2013 Commercial Medication Formulary

Effective December 1, 2013

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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 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 Medication: A self-injectable or high cost oral medication approved by the FDA. These medications must be prescribed by a physician and dispensed by either a retail or participating specialty pharmacy, depending on the medication. 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. 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
Antidiabetic Agents: Oral						
JANUMET	2	60/30 days				
JANUVIA	2	30/30 days				
KOMBIGLYZE XR	2	30/30 days				2.5/1000 mg strength- QL 60/30
metformin hcl (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 X 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 VIII and IX for a complete list of medications that require prior authorization.

Specialty Pharmacy: Specialty medications include many self- injectable and high cost oral medications approved by the FDA that may be used to treat complex, chronic diseases. These medications must be prescribed by a physician and dispensed by a participating specialty 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 specialty medication coverage extends to many self-injectable and high cost oral medications approved by the FDA. These medications must be ordered by a prescriber and dispensed by a retail or specialty pharmacy, depending on the type of medication. 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.

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.

Prior Authorization Process

The prior authorization process requires the practitioner to provide information to support a requested exception request. These authorizations may be initiated by verbal authorization by calling the pharmacy benefit manager at 1-866-643-6681 (growth hormone and Hepatitis C excluded). The practitioner may also fax the medication exception request form available at http://www.avmed.org/pdf/unsecure/PML/Medication_Exception_Request_Form.pdf) to 1-888-800-9602.

Information needed to make coverage determinations of medications requiring prior authorization (listed in a table at the beginning of the formulary) may include lab values, prescription history, a statement of medical necessity and any other pertinent information to satisfy the established coverage guideline for the requested medication. Coverage determinations will be made within 72 hours if authorization is deemed urgent and within 14 days if identified as standard or routine.

Member Initiated Prior Authorization Process

Members may request a prior authorization by directly contacting member services at the number on their membership card. The member should have prescriber information (phone number) and any pertinent information related to the request to provide to the member services department. Member services will then contact the AvMed Clinical Pharmacy Management (CPM) Department to initiate the prior authorization process. CPM will then contact the pharmacy benefit manager to contact the provider to gather all information needed to make the coverage determination.

Quantity Limit Exception

Certain medications allow for a maximum quantity per prescription and/or time period for one co-pay or co-insurance. Medications with applicable quantity limits are noted on the formulary. Quantity limits are developed based upon FDA-approved medication labeling and nationally recognized therapeutic clinical guidelines. If a prescription exceeds the quantity limit, the prescriber should provide a statement of medical necessity and request a prior authorization as described above.

Progressive Medication Program

Medications included in these programs (identified in a table at the beginning of the formulary) require trial of one or more first and/or second-line medications in order for the requested medication to be covered under the pharmacy benefit. If, for medical reasons, the member cannot use the first and/or second –line medication, the prescriber should request a prior authorization as described above. All medications in the Progressive Medication Program are.

Non-Formulary Medication Requests

Requests for a non-formulary medication require documentation from the member's medical records and/or in the member's prescription claims history verifying all of the following: statement of medical necessity; specific details of contraindications to ALL other formulary alternatives; AND therapeutic failure of adequate trials of one to three months of each and ALL other formulary alternatives. Non-formulary requests may be requested by the PRESCRIBER through the prior authorization as described above.

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 or High-Cost Oral Medications) –** These are self-injectable or high cost oral 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
- 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, iron products for members 1 year of age and under, vitamin D (over-the-counter) products for members ages 65 years of age or older, certain contraceptives and contraceptive devices for women less than 55 years of age.

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.

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 to obtain a Medication Exception Request Form (MER).

ABILIFY	CRINONE	GATTEX	PEG-INTRON	STIMATE
ABSTRAL	CYSTARAN	GILENYA	PERFOROMIST	STIVARGA
adapalene (DIFFERIN)	DALIRESP	HUMIRA	POMALYST	**sumatriptan injectable** (IMITREX STATDOSE)
ADCIRCA	DIFICID	ICLUSIG	POTIGA	SYLATRON
adefovir dipivoxil (HEPSERA)	**dihydroergotamine** (D.H.E 45)	INCIVEK	PROAIR HFA	TAFINLAR
ADHD medications[†] (see formulary)	**dronabinol** (MARINOL)	INLYTA	PROCRIT	TECFIDERA
AMPYRA	ENBREL	INTRON-A	PROCYSBI	TESTIM
ANDRODERM	**enoxaparin sodium** (LOVENOX)	**itraconazole** (SPORANOX)	PROMACTA	TESTIM
ANDROGEL PUMP	EMEND	JAKAFI	PROVENTIL HFA	**tretinoin** (RETIN-A)
ARANESP	EMSAM	JUXTAPID	**modafinil** (PROVIGIL)	**tretinoin microsphere gel** (RETIN-A MICRO)
ARIXTRA	ENDOMETRIN	KALYDECO	QUILLIVANT	TYVASO
AXIRON	EPISIL	KINERET	**quinine sulfate** (QUALAQUIN)	ULORIC
AVITA	EPOGEN	KORLYM	RAVICTI	**vancomycin** (VANCOCIN HCL)
AVONEX	ERIVEDGE	KYNAMRO	REGRANEX	VENTAVIS
AUBAGIO	**fentanyl citrate oral transmucosal** (ACTIQ)	LAZANDA	RESTASIS	VICTRELIS
BETASERON	FENTORA	LEUKINE	**sildenafil citrate** (REVATIO)	VIMPAT
BOSULIF	FERRIPROX	LOTRONEX	**ribavirin** (COPEGUS, REBETOL, RIBAPAK, RIBASPHERE)	XALKORI
BROVANA	FIRAZYR	MEKINIST	SABRIL	XELJANZ
budesonide (PULMICORT RESPULES)	**fluoride**	MUGARD	SANCUSO	XOPENEX HFA
BUPHENYL	**folic acid**	NEUPOGEN	SEROSTIM	XIFAXAN
butorphanol tartrate (STADOL)	FORTEO	NUVIGIL	SEROQUEL XR	XTANDI
CAPHOSOL	FORTESTA	OMNITROPE	SIGNIFOR	XYREM
CELEBREX	FRAGMIN	**oxandrolone** (OXANDRIN)	SIMPONI	ZELBORAF
CIMZIA	FULYZAQ	PEGASYS	SIRTURO	ZYTIGA
COMETRIQ	GAMMAGARD INJ	PEGASYS PROCLICK	SOMATULINE DEPOT	ZYVOX

* This list of Prior Authorizations is subject to change.

†PA required only for Members >18 years old

Medical Prior Authorization

The following medications are designated by AvMed as prescription drugs that require administration by a medical professional (physician, nurse, etc.). These medications require prior authorization prior to administration by a medical professional and will be covered under your medical benefits if you have applicable coverage and should not be covered through your prescription benefits. Your prescriber may need to provide clinical information so that coverage may be considered. To initiate a Medical Prior Authorization, please visit our website at www.avmed.org to obtain a Medication Exception Request Form (MER).

ACTEMRA**	ERWINAZE	KRYSTEXXA	NEUPOGEN**	SOLIRIS
ADCETRIS	GAMUNEX-C	LEUKINE**	NPLATE	STELARA**
ARANESP**	GEL-ONE	LUPRON DEPOT	ORENCIA**	SUPPRELIN LA
BENLYSTA	INTRON-A	LUPRON DEPOT-PED	PROCRIT**	SYNAGIS
BOTULINUM TOXIN	IVIG**‡	MAKENA	PROVENGE	TYSABRI
CINRYZE	JEVTANA	NEULASTA**	REMICADE**	XOLAIR
EPOGEN**	KADCYLA	NEUMEGA	RITUXAN**	YERVOY

* This list of Medical Prior Authorizations is subject to change.
** Requires Medical PA review with ICORE if done in office. Please call 800-424-1740 or use website www.icorehealthcare.com
‡Octagam is the preferred IVIG product

Progressive Medication Program

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

Medication Category	1st Line Meds (typically generics)	2nd Line Meds
ADHD (CNS Stimulants)**	**amphetamine/dextroamphetamine/-sr, dexmethylphenidate, dextroamphemtamine, methamphetamine, methlyphenidate/-sr**	DAYTRANA, FOCALIN XR, INTUNIV, **methyphenidate er** (CONCERTA), **dextroamphetamine sulf soln** (PROCENTRA), RITALIN LA, STRATTERA, VYVANSE
Antidiabetics (Injectable)	Insulin	SYMLIN *(must continue on 1st line medication)*
Antidiabetics (Oral)	**metformin ER** (GLUCOPHAGE XR): 500mg and 750mg	GLUMETZA
Antidiabetics (Oral)	JANUVIA, JANUMET, JANUMET XR, KOMBIGLYZE XR or ONGLYZA	KAZANO, NESINA, OSENI, JENTADUETO TRADJENTA,
Antihyperlipidemics (Other)	**fenofibrate** (for LOVAZA and VASCEPA), **Slo Niacin OTC** (for **niacin er -** NIASPAN)	**niacin er** (NIASPAN), LOVAZA, VASCEPA
Antihypertensives** (ACEI/ARB)	**benazepril/-hct**, **captopril/-hct**, **enalapril/-hct**, DIOVAN, **fosinopril/-hct**, **lisinopril/-hct**, **moexipril/-hct**, **quinapril/-hct**, **ramipril, trandolapril/-hct**, **irbesartan/-hctz** (AVAPRO/AVALIDE), **candesartan/-hctz** (ATACAND/- HCT), **losartan/-hctz** (COZAAR/HYZAAR), **valsartan/hctz** (DIOVAN HCT)	AZOR, BENICAR/-HCT, EDARBI/EDARBYCLOR, **eprosartan** (TEVETEN), EXFORGE, MICARDIS/-HCT, TEVETEN HCT, TRIBENZOR
Cholesterol (Statins)**	**atorvastatin** (LIPITOR), **fluvastatin** (LESCOL), **lovastatin, pravastatin, simvastatin,** CRESTOR	LESCOL XL, LIPTRUZET, VYTORIN
Depression (SNRIs)**	**citalopram hbr**, **fluoxetine hcl/-dr**, **fluvoxamine**, **paroxetine**, **sertraline hcl**, **venlafaxine ER**	CYMBALTA, PRISTIQ
Heartburn/Ulcer (Proton Pump Inhibitors)	**omeprazole Rx/OTC** (PRILOSEC)**, pantoprazole, lansoprazole OTC** (PREVACID 24HR), **lansoprazole, omeprazole/sodium bicarbonate** (ZEGERD), ZEGERID OTC	ACIPHEX, DEXILANT, NEXIUM, PREVACID SOLUTABS
Insomnia (Sleep aids)	**zolpidem IR, zaleplon**	**zolpidem ER**, LUNESTA, ROZEREM
Migraine (Triptans)	**sumatriptan, naratriptan, rizatriptan/-odt** (MAXALT/-MLT), **zolmitriptan** (ZOMIG/-ZMT)	AXERT, FROVA, RELPAX
Allergy (Nasal Steroids)**	**flunisolide**, **fluticasone propionate** (FLONASE) , **triamcinolone acetonide** (NASACORT AQ), NASONEX	BECONASE AQ, DYMISTA, OMNARIS, QNASL, RHINOCORT AQUA, VERAMYST, ZETONNA
Oral Contraceptives	**generic oral contraceptives** (listed as Tier 1), ZOVIA 1/50E, NECON 1/50-28, NECON 10/11-28	All brand oral contraceptives (listed as Tier 3)
Osteoporosis (Oral Bisphosphonate)	**alendronate** (FOSAMAX)	ACTONEL, ATELVIA, FOSAMAX PLUS D, **ibandronate** (BONIVA)
Pain (Opioids)	**morphine sulfate ER**	OXYCONTIN

