP 50mg	2					
<b>cyclosporine modified (NEORAL)</b>	1					
CYSTADANE	2					
CYSTAGON	2					
DEMSER	3					
disulfiram (ANTABUSE)	1					
ELMIRON	3					
ENBREL	4			Y	Y	Curascript Only
ENBREL SURECLICK	4			Y	Y	Curascript Only
<b>etidronate disodium (DIDRONEL)</b>	1					
FINASTERIDE	1	30/30 days				
<b>fluoride</b>	1			Y		Preventive Medication: \$0 copay; PA for age 5 and under , others excluded; only generic covered with retail Rx
<b>folic acid</b>	1			Y		Preventive Medication: \$0 copay; women 15-50, other age requires PA; generic covered with retail Rx
FOSAMAX SOLN	2	300/30 days				
FOSAMAX PLUS D	2	4/28 days	Y			Progressive Medication Program with alendronate required.
GAMMAGARD INJ	4			Y		Curascript Only
GAMUNEX-C	4			Y		Curascript Only
GILENYA	4	30/30 days		Y		
HUMIRA	4			Y	Y	Curascript Only
HUMIRA PEN	4			Y	Y	Curascript Only
<b>iron</b>	1					Preventive Medication: \$0 copay; Excluded over age 1; only generic covered with retail Rx
JALYN	2	30/30 days				
KINERET	4			Y	Y	Curascript Only
<b>leflunomide (ARAVA)</b>	1					
LEUCOVORIN CALCIUM 10&15mg	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
leucovorin calcium	1					
levocarnitine (CARNITOR)	1					
MEPHYTON	2					
MESNEX	3					
mycophenolate (CELLCEPT)	1					
MYFORTIC	3					
ORENCIA SOL	4			Y	Y	Curascript Only
ORFADIN	2					
RAPAMUNE	2					
REBIF	4	6/30 days			Y	Curascript Only; Copaxone and Rebif are preferred products
REBIF TITRATION PACK	4	4/30 days			Y	Curascript Only; Copaxone and Rebif are preferred products
RELISTOR	4	32/30 days				
REVLIMID	2	21/28 days			Y	Curascript Only
RIMSO-50	2					
SAMSCA	3	60/30 days				
SENSIPAR	2	60/30 days				
SIMPONI	4			Y	Y	Humira and Enbrel required first; Curascript Only
SKELID	2					
SOMATULINE DEPOT	4	1/28 days		Y	Y	Curascript Only
SORIATANE	2	30/30 days				
SORIATANE CK	2	1/30 days				
tacrolimus (PROGRAF)	1					
tamsulosin (FLOMAX)	1	60/30 days				
THALOMID	2				Y	Curascript Only
THIOLA	2					
SYNALGOS-DC	3	300/30 days				
ULORIC	3	30/30 days		Y		
ZAVESCA	2	90/30 days				
ZORTRESS	2	60/30 days				
<b>Ophthalmic Agents: Anti-Allergy</b>						
ALAMAST	3	10/30 days				
ALOCRIAL	2	15/30 days				
ALOMIDE	2	10/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
azelastine (OPTIVAR)	1	6/30 days				
BEPREVE	2	10/30 days				
cromolyn sodium (CROLOM)	1	10/30 days				
EMADINE	3	5/30 days				
epinastine hcl (ELESTAT)	1	5/30 days				
LASTACRAFT SOL 0.25%	3	3ml/30 days				
PATADAY	2	10/30 days				
PATANOL	2	10/30 days				
ZADITOR OTC	1	10/30 days				

### Ophthalmic Agents: Antiglaucoma

ALPHAGAN P	2	10/30 days				ONLY 0.1% Strength
AZOPT	2	10/30 days				
BETAXOLOL HCL	2	10/30 days				
BETIMOL	2	10/30 days				
BETOPTIC-S	2	10/30 days				
brimonidine tartrate (ALPHAGAN P)	1	10/30 days				Tier 1 applies to 0.15% and 0.2% strengths
carboptic (ISOPTO CARBACHOL)	1	15/30 days				
carteolol hcl	1	10/30 days				
COMBIGAN	3	5/30 days				
dorzolamide (TRUSOPT)	1	10/30 days				
dorzolamide hcl/ timolol maleate (COSOPT)	1	10/30 days				
ISOPTO CARBACHOL	3	15/30 days				
ISTALOL	2	10/30 days				
latanoprost ophth soln (XALATAN)	1	2.5/30 days				
levobunolol hcl (BETAGAN)	1	10/30 days				
levobunolol hcl (BETAGAN WITHOUT C CAP)	1	10/30 days				
LUMIGAN	3	2.5/30 days				
metipranolol (OPTIPRANOLOL)	1	10/30 days				
PHOSPHOLINE IODIDE	2	15/30 days				
pilocarpine hcl (ISOPTO CARPINE)	1	15/30 days				
PILOPINE HS	2					
timolol maleate (TIMOPTIC)	1	10/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
<b>timolol maleate ophthalmic gel forming (TIMOPTIC-XE)</b>	1	10/30 days				
TRAVATAN	2	2.5/30 days				
TRAVATAN Z	2	2.5/30 days				
<b>Ophthalmic Agents: Mydriatics</b>						
<b>atropine sulfate</b>	1	3.5/30 days				
<b>atropine sulfate (ISOPTO ATROPINE)</b>	1	15/30 days				
CYCLOGYL	3	15/30 days				
CYCLOMYDRIL	3	2/30 days				
<b>cyclopentolate hcl (CYCLOGYL)</b>	1	15/30 days				
<b>dipivefrin hcl (PROPINE)</b>	1	10/30 days				
<b>homatropaire (ISOPTO HOMATROPINE)</b>	1	15/30 days				
ISOPTO HOMATROPINE	2	15/30 days				
ISOPTO HYOSCINE	2	15/30 days				
<b>Ophthalmic Agents: Vasoconstrictors</b>						
<b>ak-con (ALBALON)</b>	1					
<b>phenylephrine hcl</b>	1					
<b>Prenatal Vitamins</b>						
ATABEX EC TAB	3	30/30 days				
ATABEX TAB PRENATAL	3	30/30 days				
BAL-CARE MIS DHA	3	60/30 days				
BP FOLINATAL TAB PLUS B	3	30/30 days				
BP MULTINATL CHW PLUS	3	30/30 days				
BP MULTINATL TAB PLUS	3	30/30 days				
CAVAN ONE CAP OMEGA	3	30/30 days				
CAVAN TAB PRENATAL	3	30/30 days				
CAVAN-ALPHA KIT	3	60/30 days				
CAVAN-EC SOD MIS DHA	3	60/30 days				
CITRANATAL CAP HARMONY	3	30/30 days				
CITRANATAL MIS 90 DHA	3	60/30 days				
CITRANATAL MIS B-CALM	3	90/30 days				
CITRANATAL PAK ASSURE	3	60/30 days				
CITRANATAL PAK DHA	3	60/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
CITRANATAL TAB RX	3	30/30 days				
COMPLETE NAT PAK DHA	3	60/30 days				
COMPLETENATE CHW	3	30/30 days				
COMPLETE-RF TAB PRENATAL	3	30/30 days				
CO-NATAL FA TAB 29-1MG	3	30/30 days				
CONCEPT DHA CAP	3	30/30 days				
CONCEPT OB CAP	3	30/30 days				
CRNATAL PAK	3	60/30 days				
DUET DHA MIS BALANCED	3	60/30 days				
ELITE OB CAP W/DHA	3	30/30 days				
ELITE-OB 400 CAP	3	30/30 days				
ELITE-OB TAB	3	30/30 days				
FOLBECAL TAB	3	30/30 days				
FOLCAL DHA CAP	3	30/30 days				
FOLCAPS CAP OMEGA 3	3	30/30 days				
FOLIVANE-EC PAK CA DHA	3	60/30 days				
FOLIVANE-OB CAP	3	30/30 days				
FOLIVANE-PRX CAP DHA NF	3	30/30 days				
GENTEX ADE TAB 28-1MG	3	30/30 days				
GESTICARE PAK DHA	3	60/30 days				
INATAL ADV TAB	3	30/30 days				
INATAL GT TAB	3	30/30 days				
INATAL ULTRA TAB	3	30/30 days				
LACTOCAL-F TAB	3	30/30 days				
LEVOMEFOLATE MIS	3	60/30 days				
MACNATAL CN CAP DHA	3	30/30 days				
MARNATAL-F CAP	3	30/30 days				
MARNATAL-F MIS PLUS DUO	3	60/30 days				
MAXINATE TAB	3	30/30 days				
M-VIT TAB 27-1MG	3	30/30 days				
MYNATAL CAP	3	30/30 days				
MYNATAL PLUS TAB	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
MYNATAL TAB	3	30/30 days				
MYNATAL TAB ADVANCE	3	30/30 days				
MYNATAL-Z TAB	3	30/30 days				
MYNATE 90 TAB PLUS	3	30/30 days				
NATAFORT TAB	3	30/30 days				
NATALVIT TAB 75-1MG	3	30/30 days				
NATELLE-EZ TAB	3	30/30 days				
NEEVO DHA CAP	3	30/30 days				
NEEVO PAK	3	60/30 days				
NESTABS DHA PAK	3	60/30 days				
NESTABS TAB	3	30/30 days				
NEXA SELECT CAP	3	30/30 days				
OB COMPLETE CAP 400	3	30/30 days				
OB COMPLETE CAP ONE	3	30/30 days				
OB COMPLETE CHW	3	30/30 days				
OB COMPLETE TAB	3	30/30 days				
OB COMPLETE TAB PREMIER	3	30/30 days				
OB COMPLETE/ CAP DHA	3	30/30 days				
OB-NATAL ONE CAP 20-7-1MG	3	30/30 days				
OB-NATAL ONE CAP 27-1MG	3	30/30 days				
OBSTETRIX EC TAB	3	30/30 days				
OBSTETRIX PAK DHA	3	60/30 days				
OBTREX DHA PAK	3	60/30 days				
OBTREX TAB	3	60/30 days				
O-CAL FA TAB	3	30/30 days				
O-CAL TAB PRENATAL	3	30/30 days				
PAIRE OB MIS	3	60/30 days				
PNV OB+DHA PAK	3	60/30 days				
PNV-DHA CAP	3	30/30 days				
PNV-DHA CAP DOCUSATE	3	30/30 days				
PNV-OMEGA CAP	3	30/30 days				
PNV-SELECT TAB	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
PNV-TOTAL CAP	3	30/30 days				
PR NATAL 400 PAK	3	60/30 days				
PR NATAL 400 PAK EC	3	60/30 days				
PR NATAL 430 PAK	3	60/30 days				
PR NATAL 430 PAK EC	3	60/30 days				
PREFERA OB MIS + DHA	3	60/30 days				
PREFERA OB TAB	3	30/30 days				
PREFERAOB CAP ONE	3	30/30 days				
PRENAFIRST TAB	3	30/30 days				
PRENAISSANCE CAP	3	30/30 days				
PRENAISSANCE CAP PLUS	3	30/30 days				
PRENAPLUS TAB	3	30/30 days				
PRENATABS FA TAB	3	30/30 days				
PRENATABS RX TAB	3	30/30 days				
PRENATABS TAB OBN	3	30/30 days				
PRENATAL 19 CHW TAB	3	30/30 days				
PRENATAL 19 TAB	3	30/30 days				
PRENATAL AD TAB	3	30/30 days				
PRENATAL TAB LOW IRON	3	30/30 days				
PRENATAL TAB PLUS	3	30/30 days				
PRENATAL TAB PLUS/FE	3	30/30 days				
PRENATAL-U CAP	3	30/30 days				
PRENATE CAP ESSENTIL	3	30/30 days				
PRENATE ELIT TAB	3	30/30 days				
PRENATE PLUS TAB	3	30/30 days				
PRENEXA CAP	3	30/30 days				
PREQUE 10 TAB	3	30/30 days				
PROTECTNATAL TAB	3	30/30 days				
PUREFE OB CAP PLUS	3	30/30 days				
SE-CARE CHW	3	30/30 days				
SE-CARE TAB CONCEIVE	3	30/30 days				
SELECT-OB CHW	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
SELECT-OB+ PAK DHA	3	60/30 days				
SE-NATAL 19 CHW	3	30/30 days				
SE-NATAL 19 TAB	3	30/30 days				
SE-NATAL 90 TAB	3	30/30 days				
SE-NATAL ONE TAB	3	30/30 days				
SE-PLETE DHA CAP	3	60/30 days				
SE-TAN DHA CAP	3	30/30 days				
SETON ET-EC PAK	3	60/30 days				
SETONET PAK	3	60/30 days				
TANDEM DHA CAP	3	30/30 days				
TANDEM OB CAP	3	30/30 days				
TARON EC PAK CALCIUM	3	60/30 days				
TARON-BC MIS	3	90/30 days				
TARON-C DHA CAP	3	30/30 days				
TARON-DUO EC PAK	3	60/30 days				
TARON-EC CAL TAB 28-1MG	3	30/30 days				
TARON-PREX CAP	3	30/30 days				
TL-ASSURE+ MIS DHA	3	60/30 days				
TL-SELECT CAP	3	30/30 days				
TRI PRENATAL CAP DHA ONE	3	30/30 days				
TRI PRENATAL CAP DHA ONE	3	30/30 days				
TRI RX TAB	3	30/30 days				
TRIADVANCE TAB	3	30/30 days				
TRICARE DHA CAP 301	3	30/30 days				
TRICARE TAB PRENATAL	3	30/30 days				
TRIMESIS RX TAB	3	30/30 days				
TRINATAL GT TAB	3	30/30 days				
TRINATAL RX TAB 1	3	30/30 days				
TRINATAL TAB ULTRA	3	30/30 days				
TRINATE TAB	3	30/30 days				
TRIVEEN-DUO PAK DHA	3	60/30 days				
TRIVEEN-ONE CAP	3	30/30 days				



Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
TRIVEEN-PRX CAP RNF	3	30/30 days				
TRIVEEN-PRX CAP RNF	3	60/30 days				
TRIVEEN-TEN TAB	3	60/30 days				
TRIVEEN-U CAP	3	30/30 days				
TRUST NATAL PAK DHA	3	60/30 days				
ULTIMATE OB MIS DHA	3	60/30 days				
ULTIMATECARE CAP ONE	3	30/30 days				
ULTIMATECARE CAP ONE NF	3	30/30 days				
ULTIMATECARE MIS ADVANTAG	3	60/30 days				
ULTIMATECARE MIS COMBO	3	60/30 days				
ULTRA TABS TAB	3	30/30 days				
VEMAVITE- CAP PRX 2	3	30/30 days				
VENA-BAL MIS DHA	3	60/30 days				
VENATAL COMP MIS DHA	3	60/30 days				
VENATAL-FA TAB	3	30/30 days				
VINACAL TAB	3	30/30 days				
VINATE AZ EX TAB	3	30/30 days				
VINATE AZ TAB	3	30/30 days				
VINATE C TAB	3	30/30 days				
VINATE CAL TAB	3	30/30 days				
VINATE CARE CHW	3	30/30 days				
VINATE GT TAB	3	30/30 days				
VINATE IC CAP	3	30/30 days				
VINATE II TAB	3	30/30 days				
VINATE M TAB	3	30/30 days				
VINATE ONE TAB	3	30/30 days				
VINATE PN TAB CARE	3	30/30 days				
VINATE ULTRA TAB	3	30/30 days				
VITAFOL-OB PAK +DHA	3	60/30 days				
VITAFOL-OB TAB 65-1MG	3	30/30 days				
VITAFOL-ONE CAP	3	30/30 days				
VITAFOL-PN TAB	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
VITA-PREN TAB	3	30/30 days				
VITASPIRE TAB	3	30/30 days				
VIVA DHA CAP	3	30/30 days				
VOL-NATE TAB	3	30/30 days				
VOL-PLUS TAB	3	30/30 days				
VOL-TAB RX TAB	3	30/30 days				
ZATEAN-CH CAP	3	30/30 days				
ZATEAN-PN CAP DHA	3	30/30 days				
ZATEAN-PN CAP PLUS	3	30/30 days				
ZATEAN-PN TAB	3	30/30 days				

### Respiratory Agents: Antitussives

AIRACOF	3					
ALBATUSSIN	3					
ALDEX GS DM TAB	3					
ALDEX GS TAB 30-190MG	3					
ALLFEN CDX	3					
<b>benzonatate</b> (TESSALON)	1	90/30 days				
<b>bromphen./phenylephrine</b> (RESPAHIST-II)	1					
<b>bromphen. /phenyleph tan</b> (J-TAN D)	1					
<b>bromphen. /pseudo</b> (J-TAN D PD)	1					
CARBATUSS SYP	3					
CARBAPHEN 12	3					
CARBA-XP LIQ	3					
CENHIST CHW 6-15MG	3					
<b>chlorpheniramine w/ hydrocodone cr</b> (TUSSIONEX SUSP EXT- REL)	1	120/30 days				
CODAR D LIQUID	3					
CODAR AR LIQUID	3					
CODAR GF LIQUID	3					
CORZALL	3					
CORZALL -PE	3					
CORZALL PLUS	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
DONATUSS DC	3					
DONATUSS XP	3					
ENDACOF-DC LIQ	3					
EXALL	3					
EXALL-D	3					
GILTUSS	3					
GILTUSS PEDIATRIC	3					
GILTUSS TR	3					
<b>guaifenesin/codeine (TUSSO-C)</b>	1					
<b>hydromet (HYCODAN)</b>	1	480/30 days				
LORTUSS EX	3					
MAR-COF BP	3					
NASOTUSS	3					
NEO AC	3					
NOTUSS-NX	3					
NOTUSS-NXD	3					
NOTUSS-PE	3					
PEDIATEX TDM	3					
<b>phenylephrine/bromphen./dm (BROVEX PEB DM)</b>	1					
<b>phenylephrine-chlorphen-dm liquid (ACCUHIST PDX)</b>	1					
<b>phenylephrine/dexchlorphenir/codeine (VANACOF CD)</b>	1					
<b>phenylephrine/diphenhy./codeine (ENDAL CD)</b>	1					
POLY HIST DHC	3					
POLY HIST NC	3					
POLY-TUSSIN AC	3					
POLY-TUSSIN EX	3					
PROHIST LQ LIQ	3					
PROHIST CD LIQ	3					
PROHIST CF LIQ	3					
<b>pseudoephedrine/bromphen./dm (BROVEX PSB DM)</b>	1					
<b>pseudoephedrine/bromphen./dm (BROVEX PSE DM)</b>	1					
<b>pseudoephedrine/chlorphen./dm (MESEHIST DM)</b>	1					
PRO-CLEAR	3					
PYRIL DM	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
RESCON-MX	3					
RESPA C&C IR	3					
RYNEZE	3					
SYMPAK DM	3					
TGQ 30PSE/150GFN/15DM	3					
TRICODE AR LIQUID	3					
TRICODE GF LIQUID	3					
TRITUSS SYP	3					
TUSSO-XR	2					
TUSSO-ZR	2					
TUSSO-ZMR	2					
Z-COF I	3					
Z-TUSS E	3					
Z-TUSS AC	3	120/30 days				
ZODRYL AC	3					
ZODRYL AC ADULT	3					
ZODRYL DAC	3					
ZOTEX- D	3					
ZOTEX-EX	3					
ZOTEX-PE	3					
ZUTRIPRO LIQ	3					

