



Physician Formulary 2008

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Dear Provider,

The 2008 Health New England (HNE) Formulary for our three-tiered pharmacy benefit package is now available on line at hne.com. The formulary lists our Tier I (generic) and Tier II (Preferred Brand) drugs. Medications not listed on the formulary default to Tier III (Non-Preferred Brand).

When prescribing for your patients, HNE encourages you to consider the cost differential between each tier. Copayments vary by plan, however, in general, the copayment differential between Tier II and Tier III is at least \$15.00/month; the difference between Tier I and III, at least \$35.00/month. By using generic drugs or prescribing therapeutic equivalents at a lower tier level, you can significantly reduce costs to your patients. Lower costs often translate to enhanced medication compliance. HNE covers at least one therapeutic agent for each disease state at the Tier I and/or Tier II level.

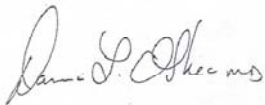
The formulary also includes the list of medications that have quantity limitations, require step therapy (i.e. a trial of a generic drug in that class), and/or prior-authorization. There are forms available to avoid delays and potential denials when prescribing these medications. Please go to the HNE website, hne.com, or contact HNE Member Services at 1-800-310-2835 for the appropriate form. Providers may obtain prior authorization by telephone, by calling our HNE designated Prior Authorization line at 1-888-806-4998.

HNE excludes newly approved brand name medications from coverage for a minimum of six months after FDA approval. During that time, the HNE Pharmacy and Therapeutics Committee reviews these medications for safety and efficacy to determine the level of coverage for the drug.

Our members have access to the formulary through print or Internet at hne.com. The HNE website is updated throughout the year as changes are made to the formulary.

At HNE, we appreciate your continued partnership in providing access to high-quality, affordable care to our community here in Western Massachusetts.

Sincerely,



Donna L. O'Shea, M.D.
Associate Medical Director

Questions about Health New England coverage?

Call Member Services at:

1-800-310-2835 or

1-413-787-4004

8 am to 5 pm

Monday through Friday

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Foreword

The Health New England Formulary is a printed result of a system for evaluating the appropriateness of a given agent or class of agents and is considered a guideline for the appropriate use of pharmaceuticals, not just a list of what is covered under the drug benefit. The Pharmacy & Therapeutics Committee (P&T) is scheduled to meet 8 times per year to review additions and or changes to the Formulary. New drug products are reviewed after the product has been available in the United States for a minimum of six (6) months.

SELECTION CRITERIA FOR FORMULARY DRUG STATUS

The formulary evaluation process considers the following objective criteria:

- Safety
- Efficacy
- Cost and outcome modeling
- Condition of potential duplication of similar drugs currently on formulary
- Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

DISTRIBUTION

The Formulary is printed and distributed by mail to all HNE clinicians annually and includes all changes made during the previous year. On request, members will receive a listing of the drugs that are on Formulary. Drugs added or deleted from the Formulary during the year are communicated through various practitioner network publications.

The Formulary is also available on the HNE website, hne.com.

HOW TO USE THE HEALTH NEW ENGLAND Physician Formulary

HNE Formulary

The HNE formulary is an open formulary with some restrictions.

The Pharmacy and Therapeutics Committee of our Pharmacy Benefit Manager (PBM) supports HNE's Pharmacy and Therapeutics Committee in evaluating drugs and recommending therapeutically effective and safe medications for treating most common medical conditions. The PBM and HNE meet at least four times per year to consider changes to the formulary. New drug reviews are assigned to one of the PBM's clinical pharmacists who gather appropriate clinical literature, contacts specialists as needed, and obtains unbiased information in peer review journals. The PBM's review also includes relevant information from other sources, such as government agencies, clinical associations, and recognized commissions. Also considered are a number of factors, including status of FDA approval, quality dimensions, and whether the drug represents breakthrough therapy. In addition, all drug classes are reviewed annually.

Important Criteria

- Drugs reviewed for addition must be FDA approved
- Drugs under consideration will be compared to existing therapies and will be evaluated based on quality dimensions.
- If the drug under consideration is not similar to existing agents and is the only drug in its class, the evaluation will be made against existing therapies, including non-drug therapies.

As part of the formulary evaluation process, we evaluate drugs based on safety, efficacy, and cost. All formulary recommendations are discussed at the HNE Clinical Care Assessment Committee, which acts as our Pharmacy and Therapeutics Committee providing a forum for additional local practicing physician involvement. Recommendations are then forwarded to the HNE Medical Policy Committee which renders the final decision. The Pharmacy and Therapeutics Committee reviews all drug categories throughout the year, evaluating requests for addition when the requested drug's category is scheduled to be reviewed. Recently approved drugs that fill a treatment void may be reviewed out of cycle.

Each year, the formulary is updated with changes from the previous year and mailed to all HNE clinicians. Members receive a formulary listing on request.

Drugs added or deleted from the formulary during the year are communicated through the HNE physician newsletter and posted on HNE's website, hne.com.

- The Formulary is divided into Therapeutic Categories, which are further divided into Therapeutic Classes.
- All drug products are listed by their most common brand names and their corresponding generic names.
- The Formulary can be accessed by using the brand name index, or by locating the therapeutic drug category in the Table of Contents.
- Any drug product not found in this Formulary Listing, or in any Formulary Listing Updates, is considered a Non-Formulary Drug (Tier 3 co-payment for the member).
- The member Tier is indicated in the Formulary Listing next to the drug name.
- Multi-source products are brand name products for which there is an equivalent generic product available. The equivalent generic product is available at the Tier 1 co-payment and the brand name product will result in a Tier 3 co-payment for members.
- It is Massachusetts State Law that the equivalent generic product be dispensed unless the words 'no substitution' are written on the prescription.

THE PRESCRIPTION DRUG BENEFIT

WHAT IS COVERED AND NOT COVERED

HNE covers most prescription drugs and a small number of non-prescription drugs and medical supplies. Covered prescriptions are divided into three tiers with different member co-payments. Together, the first two tiers described below are known as the Health New England Formulary. If a covered medication is not in the *Formulary*, it is considered Brand/Non-Formulary (Tier 3). Members still have access to these medications, but at the highest co-payment. Specific prescription drug co-payments are listed on the member's HNE ID card.

CO-PAYMENTS

Co-payments will vary according to an individual member's coverage. HNE has adopted a three-tier co-payment structure. Co-payments must be paid to the pharmacy at the time of purchase. If the applicable co-payment is more than the retail price of a drug, the member pays the retail price; except as noted elsewhere, each co-payment covers up to a 30-day supply of a prescription or refill. If the prescription is for less than a 30-day supply of medication, a full co-payment applies. Some of our prescription benefits include calendar year deductibles per person (i.e., \$100, \$250).