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Analgesics: Miscellaneous						
ALAGESIC LQ	3					
butalbital /acetaminophen /caffeine (ESGIC-PLUS)	1	180/30 days				
butalbital /apap /caffeine (FIORICET)	1	180/30 days				
butalbital/acetaminophen 50/325mg	1	180/30 days				
butalbital/apap/caffeine (ESGIC)	1	180/30 days				
butalbital/aspirin/caffeine (FIORINAL)	1	180/30 days				
DOLGIC PLUS	3	150/30 days				
PHRENILIN FORTE	2	180/30 days				
RIDAURA	2	90/30 days				
Analgesics: Nonsteroidal Anti-inflammatory Drugs						
CAMBIA	3	9/30 days				
CELEBREX	3	60/30 days		Y		
choline magnesium trisalicylate (TRILISATE)	1					
diclofenac/misoprostol (ARTHROTEC)	1	120/30 days				QL varies: 50mg-120/30 days 75mg-90/30 days
diclofenac potassium (CATAFLAM)	1	120/30 days				
diclofenac sodium (VOLTAREN)	1	120/30 days				
diclofenac sodium tab delayed release (DICLOFENAC SODIUM EC)	1	120/30 days				
diclofenac sodium er (VOLTAREN-XR)	1	60/30 days				
diflunisal	1	90/30 days				
etodolac tabs	1	60/30 days				
etodolac caps	1	90/30 days				
etodolac er tabs	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				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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/asa/caffeine	1	120/30 days				
oxaprozin (DAYPRO)	1	90/30 days				
PENNSAID	3	300/30 days				
piroxicam (FELDENE)	1					
salsalate	1					
sulindac (CLINORIL)	1					
tolmetin sodium	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Analgesics: Opiate Agonists						
ABSTRAL	4	120/30 days		Y		
acetaminophen/caffeine/dihydrocodeine bitartrate (PANLOR SS)	1	150/30 days				Tier 3 copay may apply
acetaminophen/codeine soln (TYLENOL/CODEINE SOLN)	1	480/30 days				
acetaminophen/codeine tabs (TYLENOL/CODEINE TABS)	1	360/30 days				
acetaminophen/codeine #3 (TYLENOL/CODEINE)	1	360/30 days				
AVINZA	2	30/30 days				
butal /asa /caff /cod (FIORINAL/CODEINE #3)	1	180/30 days				
butalbital /apap /caffeine /codeine (FIORICET/CODEINE)	1	180/30 days				
CAPITAL/CODEINE	2	180/30 days				
CODEINE PHOSPHATE	2					
CODEINE SULFATE	3					
EXALGO	3	60-240/30 days				QL 240/30: 8mg QL 120/30: 12mg and 16mg QL 60/30: 32mg
fentanyl (DURAGESIC)	1	10/30 days				
fentanyl citrate oral transmucosal (ACTIQ)	4	120/30 days		Y		
FENTORA	4	112/28 days		Y		
hydrocodone/acetaminophen (LORCET, LORTAB, VICODIN, XODOL)	1	200/30 days				
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					
LAZANDA	4	30/30 days		Y		
meperidine hcl (DEMEROL)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
methadone hcl (DOLOPHINE)	1					
methadone hcl soln	1					
morphine sulfate	1					
morphine sulfate (RMS)	1					
morphine sulfate conc	1					
morphine sulfate cr (MS CONTIN)	1					
morphine sulfate er (MS CONTIN)	1					
morphine sulfate cap sr 24hr (KADIAN)	1	60/30 days				
ONSOLIS	4	120/30 days				
OPANA ER (CRUSH RESISTANT)	2	60/30 days				
oxycodone hcl	1					
oxycodone hcl soln	1					
oxycodone hcl conc	1	60/30 days				
oxycodone/acetaminophen (ENDOCET, PERCOCET)	1	200/28 days				
oxycodone/aspirin (PERCODAN)	1	360/30 days				
OXYCONTIN	3	60/30 days	Y			Progressive Medication program therapy required with morphine sulfate ER first
oxymorphone hcl (OPANA)	1	60/30 days				
oxymorphone hcl er	1	60/30 days				Only 7.5MG AND 15MG Tier 1
ROXICET SOLN	3	480/30 days				
ROXICET TABS	3	200/30 days				
SYNALGOS-DC	3	300/30 days				
tramadol hcl (ULTRAM)	1	240/30 days				
tramadol SR (ULTRAM ER)	1	30/30 days				
tramadol hcl tab sr 24hr biphasic release (RYZOLT)	1	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
tramadol hydrochloride/acetaminophen (ULTRACET)	1	240/30 days				
trezix (PANLOR DC)	3	300/30 days				
ZYDONE	3	200/30 days				
Analgesics: Opiate Partial Agonists						
buprenorphine	1	90-180/30 days				
buprenorphine/naloxone hcl sl tabs (SUBOXONE)	1	90-180/30 days				QL 90/30: 8-2mg QL 180/30: 2-0.5mg
butorphanol tartrate (STADOL)	1	5/30 days		Y		
pentazocine /acetaminophen (TALACEN)	1	360/30 days				
pentazocine/naloxone hcl (TALWIN NX)	1	360/30 days				
SUBOXONE	3	60-180/30 days				QL 90/30: 8-2mg QL 180/30: 2-0.5mg QL 60/30: 12-3mg and 4-1mg
Antibacterials: Cephalosporins						
CEDAX	3					
CEDAX SUSP	3					
cefaclor caps	1					
cefaclor er	2					
cefaclor susp	1					
cefadroxil	1					
cefadroxil susp	1					
cefdinir	1					
cefdinir susp	1					
cefditoren pivoxil (SPECTRACEF)	1					
cefpodoxime proxetil	1					
cefprozil	1					
cefuroxime axetil (CEFTIN)	1					
cefuroxime axetil susp (CEFTIN)	1					
cephalexin (KEFLEX)	1					750mg strength Non Formulary
cephalexin susp	1					
SUPRAX	3					
SUPRAX SUSP	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Antibacterials: Macrolides						
azithromycin pack (Z-PACK)	1	2/30 days				
azithromycin (ZITHROMAX)	1	12/30 days				
azithromycin susp (ZITHROMAX SUSP)	1					
clarithromycin (BIAXIN)	1					
clarithromycin er (BIAXIN XL)	1					
clarithromycin susp (BIAXIN)	1					
ERYPED 200	2					
ERYPED 400	2					
ERY-TAB	2					
erythromycin/sulfisoxazole	1					
erythromycin base	2					
erythromycin ethylsuccinate tab (E.E.S 400)	3					
KETEK	3					
PCE	2					
ZMAX	2	1/30 days				
Antibacterials: Other						
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				
TOBI PODHALER CAP	2					
vancomycin (VANCOCIN HCL)	1	40/30 days		Y		
XIFAXAN	3	60/30 days		Y		QL 200mg strength #9/30; PA required for 550mg dose
ZYVOX	2	56/28 days		Y		Suspension QL-1680/28 days
Antibacterials: Penicillins						

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
amoxicillin	1					
amoxicillin/clavulanate potassium susp (AUGMENTIN)	1					
amoxicillin/clavulanate potassium (AUGMENTIN)	1					
amoxicillin/clavulanate potassium (AUGMENTIN CHEW)	1					
amoxicillin/clavulanate potassium (AUGMENTIN ES-600)	1					
amoxicillin/clavulanate potassium sr (AUGMENTIN XR)	1	40/30 days				
ampicillin caps	1					
AMPICILLIN SUSP	2					
AUGMENTIN SUSP	2					Only 125MG Tier 2
dicloxacillin sodium	1					
penicillin v potassium	1					
Antibacterials: Quinolones						
AVELOX	2	30/30 days				
ciprofloxacin er (CIPRO XR)	1	30/30 days				
ciprofloxacin hcl (CIPRO)	1					
FACTIVE	3	10/30 days				
levofloxacin (LEVAQUIN IV SOLN)	1					
levofloxacin (LEVAQUIN TABS)	1	14/30 days				
ofloxacin	1					
Antibacterials: Sulfonamides						
sulfadiazine	2					
sulfamethoxazole /trimethoprim (BACTRIM)	1					
sulfamethoxazole/trimethoprim ds (BACTRIM DS)	1					
sulfasalazine (AZULFIDINE EN-TABS)	1					
sulfazine (AZULFIDINE)	1					
Antibacterials: Tetracyclines						
demeclocycline hcl	1					
doxycycline hyclate (VIBRAMYCIN)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
doxycycline monohydrate susp (VIBRAMYCIN)	1					
doxycycline monohydrate tab (ADOXA)	1	30/30 days				75mg CAPSULES are excluded, must use TAB instead; 75mg QL 60/30
minocycline hcl (DYNACIN, MINOCIN)	1	60/30 days				
tetracycline hcl	1					
Antidiabetic Agents: Diabetic Meter Systems and Supplies						
ACCU-CHEK **AVIVA PLUS** 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 **COMPACT PLUS** 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 NANO SMARTVIEW KIT	Roche Pharma Free Meter Program	1/365 days				Call 1-888-355-4242 to place your order. A prescription is REQUIRED
ACCU-CHEK SMARTVIEW CONTROL LIQUID	2					For use with ACCU-CHEK NANO meter system
ACCU-CHEK SMARTVIEW TEST STRIPS	2	200/30 days				For use with ACCU-CHEK NANO meter system
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 system
ACCU-CHEK **COMFORT CURVE** TEST STRIPS	2	200/30 days				For use with ACCU-CHEK Advantage meter system
ACCU-CHEK **AVIVA PLUS** TEST STRIPS	2	200/30 days				For use with ACCU-CHEK AVIVA PLUS meter system

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ACCU-CHEK **COMPACT** STRIPS	2	204/30 days				For use with ACCU-CHEK COMPACT PLUS meter system
ACCU-CHEK **COMPACT** TEST DRUM	2	204/30 days				For use with ACCU-CHEK COMPACT PLUS meter system
ACCU-CHEK **ACTIVE** 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 **AVIVA** CONTROL SOLUTION	2					For use with ACCU-CHEK AVIVA meter system
ACCU-CHEK **COMPACT BLUE** CONTROL SOLUTION	2					For use with ACCU-CHEK COMPACT PLUS meter system
ACCU-CHEK INSTANT GLUCOSECONTROL SOLUTION	2					
Antidiabetic Agents: Insulins and Supplies						
LANTUS	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				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X ½"	2	120/30 days				
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 ½"	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 ½"	2	120/30 days				
INSULIN SYRINGE/0.5ML/29G X ½"	2	120/30 days				
INSULIN SYRINGE/1ML/29G X ½"	2	120/30 days				
INSULIN SYRINGE/1ML/31G X 5/16"	2	120/30 days				
V-GO	2	30/30 days				
Antidiabetic Agents: Miscellaneous						
BYDUREON	2	4/30 days				
BYETTA	2	2.4/30 days				
SYMLINPEN 120	2	11/30 days	Y			Progressive Medication Program Therapy with insulin required *Must continue on 1st line medication.*
SYMLINPEN 60	2	6/30 days	Y			Progressive Medication Program Therapy with insulin required *Must continue on 1st line medication.*
VICTOZA	2	9/30 days				
Antidiabetic Agents: Oral						
acarbose (PRECOSE)	1	90/30 days				
ACTOPLUS MET XR	2	30/30 days				
AVANDAMET	2	60/30 days				
AVANDARYL	2	30/30 days				
AVANDIA	2	30/30 days				
chlorpropamide (DIABINESE)	1					
glimepiride (AMARYL)	1					
glipizide (GLUCOTROL)	1					
glipizide xl (GLUCOTROL XL)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
glipizide/metformin hcl (METAGLIP)	1					
GLUMETZA	3	60/30 days	Y			Progressive Medication Program with generic metformin ER (GLUCOPHAGE XR): 500mg and 750mg required
glyburide (DIABETA)	1					
glyburide micronized (GLYNASE)	1					
glyburide/metformin hcl (GLUCOVANCE)	1					
GLYSET	2	90/30 days				
INVOKANA	2	30/30 days				
JANUMET	2	60/30 days				
JANUMET XR	2	60/30 days				100/1000mg strength- QL 30/30
JANUVIA	2	30/30 days				
JUVISYNC	2	30/30 days				
JENTADUETO	3	60/30 days	Y			Progressive Medication Program therapy with at least 2 of the following: Januvia, Janumet, Janumet XR, Kombiglyze XR or Onglyza required.
KAZANO	3	60/30 days	Y			Progressive Medication Program therapy with at least 2 of the following: Januvia, Janumet, Janumet XR, Kombiglyze XR or Onglyza required.
KOMBIGLYZE XR	2	30/30 days				2.5/1000 mg strength- QL 60/30
metformin hcl (GLUCOPHAGE)	1	75/30 days				
metformin er 500mg, 750mg tab (GLUCOPHAGE XR)	1	120/30 days				Different QL may apply depending on strength
nateglinide (STARLIX)	1	90/30 days				
NESINA	3	30/30 days	Y			Progressive Medication Program therapy with at least 2 of the following: Januvia, Janumet, Janumet XR, Kombiglyze XR or Onglyza required.
ONGLYZA	2	30/30 days				
OSENI	3	30/30 days	Y			Progressive Medication Program therapy with at least 2 of the following: Januvia, Janumet, Janumet XR, Kombiglyze XR or Onglyza required.