**Respiratory Agents: Bronchodilators**

<b>albuterol sulfate neb solution (ACCUNEB)</b>	1	375/30 days				
<b>albuterol sulfate neb solution (PROVENTIL)</b>	1	375/30 days				
<b>albuterol sulfate neb solution (VENTOLIN)</b>	1	375/30 days				
<b>albuterol sulfate syrup (VENTOLIN)</b>	1	480/30 days				
<b>albuterol sulfate er tab (VOSPIRE ER)</b>	1					
<b>albuterol sulfate/ipratropium bromide neb solution (DUONEB)</b>	1	540/30 days				
ALUPENT	3	28/30 days				
<b>aminophylline</b>	1					
BROVANA	3			Y		
COMBIVENT	2	29.4/30 days				
<b>copd (LUFYLLIN-GG)</b>	1					
DALIRESP	3	30/30 days		Y		
<b>DY-G</b>	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
DYLIX	2					
<b>dyphylline-gg</b> (LUFYLLIN-GG)	1					
FORADIL AEROLIZER	2	60/30 days				
<b>ipratropium bromide</b> (ATROVENT)	1	360/30 days				
<b>jay-phyl</b> (PANFIL-G)	1					
<b>levalbuterol hcl concentrate</b> (XOPENEX CONCENTRATE)	1	96/30 days				*ONLY concentrate on tier 1
LUFYLLIN	2					
MAXAIR AUTOHALER	2	14/30 days				
<b>metaproterenol sulfate nebu</b>	1	300/30 days				
<b>metaproterenol sulfate syrup</b>	1	480/30 days				
METAPROTERENOL SULFATE TABS	2					
PERFOROMIST	3			Y		
PROAIR HFA	3	17/30 days				2 inhalers per month
PROVENTIL HFA	3	13.4/30 days				2 inhalers per month
SEREVENT DISKUS	2	60/30 days				
<b>terbutaline sulfate</b> (BRETHINE)	1					
THEO-24	2					
<b>theophylline er</b> (UNIPHYL)	2					
VENTOLIN HFA	2	36/30 days				2 inhalers per month
XOPENEX	3	288/30 days				
XOPENEX HFA	3	30/30 days				
<b>Respiratory Agents: Devices</b>						
AEROCHAMBER PLUS	2	1/365 days				
E-Z SPACER	2	1/365 days				
<b>Respiratory Agents: Leukotriene Modifiers</b>						
SINGULAIR	2	30/30 days				
<b>zafirlukast</b> (ACCOLATE)	1	60/30 days				
ZYFLO	2	120/30 days				
ZYFLO CR	2	120/30 days				
<b>Respiratory Agents: Mast Cell Stabilizers</b>						
<b>cromolyn sodium</b> (INTAL)	1	240/30 days				
INTAL INHALER	2	30/30 days				
TILADE	2	48.6/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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### Respiratory Agents: Miscellaneous

acetylcysteine (MUCOMYST)	1					
baclofen	1					
carisoprodol (SOMA)	1	120/30 days				Only the 350mg strength is covered
carisoprodol /aspirin /codeine (SOMA COMPOUND/ CODEINE)	1	120/30 days				
carisoprodol/aspirin (SOMA COMPOUND)	1	120/30 days				
chlorzoxazone (PARAFON FORTE DSC)	1					
cyclobenzaprine hcl (FLEXERIL)	1	90/30 days				
dantrolene sodium (DANTRIUM)	1					
metaxalone (SKELAXIN)	1	120/30 days				
methocarbamol (ROBAXIN)	1					
NEBUSAL 6%	3					
orphenadrine citrate er (NORFLEX)	1	60/30 days				
tizanidine hcl (ZANAFLEX)	1					

### Toxicologic Agents

CHEMET	2					
CUPRIMINE	2					
DEPEN TITRATABS	3					
EXJADE	2	180/30 days			Y	Curascript Only
naltrexone hcl (REVIA)	1					
SYPRINE	2					

### Vitamin D Agents

calcitriol (ROCALTROL)	1					
HECTOROL	2					
ZEMPLAR	2					

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<b>B</b>
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<b>C</b>
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<b>flurbiprofen</b> (ANSAID)	11	GLEEVEC	28
<b>flurbiprofen sodium</b> (OCUFEN)	59	<b>glimepiride</b> (AMARYL)	21
<b>flutamide</b>	28	<b>glipizide</b> (GLUCOTROL)	21
<b>fluticasone propionate</b> (CUTIVATE)	52	<b>glipizide xl</b> (GLUCOTROL XL)	21
<b>fluticasone propionate</b> (FLONASE)	59	<b>glipizide/metformin hcl</b> (METAGLIP)	21
<b>flvoxamine maleate</b>	46	GLUCAGEN HYPOKIT	26
FML FORTE	59	GLUMETZA	21
FML S.O.P.	59	<b>glyburide</b> (MICRONASE)	21
FOCALIN XR	48	<b>glyburide micronized</b> (GLYNASE)	21
FOLBECAL TAB	76	<b>glyburide/metformin hcl</b> (GLUCOVANCE)	21
FOLCAL DHA CAP	76	<b>glycopyrrolate</b> (ROBINUL)	31
FOLCAPS CAP OMEGA 3	76	<b>glycopyrrolate forte</b> (ROBINUL FORTE)	31
<b>folic acid</b>	72	GLYCRON	21
FOLIVANE-EC PAK CA DHA	76	GLYSET	21
FOLIVANE-OB CAP	76	<b>granisetron hcl</b> (KYTRIL)	61
FOLIVANE-PRX CAP DHA NF	76	GRIFULVIN V	21
<b>fondaparinux sodium</b> (ARIXTRA)	33	<b>griseofulvin microsize</b> (GRIFULVIN V)	21
FORADIL AEROLIZER	84	GRIS-PEG	22
FORTEO	70	<b>guaifenesin/codeine</b> (TUSSO-C)	82
FORTESTA GEL 10MG/ACT	65	GUANABENZ ACETATE	35
FOSAMAX PLUS D	72	<b>guanfacine hcl</b> (TENEX)	35
FOSAMAX SOLN	72	GUANIDINE HCL	32
<b>fosinopril sodium</b> (MONOPRIL)	34	GYNAZOLE-1	50
<b>fosinopril sodium/hydrochlorothiazide</b> (MONOPRIL HCT)	34		
FOSRENOL	57	<b>H</b>	
FRAGMIN	33	HALFLYTELY BOWEL PREP	63
FRENADOL	X	<b>halobetasol propionate</b> (ULTRAVATE)	52
FROVA	26	HALOG	52
<b>furosemide</b> (LASIX)	38	<b>haloperidol</b>	43
FUROSEMIDE SOLN	38	HECTOROL	85
FUZEON	24	HELIDAC	26
		<b>hemril-30</b> (PROCTOCORT)	52
<b>G</b>		<b>heparin sodium</b>	33
<b>gabapentin</b> (NEURONTIN)	44	HEPARIN SODIUM	33
<b>gabapentin solution</b> (NEURONTIN SOLN)	44	<b>heparin sodium dcu</b>	33
GABITRIL	44	HEPSERA	30
<b>galantamine</b> (RAZADYNE)	32	HEXALEN	28
<b>galantamine er</b> (RAZADYNE ER)	32	HISTEX SR	23
GALZIN	57	<b>homatropaire</b> (ISOPTO HOMATROPINE)	75
GAMMAGARD INJ	72	HUMALOG	18
GAMUNEX-C	72	HUMALOG KWIKPEN	18
GANCICLOVIR	30	HUMALOG MIX 50/50	18
GANTRISIN PEDIATRIC	16	HUMALOG MIX 50/50 KWIKPEN	18
GASTRINEX	62	HUMALOG MIX 50/50 PEN	18
GELNIQUE	65	HUMALOG MIX 75/25	18
<b>gemfibrozil</b> (LOPID)	39	HUMALOG MIX 75/25 KWIKPEN	18
		HUMALOG MIX 75/25 PEN	19