BENEFIT VARIATION

Several different benefit packages are provided to HNE members and vary depending on the employer group benefit package. Some benefit packages do not provide coverage for specific drugs or drug classes, such as birth control products and devices. If the Employer Group Agreement provides for different coverage than in this section, the coverage described in the Employer Group Agreement governs.

Please note: Attention Deficit Disorder Medications that are classified as a controlled substance (CII & CIII) can now be filled for up to a 60-day supply at an In-Plan retail Pharmacy (this is subject to the stores internal policy). One co-payment applies for each 30-day supply. This applies to the state of Massachusetts pharmacies only. All other states are subject to their own state laws and internal store policies.

GENERIC DRUGS (TIER 1)

Approved by the U.S. Food and Drug Administration (FDA), Generic Drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. HNE encourages the dispensing of generic drugs whenever possible. Members pay the lowest co-payment for generic drugs.

BRAND/FORMULARY DRUGS (TIER 2)

Brand/Formulary Drugs (Tier 2) are marketed under a trademarked brand name, usually by one manufacturer and do not have less costly generic equivalents. Brand/Formulary Drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. The member's co-payment for Brand/Formulary Drugs are higher than for Generic Drugs, but lower than for Brand/Non-Formulary Drugs, which are described below.

Brand/Non-Formulary Drugs (Tier 3)

Any brand name drug that HNE has not selected as a Brand/Formulary Drug is a Brand/Non-Formulary Drug (Tier 3). This category includes, but is not limited to, any brand name drug that has a generic equivalent (Tier 1). The member and their physician may decide that a Brand/Non-Formulary Drug is most appropriate for them. These medications are still covered, but at the highest copayment level.

Compounded Medications

Compounding is the producing of a medication using raw chemicals and ingredients that are customized to meet the specific needs of a patient according to a doctor's specifications. All compounded medications require at least a Tier-2 co-payment.

HNE Pharmacy Network

Through our national pharmacy network, members can get medications at participating pharmacies wherever they are located, or at certain other pharmacies that do not have locations in Western Massachusetts. That means whether they are home, on vacation, or away for business or other reasons, members can fill prescriptions at any of the more than 50,000 pharmacies that participate in our national network. A partial list of national pharmacies includes: CVS, Walgreens, Brooks, as well as Stop & Shop, Costco, Target and independently owned pharmacies. HNE's pharmacy benefits manager maintains the network by negotiating contracts and ongoing analyses to monitor quality of care and service.

Specialty Network

CuraScript

For members who require injectable medications, we work with CuraScript, a specialty pharmacy that specializes in managing specialty pharmacy drugs. These products must be stored, distributed and administered in a non-standard way.

CuraScript supplies all forms of injectable medications for HNE members with a prescription benefit. Members without the benefit are covered only for medical injectables (i.e. administered by a medical professional) and are not covered for self-injectable medications. Prescription yearly deductibles only apply to self administered injectable medications. Members will not incur a co-payment for any specialty injectable medications ordered through CuraScript.

CuraScript will provide injectable drugs to HNE members in the following settings:

- Private physician offices
- Hospital clinics
- Members' homes

CuraScript provides service to both HNE providers and members. Please call 866-848-9870 to request drug order forms.

MAIL ORDER

A mail service option for members who wish to receive their prescriptions through the mail is available. Only maintenance medications for which a 90-day supply is appropriate may be obtained by mail. Member co-payments for mail service prescriptions may differ from standard prescription co-payments. Each co-payment covers up to a 90-day supply of a prescription or refill.

**** Only FDA approved maintenance drugs are allowed through mail-order. ****

The following items may not be purchased through the mail service:

- Any drugs for which mail service is prohibited by law
- Injectable
- Prescriptions for which a 90-day supply may not be appropriate as determined by HNE

Prescribing Information

EXCLUDED MEDICATIONS, NEWLY APPROVED DRUGS, PRIOR APPROVAL, QUANTITY LIMITATIONS, AND STEP THERPY MEDICATIONS.

EXCLUDED MEDICATIONS:

Brand Drug Name	Indication
Aclaro PD 4% Emulsion	bleaching
Aquoral Spray	dry mouth and throat
Avage	cosmetic
Didrex	weight loss
Eldopaque Forte	bleaching
Glyquin XM	depigmenting
Lustra	bleaching
Melenex	bleaching
Obagi-Nu-Derm	bleaching
Penlac	onychomycosis
Propecia	male pattern baldness
Provigil	narcolepsy/ms fatigue
Remergent HQ	bleaching
Renova	treatment of fine wrinkles
Rogaine	male pattern baldness
Singulair	asthma
Solage	hypopigmentation
Solaquin Forte	bleaching
Tri-Luma	depigmenting
Vaniga	cosmetic
Xyrem	cataplexy

NEWLY APPROVED DRUGS

Newly approved brand name medications are excluded from coverage for a minimum of 6 months after FDA approval, referred to as the Clinical Review Period (CRP). The Pharmacy and Therapeutics Committee will then review these medications for safety and efficacy to make a decision on the level of coverage for the drug. After review, these drugs will be covered under either the middle co-payment level (Tier 2) for Formulary additions or our highest co-payment level (Tier 3) for drugs not added to the Formulary. The Clinical Review Period does not apply to newly

approved, generic drugs. Generic drugs are covered under the lowest co-payment level (Tier 1) as soon as they become available.

REVIEW REQUEST FOR NEWLY APPROVED DRUGS AND QUANTITY LIMITATIONS

If a physician requests an FDA approved medication for a non-FDA approved disease state/condition or dosing schedule, the prescribing physician must submit at least 3 peer-reviewed journal articles or abstracts; a national or published Clinical Guideline; and/or published information regarding current standard of care.

Review Process

Providers may initiate a medication request form by completing our Clinical Review Period Benefit Exception form located on our website, hne.com (under the pharmacy tab-Forms) or by contacting provider services (800-842-4464) and having the form faxed directly to them.

Prior Approval Required

Prior approval is required for selected prescription medications. Express-Scripts, the Health New England Pharmacy Benefit Manager, has been delegated to perform prior review using Health New England approved criteria.

- For a copy of a prior approval form please call Express-Scripts at 800-417-8164 and/or visit us at hne.com or contact Health New England’s Member Services Dept. at 800-310-2835.
- Please fax completed forms to Express-Scripts at 1-877-837-5922.
- For a copy of the criteria used in the prior approval process please visit us at hne.com
- Providers may also call 1-888-806-4998 to request prior authorization.