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
pioglitazone (ACTOS)	1	30/30 days				
pioglitazone/glimepiride (DUETACT)	1	30/30 days				
pioglitazone/metformin (ACTOPLUS MET)	1	90/30 days				
repaglinide (PRANDIN)	1	120/30 days				
tolazamide	1					
TRADJENTA	3	30/30 days	Y			Progressive Medication Program therapy with at least 2 of the following: Januvia, Janumet, Janumet XR, Kombiglyze XR or Onglyza required.
Antifungals						
fluconazole susp (DIFLUCAN SUSP)	1					
fluconazole tabs(DIFLUCAN TABS)	1	4/30 days				
flucytosine (ANCOBON)	1					
griseofulvin microsize (GRIFULVIN V)	1					
griseofulvin microsize susp (GRIFULVIN V)	1					
griseofulvin ultramicrosize (GRIS-PEG)	1					
itraconazole (SPORANOX)	1/5			Y		For 5 Tier benefit, PA not required. Copay Tier 5 applies.
ketoconazole tab	1	60/30 days				
NOXAFIL	2					
nystatin tab	1					
terbinafine hcl (LAMISIL)	1					
voriconazole tab (VFEND)	1	60/30 days				
voriconazole susp (VFEND SUSP)	1	150/30 days				
Antigout Agents						
probenecid	1					
probenecid/colchicine	1					
Antihelmintics						

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ALBENZA	3					
BILTRICIDE	3					
mebendazole	1					
Antihistamines: 1st Generation						
ALPAIN	2					
brompheniramine/dextromethorphan/phenylephrine (ALAHIST DM)	1					
CARBAPHEN 12 PED	3					
carbinoxamine maleate (CARBINOXAMINE MALEATE)	1					
chlorpheniramine/phenylephrine hcl	1					
cyproheptadine hcl	1					
dexchlorpheniramine maleate	2					
dologen	1					
DOLOGESIC	2					
DRYMAX	3					
ED-CHLOR-TAN	2					
NEUTRAHIST PDX	3					
PALGIC	2					
RESCON-MX	3					
promethazine hcl supp	1	12/30 days				
promethazine hcl tabs	1					
promethazine hcl plain syrup	1					
RELAGESIC	3					
RELHIST	3					
RESCON	3					
RESCON-JR	3					
RESPA-BR	3					
RYDEX	3					
ZODEN PD	3					
Anti-HIV Agents: Fusion Inhibitors						

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
FUZEON	4				Y	Curascript Only
SELZENTRY	3					
Anti-HIV Agents: Integrase Inhibitors						
ISENTRESS	3	60/30 days				
ATRIPLA	3	30/30 days				
Anti-HIV Agents: Nonnucleoside RTIs						
INTELENCE	3	60/30 days				25mg - QL 120/30
nevirapine tab (VIRAMUNE)	1	60/30 days				
RESCRIPTOR	2	180/30 days				
SUSTIVA	2	30/30 days				
nevirapine susp (VIRAMUNE SUSP)	2					
VIRAMUNE XR TABLET	3	30/30 days				100mg – QL 120/30
Anti-HIV Agents: Nucleoside/Nucleotide RTIs						
abacavir (ZIAGEN TABS)	1	60/30 days				
COMPLERA	3	30/30 days				
didanosine (VIDEX EC)	1					
EDURANT	3	30/30 days				
EMTRIVA CAPS	2	30/30 days				
EMTRIVA SOLN	2	75/30 days				
EPIVIR SOLN	2					
EPIVIR HBV	2	90/30 days				
EPZICOM	3	30/30 days				
lamivudine (EPIVIR TABLETS)	1	60/30 days				
lamivudine-zidovudine tab 150-300 mg (COMBIVIR)	1					
stavudine (ZERIT)	1	60/30 days				
STRIBILD	3	30/30 days				
TRIZIVIR	3	60/30 days				
TRUVADA	3	30/30 days				
VIDEX EC	3					
VIDEX PEDIATRIC	2					
VIREAD	2	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ZIAGEN SOLN	2	900/30 days				
zidovudine (RETROVIR)	1					
Anti-HIV Agents: Protease Inhibitors						
APTIVUS	3	120/30 days				
APTIVUS SOLN	2	300/30 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				
LEXIVA	2	120/30 days				
NORVIR	2					
PREZISTA	3	60/30 days				QL 30/30- 800mg
PREZISTA SUSP	3	400/30 days				
REYATAZ	3	30/30 days				
VIRACEPT TABS	2	120/30 days				
Antihypoglycemics						
GLUCAGEN HYPOKIT	2	2/365 days				
GLUCAGON EMERGENCY KIT	2	2/365 days				
Anti-infectives: Miscellaneous						
HELIDAC	3	224/30 days				
PYLERA	3	120/30 days				
Anti-infectives: Urinary						
MACRODANTIN	2					
methenamine/hyosc/meth blue/benz acid/phenyl tab (PROSED D/S)	1					
methenamine hippurate (HIPREX)	1					
MONUROL	2					
nitrofurantoin susp (FURADANTIN)	1					
nitrofurantoin macrocrystalline (MACRODANTIN)	1					
nitrofurantoin monohydrate (MACROBID)	1					
PRIMSOL	2					
trimethoprim (PROLOPRIM)	1					
URETRON D/S	2					
urogesic-blue	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
UTA	2					
UROQID #2	2					
Antimigraine Agents						
AXERT	3	6/30 days	Y			
dihydroergotamine mesylate (D.H.E. 45)	1			Y		
ERGOMAR	2					
ergotamine tartrate/caffeine (CAFERGOT)	1					
FROVA	3	9/30 days	Y			
MIGERGOT	2	20/30 days				
MIGRAL	3					
MIGRANAL	3	8/30 days				
naratriptan tab (AMERGE)	1	9/30 days				
RELPAX	3	9/30 days	Y			
rizatriptan (MAXALT)	1	12/30 days				
rizatriptan odt (MAXALT-MLT)	1	12/30 days				
sumatriptan inj soln (IMITREX SOLN)	1	6/30 days				
sumatriptan succinate refill (IMITREX STATDOSE REFILL)	1			Y		
sumatriptan succinate (IMITREX STATDOSE SYSTEM)	1			Y		
sumatriptan tabs (IMITREX TABS)	1	9/30 days				
zolmitriptan tabs (ZOMIG)	1	6/30 days				
zolmitriptan disintegrating tabs (ZOMIG-ZMT)	1	6/30 days				
Antimycobacterials						
cycloserine (SEROMYCIN)	2					
DAPSONE	2					
ethambutol hcl (MYAMBUTOL)	1					
isoniazid & rifampin cap (RIFAMATE)	1					
isoniazid syrup	1					
isoniazid tabs	1					
MYCOBUTIN	2					
PASER	2					
PRIFTIN	2					
pyrazinamide	1					
rifampin (RIFADIN)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
RIFATER	2					
SIRTURO	2	188/180 days		Y		
TRECATOR	2					
Antineoplastics						
AFINITOR	4	30/30 days			Y	Curascript Only
AFINITOR DISPERZ	4	30/30 days			Y	Curascript Only
ALKERAN	2					
anastrozole (ARIMIDEX)	1	30/30 days				
bicalutamide (CASODEX)	1	30/30 days				
BOSULIF	4			Y	Y	Curascript Only
CAPRELSA	4					
COMETRIQ	4	1 kit/28 days		Y	Y	One: 60mg, 100mg or 140mg daily dose kit per 28 days
CYCLOPHOSPHAMIDE	2					
DROXIA	2					
EMCYTE	2					
ERIVEDGE	4			Y	Y	Curascript Only
etoposide (VEPESID)	4					
exemestane (AROMASIN)	1					
FARESTON	4	30/30 days				
flutamide	1	180/30 days				
GLEEVEC	4	60/30 days			Y	Curascript Only
HEXALEN	4					
HYCAMTIN	4				Y	Curascript Only
hydroxyurea (HYDREA)	1					
ICLUSIG	4	30-60/30 days		Y	Y	Curascript Only 15mg-QL:60/30 days, 45mg-QL:30/30 days
INLYTA	4			Y	Y	Curascript Only
INTRON-A	4			Y	Y	Curascript Only
INTRON-A W/DILUENT	4			Y	Y	Curascript Only
JAKAFI	4	60/30 days		Y	Y	Curascript Only
letrozole (FEMARA)	1	30/30 days				
LEUKERAN	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
lomustine cap	2	3/30 days				
LYSODREN	2					
MATULANE	4					
megestrol acetate (MEGACE)	1					
MEKINIST	4	30/30 days		Y	Y	Curascript Only
mercaptopurine (PURINETHOL)	1					
methotrexate	1					
MYLERAN	2					
NEXAVAR	4	120/30 days			Y	Curascript Only
NILANDRON	2					
SOLTAMOX	2	300/30 days				
SPRYCEL	4	60/30 days			Y	Curascript Only; QL 30/30 - 80MG AND 140MG
STIVARGA	4	84/28 days		Y	Y	Curascript Only
SUTENT	4	30/30 days			Y	Curascript Only
SYLATRON INJ KIT	4			Y	Y	Curascript Only
TABLOID	2					
TAFINLAR	4	120/30 days		Y	Y	Curascript Only
tamoxifen citrate	1	60/30 days				
TARCEVA	4	30/30 days			Y	Curascript Only
TARGRETIN	2					
TASIGNA 150 MG	4	120/30 days			Y	Curascript Only
TASIGNA 200 MG	4	112/28 days			Y	Curascript Only
temozolomide (TEMODAR)	1				Y	Curascript Only
tretinoin (VESANOID)	4					
TYKERB	4	150/30 days			Y	Curascript Only
VOTRIENT	4	60/30 days				
XALKORI	4	60/30 days		Y	Y	Curascript Only
XELODA	4				Y	Curascript Only
XTANDI	4			Y	Y	Curascript Only
ZELBORAF	4	240/30 days		Y	Y	Curascript Only
ZOLINZA	4	120/30 days			Y	Curascript Only