HUMALOG PEN	19	INATAL GT TAB	76
HUMIRA	72	INATAL ULTRA TAB	76
HUMIRA PEN	72	INCIVEK	30
HUMULIN 50/50	19	INCRELEX	69
HUMULIN 70/30	19	<b>indapamide (LOZOL)</b>	38
HUMULIN 70/30 PEN	19	<b>indomethacin caps</b>	11
HUMULIN N	19	<b>indomethacin er (INDOCIN SR)</b>	11
HUMULIN N U-100 PEN	19	INDOMETHACIN SUPP.	11
HUMULIN R	19	INFERGEN	30
HUMULIN R U-500 (CONCENTRATED)	19	INNOPRAN XL	41
HYCAMPTIN	28	INSULIN SYRINGE/0.3ML/29G X ½	20
HYDRALAZINE /HYDROCHLOROTHIAZIDE	42	INSULIN SYRINGE/0.5ML/29G X ½	20
<b>hydralazine hcl</b>	42	INSULIN SYRINGE/1ML/29G X ½	20
<b>hydrocet (BANCAP-HC)</b>	12	INSULIN SYRINGE/1ML/31G X 5/16	20
<b>hydrochlorothiazide</b>	38	INTAL INHALER	84
<b>hydrochlorothiazide (MICROZIDE)</b>	38	INTELENCE	24
<b>hydrocodone /acetaminophen (ANEXSIA, LORCET LORTAB, VICODIN, XODOL)</b>	12	INTRON-A	28
<b>hydrocodone /acetaminophen (LORTAB)</b>	13	INTRON-A W/DILUENT	28
<b>hydrocodone bitartrate/acetaminophen (MAXIDONE)</b>	13	INTUNIV	49
<b>hydrocodone/ibuprofen (VICOPROFEN)</b>	13	INVEGA	43
<b>hydrocodone-acetaminophen soln 7.5-325 mg/15ml (HYCETSOLN)</b>	13	INVIRASE CAPS	25
<b>hydrocortisone</b>	52	INVIRASE TABS	25
<b>hydrocortisone (CORTEF)</b>	68	IOPIDINE	61
<b>hydrocortisone (CORTENEMA)</b>	61	IPILEX	69
<b>hydrocortisone (HYTONE)</b>	52	<b>ipratropium bromide</b>	31
<b>hydrocortisone acetate (ANUSOL-HC)</b>	52	<b>ipratropium bromide (ATROVENT)</b>	84
<b>hydrocortisone acetate/pramoxine (ANALPRAM-HC)</b>	55	IQUIX	58
<b>hydrocortisone butyrate (LOCOID)</b>	52	IRESSA	28
<b>hydrocortisone valerate (WESTCORT)</b>	52	<b>iron</b>	72
<b>hydromet (HYCODAN)</b>	82	ISENTRESS	24
<b>hydromorphone hcl (DILAUDID)</b>	13	<b>isometh/apap (MIDRIN CAPS)</b>	26
<b>hydroxyurea (HYDREA)</b>	28	<b>isonarif (RIFAMATE)</b>	27
<b>hydroxyzine hcl (ATARAX)</b>	48	ISONIAZID SYRP	27
<b>hydroxyzine pamoate (VISTARIL)</b>	48	<b>isoniazid tabs</b>	27
<b>hyomax-dt (SYMAY DUOTAB)</b>	31	ISOPTO CARBACHOL	74
<b>hyoscyamine</b>	31	ISOPTO HOMATROPINE	75
<b>hyoscyamine sulfate (ANASPAZ)</b>	31	ISOPTO HYOSCINE	75
<b>hyoscyamine sulfate (LEVSIN)</b>	31	ISORDIL TITRADOSE	42
<b>hyoscyamine sulfate (LEVSIN/SL)</b>	31	<b>isosorbide dinitrate (ISORDIL)</b>	42
<b>hyoscyamine sulfate er (LEVBID)</b>	31	<b>isosorbide dinitrate er (ISORDIL)</b>	42
<b>hyoscyamine sulfate er (LEVSINEX)</b>	31	<b>isosorbide mononitrate (ISMO)</b>	42
<b>hyoscyamine/ phenyltoloxamine (DIGEX NF)</b>	63	<b>isosorbide mononitrate (MONOKET)</b>	42
<b>hypercare (DRYSOL)</b>	55	<b>isosorbide mononitrate er (IMDUR)</b>	42
		<b>isoxsuprine hcl (VASODILAN)</b>	42
		<b>isradipine (DYNACIRC)</b>	37
		ISTALOL	74
		<b>itraconazole (SPORANOX)</b>	22

<b>I</b>
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<b>ibuprofen (MOTRIN)</b>	11
<b>imipramine hcl (TOFRANIL)</b>	45
IMIPRAMINE PAMOATE	45
<b>imiquimod (ALDARA)</b>	55
IMITREX STATDOSE REFILL	27
IMITREX STATDOSE SYSTEM	27
INATAL ADV TAB	76

<b>J</b>
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JALYN	72
<b>jantoven (COUMADIN)</b>	32
JANUMET	21
JANUVIA	21
<b>jay-phyll (PANFIL-G)</b>	84
<b>jolessa (SEASONALE)</b>	66
<b>junel 1.5/30 (LOESTRIN 1.5/30-21)</b>	66

## K

KALETRA SOLN	25
KALETRA TABS/CAPS	25
<b>kariva</b> (MIRCETTE)	66
<b>kelnor 1/35</b> (DEMULEN 1/35-28)	66
KEMADRIN	29
KENALOG	53
KEPPRA SOLN	44
KETEK	15
<b>ketoconazole</b> (NIZORAL)	22, 50, 51
<b>ketoprofen</b>	11
KETOPROFEN ER	11
<b>ketorolac tromethamine</b> (TORADOL)	11
KINERET	72
<b>klor-con</b> (K-LOR)	57
<b>klor-con 8</b>	57
KLOR-CON M15	57
<b>klor-con m20</b> (K-DUR)	57
<b>klotrix</b> (K-TABS)	57
KOMBIGLYZE XR	21
<b>kovia</b> (ACCUZYME)	55
<b>kovia 6.5</b>	55
K-PHOS	57
K-PHOS MF	57
K-PHOS NO 2	57
<b>k-tan</b> (RYNA-12)	23
<b>k-tan 4</b> (RYNA-12 S)	23

## L

<b>labetalol hcl</b> (TRANDATE)	41
LACRISERT	61
LACTOCAL-F TAB	76
<b>lactulose</b>	57
<b>lamotrigine</b> (LAMICTAL)	44
<b>lamotrigine chewable dispersible</b> (LAMICTAL CHEWABLE DISPERSIBLE)	44
<b>lansoprazole</b> (PREVACID)	64
<b>lansoprazole odt</b> (PREVACID SOLUTAB)	64
LANTUS	19
LANTUS FOR OPTICLIK	19
LANTUS SOLOSTAR	19
LASTACFT SOL 0.25%	74
<b>latanoprost ophth soln</b> (XALATAN)	74
LATUDA	43
<b>leena</b> (TRI-NORINYL 28)	66
LESCOL	39
LESCOL XL	39
LETAIRIS	42
<b>letrozole</b> (FEMARA)	28
<b>leucovorin calcium</b>	73
LEUCOVORIN CALCIUM 10&15mg	72
LEUKERAN	28
LEUKINE	33
LEVACET	11

<b>levabuterol hcl concentrate</b> (XOPENEX CONCENTRATE)	84
LEVATOL	41
LEVEMIR	19
LEVEMIR FLEXPEN	19
<b>levetiracetam</b> (KEPPRA)	44
levetiracetam er (KEPPRA XR)	44
<b>levobunolol hcl</b> (BETAGAN WITHOUT C CAP)	74
<b>levobunolol hcl</b> (BETAGAN)	74
<b>levocarnitine</b> (CARNITOR)	73
<b>levofloxacin</b> (LEVAQUIN IV SOLN)	16
<b>levofloxacin</b> (LEVAQUIN TABS)	16
<b>levofloxacin</b> (QUIXIN)	58
LEVOMEFOLATE MIS	76
<b>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</b> (LYBREL)	66
<b>levonorg-eth est tab 0.15-0.03mg(84) &amp; eth est tab 0.01mg(7)</b> (SEASONIQUE)	67
<b>levothroid</b>	70
<b>levothyroxine sodium</b>	70
<b>levoxy</b>	70
LEXAPRO SOLN	46
LEXAPRO TABS	46
LEXIVA	26
LEXXEL	37
LIALDA	61
<b>lidazone hc</b> (ANAMANTLE HC)	55
<b>lidocaine</b>	55
<b>lidocaine</b> (LIDAMANTLE)	55
<b>lidocaine hcl jelly</b> (XYLOCAINE JELLY)	55
<b>lidocaine hcl/hydrocortisone acetate</b> (LIDAMANTLE HC)	53
<b>lidocaine/prilocaine</b> (EMLA)	55
LIDODERM	55
<b>lindane</b>	55
<b>liothyronine</b> (CYTOMEL)	70
LIPITOR	39
LIPOFEN	39
LIPRAM 4500	62
LIPRAM-PN10	62
LIPRAM-PN16	62
LIPRAM-PN20	62
LIPRAM-UL12	62
LIPRAM-UL18	62
LIPRAM-UL20	62
<b>liquadd</b>	49
<b>lisinopril</b> (ZESTRIL)	34
<b>lisinopril /hydrochlorothiazide</b> (PRINZIDE)	34
<b>lithium carbonate</b> (LITHIUM CARBONATE)	46
<b>lithium carbonate er</b> (LITHOBID)	47
<b>lithium citrate</b>	47
LITHOSTAT	57
LO LOESTRIN FE	66
LOCOID LIPOCREAM	53
LODOSYN	29
LOESTRIN 24 FE	66
<b>lohist-pd</b> (ACCUHIST)	23
<b>loperamide hcl</b>	63