Health New England – Prior Authorization Drugs 2008

Copayment Tier	Brand Drug Name	Maintenance Med
Tier 3	Actiq	no
Medical	Amevive	no
Tier 3	Aranesp	no
Medical	Botox	no
Tier 3	Bravelle	no
Tier 2	Celebrex	yes
Medical	Cerezyme	no
Tier 2	Cetrotide	no
Tier 3	Differin	no
Medical	Elaprase	no
Tier 2	Enbrel	no
Tier 2	Epogen	no
Tier 3	Exubera	yes
Medical	Fabrazyme	no
Tier 1	fentanyl lozenge	no
Tier 3	Fentora	no
Tier 3	Fertinex	no
Medical	Folan	no
Tier 3	Follistim	no
Tier 2	Ganirelix	no
Tier 3	Genotropin	no
Tier 3	Gleevec	no
Tier 2	Gonal-F	no
Tier 3	Humatrope	no

Copayment Tier	Brand Drug Name	Maintenance Med
Tier 2	Humira	no
Tier 2	Humira starter kit	no
Tier 3	Increlex	yes
Tier 3	Iplex	no
Tier 3	Kineret	no
Tier 3	Leukine	no
Tier 3	Luveris	no
Tier 1	meloxicam	yes
Tier 3	Menopur	no
Tier 3	Meridia	no
Tier 2	Metrodin	no
Tier 3	Mobic	yes
Medical	Myobloc	no
Tier 3	Nexavar	no
Tier 3	Norditropin	no
Tier 3	Noxafil	no
Tier 2	Nutropin	no
Medical	Orencia	no
Tier 2	Pergonal	no
Tier 2	Procrit	no
Tier 3	Provigil	no
Tier 3	Raptiva	no
Medical	Remicade	no
Medical	Remodulin	no
Tier 2	Repronex	no
Tier 3	Retin-A .	no
Tier 3	Retin-A Micro	no
Tier 2	Revatio	no
Tier 3	Revlimid	no
Medical	Rituxan	no
Tier 3	Saizen	no
Tier 3	Serostim	no
Tier 2	Singulair	yes
Tier 3	Sprycel	no
Tier 3	Sutent	no
Tier 3	Tazorac	no
Tier 2	Tev-Tropin	no
Tier 3	Tracleer	no
Tier 1	trentinoin	no
Tier 3	Tykerb	no
Medical	Tysabri	no
Tier 3	Ventavis	yes
Tier 3	Vfend	no
Tier 3	Xenical	no
Medical	Xolair	no
Tier 3	Zolinza	no
Tier 3	Zorbtive	no
Tier 3	Zyvox	no

QUANTITY LIMITATIONS

Quantities for some medications are limited to amounts that are generally considered medically necessary and/or the maximum daily dose approved by the FDA. The limits are in place in order to ensure safe and appropriate use and to minimize potential waste of expensive medications.

IN ORDER TO PRESCRIBE OUTSIDE THE QUANTITY LIMIT

Providers may initiate a medication request form by completing our Quantity Limitation Benefit Exception form located on our website hne.com (under the pharmacy tab-Forms) or by contacting provider services (800-842-4464) and having the form faxed directly to them.

Copayment Tier	Brand Drug Name	Coverage Limitations	Maintenance Med
Tier 3	Aciphex	30 tablets per 30 day period	yes
Tier 3	Actiq	120 lozenges per 30 day period	no
Tier 2	Adderall XR	20mg = 60 capsules per 30 day period, 5mg, 10mg, 15mg, 25mg & 30mg = 30 capsules per 30 day period	yes
Tier 2	Advair Diskus	1 diskus = 60 metered dose per 30 day period	yes
Tier 2	Advair HFA	1 inhaler (120 actuations) for 30 day period	yes
Tier 3	Advicor	60 tablets per 30 day period	yes
Tier 3	Allegra	30mg & 60mg = 60 tablets per 30 day period; 180mg = 30 tablets per 30 day period	yes
Tier 3	Allegra-D-12 hour	60 tablets per 30 day period	no
Tier 3	Allegra-D-24 hour	30 tablets per 30 day period	no
Tier 3	Altoprev	30 tablets per 30 day period	yes
Tier 3	Ambien	30 tablets per 30 day period	no
Tier 3	Ambien CR	30 tablets per 30 day period	no
Tier 3	Amerge	12 tablets per 30 day period	no
Tier 3	Amitiza	60 capsules per 30 day period	no
Tier 1	amlodipine	2.5mg & 5mg = 45 tablets per 30 day period; 10mg = 30 tablets per 30 day period	yes
Tier 3	Anzemet	2 tablets per 30 day period	no
Tier 3	Arixtra	14 days supply of medication per fill	no
Tier 3	Axert	12 tablets per fill	no
Tier 1	Buproban	90 day supply per 12 month period	no
Tier 2	Byetta	1 pen per 30 day period for 5mcg strength and 1 pen per 30 days for 10mcg strength	yes
Tier 3	Caduet	30 tablets per 30 day period	yes
Tier 3	Cardura	1mg, 2mg & 4mg = 30 tablets per 30 day period; 8mg = 60 tablets per 30 day period	yes
Tier 3	Cardura XL	4mg & 8mg = 30 tablets per 30 day period	yes
Tier 2	Catapres TTS-1	4 patches in a 30 day period	yes
Tier 2	Catapres TTS-2	4 patches in a 30 day period	yes
Tier 2	Catapres TTS-3	4 patches in a 30 day period	yes
Tier 2	Caverject	4 doses per 30 day period	no
Tier 2	Celebrex	60 capsules per 30 day period	yes
Tier 3	Celexa	45 tablets per 30 day period	yes

Copayment Tier	Brand Drug Name	Coverage Limitations	Maintenance Med
Tier 3	Chantix	60 tabs per 30 day period, AND 90 days only per 12 month period. May get second 90 day supply at 50/50 rate per 12 month period	no
Tier 3	Cialis	4 tablets per 30 day period	no
Tier 1	citalopram	45 tablets per 30 day period	yes
Tier 3	Clarinet	30 tablets per 30 day period	yes
Tier 3	Clarinet D 12 hour	60 tablets per 30 day period	no
Tier 3	Clarinet D 24hr	30 tablets per 30 day period	no
Tier 3	Clarinet Reditabs	30 tablets per 30 day period	yes
Tier 1	clozapine	14 day supply for fill the first year, copay applies each fill. After 1 year then 30 day supply per fill.	no
Tier 3	Clozaril	14 day supply for fill the first year, copay applies each fill. After 1 year then 30 day supply per fill.	no
Tier 2	Concerta	18mg, 27mg, 54mg= 30 tablets per 30 day period; 36mg = 60 tablets per 30 day period	yes
Tier 3	Crestor	30 tablets per 30 day period	yes
Tier 3	Cymbalta	20mg = 60 capsules per 30 day period; 30mg & 60mg = 30 capsules per 30 day period	yes
Tier 3	Daytrana patch	30 patches per 30 day period	yes
Tier 1	doxazosin	1mg, 2mg & 4mg = 30 tablets per 30 day period; 8mg = 60 tablets 30 day period	yes
Tier 2	Edex	4 doses per 30 day period	no
Tier 3	Effexor	60 tablets per 30 day period	yes
Tier 2	Effexor XR	37.5mg = 30 capsules per 30 day period, 75mg = 90 capsules per 30 day period; 150mg = 60 capsules per 30 day period	yes
Tier 3	Emend	125mg = 1 tablet per 30 day period; 40mg & 80mg = 2 tablets per 30 day period; trifold = 1 pack per 30 day period	no
Tier 2	Enbrel	25mg= 8 syringes per 30 day period; 50mg = 4 syringes per 30 day period.	no
Tier 2	Epi-pen	1 kit per fill	no
Tier 3	Exforge	30 tablets per 30 day period	yes
Tier 1	fentanyl lozenge	120 lozenges per 30 day period	no
Tier 3	Fentora	120 tablets per 30 day period	no
Tier 1	fexofenadine	30mg & 60mg = 60 tablets per 30 day period; 180mg = 30 tablets per 30 day period	yes
Tier 1	fluoxetine	10mg & 20mg= 90 capsules per 30 day period; 40mg = 60 capsules per 30 day period.	yes
Tier 1	fluvoxamine	25mg =45 tablets per 30 day period; 50mg = 60 tablets per 30 day period, 100mg = 90 tablets per 30 day period.	yes