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ZYTIGA	4	120/30 days		Y	Y	Requires prior trial of docetaxel; Curascript Only
Antiparkinsonian Agents						
AMANTADINE HCL TABS	2					
amantadine hcl (SYMMETREL)	1					
APOKYN	4	18/30 days			Y	Curascript Only
AZILECT	2	30/30 days				
benztropine mesylate (COGENTIN)	1					
bromocriptine mesylate (PARLODEL)	1					
cabergoline (DOSTINEX)	1					
carbidopa/levodopa (SINEMET)	1					
carbidopa/levodopa er (SINEMET CR)	1					
entacapone (COMTAN)	1					
EMSAM	3	30/30 days		Y		
LODOSYN	2					
MIRAPEX ER	3	30/30 days				
NEUPRO	2	30/30 days				
PARCOPA	2					
pramipexole (MIRAPEX)	1	135/30				
ropinirole hcl (REQUIP)	1					
ropinirole hcl sr (REQUIP XL)	1					
selegiline hcl (ELDEPRYL)	1					
STALEVO	2					
TASMAR	2					
trihexyphenidyl hcl (ARTANE)	1					
Antiprotozoals						
ALINIA TAB	3	6/30 days				
ALINIA SUS	3	180/30 days				
atovaquone-proguanil hcl tab (MALARONE)	1	12/365 days				
chloroquine phosphate tabs (ARALEN)	1	5/365 days				
COARTEM	2	24/30 days				
FLAGYL ER	3					
hydroxychloroquine (PLAQUENIL)	1					
mefloquine hcl tabs	1	5/365 days				
MEPRON	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
metronidazole (FLAGYL)	1					
NEBUPENT	3					
quinine sulfate (QUALAQUIN)	1			Y		
tinidazole (TINDAMAX)	1					
YODOXIN	2					
Antivirals						
acyclovir (ZOVIRAX)	1					
adefovir dipivoxil (HEPSERA)	1	30/30 days		Y		
BARACLUDE SOLN	2	180/30 days				
BARACLUDE TABS	2	30/30 days				
famciclovir (FAMVIR)	1	90/30 days				
INCIVEK	4			Y	Y	Curascript Only; Victrelis is preferred product
INFERGEN	4	2/28 days			Y	Curascript Only
PEGASYS	4			Y	Y	Curascript Only; Peg-Intron is preferred product
PEGASYS PROCLICK	4			Y	Y	Curascript Only; Peg-Intron is preferred product
PEG-INTRON	4			Y	Y	Curascript Only; Peg-Intron is preferred product
PEG-INTRON REDIPEN PAK 4	4			Y	Y	Curascript Only; Peg-Intron is preferred product
REBETOL SOLUTION	2			Y	Y	Curascript Only
RELENZA DISKHALER	3	20/30 days				
RIBAPAK	4			Y	Y	Curascript Only
ribavirin (COPEGUS, RIBASPHERE)	1			Y	Y	Curascript Only
ribavirin (REBETOL, RIBASPHERE)	1			Y	Y	Curascript Only
rimantadine hcl (FLUMADINE)	1	15/30 days				
TAMIFLU CAPS	3	20/365 days				
TAMIFLU SUSP	3	75/30 days				
TYZEKA	2	30/30 days				
valacyclovir (VALTREX)	1	60/30 days				
VALCYTE	2					
VICTRELIS	4			Y	Y	Curascript Only; Victrelis is preferred product
XERESE	3	5/30 days				
Autonomic Drugs: Anti-Cholingics						
ATROVENT HFA	3	40/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
CANTIL	2					
chlordiazepoxide /clidinium (LIBRAX)	1					
CUVPOSA	3					
dicyclomine hcl (BENTYL)	1					
ergoloid mesylates	1					
glycopyrrolate (ROBINUL)	1					
glycopyrrolate forte (ROBINUL FORTE)	1					
SYMAX DUOTAB	2					
hyoscyamine	1					
hyoscyamine sulfate (ANASPAZ)	1					
hyoscyamine sulfate (LEVSIN)	1					
hyoscyamine sulfate (LEVSIN/SL)	1					
hyoscyamine sulfate er (LEVBID)	1					
hyoscyamine sulfate er (LEVSINEX)	1					
ipratropium bromide	1	360/30 days				
methscopolamine bromide (PAMINE)	1					
methscopolamine bromide (PAMINE FORTE)	1					
midodrine hcl (PROAMATINE)	1					
PROPANTHELINE BROMIDE	2					
SPIRIVA HANDIHALER	2	30/30 days				
symax fastabs (NULEV)	1					
TUDORZA PRESSAIR	2	1/30 days				
Autonomic Drugs: Cholinergics						
bethanechol chloride (URECHOLINE)	1					
cevimeline (EVOXAC)	1	90/30 days				
donepezil (ARICEPT)	1	30/30 days				
donepezil odt (ARICEPT ODT)	1	30/30 days				
EXELON PATCH	2	30/30 days				
EXELON SOLN	2	600/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
galantamine (RAZADYNE)	1	60/30 days				
galantamine hydrobromide oral soln (RAZADYNE SOLN)	1	600/30 days				
galantamine er (RAZADYNE ER)	1	30/30 days				
GUANIDINE HCL	2					
MESTINON SYP	3					
MESTINON TIMESPAN	3					
pilocarpine hcl (SALAGEN)	1					
PROSTIGMIN	2					
pyridostigmine bromide (MESTINON)	1					
rivastigmine cap (EXELON)	1	60/30 days				
Blood Regulators: Anticoagulants						
ELIQUIS	2	60/30 days				
jantoven (COUMADIN)	1					
warfarin sodium (COUMADIN)	1					
XARELTO	2	30/30 days				15mg-QL:42/21 days
Blood Regulators: Antithrombotics						
AGGRENOX	2	60/30 days				
anagrelide hydrochloride (AGRYLIN)	1					
BRILINTA	3	60/30 days				
cilostazol (PLETAL)	1	60/30 days				
clopidogrel (PLAVIX)	1	33/30 days				
EFFIENT	2	35/30 days				
enoxaparin sodium (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
fondaparinux sodium (ARIXTRA)	1	21/60 days		Y		Prior authorization required >21 day supply in 60 days
heparin sodium	1					
HEPARIN SODIUM	2					
heparin sodium dcu	1					
PRADAXA	2	60/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ticlopidine hcl (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					
aminocaproic acid (AMICAR)	1					
pentoxifylline er	1					
PROMACTA	3	30/30 days		Y		
tranexamic acid (LYSTEDA)	1	30/23 days				
Cardiovascular Agents: a-Adrenergic Blockers						
CARDURA XL	3	30/30 days				
doxazosin mesylate (CARDURA)	1					
prazosin hcl (MINIPRESS)	1					
terazosin hcl (HYTRIN)	1					
Cardiovascular Agents: ACE Inhibitors						
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					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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					
quinapril/hydrochlorothiazide (ACCURETIC)	1					
ramipril (ALTACE)	1	30/30 days				
trandolapril (MAVIK)	1					
Cardiovascular Agents: Aldosterone Receptor Agonists						
eplerenone (INSPRA)	1	60/30 days				
spironolactone (ALDACTONE)	1					
spironolactone /hydrochlorothiazide (ALDACTAZIDE)	1					
Cardiovascular Agents: Alpha-adrenergic Agonists						
clonidine hcl (CATAPRES)	1					
clonidine hcl td patch (CATAPRES-TTS)	1	4-8/28 days				
GUANABENZ ACETATE	2					
guanfacine hcl (TENEX)	1					
methyldopa (ALDOMET)	1					
METHYLDOPA /HYDROCHLOROTHIAZIDE	2					
Cardiovascular Agents: Antiarrhythmics						
amiodarone hcl (CORDARONE)	1	60/30 days				
amiodarone hcl (PACERONE)	1	60/30 days				
disopyramide phosphate (NORPACE)	1					
flecainide acetate (TAMBOCOR)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
mexiletine hcl	1					
MULTAQ	2	60/30 days				
NORPACE CR	2					
procainamide inj soln	2					
propafenone hcl (RYTHMOL)	1					
propafenone hcl sr (RYTHMOL SR)	1					
quinidine gluconate cr	1					
quinidine sulfate	1					
quinidine sulfate er	1					
TIKOSYN	2	60/30 days				
Cardiovascular Agents: ARBs						
BENICAR	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
BENICAR HCT	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
candesartan (ATACAND)	1	30/30 days				
candesartan/hctz (ATACAND HCT)	1	30/30 days				
DIOVAN	2	30/30 days				
EDARBI TAB	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
EDARBYCLOR	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
eprosartan mesylate tab (TEVETEN)	1	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required; **Tier 1 does NOT apply to the 400MG strength; 400MG is Tier 3**

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
EXFORGE	2	30/30 days	Y			Progressive Medication Program with ACE Inhibitor required
irbesartan (AVAPRO)	1	30/30 days				
irbesartan/hctz (AVALIDE)	1	30/30 days				
losartan (COZAAR)	1	30/30 days				
losartan/hctz (HYZAAR)	1	30/30 days				
MICARDIS	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
MICARDIS HCT	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
TEVETEN HCT	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
TRIBENZOR	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
valsartan/hctz (DIOVAN HCT)	1	30/30 days				
Cardiovascular Agents: Calcium-Channel Blockers						
amlodipine besylate (NORVASC)	1	30/30 days				
amlodipine besylate/benazepril hydrochloride (LOTREL)	1	30/30 days				
AZOR	3	30/30 days	Y			Progressive Medication Program with ACE Inhibitor AND generic ARB AND DIOVAN required
CARDENE SR	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
diltiazem cd (CARDIZEM CD)	1					
diltiazem hcl (CARDIZEM)	1					
diltiazem hcl er (DILT-XR)	1					
diltiazem hcl er (TIAZAC)	1					
diltiazem hcl sr (CARDIZEM LA)	1					
felodipine er (PLENDIL)	1					
isradipine (DYNACIRC)	1	120/30 days				
nicardipine hcl (CARDENE)	1					
nifediac cc (ADALAT CC)	1					
nifedical xl (PROCARDIA XL)	1					
NIFEDIPINE 20mg	2					
nifedipine (PROCARDIA)	1					
nifedipine er (PROCARDIA XL)	1					
nisoldipine sr (SULAR)	1	30/30 days				Tier 3 copay may apply
NYMALIZE SOLN	3					
TARKA	3	30/30 days				Generic no longer available
verapamil hcl (CALAN)	1					
verapamil hcl er (CALAN SR)	1					
verapamil hcl er (VERELAN**)**	1					
verapamil hcl er (VERELAN PM)	1					
verapamil hcl sr (VERELAN)	1					
Cardiovascular Agents: Diuretics						
acetazolamide	1					
amiloride /hydrochlorothiazide (MODURETIC 5-50)	1					
AMILORIDE HCL	2					
bumetanide (BUMEX)	1					
chlorothiazide	1					
chlorthalidone	1					
CHLORTHALIDONE 100mg	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
DIURIL	3					
DYRENIUM	2					
EDECRIN	3					
FUROSEMIDE SOLN	2					
furosemide (LASIX)	1					
hydrochlorothiazide	1					
hydrochlorothiazide (MICROZIDE)	1					
indapamide (LOZOL)	1					
methazolamide	1					
METHYCLOTHIAZIDE	2					
metolazone (ZAROXOLYN)	1					
torsemide (DEMADEX)	1					
triamterene /hydrochlorothiazide	1					
triamterene /hydrochlorothiazide (MAXZIDE)	1					
triamterene /hydrochlorothiazide (MAXZIDE-25)	1					
Cardiovascular Agents: Dyslipidemics						
ADVICOR	2	30/30 days				
atorvastatin (LIPITOR)	1	30/30 days				
cholestyramine (QUESTRAN)	1					
cholestyramine light (QUESTRAN LIGHT)	1					
colestipol hcl (COLESTID)	1					
colestipol hcl for oral suspension (COLESTID)	1					
CRESTOR	2	30/30 days				
fenofibrate (ANTARA)	1	30/30 days				
fenofibrate (LOFIBRA)	1	30/30 days				
fenofibrate (TRICOR)	1	30/30 days				
fenofibric acid (TRILIPIX)	1	30/30 days				
fluvastatin (LESCOL)	1	30/30 days				
gemfibrozil (LOPID)	1	60/30 days				
JUXTAPID	4	28-84/28 days		Y	Y	5 and 10mg-QL:28/28 days, 20mg-QL:84/28 days

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
KYNAMRO	4	4/30 days		Y	Y	Curascript Only
LESCOL XL	3	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin AND Crestor required
LIPOFEN	3	30/30 days				
LIPTRUZET	3	30/30 days	Y			Progressive Medication Program with lovastatin, pravastatin, or simvastatin AND Crestor required
lovastatin (MEVACOR)	1	30/30 days				
LOVAZA	3	120/30 days	Y			Progressive Medication program therapy requires trial of generic fenofibrate first
niacin er (NIASPAN)	1	60/30 days	Y			Progressive Medication program therapy requires trial of Slo-Niacin OTC first
pravastatin sodium (PRAVACHOL)	1	30/30 days				
SIMCOR	2	60/30 days				
SLO-NIACIN	1					
simvastatin (ZOCOR)	1	30/30 days				
TRIGLIDE	3	60/30 days				
VASCEPA	3	120/30 days	Y			Progressive Medication program therapy requires trial of generic fenofibrate first
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				
Cardiovascular Agents: Other						

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
aspirin	1					Preventive Medication: $0 copay; men 45-79, women 55-79; only generic covered with retail Rx
digoxin (LANOXIN)	1					
digoxin oral soln	1					
RANEXA	2	60/30 days				
Cardiovascular Agents: ß-Adrenergic Blockers						
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				
DUTOPROL	2	60/30 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					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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					
Cardiovascular Agents: Vasodilators						
ADCIRCA	3	60/30 days		Y	Y	Curascript Only
BIDIL	3	180/30 days				
DILATRATE SR	2					
dipyridamole (PERSANTINE)	1					
HYDRALAZINE /HYDROCHLOROTHIAZIDE	2					
hydralazine hcl	1					
ISORDIL TITRADOSE	3					
isosorbide dinitrate (ISORDIL)	1					
isosorbide dinitrate er (ISODITRATE ER)	1					
isosorbide mononitrate (ISMO)	1					
isosorbide mononitrate (MONOKET)	1					
isosorbide mononitrate er (IMDUR)	1					
isoxsuprine hcl (VASODILAN)	1					
LETAIRIS	2	30/30 days			Y	Curascript Only
minoxidil	1					
NITRO-BID	2	120/30 days				
NITRO-DUR	3	30/30 days				
NITROMIST	2					
NITROSTAT	2					
nitroglycerin cr	1					
nitroglycerin er	1					
nitroglycerin transdermal (NITRO-DUR)	1	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
nitroglycerin pumpspray (NITROLINGUAL PUMPSPRAY)	1					
papaverine hcl	1					
PROGLYCEM	3					
TRACLEER	2	60/30 days			Y	Curascript Only
sildenafil citrate (REVATIO)	1			Y	Y	Curascript Only
TYVASO	3	28/28 days		Y		
VENTAVIS	3			Y		

Cardiovascular Agents: Vasopressors

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ADRENACLICK	2					
AUVI-Q	2	1/365 days				1 pack per 365 days
EPIPEN 2-PAK	2	1/365 days				1 pack per 365 days
EPIPEN-JR 2-PAK	2	1/365 days				1 pack per 365 days