LOPROX SHAMPOO	51	MEPHYTON	73
<b>lorazepam</b> (ATIVAN)	47	<b>meprobamate</b> (MEPROBAMATE)	48
LORAZEPAM INTENSOL	47	MEPRON	30
LORTUSS EX	82	<b>mercaptapurine</b> (PURINETHOL)	28
<b>losartan</b> (COZAAR)	36	<b>mesalamine</b> (ROWASA)	61
<b>losartan/hctz</b> (HYZAAR)	36	MESNEX	73
LOSEASONIQUE	66	MESTINON	32
LOTEMAX OINTMENT	60	MESTINON TIMESPAN	32
LOTEMAX SUSP	60	METADATE CD	49
LOTRONEX	63	<b>metaproterenol sulfate nebu</b>	84
<b>lovastatin</b> (MEVACOR)	40	<b>metaproterenol sulfate syrup</b>	84
LOVAZA	40	METAPROTERENOL SULFATE TABS	84
LOVENOX	33	<b>metaxalone</b> (SKELAXIN)	85
<b>loxapine succinate</b> (LOXITANE)	43	<b>metformin hcl</b> (GLUCOPHAGE)	21
LUFYLLIN	84	<b>metformin hcl er</b> (GLUCOPHAGE XR)	21
LUMIGAN	74	<b>methadex</b> (MAXITROL)	60
LUPRON DEPOT-PED**	VIII	<b>methadone hcl</b> (DOLOPHINE)	13
LUXIQ	53	<b>methadone hcl soln</b>	13
LYRICA	44	<b>methamphetamine hcl</b> (DESOXYN)	49
LYSODREN	28	<b>methazolamide</b>	38
LYSTEDA	33	<b>methenamine hippurate</b> (HIPREX)	26
<b>M</b>			
MACNATAL CN CAP DHA	76	<b>methenamine/hyosc/meth blue/benz acid/phenyl sol</b> (PROSED D/S)	26
MACRODANTIN	26	<b>methenamine/hyosc/meth blue/benz acid/phenyl tab</b> (PROSED D/S)	26
MALARONE	30	<b>methimazole</b> (TAPAZOLE)	70
<b>malathion</b> (OVIDE)	55	<b>methocarbamol</b> (ROBAXIN)	85
<b>maldemar</b> (SCOPACE)	61	<b>methotrexate</b>	28
MAPROTILINE HCL	45	<b>methscopolamine bromide</b> (PAMINE FORTE)	31
MAR-COF BP	82	<b>methscopolamine bromide</b> (PAMINE)	31
MARNATAL-F CAP	76	METHYLCLOTHIAZIDE	39
MARNATAL-F MIS PLUS DUO	76	<b>methyldopa</b> (ALDOMET)	35
MARPLAN	47	METHYLDOPA /HYDROCHLOROTHIAZIDE	35
MATULANE	28	<b>methylergonovine maleate</b> (METHERGINE)	70
MAXAIR AUTOHALER	84	<b>methylin er</b> (METADATE ER)	49
MAXALT	27	<b>methylphenidate hcl</b> (RITALIN SR)	49
MAXALT-MLT	27	<b>methylphenidate hcl</b> (RITALIN)	49
MAXIDEX	60	<b>methylphenidate hcl soln.</b> (METHYLIN SOLN)	49
MAXINATE TAB	76	<b>methylprednisolone</b> (MEDROL DOSEPAK)	68
<b>mebendazole</b>	22	<b>methylprednisolone</b> (MEDROL)	68
MECLOFENAMATE SODIUM	11	<b>metipranolol</b> (OPTIPRANOLOL)	74
<b>medroxyprogesterone acetate</b> (DEPO-PROVERA CONTRACEPTIVE)	70	<b>metoclopramide hcl</b> (REGLAN)	63
<b>medroxyprogesterone acetate</b> (PROVERA)	70	<b>metolazone</b> (ZAROXOLYN)	39
<b>mefenamic acid</b> (PONSTEL)	11	<b>metoprolol /hydrochlorothiazide</b> (LOPRESSOR HCT)	41
MEFLOQUINE HCL TABS	30	<b>metoprolol succinate er</b> (TOPROL XL)	41
MEGACE ES	70	<b>metoprolol tartrate</b> (LOPRESSOR)	41
<b>megestrol acetate</b> (MEGACE)	28	METROGEL	50
<b>meloxicam susp</b>	11	METROGEL 1% KIT	50
<b>meloxicam tabs</b> (MOBIC)	11	<b>metronidazole</b> (FLAGYL)	30
MENEST	69	<b>metronidazole</b> (METROCREAM)	50
MENOSTAR	69	<b>metronidazole</b> (METROGEL)	50
MEPERIDINE HCL	13	<b>metronidazole</b> (METROLOTION)	50
<b>meperidine hcl</b> (DEMEROL)	13	<b>metronidazole vaginal</b> (METROGEL VAGINAL)	50
<b>meperidine/promethazine</b> (MEPERGAN FORTIS)	13	<b>mexar wash</b> (OVACE WASH)	50
<b>mephobarbital</b> (MEBARAL)	47	MEXILETINE HCL	35
		MIACALCIN INJ SOLN	70
		MICARDIS	36

MICARDIS HCT	36	NAMENDA TITRATION PAK	47
<b>microgestin 1/20</b> (LOESTRIN 1/20-21)	66	NAPRELAN	11
<b>microgestin fe (LOESTRIN FE 1/20)</b>	66	<b>naproxen dr</b> (EC-NAPROSYN)	11
<b>microgestin fe 1.5/30</b> (LOESTRIN FE 1.5/30)	66	<b>naproxen sodium</b> (ANAPROX DS)	11
MICRO-K	57	<b>naproxen sodium</b> (ANAPROX)	11
<b>midodrine hcl</b> (PROAMATINE)	32	<b>naproxen sodium</b> (NAPRELAN)	11
MIGERGOT	27	<b>naproxen susp</b> (NAPROSYN SUSP)	11
MIGRAL	27	<b>naproxen tabs</b> (NAPROSYN TABS)	11
MIGRANAL	27	<b>naratriptan tab</b> (AMERGE)	27
<b>minocycline hcl</b> (DYNACIN, MINOCIN)	17	NASONEX	60
<b>minoxidil</b>	42	NASOTUSS	82
MIRAPEX ER	29	NATACYN	58
<b>mirtazapine</b> (REMERON SOLTAB)	46	NATAFORT TAB	77
<b>mirtazapine</b> (REMERON)	46	NATALVIT TAB 75-1MG	77
<b>misoprostol</b> (CYTOTEC)	65	NATAZIA	66
MOBAN	43	<b>natelinide</b> (STARLIX)	21
<b>moexipril /hydrochlorothiazide</b> (UNIRETIC)	34	NATELLE-EZ TAB	77
<b>moexipril hcl</b> (UNIVASC)	34	NATURE-THROID	70
<b>mometasone furoate</b> (ELOCON)	53	NAVANE	43
<b>mononessa</b> (ORTHO-CYCLEN-28)	66	NEBUPENT	30
MONUROL	26	NEBUSAL 6%	85
<b>morphine sulfate</b>	13	NECON 10/11-28	66
<b>morphine sulfate</b> (RMS)	13	NEEVO DHA CAP	77
<b>morphine sulfate</b> (ROXANOL)	13	NEEVO PAK	77
<b>morphine sulfate cap sr 24hr</b> (KADIAN)	13	<b>nefazodone hcl</b>	46
<b>morphine sulfate cr</b> (MS CONTIN)	13	<b>neo /poly /bac /hc</b>	60
<b>morphine sulfate er</b> (MS CONTIN)	13	NEO AC	82
MOVIPREP	63	<b>neomycin /polymyxin /dexamethasone</b>	
MOXEZA	58	(MAXITROL)	60
<b>mst 600</b> (NOVASAL)	11	<b>neomycin /polymyxin /gramicidin</b> (NEOSPORIN)	58
MUGARD	58	<b>neomycin /polymyxin /hydrocortisone ophth susp</b>	60
MULTAQ	35		
<b>mupirocin</b> (BACTROBAN)	50	<b>neomycin /polymyxin /hydrocortisone otic soln</b>	60
M-VIT TAB 27-1MG	76	(CORTISPORIN)	60
MYCOBUTIN	27	<b>neomycin sulfate</b>	15
<b>mycophenolate</b> (CELLCEPT)	73	NESTABS DHA PAK	77
MYFORTIC	73	NESTABS TAB	77
MYLERAN	28	NEUPOGEN	33
MYNATAL CAP	76	NEUPRO	29
MYNATAL PLUS TAB	76	NEXA SELECT CAP	77
MYNATAL TAB	77	NEXAVAR	28
MYNATAL TAB ADVANCE	77	NEXIUM	64
MYNATAL-Z TAB	77	<b>next choice</b> (PLAN B)	66
MYNATE 90 TAB PLUS	77	NIASPAN	40
MYTELEASE	32	<b>nicardipine hcl</b> (CARDENE)	38
<b>N</b>			
<b>nabumetone</b> (RELAFEN)	11	<b>nifediac cc</b> (ADALAT CC)	38
<b>nadolol</b> (CORGARD)	41	<b>nifedical xl</b> (PROCARDIA XL)	38
<b>nadolol /bendroflumethiazide</b> (CORZIDE)	41	<b>nifedipine</b> (PROCARDIA)	38
NAFTIN	51	NIFEDIPINE 20mg	38
NAFTIN-MP	51	<b>nifedipine er</b> (PROCARDIA XL)	38
NALEX-A 12	23	NILANDRON	28
NALFON	11	<b>nisoldipine sr</b> (SULAR)	38
<b>naltrexone hcl</b> (REVIA)	85	NITRO-BID	42
NAMENDA	47	NITRO-DUR	42
		<b>nitrofurantoin macrocrystalline</b> (MACRODANTIN)	26
		<b>nitrofurantoin monohydrate</b> (MACROBID)	26
		<b>nitrofurantoin susp</b> (FURADANTIN)	26