Copayment Tier	Brand Drug Name	Coverage Limitations	Maintenance Med
Tier 3	Focalin XR	30 tablets per 30 day period	yes
Tier 2	Foradil Aerolizer	1 package (60 blisters) per 30 day period	yes
Tier 3	Fragmin	14 days supply of medication per fill	no
Tier 3	Frova	12 tablets per 30 day period	no
Tier 3	Gleevec	100mg = 60 per 30 day period, 400mg = 30 per 30 day period	no
Tier 2	Humira	2 injections per 30 day period	no
Tier 2	Humira starter pack	One starter pack per authorization, then 2 injections per 30 day period.	no
Tier 3	Hytrin	1mg & 5mg = 30 capsules per 30 day period; 2mg & 10mg = 60 capsules per 30 day period	yes
Tier 2	Imitrex, injection	1Kit (2 syringes) per 30 day period	no
Tier 2	Imitrex, intranasal	6 units per 30 day period	no
Tier 2	Imitrex, oral	12 tablets per 30 day period	no
Tier 3	Innohep	14 days supply of medication per fill	no
Tier 1	itraconazole	90 day supply per 12 month period	no
Tier 3	Janumet	30 tablets per 30 day period	yes
Tier 2	Januvia	30 tablets per 30 day period	yes
Tier 3	Kytril	6 tablets per 30 day period; solution-1 bottle (30ml) per 30 day period	no
Tier 3	Lamisil	90 day supply per 12 month period	no
Tier 3	Lescol, Lescol XL	30 capsules per 30 days	yes
Tier 3	Levitra	4 tablets per 30 day period	no
Tier 2	Lexapro	45 tablets per 30 day period	yes
Tier 3	Lipitor	30 tablets per 30 day period	yes
Tier 3	Lotronex	60 tablets per 30 day period	yes
Tier 1	lovastatin	30 tablets per 30 day period	yes
Tier 2	Lovenox	14 days supply of medication per fill	no
Tier 3	Lunesta	30 tablets per 30 day period	no
Tier 3	Luvox	25mg =45 tablets per 30 day period; 50mg = 60 tablets per 30 day period, 100mg = 90 tablets per 30 day period	yes
Tier 3	Maxalt	12 tablets per 30 day period	no
Tier 3	Maxalt MLT	12 tablets per 30 day period	no
Tier 1	meloxicam	30 tablets per 30 day period	yes
Tier 3	Mevacor	30 tablets per 30 day period	yes
Tier 3	Mobic	30 tablets per 30 day period	yes
Tier 2	MUSE	4 doses per 30 day period	no
Tier 3	Neulasta	2 syringes per 30 day period	no
Tier 3	Neupogen	10 vials/syringes per 30 day period	no
Tier 3	Nexavar	120 tablets per 30 day period	no
Tier 3	Nexium	30 tablets per 30 day period	yes
Tier 3	Nexium packet	30 packets per 30 day period	yes
Tier 3	Nicotrol Inhaler	168 units per rx, 90 day supply per 12 month period	no
Tier 3	Nicotrol Nasal Spray	4 bottles per rx, 90 day supply per 12 month period	no

Copayment Tier	Brand Drug Name	Coverage Limitations	Maintenance Med
Tier 3	Norvasc	2.5mg & 5mg = 45 tablets per 30 day period; 10mg = 30 tablets per 30 day period	yes
Tier 1	omeprazole	10mg & 40mg = 30 capsules per 30 day period, 20mg = 60 capsules per 30 day period	yes
Tier 1	ondansetron HCl (injectable)	solution - 1 day supply per 30 day period	no
Tier 1	ondansetron HCL	4mg, 8mg-12 tablets per fill; 24mg - 1 tablet per 30 day period; solution - 1 day supply per 30 day period	no
Tier 3	Ortho-Evra	3 patches per 30 day period	yes
Tier 3	Oxycontin	120 tablets per 30 day period	no
Tier 1	paroxetine	10mg & 40mg = 45 tablets per 30 day period; 20mg & 30mg = 60 tablets per 30 day period	yes
Tier 3	Paxil	10mg & 40mg = 45 tablets per 30 day period; 20mg & 30mg = 60 tablets per 30 day period	yes
Tier 3	Paxil CR	12.mg = 30 tablets per 30 day period; 25mg & 37.5mg = 60 tablets per 30 day period	yes
Tier 3	Pexeva	10mg& 40mg = 45 tablets per 30 day period; 20mg & 30mg = 60 tablets per 30 day period	yes
Tier 3	Pravachol	30 tablets per 30 day period	yes
Tier 1	pravastatin	30 tablets per 30 day period	yes
Tier 3	Prevacid	30 tablets per 30 day period	yes
Tier 3	Prilosec	10mg and 40mg = 30 capsules per 30 day period, 20mg = 60 capsules per 30 day period	yes
Tier 1	Prilosec OTC	42 tablets per 42 days	yes
Tier 2	Protonix	30 tablets per 30 day period	yes
Tier 3	Prozac	10mg & 20mg= 90 capsule per 30 day period; 40mg = 60 capsules per 30 day period	yes
Tier 3	Prozac Weekly	4 capsules per 30 day period	yes
Tier 3	Regranex	1 tube in a 30 day period; 3 tubes (90 day supply) per 12 month period	no
Tier 3	Relenza	1 kit per 30 day period; 2 kits per 12 month period	no
Tier 3	Relpax	12 tablets per 30 days	no
Tier 3	Revlimid	30 tablets per 30 day period	no
Tier 3	Rozerem	30 tablets per 30 day period	no
Tier 3	Sarafem	30 capsules per 30 day period	no
Tier 2	Serevent Diskus	60 metered doses per 30 day period	yes
Tier1	sertraline	25mg & 50mg = 45 tablets per 30 day period; 100mg = 60 tablets per 30 day period	yes
Tier 1	simvastatin	30 tablets per 30 day period.	yes
Tier 3	Sonata	14 capsules per 30 day period	no
Tier 3	Sporanox	90 day supply per 12 month period	no