Central Nervous System Agents: Antipsychotics: Atypical

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ABILIFY SOLN	3	300/30 days		Y		Must be prescribed by a psychiatric specialist
ABILIFY TABS	3	30/30 days		Y		Must be prescribed by a psychiatric specialist
ABILIFY DISCMELT	3	30/30 days		Y		Must be prescribed by a psychiatric specialist
clozapine (CLOZARIL)	1					
FAZACLO	3	90/30 days				QL 90/30- 12.5mg; QL 120/30 25mg, 100mg, & 200mg; QL 180/30-150 mg
INVEGA	3	30/30 days				
LATUDA	3	30/30 days				
olanzapine tab (ZYPREXA)	1	30/30 days				
olanzapine orally disintegrating tab (ZYPREXA ZYDIS)	1	30/30 days				
risperidone soln (RISPERDAL SOLN)	1	240/30 days				
risperidone tabs (RISPERDAL TABS)	1	60/30 days				
risperidone odt (RISPERDAL M-TABS)	1	60/30 days				
SEROQUEL XR	3	30/30 days		Y		Must be prescribed by a psychiatric specialist
quetiapine (SEROQUEL)	1	90/30 days				200mg QL 120/30 300mg QL 60/30 400MG QL 60/30
ziprasidone (GEODON)	1	60/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Central Nervous System Agents: Anitpsychotics: Conventional						
chlorpromazine hcl (THORAZINE)	1					
compro	1					
fluphenazine hcl (PROLIXIN)	1					
haloperidol	1					
loxapine succinate (LOXITANE)	1					
ORAP	2					
perphenazine	1					
prochlorperazine maleate	1					
thioridazine hcl	1					
thiothixene	1					
trifluoperazine hcl	1					
Central Nervous System Agents: Anticonvulsants						
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
divalproex (DEPAKOTE)	1					
divalproex er (DEPAKOTE ER)	1					
divalproex sprinkles (DEPAKOTE SPRINKLES)	1					
epitol (TEGRETOL)	1					
ethosuximide (ZARONTIN)	1					
felbamate (FELBATOL)	1					
felbamate susp (FELBATOL SUS)	1					
gabapentin (NEURONTIN)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
gabapentin solution (NEURONTIN SOLN)	1	1080mL/30 days				
KEPPRA SOLN	3	900/30				
lamotrigine (LAMICTAL)	1					
lamotrigine chewable dispersible (LAMICTAL CHEWABLE DISPERSIBLE)	1					
lamotrigine er (LAMICTAL XR)	1					
levetiracetam (KEPPRA)	1	90/30 days				
levetiracetam er (KEPPRA XR)	1	180/30 days				750MG limited to 120/30 days
LYRICA	3	90/30 days				300mg QL 60/30; Oral solution QL 900ml/30 days
oxcarbazepine (TRILEPTAL)	1					Suspension QL 1200ML/30 days
PEGANONE	2					
phenytoin (DILANTIN, PHENYTEK)	1					
phenytoin infatabs (DILANTIN INFATABS)	1					
phenytoin sodium extended (DILANTIN)	1					
POTIGA	3			Y		
primidone (MYSOLINE)	1					
SABRIL	2	180/30 days		Y		QL for packets: 150/30 days; PA required > 2 yoa
tiagabine (GABITRIL)	1					
topiramate (TOPAMAX)	1	240/30 days				
topiramate sprinkles (TOPAMAX SPRINKLES)	1					
valproic acid (DEPAKENE)	1					
VIMPAT	3	60/30 days		Y		QL for oral solution 1200ml/30 days
zonisamide (ZONEGRAN)	1					
Central Nervous System Agents: Antidepressants: NRIs and TCAs						
amitriptyline hcl	1					
AMOXAPINE	2					
chlordiazepoxide /amitriptyline (LIMBITROL)	1					
chlordiazepoxide /amitriptyline (LIMBITROL DS)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
clomipramine hcl (ANAFRANIL)	1					
desipramine hcl (NORPRAMIN)	1					
doxepin hcl	1					
imipramine hcl (TOFRANIL)	1					
IMIPRAMINE PAMOATE	3					
MAPROTILINE HCL	2					
nortriptyline hcl (PAMELOR)	1					
PERPHENAZINE /AMITRIPTYLINE	2					
trimipramine maleate (SURMONTIL)	1					
VIVACTIL	2					
Central Nervous System Agents: Antidepressants: Other						
budeprion sr (WELLBUTRIN SR)	1	60/30 days				
bupropion hcl xl (WELLBUTRIN XL)	1	30/30 days				
bupropion hcl (WELLBUTRIN)	1					
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					
Central Nervous System Agents: Antidepressants: Selective Serotonin and Norepinephrine-reuptake Inhibitors						
CYMBALTA	3	30/30 days	Y	Y		Progressive medication program with generic SSRI AND Venlafaxine ER required for depression; Must be prescribed by a neurologist or pain specialist if indicated for pain.
PRISTIQ	3	30/30 days	Y			Progressive medication program with generic SSRI AND Venlafaxine ER required
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

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Central Nervous System Agents: Antidepressants: SSRIs						
citalopram hydrobromide (CELEXA)	1	Maximimum 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.
escitalopram (LEXAPRO)	1	30/30 days				QL solution - 300/30 days
fluoxetine hcl (PROZAC)	1					
fluoxetine hcl dr (PROZAC WEEKLY)	1	4/28 days				
fluvoxamine maleate	1					
olanzapine/fluoxetine (SYMBYAX)	1	30/30 days				
PAXIL SUSP	3	600/30 days				
paroxetine hcl tabs (PAXIL TABS)	1					
paroxetine hcl (PAXIL CR)	1	30/30 days				
sertraline hcl (ZOLOFT)	1					
Central Nervous System Agents: Antimanics						
lithium carbonate (LITHIUM CARBONATE)	1					
lithium carbonate er (LITHOBID)	1					
lithium citrate	1					
Central Nervous System Agents: Barbiturates						
SECONAL	2					
Central Nervous System Agents: Benzodiazepines						
alprazolam (XANAX)	1					
alprazolam xr (XANAX XR)	1	30/30 days				
chlordiazepoxide hcl (LIBRIUM)	1					
clorazepate dipotassium (TRANXENE T)	1					
diazepam (VALIUM)	1					
DORAL	3					
estazolam (PROSOM)	1					
flurazepam hcl (DALMANE)	1					
lorazepam (ATIVAN)	1					
LORAZEPAM INTENSOL	3	60/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
oxazepam (SERAX)	1					
temazepam (RESTORIL)	1	30/30 days				
triazolam (HALCION)	1					
Central Nervous System Agents: MAO Inhibitors						
MARPLAN	3					
phenelzine sulfate (NARDIL)	1					
tranylcypromine sulfate (PARNATE)	1					
Central Nervous System Agents: Miscellaneous						
NAMENDA	2	60/30 days				
NAMENDA TITRATION PAK	2	49/28 days				
NAMENDA XR	2	30/30 days				
NAMENDA XR TITRATION PAK	2	28/28 days				
riluzole tab (RILUTEK)	1	60/30 days				
STRATTERA	3	30/30 days	Y	Y		PA members >18 years old
XENAZINE	2	90/30 days				
XYREM	2			Y		
Central Nervous System Agents: Sedatives/Hypnotics						
buspirone hcl (BUSPAR)	1					Tier 1 does NOT apply to 7.5mg strength; 7.5mg strength is Tier 3
CHLORAL HYDRATE SUPP	2					
chloral hydrate syrup	1					
EQUAGESIC	2					
hydroxyzine hcl (ATARAX)	1					
hydroxyzine pamoate (VISTARIL)	1					
LUNESTA	3	30/30 days	Y			Progressive medication program with zolpidem IR or zaleplon required
meprobamate (MEPROBAMATE)	1					
ROZEREM	3	30/30 days	Y			Progressive medication program with zolpidem IR or zaleplon required
zaleplon (SONATA)	1	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
zolpidem tartrate (AMBIEN)	1	30/30 days				
zolpidem tartrate er (AMBIEN CR)	1	30/30 days	Y			Progressive medication program with zolpidem IR or zaleplon required

Central Nervous System Agents: Skeletal Muscle Relaxants

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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					
orphenadrine citrate er (NORFLEX)	1	60/30 days				
tizanidine hcl tabs (ZANAFLEX)	1					

Central Nervous System Stimulating Agents

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
amphetamine/dextroamphetamine sr (ADDERALL XR)	1	60/30 days		Y		PA members >18 years old
amphetamine/dextroamphetamine (ADDERALL)	1	60/30 days		Y		PA members >18 years old
DAYTRANA	3	30/30 days	Y	Y		PA members >18 years old