<b>nitroglycerin (NITROSTAT)</b>	42	<b>ocella (YASMIN-28)</b>	67
<b>nitroglycerin cr</b>	42	<b>ofloxacin (FLOXIN OTIC)</b>	58
<b>nitroglycerin er</b>	42	<b>ofloxacin (FLOXIN)</b>	16
<b>nitroglycerin transdermal (NITRO-DUR)</b>	42	<b>ofloxacin (OCUFLOX)</b>	58
NITROLINGUAL PUMPSPRAY	42	OFORTA	28
NITROMIST	42	OGESTREL	67
<b>nizatadine (AXID)</b>	63	<b>olanzapine orally disintegrating tab (ZYPREXA ZYDIS)</b>	43
<b>norethindrone &amp; ethinyl estradiol-fe chew tab (FEMCON FE CHW)</b>	66	<b>olanzapine tab (ZYPREXA)</b>	43
<b>norethindrone acetate (AYGESTIN)</b>	70	OLEPTRO	46
<b>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg (FEMHRT 1/5)</b>	69	OLUX-E	53
NORITATE	50	<b>omeprazole (PRILOSEC)</b>	64
NORPACE CR	35	<b>omeprazole otc (PRILOSEC OTC)</b>	64
<b>nortrel 0.5/35 (28) (BREVICON-28)</b>	66	<b>omeprazole/sodium bicarbonate cap (ZEGERID)</b>	64
<b>nortrel 1/35 (28) (NORINYL 1+35)</b>	67	OMNARIS SPR	60
<b>nortrel 7/7/7 (ORTHO-NOVUM 7/7/7-28)</b>	67	OMNITROPE	69
<b>nortriptyline hcl (PAMELOR)</b>	45	<b>ondansetron hcl (ZOFRAN)</b>	61
NORVIR	26	<b>ondansetron odt (ZOFRAN ODT)</b>	61
NOTUSS-NX	82	ONGLYZA	21
NOTUSS-NXD	82	ONSOLIS	13
NOTUSS-PE	82	OPANA ER	13
NOVACORT	53	ORACIT	57
NOVOLIN 70/30	19	ORAP	43
NOVOLIN N	19	ORENCIA SOL	73
NOVOLIN R	19	ORFADIN	73
NOVOLOG	19	<b>orphenadrine citrate er (NORFLEX)</b>	85
NOVOLOG FLEXPEN	19	<b>orphenadrine compound (NORGESIC)</b>	11
NOVOLOG MIX 70/30	19	ORPHENADRINE COMPOUND DS	11
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	19	ORTHO EVRA	67
NOVOLOG PENFILL	19	ORTHO TRI-CYCLEN LO	67
NOXAFIL	22	OSMOPREP	63
NUVARING	67	<b>oticaine otic</b>	58
NUVIGIL	49	<b>otogesic (TYMPAGESIC DROPS)</b>	58
<b>nystatin</b>	22	<b>otomar (CORTANE-B-OTIC)</b>	60
<b>nystatin (MYCOSTATIN)</b>	51	OVCON-50 28	67
NYSTATIN VAGINAL	51	OVIDE	55
<b>nystatin/triamcinolone</b>	53	<b>oxandrolone (OXANDRIN)</b>	65
<b>nystatin/triamcinolone (MYCOLOG II)</b>	53	<b>oxaprozin (DAYPRO)</b>	12
<b>nystop (MYCOSTATIN)</b>	51	<b>oxazepam (SERAX)</b>	47
<b>O</b>			
OB COMPLETE CAP 400	77	<b>oxcarbazepine (TRILEPTAL)</b>	44
OB COMPLETE CAP ONE	77	OXISTAT	51
OB COMPLETE CHW	77	OXSORALEN ULTRA	55
OB COMPLETE TAB	77	<b>oxybutynin chloride (DITROPAN)</b>	65
OB COMPLETE TAB PREMIER	77	<b>oxybutynin chloride er (DITROPAN XL)</b>	65
OB COMPLETE/ CAP DHA	77	<b>oxycodone /acetaminophen (PERCOCET)</b>	14
OB-NATAL ONE CAP 20-7-1MG	77	<b>oxycodone hcl (OXYIR)</b>	13
OB-NATAL ONE CAP 27-1MG	77	<b>oxycodone hcl (ROXICODONE INTENSOL)</b>	13
OBSTETRIX EC TAB	77	<b>oxycodone hcl (ROXICODONE)</b>	13
OBSTETRIX PAK DHA	77	<b>oxycodone hcl er (OXYCONTIN)</b>	13
OBTREX DHA PAK	77	<b>oxycodone/acetaminophen (TYLOX)</b>	13
OBTREX TAB	77	<b>oxycodone/aspirin (PERCODAN)</b>	14
O-CAL FA TAB	77	OXYCONTIN	14
O-CAL TAB PRENATAL	77	<b>oxymorphone hcl (OPANA)</b>	14
<b>P</b>			
		PAIRE OB MIS	77

PALGIC	23	<b>phenylephrine hcl</b>	75
PANAFIL SE	55	<b>phenylephrine/bromphen./dm</b> (BROVEX PEB DM)	
PANCREASE MT 10	62		82
PANCREASE MT 16	62	<b>phenylephrine/dexchlorphenir/codeine</b> (VANACOF CD)	82
PANCREASE MT 20	62		
PANCREASE MT 4	62	<b>phenylephrine/diphenhy./codeine</b> (ENDAL CD)	82
PANCREATIN	62	<b>phenylephrine-chlorphen-dm liquid</b> (ACCUHIST PDX)	82
PANCREAZE	62		
PANCRECARB MS-16	62	<b>phenytoin</b> (DILANTIN, PHENYTEK)	45
PANCRECARB MS-4	62	<b>phenytoin sodium extended</b> (DILANTIN)	45
PANCRECARB MS-8	62	PHISOHEX	55
PANCRELIPASE	62	PHOSPHOLINE IODIDE	74
PANDEL	53	PHRENILIN FORTE	X
PANGESTYME CN 10	62	<b>pilocarpine hcl</b> (ISOPTO CARPINE)	74
PANGESTYME CN 20	62	<b>pilocarpine hcl</b> (SALAGEN)	32
PANGESTYME EC	62	PILOPINE HS	74
PANGESTYME MT 16	62	PINDOLOL	41
PANGESTYME UL 12	62	<b>piroxicam</b> (FELDENE)	12
PANGESTYME UL 18	62	<b>plaretase 8000</b>	62
PANGESTYME UL 20	62	PLARETASE 8000	62
PANRETIN	55	PLAVIX	33
<b>pantoprazole sodium</b> (PROTONIX)	64	PNV OB+DHA PAK	77
<b>papaverine hcl</b>	42	PNV-DHA CAP	77
<b>papaverine hcl cr</b>	42	PNV-DHA CAP DOCUSATE	77
PARCOPA	29	PNV-OMEGA CAP	77
<b>paregoric</b>	63	PNV-SELECT TAB	77
<b>paroxetine hcl</b> (PAXIL CR)	46	PNV-TOTAL CAP	78
<b>paroxetine hcl susp</b> (PAXIL SUSP)	46	<b>podofilox</b> (CONDYLOX W/APPLICATORS)	55
<b>paroxetine hcl tabs</b> (PAXIL TABS)	46	POLY HIST DHC	82
PASER	27	POLY HIST NC	82
PATADAY	74	<b>polyethylene glycol 3350</b> (MIRALAX)	63
PATANASE	61	POLY-PRED	60
PATANOL	74	POLY-TUSSIN AC	82
PCE	15	POLY-TUSSIN EX	82
PEDIATEX TDM	82	<b>potassium bicarbonate</b> (K-LYTE)	57
<b>peg 3350/electrolytes</b> (COLYTE)	63	<b>potassium chloride</b>	57
PEGANONE	45	<b>potassium chloride er</b> (K-DUR)	57
PEGASYS	30	<b>potassium chloride er</b> (MICRO-K)	57
PEGASYS PROCLICK	30	<b>potassium chloride powder packet</b> (KLOR-CON 25)	57
PEG-INTRON	30	<b>potassium citrate</b> (UROCIT-K 5)	57
PEG-INTRON REDIPEN PAK 4	30	<b>potassium citrate extended-release</b> (UROCIT-K 10)	57
<b>penicillin v potassium</b>	16		
PENNSAID	12	PR NATAL 400 PAK	78
PENTASA	61	PR NATAL 400 PAK EC	78
<b>pentazocine /acetaminophen</b> (TALACEN)	14	PR NATAL 430 PAK	78
<b>pentazocine/naloxone hcl</b> (TALWIN NX)	14	PR NATAL 430 PAK EC	78
<b>pentoxifylline er</b> (TRENTAL)	34	PRADAXA	33
PEPCID SUSP	63	<b>pramipexole</b> (MIRAPEX)	29
PERFOROMIST	84	<b>pramoxine/chloroxylenol</b>	58
<b>perinodopril</b> (ACEON)	34	<b>pramoxine/chloroxylenol</b> (PRAMOTIC)	58
<b>perphenazine</b>	43	<b>pramoxine-hc</b> (PRAMOSONE)	55
PERPHENAZINE /AMITRIPTYLINE	45	PRANDIN	21
<b>phenazopyridine hcl</b> (PYRIDIUM)	55	<b>prascion fc</b> (PLEXION CLEANSING CLOTH)	55
<b>phenazopyridine plus</b> (PYRIDIUM PLUS)	55	<b>pravastatin sodium</b> (PRAVACHOL)	40
<b>phenelzine sulfate</b> (NARDIL)	47	<b>prazosin hcl</b> (MINIPRESS)	34
<b>phenyl chlor-tan</b> (RYNATAN PEDIATRIC)	23	PRED MILD	60
<b>phenylephrine cm</b> (RESCON-MX)	23	PRED-G	60