Copayment Tier	Brand Drug Name	Coverage Limitations	Maintenance Med
Tier 3	Sprycel	120 tablets per 30 day period	no
Tier 3	Strattera	10mg, 18mg, 25mg, 60mg, 80mg & 100mg = 30 tablets per 30 day period; 40mg = 60 tabs per 30 day period	yes
Tier 3	Suboxone	2mg=270 tablets per 30 day supply (max 90 days supply per 12 month period); 8mg=90 tablets per 30 day period.	no
Tier 3	Subutex	2mg=270 tablets per 30 day supply (max 90 days supply per 12 month period); 8mg=90 tablets per 30 day period.	no
Tier 3	Sutent	30 tablets per 30 day period	no
Tier 2	Symlin	4 vials per 30 day period	yes
Tier 3	Tamiflu	10 capsules per 30 day period, 20 capsules per 12 month period; liquid=3 bottles per 30 day period or 6 bottles per 12 month period	no
Tier 1	terazosin	1mg & 5mg = 30 capsules 30 day period; 2 mg & 10mg = 60 capsules per 30 day period	yes
Tier 1	terbinafine	90 day supply per 12 month period, per member	no
Tier 1	Toradol	5 day supply per fill	no
Tier 2	Transderm Scop	1 box (4 patches) per copay	no
Tier 3	Tykerb	150 tablets per 30 day period	no
Tier 1	venlafaxine	60 tablets per 30 day period	yes
Tier 2	Viagra	4 tablets per 30 day period	no
Tier 2	Vytorin	30 tablets per 30 day period	yes
Tier 3	Xifaxan	9 tablets per 30 day period	no
Tier 3	Zegerid	30 units per 30 day period	yes
Tier 3	Zelnorm	60 tablets per 30 day period	no
Tier 2	Zetia	30 tablets per 30 day period	yes
Tier 3	Zocor	30 tablets per 30 day period	yes
Tier 3	Zofran	4mg, 8mg-12 tablets per fill; 24mg - 1 tablet per 30 day period; solution - 1 day supply per 30 day period	no
Tier 3	Zofran (injectable)	solution - 1 day supply per 30 day period	no
Tier 3	Zolinza	120 capsules per 30 day period	no
Tier 3	Zoloft	25mg & 50mg = 45 tablets per 30 day period; 100mg = 60 tablets per 30 day period	yes
Tier 1	zolpidem	30 tablets per 30 day period	no
Tier 2	Zomig	12 tablets per 30 day period	no
Tier 2	Zomig Nasal Spray	6 units per 30 day period	no
Tier 2	Zomig ZMT	12 tablets per 30 day period	no
Tier 3	Zyban	90 day supply per 12 month period	no
Tier 3	Zyrtec	30 tablets per 30 day period	yes
Tier 3	Zyrtec-D	60 tablets per 30 day period	yes

Step Therapy

Step therapy is an approach to medication management. **Step Therapy** is a program designed exclusively for people who have **certain conditions**—arthritis, high blood pressure, and high cholesterol, for example — that require them to **take medications regularly**. The HNE Step Therapy program **is all about value** — about getting the most for your money. Most simply, that means getting a tried-and-true medication that’s proven **safe and effective** for your condition, and getting it at the lowest possible cost.

This program is designed to have your prescription drugs be more affordable. We will work with you and your physician to be certain that you are getting the appropriate drug for your condition. Claims for drugs listed in the first column below will process only if you have had a prescription filled of at least one of the first line medications listed in the third column within the last 180 days.

If you have any questions about the program or need any pharmacy forms, please contact our Member Services Department at 1-800-310-2835 or 413-787-4004, or visit our website at hne.com

Please note: The use of samples does not satisfy the requirements of documented usage of a First Line drug of medical necessity for a Step Therapy drug. If it is medically necessary for you to use a Step Therapy drug before trying a First Line drug, then your doctor can contact HNE to request a Pharmacy review.

Step Therapy Drug	Indications	First Line Protocol (no form required)	Process when protocol is not met
Angiotensin II Receptor Antagonist Blocker (ARB) Atacand Atacand HCT Avapro Avalide Benicar Benicar HCT Cozaar Diovan Diovan HCT Exforge Hyzaar Micardis Micardis HCT Teveten Teveten HCT	<ul style="list-style-type: none"> Hypertension Nephropathy in type 2 diabetes Reduce stroke risk Heart failure Post- MI 	<ul style="list-style-type: none"> Must have tried and failed at least one of the following generic drugs within the previous 180 days: <ul style="list-style-type: none"> Benazepril hydrochloride Benazepril/hydrochlorothiazide Captopril Captopril/hydrochlorothiazide Enalapril maleate Enalapril/hydrochlorothiazide Fosinopril sodium Fosinopril/hydrochlorothiazide Lisinopril Lisinopril/hydrochlorothiazide Moexipril hydrochloride Moexipril/hydrochlorothiazide Quinapril hydrochloride Quinapril/hydrochlorothiazide Trandolapril 	PA form to be submitted by the requesting physician. (See specific medical necessity form available for the ARB)
Anti-depressants: Cymbalta, Effexor XR, Lexapro, Paxil CR, Pexeva, Prozac weekly, Wellbutrin XL	Depression	<ul style="list-style-type: none"> Must have tried and failed at least one of the following generic drugs within the previous 180 days: <ul style="list-style-type: none"> budeprion, bupropion, citalopram HBR, fluoxetine HCL, fluvoxamine maleate, mirtazapine, paroxetine HCL, sertraline, venlafaxine HCL. Does not exceed quantity limit (please reference quantity limitation list) Does not apply members who are 18 and under. 	Step Therapy exception form must be submitted by the requesting physician.
Cardiovascular Medications: Advicor, Altoprev, Caduet, Crestor, Lescol, Lescol XL, Lipitor,	<ul style="list-style-type: none"> Hypercholesterolemia 	<ul style="list-style-type: none"> Must have tried and failed at least one of the following generic drugs within the previous 180 days: <ul style="list-style-type: none"> lovastatin, pravastatin, simvastatin. Does not exceed quantity limit (please reference quantity limitation list) 	Step Therapy exception form must be submitted by the requesting physician.