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
dexmethylphenidate hcl (FOCALIN)	1	60/30 days		Y		PA members >18 years old
dextroamphetamine sulfate (DEXTROSTAT)	1	180/30 days		Y		PA members >18 years old
dextroamphetamine sulfate cap sr 24hr (DEXEDRINE)	1	90/30 days		Y		PA members >18 years old
dextroamphetamine sulfate oral soln (PROCENTRA)	1	600ml/30 days	Y	Y		PA members >18 years old
FOCALIN XR	3	30/30 days	Y	Y		PA members >18 years old
INTUNIV	3	30/30 days	Y	Y		PA members >18 years old
methamphetamine hcl (DESOXYN)	1			Y		PA members >18 years old
methylphenidate hcl (RITALIN)	1	90/30 days		Y		PA members >18 years old
methylphenidate hcl cap cr (METADATE CD)	1	30/30 days		Y		PA members >18 years old
methylphenidate hcl cap sr 24 (RITALIN LA)	1	30/30 days		Y		Tier 1 does NOT apply to the 10mg brand strength; PA members >18 years old
methylphenidate hcl tab cr (RITALIN SR, METADATE ER, METHYLIN ER)	1	60/30 days		Y		PA members >18 years old
methylphenidate hcl tab er (CONCERTA)	1	60/30 days	Y	Y		PA members > 18 years old
methylphenidate hcl soln (METHYLIN SOLN)	1	450/30 days		Y		PA members >18 years old
modafinil (PROVIGIL)	1	60/30 days		Y		
NUVIGIL	3	30/30 days		Y		
QUILLIVANT	3	360ml/30 days		Y		
RITALIN LA	3	30/30 days	Y	Y		PA members >18 years old; 10mg strength is still brand
VYVANSE	3	30/30 days	Y	Y		PA members >18 years old
Dermatological Agents: Antibacterials						
AKNE-MYCIN	3					
ALTABAX	3	15/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
BENZACLIN	3	50/30 days				Copay per 25 grams
CLEOCIN	2	6/30 days				
clindamax (CLEOCIN)	1					
clindamycin hcl cap (CLEOCIN)	1					
clindamycin phosphate (CLEOCIN-T)	1					
clindamycin phosphate foam (EVOCLIN)	1	100/30 days				
clindamycin/benzoyl peroxide gel 1-5%	1	50/30 days				Copay per 25 grams
clindamycin/benzoyl peroxide gel 1.2-5% (DUAC)	1					
CLINDESSE	3					
erythromycin	1					
erythromycin (ERYGEL)	1					
erythromycin/benzoyl peroxide (BENZAMYCIN)	1	46.6/30 days				Copay per 25 grams
gentamicin sulfate	1					
metronidazole (METROCREAM)	1	45/30 days				
metronidazole gel 1% (METROGEL)	1	60/30 days				
metronidazole (METROLOTION)	1	60/30 days				
metronidazole vaginal (METROGEL VAGINAL)	1					
mupirocin calcium (BACTROBAN CREAM)	1	30/30 days				
mupirocin (BACTROBAN)	1	44/30 days				
NORITATE	2					
sodium sulfacetamide wash 10% (SEB-PREV WASH, OVACE PLUS WASH)	1	360/30 days				
sulfacetamide sodium-urea pad (SOD SULFACET PAD)	1					
sulfacetamide sodium (KLARON)	1	336/30 days				
Dermatological Agents: Antifungals						
ciclopirox (LOPROX)	1					
ciclopirox nail lacquer (PENLAC NAIL LACQUER)	1					
clotrimazole troche	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
clotrimazole/betamethasone dipropionate (LOTRISONE)	1					
econazole nitrate (SPECTAZOLE)	1					
ERTACZO	3	60gm/30 days				
EXELDERM	2					
GYNAZOLE-1	2					
ketoconazole cream	1	120/30 days				
ketoconazole shampoo (NIZORAL)	1	240/30 days				
LOPROX SHAMPOO	3	240/30 days				
NAFTIN	2					
NAFTIN GEL	2					
nystatin tab	1					
nystatin topical powder (NYAMIC, NYSTOP, PEDI-DRI)	1					
OXISTAT	2	60/30 days				
terconazole cream (TERAZOL 3 CREAM)	1	40/30 days				
terconazole supp (TERAZOL 3 SUPP)	1	6/30 days				
terconazole (TERAZOL 7)	1	90/30 days				
zazole (TERAZOL 3)	1	40/30 days				
zazole (TERAZOL 7)	1	90/30 days				
Dermatological Agents: Anti-inflammatories						
ALA-SCALP	3					
alclometasone dipropionate (ACLOVATE)	1					
AMCINONIDE LOTN	2					
amcinonide cream (CYCLOCORT CREAM)	1					
ANUSOL-HC CREAM	1	30/30 days				
apexicon e (PSORCON E)	1	60/30 days				
augmented betamethasone dipropionate (DIPROLENE)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
augmented betamethasone dipropionate (DIPROLENE AF)	1					
betamethasone dipropionate	1					
betamethasone valerate	1					
betamethasone valerate aerosol foam (LUXIQ)	1	100/30 days				Copay per 50 grams
beta-val	1					
CAPEX	3					
clobetasol propionate emulsion (OLUX-E)	1	100/30 days				Copay per 50 grams
clobetasol propionate foam	1	100/30 days				Copay per 50 grams
clobetasol propionate (TEMOVATE)	1					
clobetasol propionate e (TEMOVATE E)	1					
clobetasol propionate lotion (CLOBEX)	1	236/30 days				
clobetasol propionate shampoo (CLOBEX)	1	236/30 days				
clobetasol propionate solution (CORMAX SCALP APPLICATION, TEMOVATE)	1					
CLOBEX SPR 0.05%	3	1/30 days				1 bottle per month
CLODERM PUMP	3					
CORDRAN	2					
CORDRAN SP	2					
CORDRAN TAPE	2					
CORTIFOAM	2					
CORTISPORIN	2					
desonide (DESOWEN)	1					
desoximetasone (TOPICORT)	1					Tier 3 copay may apply
diflorasone diacetate	1					
EPIFOAM	2					
EPISIL	3	40/30 days		Y		
fluocinolone acetonide soln 0.01%	1					
fluocinolone acetonide ointment	1					
fluocinolone acetonide cream	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
fluocinolone acetonide oil (DERMA-SMOOTHE/FS BODY OIL/ DERMA-SMOOTHE/FS SCALP OIL)	1					
fluocinolone acetonide (otic) oil 0.01% (DERMOTIC OTIC OIL)	1					
fluocinonide (LIDEX)	1					
fluocinonide emollient base (LIDEX-E)	1					
fluticasone propionate (CUTIVATE)	1					
halobetasol propionate (ULTRAVATE)	1					
HALOG	2					
hydrocortisone	1					
hydrocortisone (HYTONE)	1					
hydrocortisone acetate supp (ANUSOL-HC)	1	12/30 days				
hydrocortisone acetate supp (HEMRIL-30, PROCTOCORT)	1	12/30 days				
hydrocortisone butyrate (LOCOID)	1					
hydrocortisone valerate (WESTCORT)	1					
KENALOG	3					
lidocaine hcl/hydrocortisone acetate (LIDAMANTLE HC)	1	177/30 days				
LOCOID LIPOCREAM	2					
mometasone furoate (ELOCON)	1					
NOVACORT	2					
nystatin/triamcinolone	1					
nystatin/triamcinolone (MYCOLOG II)	1					
PANDEL	3	80/30 days				
prednicarbate (DERMATOP)	1					
PROCTOSOL HC	1	30/30 days				
PROCTOFOAM HC	2					
PROCTOZONE-HC	1	30/30 days				
TACLONEX	3	100/30 days				
TACLONEX SUSP	3	240/30 days				
TEXACORT	3					
triamcinolone acetonide (KENALOG)	1					
triamcinolone in orabase (KENALOG IN ORABASE)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
VANOS	3	120/30 days				
VOLTAREN GEL	3					
Dermatological Agents: Antivirals						
acyclovir ointment (ZOVIRAX)	1	15/30 days				
DENAVIR	3	5/30days				
ZOVIRAX CREAM	2	5/30 days				
Dermatological Agents: Miscellaneous						
ACID JELLY	2					
acticin (ELIMITE)	1					
adapalene cream (DIFFERIN CREAM)	1	45/30 days		Y		PA required >26 years of age
adapalene gel (DIFFERIN GEL)	1	45/30 days		Y		PA required >26 years of age
ALCORTIN A	3					
amnesteem (ACCUTANE)	1					
ANACAINE	2					
anthralin (DRITHO-CRÈME HP)	1	50/30 days				
ATOPICLAIR	2	200/30 days				Copay per 100 grams
avita (RETIN-A)	1			Y		PA required >26 years of age
AZELEX	2					
CALCIPOTRIENE OINT	2	60/30 days				
calcipotriene (DOVONEX)	1	60/30 days				
CARAC	2	30/30 days				
isotretinoin (CLARAVIS)	1					
CONDYLOX	3	3.5/30 days				
dermazene (VYTONE)	1					
DIFFERIN LOTION	2	59/30 days		Y		PA required >26 years of age
DOVONEX	2	120/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ELIDEL	2	120/30 days				Copay per 60 grams
EURAX	3					
FEM PH	2					
FINACEA	2	50/30 days				
FLUOROPLEX	2	30/30 days				
fluorouracil cream (EFUDEX CREAM)	1	40/30 days				
fluorouracil soln (EFUDEX SOLN)	1	10/30 days				
hydrocortisone acetate/pramoxine (ANALPRAM-HC)	1					
hypercare (DRYSOL)	1					
imiquimod (ALDARA)	1	12/30 days				
lidazone hc (ANAMANTLE HC)	1	98/30 days				
lidocaine	1					
lidocaine (LIDAMANTLE)	1	177/30 days				
lidocaine hcl jelly (XYLOCAINE JELLY)	1					
lidocaine patch 5% (LIDODERM)	1	60/30 days				
lidocaine/prilocaine (EMLA)	1					
lindane	1					
malathion (OVIDE)	1					
OXSORALEN ULTRA	2					
PANRETIN	2	60/30 days				
permethrin	1					
phenazopyridine hcl (PYRIDIUM)	1					
phenazopyridine plus (PYRIDIUM PLUS)	1					
PHISOHEX	3	296/30 days				
PICATO	3					
PLIAGLIS	3					
podofilox (CONDYLOX W/APPLICATORS)	1					
pramoxine-hc (PRAMOSONE)	1					
prascion fc (PLEXION CLEANSING CLOTH)	1	60/30 days				Tier 3 copay may apply

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
PROCORT CREAM	3					
PROTOPIC	2	120/30 days				Copay per 60 grams
prudoxin (ZONALON)	1					
REGRANEX	3			Y		
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 days				
sodium sulfacetamide & sulfur cleanser	1	341/30 days				
sodium sulfacetamide & sulfur cleanser (AVAR CLEANSER)	1					
SULFAMYLON	2					
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
tretinoin microsphere gel (RETIN-A MICRO)	1	50/30 days		Y		PA required >26 years of age
tretinoin microsphere gel (RETIN-A MICRO PUMP)	1	50/30 days		Y		PA required >26 years of age
XCLAIR	2	150/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
XERAC AC	2	60/30 days				
ZITHRANOL	3	85/30 days				

Electrolyte and Fluid Maintenance

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
acetic acid 0.25%	1					
calcium acetate (PHOSLO)	1					
CARBAGLU TAB	2					
effervescent potassium/chloride (EFFER-K)	1					
effervescent potassium bicarbonate & citrate tab (KLOR-CON/EFF, K-VESCENT)	1					
FOSRENOL	2	90/30 days				
GALZIN	2					
klor-con (K-LOR)	1					
klor-con 8	1					
KLOR-CON M15	2					
klor-con m20 (K-DUR)	1					
K-PHOS	2					
K-PHOS NO 2	2					
lactulose	1	2880/30 days				
LITHOSTAT	2					
ORACIT	2					
potassium bicarbonate (K-LYTE)	1					
potassium chloride	1					
potassium chloride powder packet (KLOR-CON 25)	1					
potassium chloride er cap (MICRO-K)	1					
potassium chloride er tab (KLOR-CON, K-TAB)	1					
potassium citrate (UROCIT-K 5)	1					
potassium citrate extended-release (UROCIT-K 10)	1					
RENAGEL	2	360/30 days				
RENVELA	2	525/30 days				
sodium polystyrene sulfonate	1	480/30 days				
sodium polystyrene sulfonate (KAYEXALATE)	1	480/30 days				
sps	1	480/30 days				
UROCIT-K 15	3					
K-PHOS NEUTRAL	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Enzyme Replacement						
PULMOZYME	2					
SUCRAID	2					
Eyes, Ears, Nose, and Throat Agents: Anesthetics						
AKTEN	3	5/30 days				
altacaine	1					
antipyrine/benzocaine otic soln (AURALGAN, AURODEX)	1					
CAPHOSOL	3	120/30 days		Y		
MUGARD	3	120/30 days		Y		
proparacaine hcl (ALCAINE)	1	15/30 days				
Eyes, Ears, Nose, and Throat Agents: Anti-infectives						
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				
gatifloxacin ophth soln (ZYMAXID)	1	2.5/30 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					
tobramycin ophthalmic soln (TOBREX)	1	4/30 days				
trifluridine (VIROPTIC)	1	8/30 days				
trimethoprim sulfate/polymyxin b sulfate (POLYTRIM)	1	10/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
VIGAMOX	2	3/30 days				
ZIRGAN	3	5/30 days				

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

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
bromfenac sodium ophth soln 0.09%	1	5/30 days				
diclofenac sodium (VOLTAREN)	1	5/30 days				
flurbiprofen sodium (OCUFEN)	1	2.5/30 days				
ILEVRO	3	1.7/30 days				
ketorolac tromethamine ophth soln 0.5% (ACULAR)	1	5/30 days				
ketorolac tromethamine ophth soln 0.4% (ACULAR LS)	1	5/30 days				
PROLENSA	3	1/30 days				1 bottle per 30 days

Eyes, Ears, Nose, and Throat Agents: Corticosteroids

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
acetic acid/hydrocortisone	1					
ALREX	3	5/30 days				
bac /poly /neomy /hc	1	4/30 days				
BECONASE AQ	3	25/30 days	Y			Progressive medication program with flunisolide , fluticasone propionate, or triamcinolone acetonide , AND NASONEX required
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				
cortisporin-tc	2					
dexamethasone sodium phosphate	1					
DUREZOL	3	10/30 days				
DYMISTA	3	23/30 days	Y			Progressive medication program with flunisolide , fluticasone propionate, or triamcinolone acetonide , AND NASONEX required
FLAREX	3	10/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
flunisolide nasal spr 0.025%	1	25/30 days				
fluorometholone (FML LIQUIFILM)	1	10/30 days				
fluticasone propionate (FLONASE)	1	16/30 days				
FML FORTE	2	10/30 days				
FML S.O.P.	2	4/30 days				
LOTEMAX GEL	3	5/30 days				
LOTEMAX SUSP	3	5/30 days				
LOTEMAX OINTMENT	3	3.5/30 days				
MAXIDEX	3					
NASONEX	2	34/30 days				
neo /poly /bac /hc	1					
neomycin/polymyxin/dexamethasone ophth susp (MAXITROL)	1					
neomycin/polymyxin/bacitracin/hc ophth oint	1					
neomycin /polymyxin /hydrocortisone otic soln (CORTISPORIN)	1					
neomycin /polymyxin /hydrocortisone opth susp	3					
OMNARIS SPR	3	12.5ml/30 days	Y			Progressive medication program with flunisolide , fluticasone propionate, or triamcinolone acetonide , AND NASONEX required
otomar (CORTANE-B-OTIC)	1					
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				
QNASL	3	8.7/30days	Y			Progressive medication program with flunisolide , fluticasone propionate, or triamcinolone acetonide , AND NASONEX required

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
RHINOCORT AQUA	3	8.6/30 days	Y			Progressive medication program with flunisolide , fluticasone propionate, or triamcinolone acetonide , AND NASONEX required
sulfacetamide sodium/prednisolone sodium phosphate	1	15/30 days				
TOBRADEX OINT	3	4/30 days				
tobramycin/ dexamethasone (TOBRADEX SUSP)	1	10/30 days				
triamcinolone acetonide (NASACORT AQ)	1	16.5/30 days				
VERAMYST	3	10/30 days	Y			Progressive medication program with flunisolide , fluticasone propionate, or triamcinolone acetonide , AND NASONEX required
VEXOL	3	5/30 days				
ZETONNA	3	6.1/30 days	Y			Progressive medication program with flunisolide , fluticasone propionate, or triamcinolone acetonide , AND NASONEX required
ZYLET	3	5/30 days				