PRED-G S.O.P.	60	PROGLYCEM	42
<b>prednicarbate</b> (DERMATOP)	53	PROHIST CD LIQ	82
<b>prednisolone</b> (PRELONE)	68	PROHIST CF LIQ	82
PREDNISOLONE SODIUM PHOSPHATE	60	PROHIST LQ LIQ	82
<b>prednisolone sodium phosphate</b> (ORAPRED)	68	PROLEX DMX	23
<b>prednisolone sodium phosphate</b> (PEDIAPRED)	68	PROMACTA	34
PREDNISOLONE TABS	68	<b>promethazine hcl plain syrup</b>	23
<b>prednisone</b> (DELTASONE)	68	<b>promethazine hcl supp</b>	23
<b>prednisone</b> (STERAPRED DS)	68	<b>promethazine hcl tabs</b>	23
PREFERA OB MIS + DHA	78	PROMETRIUM	70
PREFERA OB TAB	78	PRONESTYL	35
PREFERA OB CAP ONE	78	PRONESTYL SR	35
PREFEST	69	<b>propafenone hcl</b> (RYTHMOL)	35
PREMARIN	69	<b>propafenone hcl sr</b> (RYTHMOL SR)	35
PREMARIN W/APPLICATOR	69	PROPANTHELINE BROMIDE	32
PREMPHASE	69	<b>proparacaine hcl</b> (ALCAINE)	58
PREMPRO	69	<b>propranolol /hydrochlorothiazide</b> (INDERIDE)	41
PRENAFIRST TAB	78	PROPRANOLOL /HYDROCHLOROTHIAZIDE	
PRENAISSANCE CAP	78	25/80mg	41
PRENAISSANCE CAP PLUS	78	<b>propranolol hcl</b> (INDERAL)	41
PRENAPLUS TAB	78	<b>propranolol hcl er</b> (INDERAL LA)	41
PRENATABS FA TAB	78	PROPRANOLOL HCL SOLN	41
PRENATABS RX TAB	78	<b>propylthiouracil</b>	70
PRENATABS TAB OBN	78	PROSTIGMIN	32
PRENATAL 19 CHW TAB	78	PROTECTNATAL TAB	78
PRENATAL 19 TAB	78	PROTID	23
PRENATAL AD TAB	78	PROTONIX PACK	64
PRENATAL TAB LOW IRON	78	PROTOPIC	55
PRENATAL TAB PLUS	78	PROVENTIL HFA	84
PRENATAL TAB PLUS/FE	78	PROVIGIL	49
PRENATAL-U CAP	78	<b>prudoxin</b> (ZONALON)	55
PRENATE CAP ESSENTIL	78	<b>pseudo cm</b>	23
PRENATE ELIT TAB	78	<b>pseudoephedrine/bromphen./dm</b> (BROVEX PSB	
PRENATE PLUS TAB	78	DM)	82
PRENEXA CAP	78	<b>pseudoephedrine/bromphen./dm</b> (BROVEX PSE	
PREQUE 10 TAB	78	DM)	82
PREVACID OTC	64	<b>pseudoephedrine/chlorphen./dm</b> (MESEHIST DM)	
PREVPAC	64		82
PREZISTA	26	PULMICORT FLEXHALER	68
PRIFTIN	27	PULMICORT RESPULES	68
PRIOLOSEC PACKETS	64	PULMOZYME	57
<b>primidone</b> (MYSOLINE)	45	PUREFE OB CAP PLUS	78
PRIMSOL	26	PYLERA	26
PRISTIQ	46	<b>pyrazinamide</b>	27
PROAIR HFA	84	<b>pyridostigmine bromide</b> (MESTINON)	32
<b>probenecid</b>	22	PYRIL DM	82
<b>probenecid/colchicine</b>	22		
PROCENTRA	49		
PROCHIEVE	70		
<b>prochlorperazine maleate</b>	43		
PRO-CLEAR	82		
PROCORT CREAM	55		
PROCROT	33		
<b>proctocream-hc</b> (ANUSOL-HC)	53		
PROCTOFOAM HC	53		
<b>proctosol hc</b>	53		
<b>proctozone hc</b>	53		

## Q

QUALAQUIN	30
<b>quinapril hcl</b> (ACCUPRIL)	34
<b>quinaretic</b> (ACCURETIC)	34
<b>quinidine gluconate cr</b>	35
<b>quinidine sulfate</b>	35
<b>quinidine sulfate er</b>	35
QVAR	68

<b>R</b>	
<b>ramipril</b> (ALTACE)	34
RANEXA	40
RANICLOR	15
<b>ranitidine hcl</b> (ZANTAC)	63
RAPAMUNE	73
RAZADYNE SOLUTION	32
REBIF	73
REBIF TITRATION PACK	73
REGRANEX	55
RELAGESIC	23
RELENZA DISKHALER	30
RELHIST	24
RELION 70/30	19
RELION 70/30 INNOLET	19
RELION N	19
RELION N INNOLET	19
RELION R	19
RELISTOR	73
RELPAK	27
RENAGEL	57
REVELA	57
REQUIP XL	29
RESCON	24
RESCON-JR	24
RESCON-MX	83
RESCRIPTOR	25
RESERPINE	40
RESPA C&C IR	83
RESTASIS	61
RETIN-A MICRO	55
RETIN-A MICRO PUMP	56
REVATIO	42
REVLIMID	73
REYATAZ	26
RHINOCORT AQUA	60
<b>rhinoflex</b>	24
<b>rhinoflex-650</b> (RELAGESIC)	24
<b>ribapak</b>	30
<b>ribasphere</b>	30
<b>ribavirin</b> (COPEGUS)	30
<b>ribavirin</b> (REBETOL)	30
RIDAURA	X
<b>rifampin</b> (RIFADIN)	27
RIFATER	27
RILUTEK	47
<b>rimantadine hcl</b> (FLUMADINE)	30
RIMSO-50	73
<b>risperidone odt</b> (RISPERDAL M-TABS)	43
<b>risperidone soln</b> (RISPERDAL SOLN)	43
<b>risperidone tabs</b> (RISPERDAL TABS)	43
RITALIN LA	49
<b>rivastigmine cap</b> (EXELON)	32
<b>ropinirole hcl</b> (REQUIP)	29
ROXICET SOLN	14
ROXICET TABS	14

ROZEREM	48
<b>r-tanna</b> (RYNATAN)	24
RYDEX	24
RYNATAN PEDIATRIC	24
RYNEZE	83
RYZOLT	14

<b>S</b>	
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SABRIL	45
SAFYRAL	67
<b>salsalate</b>	12
SAL-TROPINE	32
SAMSCA	73
SANCTURA XR	65
SANCUSO	61
SANTYL	56
SAVELLA	46
<b>seb-prev wash</b> (OVACE WASH)	50
SE-CARE CHW	78
SE-CARE TAB CONCEIVE	78
SECONAL	47
<b>se-donna pb hyos</b> (DONNATAL ELX)	63
SELECT-OB CHW	78
SELECT-OB+ PAK DHA	79
<b>selegiline hcl</b> (ELDEPRYL)	29
<b>selenium sulfide</b> (SELSUN SHAMPOO)	56
SELZENTRY	24
SE-NATAL 19 CHW	79
SE-NATAL 19 TAB	79
SE-NATAL 90 TAB	79
SE-NATAL ONE TAB	79
SENSIPAR	73
SE-PLETE DHA CAP	79
SEREVENT DISKUS	84
SEROQUEL	43
SEROQUEL XR	43
SEROSTIM	70
<b>sertraline hcl</b> (ZOLOFT)	46
SE-TAN DHA CAP	79
SETON ET-EC PAK	79
SETONET PAK	79
<b>silver sulfadiazine</b> (SILVADENE)	56
SIMCOR	40
SIMPONI	73
<b>simvastatin</b> (ZOCOR)	40
SINGULAIR	84
SKELID	73
SLO-NIACIN	40
<b>sodium hyaluronate</b>	56
<b>sodium polystyrene sulfonate</b>	57
<b>sodium polystyrene sulfonate</b> (KAYEXALATE)	57
<b>sodium sulfacetamide</b> (BLEPH-10)	58
<b>sodium sulfacetamide/sulfur</b> (PLEXION TS)	56
SOLARAZE	56
SOLTAMOX	28
SOMATULINE DEPOT	73