Step Therapy Drug	Indications	First Line Protocol (no form required)	Process when protocol is not met
Mevacor, Pravachol, Vytorin, Zocor			
Constipation: Amitiza	<ul style="list-style-type: none"> Constipation 	<ul style="list-style-type: none"> Must have tried and failed the following generic drug within the previous 180 days lactulose Does not exceed quantity limit (please reference quantity limitation list) 	Step Therapy exception form must be submitted by the requesting physician.
Hypnotics: Ambien Ambien Cr Lunesta Rozerem Sonata	<ul style="list-style-type: none"> Insomnia 	<ul style="list-style-type: none"> Must have tried and failed the following generic drug within the previous 180 days zolpidem 	Step Therapy exception form must be submitted by the requesting physician.
Overactive Bladder: Detrol Detrol LA Ditropan Ditropan XL Enablex Sanctura Vesicare	<ul style="list-style-type: none"> Overactive bladder 	<ul style="list-style-type: none"> Must have tried and failed one of the following generic drugs within the previous 180 days oxybutynin oxybutynin XL 	Step Therapy exception form must be submitted by the requesting physician
Proton Pump Inhibitors: Aciphex, Nexium, Prevacid, Prilosec, Protonix, Zegerid	<ul style="list-style-type: none"> Gastroesophageal reflux (GERD) Erosive esophagitis Pathologic hypersecretory 	<ul style="list-style-type: none"> Must have tried and failed at least one of the following generic drugs within the previous 180 days: omeprazole, Prilosec 20mg OTC. Does not exceed quantity limit (please reference quantity limitation list) Does not apply to members who are 18 and under 	Step Therapy exception form must be submitted by the requesting physician.
Bravelle	<ul style="list-style-type: none"> Infertility 	<ul style="list-style-type: none"> Must have an approved infertility cycle Must have tried and failed Gonal-F 	Medical Necessity PA form to be submitted by requesting physician
Celebrex	<ul style="list-style-type: none"> Rheumatoid Arthritis Osteoarthritis Acute Pain 	<ul style="list-style-type: none"> Age greater than 60 or Within the past 180 days filled prescription for at least 2 different anti-inflammatory drugs Filled one prescription for an oral corticosteroid Filled one prescription for a anticoagulant or antiplatelet agent within the previous 90 days. Does not exceed quantity limit (please reference quantity limitation list) 	PA form must be submitted by requesting physician
Emend	<ul style="list-style-type: none"> Nausea and vomiting associated with chemotherapy 	<ul style="list-style-type: none"> Prescription is written by an In-Plan Oncologist/ Hematologist or All other specialties; Does not exceed quantity limit (please reference quantity limitation list) 	Medication Review form must be submitted by the requesting physician.
Enbrel Please Note:	<ul style="list-style-type: none"> Rheumatoid Arthritis <p>For the diagnosis of psoriasis prior authorization is required and step therapy does not apply.</p>	<ul style="list-style-type: none"> Must have filled at least one prescription written by an In-Plan Rheumatologist within a 12 month period. Does not exceed quantity limit (please reference quantity limitation list) 	PA form must be submitted by requesting physician
Follistim	<ul style="list-style-type: none"> Infertility 	<ul style="list-style-type: none"> Must have an approved infertility cycle Must have tried and failed Gonal-F 	Medical Necessity PA form to be submitted by requesting physician
Humira	<ul style="list-style-type: none"> Rheumatoid Arthritis Crohn's Disease Psoriasis 	<ul style="list-style-type: none"> Must have filled at least one prescription written by an In-Plan Rheumatologist within a 12 month period. 	PA form must be submitted by requesting physician

Step Therapy Drug	Indications	First Line Protocol (no form required)	Process when protocol is not met
		<ul style="list-style-type: none"> Does not exceed quantity limit (please reference quantity limitation list) 	
Kineret	<ul style="list-style-type: none"> Rheumatoid Arthritis 	Must have filled at least one prescription written by an In-Plan Rheumatologist within a 12 month period.	PA form must be submitted by requesting physician
Lyrica	<ul style="list-style-type: none"> Diabetic Neuropathy 	Must have filled at least one prescription, for one of the following or a combination of within the previous 180 day Carbamazepine, Depakote, Dilantin, Felbatol, Gabitril, Gabapentin, Lamictal, Keppra, Neurontin, Tegretol, Topamax, Zonegran	Step Therapy exception form must be submitted by the requesting physician
Mobic (meloxicam)	<ul style="list-style-type: none"> Osteoarthritis Arthritis 	<ul style="list-style-type: none"> Age greater than 60 or Within the past 180 days filled prescription for at least 2 different anti- inflammatory drugs Filled one prescription for an oral corticosteroid Filled one prescription for an anticoagulant or antiplatelet agent within the previous 90 days. Does not exceed quantity limit (please reference quantity limitation list) 	PA form must be submitted by requesting physician
Singulair	<ul style="list-style-type: none"> Asthma 	Must have filled at least one prescription within the previous 180 days used for the treatment of Asthma.	PA form must be submitted by requesting physician
Vfend	<ul style="list-style-type: none"> Antifungal 	Prescription is written by an In-Plan Oncologist/ Hematologist or Infectious Disease	PA form must be submitted by requesting physician

Formulary Listing

Tables	Classes of Drugs
1	ANESTHETICS
2	ANTIINFECTIVES
3	ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS
4	CARDIOVASCULAR MEDICATIONS
5	AUTONOMIC & CNS MEDICATIONS
6	DERMATOLOGICAL MEDICATIONS
7	EAR-NOSE-THROAT MEDICATIONS
8	ENDOCRINE MEDICATIONS
9	GASTROINTESTINAL MEDICATIONS
10	IMMUNOLOGICALS & VACCINES
11	MUSCULOSKELETAL MEDICATIONS
12	NUTRITION, BLOOD
13	OBSTETRICAL & GYNECOLOGICAL MEDICATIONS
14	OPHTHALMIC MEDICATIONS
15	RESPIRATORY MEDICATIONS
17	DIAGNOSTIC & MISCELLANEOUS MEDICATIONS
18	MEDICAL (MISCELLANEOUS) SUPPLIES

DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
		1	2	3	
CHAPTER 1: ANESTHETICS					
1.2 TOPICAL ANESTHETICS					
\$	lidocaine hcl		X		
\$	lidocaine hcl viscous		X		
!!!!	LIDODERM			X	
CHAPTER 2: ANTIINFECTIVES					
2.1.1 CEPHALOSPORINS					
\$	cefaclor		X		
\$	cefaclor er		X		
\$	cefadroxil		X		
\$	cefdinir		X		
\$	cefpodoxime proxetil		X		
\$	cefprozil		X		
\$	cefuroxime (tab)		X		
\$	cephalexin		X		
\$	cephradine		X		
\$\$	SPECTRACEF			X	generics
\$\$\$	CEDAX			X	generics
\$\$\$	OMNICEF			X	generics
\$\$\$	SUPRAX (SUSP)			X	
\$\$\$\$	CEFTIN (SUSP)			X	
\$\$\$\$	CEFZIL			X	generics
\$\$\$\$	LORABID			X	generics
\$\$\$\$	VANTIN			X	generics
2.1.3 CLINDAMYCINS					
\$	clindamycin hcl		X		
2.1.4 ERYTHROMYCINS					
\$	erythrocin stearate		X		
\$	erythromycin base		X		
\$	erythromycin ethylsuccinate		X		

This list is subject to change

DRUG NAME		PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$	PCE				X	erythromycin
2.1.4.1 OTHER MACROLIDES						
\$	azithromycin		X			
\$	clarithromycin		X			
\$	clarithromycin extended release		X			
\$\$	ZITHROMAX				X	azithromycin
\$\$	ZITHROMAX TRI-PAK				X	
\$\$\$	BIAXIN suspension				X	clarithromycin
2.1.5 PENICILLINS						
\$	amox tr/potassium clavulanate (susp)		X			
\$	amoxicillin		X			
\$	penicillin v potassium		X			
\$	TRIMOX		X			
\$\$\$	AUGMENTIN XR			X		
2.1.6 SULFONAMIDES						
\$	erythromycin w/sulfisoxazole		X			
\$	sulfamethoxazole/trimethoprim		X			
2.1.7 TETRACYCLINES						
\$	doxycycline hyclate		X			
\$	minocycline hcl		X			
\$	tetracycline hcl		X			
2.1.8 URINARY ANTIINFECTIVES						
\$	nitrofurantoin macrocrystal (100 mg)		X			
2.1.9 QUINOLONES						
\$	ciprofloxacin hcl, - er		X			
\$	ofloxacin (tabs)		X			
\$\$\$	CIPRO XR				X	ciprofloxacin hcl er
\$\$\$	NOROXIN				X	ofloxacin, LEVAQUIN, ciprofloxacin hcl
\$\$\$\$	AVELOX				X	ofloxacin, LEVAQUIN, ciprofloxacin hcl
\$\$\$\$	AVELOX ABC PACK				X	ofloxacin, LEVAQUIN, ciprofloxacin hcl
\$\$\$\$	LEVAQUIN			X		
\$\$\$\$	TEQUIN				X	ofloxacin, LEVAQUIN, ciprofloxacin hcl
\$\$\$\$\$	FACTIVE				X	
2.2 TOPICAL ANTIBACTERIAL DRUGS						
\$	gentamicin sulfate		X			
\$	mupirocin		X			
\$	silver sulfadiazine		X			
\$\$	BACTROBAN			X		
2.3 ORAL ANTIFUNGAL DRUGS						

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	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	clotrimazole		X			
\$	fluconazole		X			
\$	itraconazole	QLL = 90 days supply/yr	X			
\$	ketoconazole		X			
\$	nystatin		X			
\$	terbinafine hcl	QLL=90 days supply per 12 month period	X			
!!!!	LAMISIL	QLL = 90 days supply/yr			X	terbinafine hcl
!!!!	SPORANOX	QLL = 90 days supply/yr			X	itraconazole
2.4.1 VAGINAL ANTIFUNGALS						
\$	terconazole		X			
\$\$	GYNAZOLE-1				X	
2.4.2 OTHER TOPICAL ANTIFUNGALS						
\$	ciclopirox		X			
\$	econazole nitrate		X			
\$	ketoconazole		X			
\$	nystatin		X			
\$	EXELDERM				X	generics
\$\$	ERTACZO				X	
\$\$	MENTAX				X	generics
\$\$	NAFTIN			X		
\$\$	OXISTAT				X	generics
\$\$\$	LOPROX				X	generics
\$\$\$\$	PENLAC					EXCLUDED from COVERAGE
!!!!	LAMISIL				X	
2.4.3 TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.						
\$	clotrimazole/betamethasone		X			
\$	nystatin w/triamcinolone		X			
2.5.1 ANTIRETROVIRALS & PROTEASE INHIBITORS (all products covered at 2nd tier)						
!!!!	EMTRIVA			X		
!!!!	FUZEON			X		
!!!!	REYATAZ			X		
!!!!	TRUVADA			X		
2.5.2 OTHER ANTIVIRAL DRUGS						
\$	acyclovir		X			
\$	amantadine hcl		X			
\$	famciclovir		X			
\$	DENAVIR				X	
\$\$	FLUMADINE				X	
\$\$	HEPSERA			X		
\$\$	RELENZA	QLL= 1 kit/30days; 2 kits per 12 month period			X	amantadine hcl
\$\$	TAMIFLU capsules, oral suspension	QLL= 10 capsules/30 days; 20 capsules per 12 month period; or liquid 3 bottles/30days or 6 bottles per 12 month period			X	amantadine hcl
\$\$\$\$	COPEGUS				X	
\$\$\$\$	RIBATAB				X	

DRUG NAME		PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$\$	VALTREX			X		
\$\$\$\$\$	EPIVIR-HBV			X		
\$\$\$\$\$	FAMVIR				X	famciclovir
!!!!	BARACLUDE				X	
2.7.2 ANTITUBERCULOSIS DRUGS						
\$	isoniazid		X			
\$	rifampin		X			
2.7.3 PLASMODICIDES						
\$	hydroxychloroquine sulfate		X			
\$	quinine sulfate		X			
2.7.5 TRICHOMONOCIDES						
\$	metronidazole		X			
2.8.2 AMINOGLYCOSIDES						
	GENTAMICIN SULFATE (INJ)				X	
CHAPTER 3: ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS						
3.0 ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS						
\$	azathioprine		X			
\$	cyclosporine		X			
\$	megestrol acetate		X			
\$	mercaptopurine		X			
\$	methotrexate		X			
\$	tamoxifen citrate		X			
\$\$\$\$	ARIMIDEX			X		
\$\$\$\$	ENBREL	PA; QLL= (50 mg: 4 vials/ 30 days; 25 mg: 8 vials/ 30 days); ST		X		
\$\$\$\$	FEMARA			X		
\$\$\$\$	HUMIRA	PA; QLL = 2 inj/30 days; ST		X		
\$\$\$\$\$	CASODEX			X		
\$\$\$\$\$	CELLCEPT			X		
\$\$\$\$\$	DEPO-PROVERA (INJ)			X		
\$\$\$\$\$	MYFORTIC				X	
\$\$\$\$\$	TRELSTAR DEPOT				X	
\$\$\$\$\$	TRELSTAR LA				X	
!!!!	SPRYCEL	QLL = 120 per 30 days, PA			X	
!!!!	ZOLINZA	QLL = 120 per 30 days, PA			X	
!!!!	ELIGARD				X	
!!!!	IRESSA				X	
!!!!	NEXAVAR	QLL = 120 per 30 days, PA			X	
!!!!	REVLIMID	QLL= 30 per 30 days, PA			X	
!!!!	SUTENT	QLL = 30 per 30 days, PA			X	
CHAPTER 4: CARDIOVASCULAR MEDICATIONS						
4.1 CARDIAC GLYCOSIDES						
\$	digitek		X			
\$	digoxin		X			
4.2 CALCIUM ANTAGONISTS						
\$	amlodipine besylate		X			
\$	cartia xt		X			