Eyes, Ears, Nose, and Throat Agents: Miscellaneous

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
acetic acid	1					
acetic acid/aluminum acetate	1					
apraclonidine (IOPIDINE)	1	15/30 days				*ONLY 0.5% at tier 1
ASTEPRO	2	30/30 days				
azelastine (ASTELIN)	1	30/30 days				
CYSTARAN	2	60/30 days		Y		
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

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ANZEMET	3	4-8/30 days				
CESAMET	3	6/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
dronabinol (MARINOL)	1	60/30 days		Y		
EMEND	2	4-12/30 days		Y		
granisetron hcl (KYTRIL)	1	2/30 days				
ondansetron hcl (ZOFRAN)	1	6-12/30 days				
ondansetron odt (ZOFRAN 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-HD	2	180/30 days				
balsalazide disodium (COLAZAL)	1	270/30 days				
CANASA	2	60/30 days				
DELZICOL	2	360/30 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 30	2					
CREON 36	2					
PERTZYE	3					
PANCREATIN	2					
PANCREAZE	2	300/30				
PANCRELIPASE	2					
ULTRESA	3					
VIOKASE	2					
ZENPEP	3					
Gastrointestinal Agents: H2 Antagonists						
cimetidine (TAGAMET)	1					
famotidine (PEPCID)	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
famotidine susp. (PEPCID SUSP)	3	150/30 days				Excluded from coverage >12 years of age
nizatadine (AXID)	1	30-480/30 days				Solution: Excluded from coverage >12 years of age
ranitidine hcl (ZANTAC)	1					
Gastrointestinal Agents: Other						
AMITIZA	2	60/30 days				
COLYTE-FLAVOR PACKS	2					
DIGEX NF	3					
diphenoxylate/atropine (LOMOTIL)	1					
DONNATAL EXTENTAB	3					
DONNATAL ELIXIR	3					
FULYZAQ	3	60/30 days		Y		
HALFLYTELY BOWEL PREP	2					
LINZESS	2	30/30 days				
loperamide hcl	1					
LOTRONEX	2			Y		
metoclopramide hcl (REGLAN)	1					
MOVIPREP	2					
OPIUM TINCTURE	3					
OSMOPREP	2					
paregoric	1					
peg 3350/electrolytes (COLYTE)	1					
PREPOPIK PAK	2					
SUCLEAR KIT	2					
SUPREP BOWEL PREP	2					
ursodiol (ACTIGALL)	1					
ursodiol 250 (URSO 250)	1					
ursodiol (URSO FORTE)	1					
VISICOL	2					
Gastrointestinal Agents: PPIs						
ACIPHEX	3/5	30/30 days	Y			Progressive Medication Program with 2 generic /OTC PPI's first
DEXILANT	3	30/30 days	Y			Progressive Medication Program with 2 generic /OTC PPI's first
lansoprazole (PREVACID)	1	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
lansoprazole otc (PREVACID 24HR)	1	56/28 days				
lansoprazole/amoxicillin/clarithromycin triple therapy pack (PREVPAC)	1	14/30 days				
NEXIUM	3/5	30/30 days	Y			Progressive Medication Program with 2 generic /OTC PPI's first
omeprazole (PRILOSEC)	1	60/30 days				QL- 30/30 days for 40 mg strength
omeprazole otc (PRILOSEC OTC)	1	56/28 days				
omeprazole/sodium bicarbonate cap (ZEGERID)	1	30/30 days				
pantoprazole sodium (PROTONIX)	1	30/30 days				
PREVACID SOLUTAB	3	30/30 days				Progressive Medication Program with 2 generic /OTC PPI's first
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				
Gastrointestinal Agents: Protectants						
CARAFATE SUSP	2	480/30 days				
misoprostol (CYTOTEC)	1	120/30 days				
sucralfate tabs (CARAFATE TABS)	1	120/30 days				
Genitourinary Agents						
DETROL LA	2	30/30 days				
ENABLEX	3	30/30 days				
GELNIQUE	3	30/30 days				QL-1 pump/30 days
flavoxate hcl (URISPAS)	1	240/30 days				
MYRBETRIQ	2	30/30 days				
oxybutynin chloride (DITROPAN)	1	480/30 days				
oxybutynin chloride er (DITROPAN XL)	1	30/30 days				
OXYTROL	3					OXYTROL (OTC): Covered at Tier 1
OXYTROL FOR WOMEN (OTC)	1					
tolterodine tartrate (DETROL)	1	60/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
TOVIAZ	3	30/30 days				
trospium chloride (SANCTURA)	1	60/30 days				
trospium chloride sr (SANCTURA XR)	1	30/30 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/30 days		Y		
danazol	1					
oxandrolone (OXANDRIN)	1			Y		
TESTIM	3	300/30 days		Y		
Hormonal Agents: Contraceptives						
apri (DESOGEN)	1	28/28 days				
aviane (ALESSE-28)	1	28/28 days				
BEYAZ	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
cesia (CYCLESSA)	1	28/28 days				
cryselle-28 (LO/OVRAL-28)	1	28/28 days				
drospirenone/ethinyl estradiol 3/0.02 mg (YAZ)	1	28/28 days				
drospirenone/ethinyl estradiol 3/0.03mg (OCELLA, YASMIN, ZARAH)	1	28/28 days				
ELLA TAB	3	1/28 days				
enpresse-28 (TRI-LEVLEN)	1	28/28 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
errin (NOR-QD)	1	28/28 days				
GENERESS FE CHEWABLE	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
jolessa (SEASONALE)	1	91/91 days				
junel 1.5/30 (LOESTRIN 1.5/30-21)	1	28/28 days				
kariva (MIRCETTE)	1	28/28 days				
kelnor 1/35 (DEMULEN 1/35-28)	1	28/28 days				
leena (TRI-NORINYL 28)	1	28/28 days				
levonorgestrel-ethinyl estradiol (continuous) tab (LYBREL)	1	28/28 days				
levonorgestrel-ethinyl estradiol (LOSEASONIQUE)	1	91/91 days				
levonorgestrel-ethinyl estradiol 0.15/0.03mg-0.01mg (SEASONIQUE)	1	91/91 days				
LO LOESTRIN FE	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
LO MINASTRIN FE	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
LOESTRIN 24 FE	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
microgestin 1/20 (LOESTRIN 1/20-21)	1	28/28 days				
microgestin fe (LOESTRIN FE 1/20)	1	28/28 days				
microgestin fe 1.5/30 (LOESTRIN FE 1.5/30)	1	28/28 days				
MINASTRIN 24 FE CHEWABLE	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
mononessa (ORTHO-CYCLEN-28)	1	28/28 days				
NATAZIA	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
NECON 1/50-28	1	28/28 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
NECON 10/11-28	1	28/28 days				
next choice (PLAN B)	1	2/30 days				Excluded for members >16 years old
next choice one dose (PLAN B ONE-STEP)	1	1/30 days				Excluded for members >16 years old
norethindrone & ethinyl estradiol-fe chew tab (FEMCON FE CHW)	1	28/28 days				
NORINYL 1+50-28	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
nortrel 0.5/35 (28) (BREVICON-28)	1	28/28 days				
nortrel 1/35 (28) (NORINYL 1+35)	1	28/28 days				
nortrel 7/7/7 (ORTHO-NOVUM 7/7/7-28)	1	28/28 days				
NUVARING	3	1/28 days				
OGESTREL	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
ORTHO EVRA	3	3/28 days				
ORTHO TRI-CYCLEN LO	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
QUARTETTE	3	91/91 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
SAFYRAL	3	28/28 days	Y			Progressive Medication Program with at least 2 generic oral contraceptives required.
tri-legest fe (ESTROSTEP FE)	1	28/28 days				
tri-sprintec (ORTHO TRI-CYCLEN)	1	28/28 days				
zenchent (OVCON-35)	1	28/28 days				
ZOVIA 1/50E	1	28/28 days				
Hormonal Agents: Corticosteroids						
ADVAIR DISKUS	2	60/30 days				
ADVAIR HFA	2	12/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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
budesonide cap sr 24hr (ENTOCORT EC)	1	90/30 days				
CELESTONE	3					
cortisone acetate	1					
DEXAMETHASONE ELIX	2					
dexamethasone tabs	1					
DEXPAK	3					
DULERA	2	13/30 days				
FLOVENT DISKUS	2	60/30 days				
FLOVENT HFA	2	21.2/30 days				
fludrocortisone acetate (FLORINEF)	1					
hydrocortisone (CORTEF)	1					
methylprednisolone (MEDROL)	1					
methylprednisolone (MEDROL DOSEPAK)	1					
MILLIPRED	2					
prednisolone (PRELONE)	1					
prednisolone sodium phosphate (ORAPRED)	1					
prednisolone sodium phosphate (PEDIAPRED)	1					
prednisone (DELTASONE)	1					
prednisone (STERAPRED DS)	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				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
SYMBICORT	2	10.2/30 days				
UCERIS	3	30/30 days				
Hormonal Agents: Estrogen Agonists						
alora	1	8/28 days				
ANGELIQ	3	28/28 days				
CENESTIN	2					
CLIMARA PRO	3	4/28 days				
COMBIPATCH	2	8/28 days				
esterified estrogens & methyltestosterone DS tab 1.25mg-2.5mg (COVARYX)	1					
esterified estrogens & methyltestosterone HS tab 0.625mg-1.25mg (COVARYX HS)	1					
ESTRACE	2					
estradiol (CLIMARA)	1	4/28 days				
estradiol (ESTRACE)	1					
estradiol/norethindrone acetate (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
estropipate (OGEN)	1					
EVAMIST SPRAY	3					
EVISTA	2	30/30 days				
FEMHRT LOW DOSE	2					
FEMRING	3	1/84 days				Covered for 3 copays
MENEST	2					
MENOSTAR	3					
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg (FEMHRT 1/5)	1					
PREFEST	2					
PREMARIN	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
PREMARIN VAG CREAM	2					
PREMPHASE	2	28/28 days				
PREMPRO	2	28/28 days				
VAGIFEM	3	18/28 days				
VIVELLE-DOT	3	8/28 days				
Hormonal Agents: Growth Hormone						
INCRELEX	4				Y	Curascript Only
OMNITROPE	4			Y	Y	Exclusive Somatropin agent covered; Curascript only
SEROSTIM	4			Y	Y	Curascript Only
Hormonal Agents: Miscellaneous						
calcitonin nasal spray (FORTICAL, MIACALCIN)	1	3.7/28 days				
FORTEO	4	3/28 days		Y	Y	Curascript Only
GATTEX	4	30/30 days		Y	Y	Curascript Only
methylergonovine maleate (METHERGINE)	1					
MIACALCIN INJ SOLN	4				Y	Curascript Only
RAVICTI	4	525/30days		Y	Y	Curascript Only
SIGNIFOR	4	60/30 days		Y	Y	Curascript Only
Hormonal Agents: Pituitary						
desmopressin acetate (DDAVP)	1					
STIMATE	3			Y		
Hormonal Agents: Progestins						
CRINONE	3			Y		
ENDOMETRIN	3			Y		
medroxyprogesterone acetate (DEPO-CONTRACEPTIVE)	1	1/84 days				
medroxyprogesterone acetate (PROVERA)	1					
MEGACE ES	3	150/30 days				
norethindrone acetate (AYGESTIN)	1					
progesterone micronized (PROMETRIUM)	1					
Hormonal Agents: Thyroid Agents						
ARMOUR THYROID	2					Brand available in 15, 120, 180, 240, and 300mg strengths
levothroid	1					
levothyroxine sodium	1					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
liothyronine (CYTOMEL)	1					
methimazole (TAPAZOLE)	1					
NATURE-THROID	2					
np thyroid	1					
propylthiouracil	1					
SYNTHROID	2					
THYROLAR-1	2					
THYROLAR-1/2	2					
THYROLAR-1/4	2					
THYROLAR-2	2					
THYROLAR-3	2					
TIROSINT	2					
unithroid direct	1					
Miscellaneous Agents						
acitretin (SORIATANE)	1	30/30 days				
ACTONEL	3	1-30/30 days	Y			Progressive Medication Program with alendronate required.
alendronate sodium (FOSAMAX)	1	4-30/30 days				
alfuzosin hcl er (UROXATRAL)	1	30/30 days				
allopurinol (ZYLOPRIM)	1					
AMPYRA	3	60/30 days		Y		
ATELVIA	3	4/28 days	Y			Progressive Medication Program with alendronate required.
AUBAGIO	4			Y	Y	Curascript only
AVODART	2	30/30 days				
AVONEX	4	4/30 days		Y	Y	Curascript Only; Copaxone and Rebif are preferred products
azathioprine (IMURAN)	1					
BETASERON	4	15/30 days		Y	Y	Curascript Only; Copaxone and Rebif are preferred products
BUPHENYL	4			Y		
CELLCEPT SUSP	2					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
cervical caps	*	1/365 days				*Preventive Medication: $0 copay, women < 55 years old
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
clonidine hcl sr tab (KAPVAY)	1					Only generic 0.1mg tab is covered
COLCRYS	3	60/30 days				
COPAXONE	4	30/30 days			Y	Curascript Only; Copaxone and Rebif are preferred products
cyclosporine (SANDIMMUNE)	1					
CYCLOSPORINE MODIFIED CAP 50mg	2					
cyclosporine modified (NEORAL)	1					
CYSTADANE	2					
CYSTAGON	2					
DEMSER	3					
diaphragms	*	1/365 days				*Preventive Medication: $0 copay, women < 55 years old
disulfiram (ANTABUSE)	1					
ELMIRON	3					
ENBREL	4			Y	Y	Curascript Only
ENBREL SURECLICK	4			Y	Y	Curascript Only
etidronate disodium (DIDRONEL)	1					
female condoms	*	12/30 days				Preventive Medication: $0 copay, women < 55 years old; Covered with retail Rx
FERRIPROX	4			Y		
finasteride (PROSCAR)	1	30/30 days				
FIRAZYR	4	3 syringes/30 days		Y		
fluoride	1			Y		Preventive Medication: $0 copay; PA for age 5 and under , others excluded; only generic covered with retail Rx
folic acid	1			Y		Preventive Medication: $0 copay; women 15-50, other age requires PA; generic covered