SOMNOTE	48
SORIATANE	73
SORIATANE CK	73
<b>sorine</b> (BETAPACE)	41
<b>sotalol hcl</b> (BETAPACE)	41
SPECTRACEF	15
SPIRIVA HANDIHALER	32
<b>spironolactone</b> (ALDACTONE)	35
<b>spironolactone /hydrochlorothiazide</b> (ALDACTAZIDE)	35
SPRYCEL	28
<b>sps</b>	57
STALEVO	29
<b>stavudine</b> (ZERIT)	25
STIMATE	70
STRATTERA	47
SUBOXONE	14
SUCRAID	57
<b>sucralfate tabs</b> (CARAFATE TABS)	65
<b>sulfacetamide sodium</b> (KLARON)	50
<b>sulfacetamide sodium/prednisolone sodium</b> <b>phosphate</b>	60
<b>sulfacetamide sodium/sulfur cleanser</b>	56
<b>sulfacetamide sodium-urea pad</b> (SOD SULFACET PAD)	50
SULFADIAZINE	17
<b>sulfamethoxazole /trimethoprim</b> (BACTRIM)	17
<b>sulfamethoxazole/trimethoprim ds</b> (BACTRIM DS)	17
SULFAMYLON	56
<b>sulfasalazine</b> (AZULFIDINE EN-TABS)	17
<b>sulfatol cleanser</b> (ROSULA)	56
<b>sulfazine</b> (AZULFIDINE)	17
<b>sulindac</b> (CLINORIL)	12
<b>sumatriptan soln</b> (IMITREX SOLN)	27
<b>sumatriptan tabs</b> (IMITREX TABS)	27
SUPRAX	15
SURMONTIL	45
SUSTIVA	25
SUTENT	28
SYLATRON INJ KIT	28
<b>symax fastabs</b> (NULEV)	32
SYMBICORT	68
SYMBYAX	46
SYMLIN SOLN	20
SYMLINPEN 120	20
SYMLINPEN 60	20
SYMPAK	24
SYMPAK DM	83
SYMPAK II	24
SYMPAK PDX	24
SYNALGOS-DC	14, 73
SYNERA	56
SYNTHROID	70
SYPRINE	85

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TABLOID	28
TACLONEX	53
TACLONEX SCALP	53
<b>tacrolimus</b> (PROGRAF)	73
TAMIFLU CAPS	30
TAMIFLU SUSP	31
<b>tamoxifen citrate</b>	28
<b>tamsulosin</b> (FLOMAX)	73
TANDEM DHA CAP	79
TANDEM OB CAP	79
TARCEVA	28
TARGETIN	28
TARKA	38
TARON EC PAK CALCIUM	79
TARON-BC MIS	79
TARON-C DHA CAP	79
TARON-DUO EC PAK	79
TARON-EC CAL TAB 28-1MG	79
TARON-PREX CAP	79
TASIGNA 150 MG	28
TASIGNA 200 MG	29
TASMAR	29
TAZORAC	56
<b>tbc</b> (GRANULEX)	56
TEKAMLO	40
TEKTURNA	40
TEKTURNA HCT	40
<b>temazepam</b> (RESTORIL)	47
TEMODAR	29
<b>terazosin hcl</b> (HYTRIN)	34
<b>terbinafine hcl</b> (LAMISIL)	22
<b>terbutaline sulfate</b> (BRETHINE)	84
<b>terconazole</b> (TERAZOL 7)	51
<b>terconazole cream</b> (TERAZOL 3 CREAM)	51
<b>terconazole supp</b> (TERAZOL 3 SUPP)	51
TESLAC	29
TESTIM	65
<b>tetracycline hcl</b>	17
TEVETEN	36
TEVETEN HCT	37
TEXACORT	53
TGQ 30PSE/150GFN/15DM	83
THALITONE	39
THALOMID	73
THEO-24	84
<b>theophylline er</b> (UNIPHYL)	84
THIOLA	73
<b>thioridazine hcl</b>	43
<b>thiothixene</b> (NAVANE)	44
<b>thyroid</b>	70
THYROLAR-1	70
THYROLAR-1/2	70
THYROLAR-1/4	71
THYROLAR-2	71
THYROLAR-3	71





<b>V</b>	
VAGIFEM	69
<b>valacyclovir</b> (VALTREX)	31
VALCYTE	31
<b>valproic acid</b> (DEPAKENE)	45
VALTURNA	40
VANOCIN HCL	15
VANOS	53
VAZOTAB	24
V-COF	24
VEMAVITE- CAP PRX 2	80
VENA-BAL MIS DHA	80
VENATAL COMP MIS DHA	80
VENATAL-FA TAB	80
<b>venlafaxine hcl</b> (EFFEXOR)	46
<b>venlafaxine hcl er tab</b> (VENLAFAXINE ER)	46
<b>venlafaxine hcl sr cap</b> (EFFEXOR XR)	46
VENTAVIS	42
VENTOLIN HFA	84
VERAMYST	60
<b>verapamil hcl</b> (CALAN)	38
<b>verapamil hcl er</b> (CALAN SR)	38
<b>verapamil hcl er</b> (VERELAN PM)	38
<b>verapamil hcl er</b> (VERELAN)	38
<b>verapamil hcl sr</b> (VERELAN)	38
VESICARE	65
VEXOL	60
VFEND SUSP	22
VFEND TABS	22
V-HIST	24
VICTOZA	20
VICTRELIS	31
VIDEX EC	25
VIDEX PEDIATRIC	25
VIGAMOX	59
VIMPAT	45
VINACAL TAB	80
VINATE AZ EX TAB	80
VINATE AZ TAB	80
VINATE C TAB	80
VINATE CAL TAB	80
VINATE CARE CHW	80
VINATE GT TAB	80
VINATE IC CAP	80
VINATE II TAB	80
VINATE M TAB	80
VINATE ONE TAB	80
VINATE PN TAB CARE	80
VINATE ULTRA TAB	80
VIKASE	63
VIKASE 16	63
VIKASE 8	63
VIRACEPT POWD	26
VIRACEPT TABS	26
VIRAMUNE SUSP	25
VIRAMUNE TABS	25

VIRAMUNE XR TABLET	25
VIREAD	25
VISICOL	63
<b>vis-phos n</b> (K-PHOS NEUTRAL)	57
<b>visqid a/a</b> (UROQID #2)	26
VITAFOL-OB PAK +DHA	80
VITAFOL-OB TAB 65-1MG	80
VITAFOL-ONE CAP	80
VITAFOL-PN TAB	80
VITA-PREN TAB	81
VITASPIRE TAB	81
VIVA DHA CAP	81
VIVACTIL	45
VIVELLE-DOT	69
VOL-NATE TAB	81
VOL-PLUS TAB	81
VOL-TAB RX TAB	81
VOLTAREN GEL	53
VOTRIENT	29
VYTORIN	40
VYVANSE	49

<b>W</b>	
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<b>warfarin sodium</b> (COUMADIN)	32
WELCHOL	40

<b>X</b>	
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XARELTO	32
XCLAIR	56
XELODA	29
XENAZINE	48
XERAC AC	56
XERESE	31
XIFAXAN	15
XOPENEX	84
XOPENEX HFA	84
XYREM	48

<b>Y</b>	
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YAZ	66
YODOXIN	30

<b>Z</b>	
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ZADITOR OTC	74
<b>zafirlukast</b> (ACCOLATE)	84
<b>zaleplon</b> (SONATA )	48
ZATEAN-CH CAP	81
ZATEAN-PN CAP DHA	81
ZATEAN-PN CAP PLUS	81
ZATEAN-PN TAB	81
ZAVESCA	73
<b>zazole</b> (TERAZOL 3)	51

<b>zazole</b> (TERAZOL 7)	51	ZOMIG ZMT	27
Z-COF I	83	<b>zonisamide</b> (ZONEGRAN)	45
ZEGERID OTC	64	ZORTRESS	73
ZEMPLAR	85	ZOTEX- D	83
<b>zenchent</b> (OVCON-35)	67	ZOTEX-EX	83
ZENPEP	63	ZOTEX-PE	83
ZETIA	40	<b>zovia 1/50e</b> (DEMULEN 1/50-28)	67
ZIAGEN SOLN	25	ZOVIRAX CREAM	53
ZIAGEN TABS	25	ZOVIRAX OINT	53
<b>zidovudine</b> (RETROVIR)	25	Z-TUSS AC	83
<b>ziox</b> (PANAFIL)	56	Z-TUSS E	83
<b>ziox 405</b> (PANAFIL)	56	ZUTRIPRO LIQ	83
ZIRGAN	59	ZYDONE	14
ZMAX	15	ZYFLO	84
ZODRYL AC	83	ZYFLO CR	84
ZODRYL AC ADULT	83	ZYLET	60
ZODRYL DAC	83	ZYMAR	59
<b>zoldipem tartrate er</b> (AMBIEN CR)	48	ZYMAXID	59
ZOLINZA	29	ZYTIGA	29
<b>zolpidem tartrate</b> (AMBIEN)	48	ZYVOX SUSP	16
ZOMIG	27	ZYVOX TABS	16