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
						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
ibandronate (BONIVA)	1	1/30 days	Y			Progressive Medication Program with alendronate required.
iron	1					Preventive Medication: $0 copay; Excluded over age 1; only generic covered with retail Rx
JALYN	2	30/30 days				
KALYDECO	4			Y	Y	Curascript Only
KAPVAY DOSE PACK	3					
KINERET	4			Y	Y	Curascript Only
KORLYM	4			Y	Y	Curascript Only
leflunomide (ARAVA)	1					
LEUCOVORIN CALCIUM 10&15mg	2					
leucovorin calcium	1					
levocarnitine (CARNITOR)	1					
MEPHYTON	2					
MESNEX	3					
mycophenolate (CELLCEPT)	1					
MYFORTIC	3					
nonoxynol-9	*	12/30 days				*Preventive Medication: $0 copay, women < 55 years old; Includes nonoxynol-9 foam, gel, vaginal suppositories, film and vaginal insert; Covered with retail Rx
ORENCIA SOL	4			Y	Y	Curascript Only

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ORFADIN	2					
ORTHO-GYNOL GEL	*	12/30 days				*Preventive Medication: $0 copay, women < 55 years old; Covered with retail Rx
POMALYST	4	21/28 days		Y	Y	Curascript Only
PROCYSBI	4	1050/30 days		Y	Y	Curascript Only
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		Y		
REVLIMID	4	21-28/28 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
tacrolimus (PROGRAF)	1					
tamsulosin (FLOMAX)	1	60/30 days				
TECFIDERA	4	60/30 days		Y	Y	Curascript Only
THALOMID	4				Y	Curascript Only
THIOLA	2					
TODAY SPONGE	*	12/30 days				*Preventive Medication: $0 copay, women < 55 years old; Covered with retail Rx
SYNALGOS-DC	3	300/30 days				
ULORIC	3	30/30 days		Y		
ZAVESCA	2	90/30 days				
ZORTRESS	2	60/30 days				
XELJANZ	4	60/30 days		Y	Y	Curascript Only
Ophthalmic Agents: Anti-Allergy						
ALOCRIL	2	15/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ALOMIDE	2	10/30 days				
azelastine hcl ophth soln (OPTIVAR)	1	6/30 days				
cromolyn sodium ophth soln	1	10/30 days				
EMADINE	3	5/30 days				
epinastine hcl (ELESTAT)	1	5/30 days				
LASTACAFT SOL 0.25%	3	3ml/30 days				
naphazoline hcl ophth soln (AK-CON)	1					
PATADAY	2	10/30 days				
PATANOL	2	10/30 days				
ZADITOR OTC	1	10/30 days				

Ophthalmic Agents: Antiglaucoma

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ALPHAGAN P	2	10/30 days				ONLY 0.1% Strength
AZOPT	2	10/30 days				
betaxolol hcl	1	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
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				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
PILOPINE HS	2					
SIMBRINZA	2	8/25 days				
timolol maleate (TIMOPTIC)	1	10/30 days				
timolol maleate ophthalmic gel forming (TIMOPTIC-XE)	1	10/30 days				
TIMOPTIC OCUDOSE	3	60/30 days				
TRAVATAN Z	3	2.5/30 days				
Ophthalmic Agents: Mydriatics						
atropine sulfate	1	3.5/30 days				
atropine sulfate (ISOPTO ATROPINE)	1	15/30 days				
CYCLOGYL	3	15/30 days				
CYCLOMYDRIL	3	2/30 days				
cyclopentolate hcl (CYCLOGYL)	1	15/30 days				1% and 2% solution only
homatropaire (ISOPTO HOMATROPINE)	1	15/30 days				
ISOPTO HOMATROPINE	2	15/30 days				
ISOPTO HYOSCINE	2	15/30 days				
Ophthalmic Agents: Vasoconstrictors						
phenylephrine hcl	1					
Prenatal Vitamins						
ACTIVE OB CAP	3	30/30 days				
ATABEX EC TAB	3	30/30 days				
ATABEX TAB PRENATAL	3	30/30 days				
BAL-CARE DHA ESSENTIAL	3	60/30 days				
BAL-CARE MIS DHA	3	60/30 days				
B-NEXA TABLET	3	30/30 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				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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				
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 BALANCED	3	60/30 days				
DUET DHA EC	3	60/30 days				
DUET DHA MIS	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				
HEMENATAL OB 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				
LEVOMEFOLATE CAP DHA	3	30/30 days				
MACNATAL CN CAP DHA	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
MARNATAL-F CAP	3	30/30 days				
MARNATAL-F MIS PLUS DUO	3	60/30 days				
M-VIT TAB 27-1MG	3	30/30 days				
MYNATAL CAP	3	30/30 days				
MYNATAL PLUS TAB	3	30/30 days				
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				
NATACHEW	3	30/30 days				
NATA KOMPLETE	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				
NESTABS ABC	3	30/30 days				
NESTABS DHA PAK	3	60/30 days				
NESTABS TAB	3	30/30 days				
NEXA PLUS	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 CAP PETITE	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				
O-CAL FA TAB	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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				
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				
PRENATA CHW 29-1MG	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 AM TAB	3	30/30 days				
PRENATE DHA CAP	3	30/30 days				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
PRENATE CAP ESSENTIL	3	30/30 days				
PRENATE ELITE TAB	3	30/30 days				
PRENATE ENHANCE CAP	3	30/30 days				
PRENATE CHW 0.6-0.4	3	30/30 days				
PRENATE MINI	3	30/30 days				
PRENATE RESTORE CAP	3	30/30 days				
PRENATAL 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				
PROVIDA OB CAP	3	30/30days				
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				
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				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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 PRENATAL COMPLEAT	3	60/30 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				
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				
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				

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
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-PLUS	3	30/30 days				
VITAFOL-PN TAB	3	30/30 days				
VITAFOL ULTRA	3	30/30 days				
VITAMEDMD REDICHEW	3	30/30 days				
VITA-PREN TAB	3	30/30 days				
VITASPIRE TAB	3	30/30 days				
VIVA CT PRENATAL CHEW	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				
VP-PNV-DHA	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						
ALBATUSSIN	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
ALDEX GS DM TAB	3					
ALDEX GS TAB 30-190MG	3					
benzonatate (TESSALON)	1	90/30 days				
J-TAN D PD	3					
CARBAPHEN 12	3					
chlorpheniramine w/ hydrocodone cr (TUSSIONEX SUSP EXT- REL)	1	120/30 days				
CODAR D LIQUID	3					
CODAR AR LIQUID	3					
CODAR GF LIQUID	3					
GILTUSS	3					
GILTUSS PEDIATRIC	3					
GILTUSS TR	3					
guaifenesin/codeine	1					
hydromet (HYCODAN)	1	480/30 days				
LOHIST-PEB	3					
LORTUSS EX	3					
MAR-COF BP	3					
NEO AC	3					
PEDIATEX TDM	3					
phenylephrine/bromphen./dm (BROVEX PEB DM)	1					
POLY-TUSSIN AC	3					
pseudoephedrine/bromphen./dm (BROMFED DM)						
pseudoephedrine/bromphen./dm (BROVEX PSB DM)	1					
pseudoephedrine/chlorphen./dm (MESEHIST DM)	1					
PYRIL DM	3					
RESCON-MX	3					
RESPA C&C IR	3					
TRICODE AR LIQUID	3					
TRICODE GF LIQUID	3					
VANACOF CD	3					
VAZOBID	3					
Z-COF I	3					
Z-TUSS E	3					

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Z-TUSS AC	3	120/30 days				
ZODRYL AC	3					
ZODRYL AC ADULT	3					
ZODRYL DAC	3					
ZUTRIPRO LIQ	3					
Respiratory Agents: Bronchodilators						
albuterol sulfate neb solution (ACCUNEB)	1	375/30 days				
albuterol sulfate neb solution (PROVENTIL)	1	375/30 days				
albuterol sulfate neb solution (VENTOLIN)	1	375/30 days				
albuterol sulfate syrup (VENTOLIN)	1	480/30 days				
albuterol sulfate er tab (VOSPIRE ER)	1	30/30 days				
albuterol sulfate/ipratropium bromide neb solution (DUONEB)	1	540/30 days				
aminophylline	1					
ARCAPTA NEOHALER	3	30/30 days				
BROVANA	3			Y		
COMBIVENT	2	29.4/30 days				
COMBIVENT RESPIMAT	2	8/30 days				
DALIRESP	3	30/30 days		Y		
DIFIL G FORTE	2					
FORADIL AEROLIZER	2	60/30 days				
ipratropium bromide (ATROVENT)	1	360/30 days				
levalbuterol hcl (XOPENEX)	1	288/30 days				
levalbuterol hcl concentrate (XOPENEX CONCENTRATE)	1	96/30 days				
MAXAIR AUTOHALER	2	14/30 days				
metaproterenol sulfate syrup	1	480/30 days				
metaproterenol sulfate tabs	2					
PERFOROMIST	3			Y		
PROAIR HFA	3	17/30 days		Y		2 inhalers per month; Trial of Ventolin HFA prior to coverage
PROVENTIL HFA	3	13.4/30 days		Y		2 inhalers per month; Trial of Ventolin HFA prior to coverage
SEREVENT DISKUS	2	60/30 days				
terbutaline sulfate (BRETHINE)	1					
THEO-24	2					
theophylline er (UNIPHYL)	2					
VENTOLIN HFA	2	36/30 days				2 inhalers per month
XOPENEX HFA	3	30/30 days		Y		Trial of Ventolin HFA prior to coverage

Medication Name	Copay Tier	Quantity Limit	Progressive Med Program	Prior Authorization	Specialty Pharmacy	Comments
Respiratory Agents: Devices						
AEROCHAMBER PLUS	2	1/365 days				
E-Z SPACER	2	1/365 days				
Respiratory Agents: Leukotriene Modifiers						
montelukast (SINGULAIR)	1	30/30 days				
zafirlukast (ACCOLATE)	1	60/30 days				
ZYFLO	2	120/30 days				
ZYFLO CR	2	120/30 days				
Respiratory Agents: Mast Cell Stabilizers						
cromolyn sodium soln nebu	1	240/30 days				
cromolyn sodium oral conc (GASTROCROM)	1					
cromolyn sodium (NASALCROM)	1	26/30 days				
Respiratory Agents: Miscellaneous						
acetylcysteine (MUCOMYST)	1					
NEBUSAL 6%	3					
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					
ergocalciferol	1					
HECTOROL	2					
paricalcitol (ZEMPLAR)	1					
vitamin d (otc)	*					*Preventive Medication: $0 copay, members $\geq$ 65 years old; Includes capsules, oral liquid, tablets, and chewable tablets; Covered with retail Rx

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