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	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	diltiazem er		X			
\$	diltiazem hcl		X			
\$	diltiazem xr		X			
\$	felodipine er		X			
\$	nicardipine hcl		X			
\$	nifedipine		X			
\$	nifedipine er		X			
\$	verapamil hcl		X			
\$\$	SULAR				X	amlodipine, PLENDIL
\$\$\$	CARDIZEM LA				X	diltiazem la
\$\$\$	COVERA-HS				X	verapamil sr
\$\$\$	DYNACIRC CR				X	amlodipine, PLENDIL
\$\$\$	NORVASC	QLL = 10mg (30 tabs/30 days); 2.5mg & 5mg (45 tabs/30 days)			X	amlodipine
\$\$\$	VERELAN PM				X	verapamil sr
\$\$\$\$	CARDENE SR				X	amlodipine, PLENDIL
4.3.1 LOOP DIURETICS						
\$	bumetanide		X			
\$	furosemide		X			
\$	toremide		X			
4.3.2 THIAZIDE AND RELATED DRUGS						
\$	hydrochlorothiazide		X			
\$	indapamide		X			
\$	metolazone		X			
4.3.3 POTASSIUM SPARING DIURETICS						
\$	amiloride hcl w/hctz		X			
\$	spironolactone		X			
\$	spironolactone w/hctz		X			
\$	triamterene w/hctz		X			
\$\$\$\$\$	INSPIRA				X	
4.4 BETA-ADRENERGIC ANTAGONIST DRUGS						
\$	atenolol		X			
\$	bisoprolol fumarate		X			
\$	carvedilol		X			
\$	labetalol hcl		X			
\$	metoprolol succ er		X			
\$	metoprolol tartrate		X			
\$	nadolol		X			
\$	propranolol hcl		X			
\$\$	INNOPRAN XL				X	
\$\$	TOPROL XL				X	
\$\$\$\$\$	COREG				X	carvedilol
4.5.1 VASODILATOR ANTIHYPERTENSIVES						
\$	doxazosin mesylate	QLL = 1mg, 2mg, 4mg (30 tabs/30 days); 8mg (60 tabs/30 days)	X			
\$	hydralazine hcl		X			

	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	prazosin hcl		X			
\$	terazosin hcl	QLL = 2mg & 10mg (60 caps/30 days); 1mg & 5mg (30 caps/30 days)	X			
4.5.2 CENTRALLY ACTING ANTIHYPERTENSIVES						
\$	clonidine hcl		X			
\$	guanfacine hcl		X			
\$	methyldopa		X			
4.5.4.1 ANGIOTENSIN CONVERTING ENZYME INHIBITORS						
\$	benazepril hcl		X			
\$	captopril		X			
\$	enalapril maleate		X			
\$	fosinopril sodium		X			
\$	lisinopril		X			
\$	moexipril		X			
\$	quinapril hcl		X			
\$	trandolapril		X			
\$\$	ACCUPRIL				X	quinapril hcl
\$\$	ALTACE				X	generic ACEs
\$\$	MAVIK				X	trandolapril
\$\$	UNIVASC				X	moexipril
\$\$\$	ACEON				X	generic ACEs
4.5.4.2 ANGIOTENSIN II RECEPTOR ANTAGONISTS						
\$\$	BENICAR	ST			X	AVAPRO, DIOVAN
\$\$\$	ATACAND	ST			X	AVAPRO, DIOVAN
\$\$\$	AVAPRO	ST		X		
\$\$\$	COZAAR	ST			X	AVAPRO, DIOVAN
\$\$\$	DIOVAN	ST		X		
\$\$\$	EXFORGE	ST			X	AVAPRO, DIOVAN
\$\$\$	MICARDIS	ST			X	AVAPRO, DIOVAN
\$\$\$	TEVETEN	ST			X	AVAPRO, DIOVAN
4.5.6 OTHER ANTIHYPERTENSIVES						
\$	atenolol w/chlorthalidone		X			
\$	benazepril/amlodipine		X			
\$	benazepril hcl-hctz		X			
\$	bisoprolol fumarate/hctz		X			
\$	captopril/hydrochlorothiazide		X			
\$	enalapril maleate/hctz		X			
\$	fosinopril-hydrochlorothiazide		X			
\$	lisinopril-hctz		X			
\$	moexipril/hctz		X			
\$	quinaretic		X			
\$\$	BENICAR HCT	ST			X	AVALIDE, DIOVAN HCT
\$\$	UNIRETIC			X		moexipril/hctz
\$\$\$	AVALIDE	ST		X		
\$\$\$	DIOVAN HCT	ST		X		
\$\$\$	HYZAAR	ST			X	AVALIDE, DIOVAN

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	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
						HCT
\$\$\$	MICARDIS HCT	ST			X	AVALIDE, DIOVAN HCT
\$\$\$	TARKA				X	generic ACE + CCB
\$\$\$	TEVETEN HCT	ST			X	AVALIDE, DIOVAN HCT
\$\$\$\$	ATACAND HCT	ST			X	AVALIDE, DIOVAN HCT
\$\$\$\$	LEXXEL				X	generic ACE + CCB
\$\$\$\$	LOTREL				X	benazepril/ amlodipine
4.6.1 NITRATES						
\$	isosorbide dinitrate		X			
\$	isosorbide mononitrate		X			
\$	nitroglycerin		X			
4.7.1.1 CLASS 1A						
\$	quinidine gluconate		X			
4.7.1.3 CLASS 1C						
\$	flecainide acetate		X			
\$	propafenone hcl		X			
4.7.3 AMIODARONES						
\$\$\$\$	PACERONE				X	
4.7.5 OTHER ANTIARRHYTHMICS						
\$	sotalol		X			
!!!!	RANEXA				X	
4.8.1 HYPOLIPOPROTEINEMICS						
\$	colestipol hcl		X			
\$	gemfibrozil		X			
\$	fenofibrate		X			
\$\$	TRIGLIDE				X	
\$\$\$	LOFIBRA				X	
\$\$\$\$	ANTARA				X	
\$\$\$\$	NIASPAN			X		
\$\$\$\$	OMACOR				X	
\$\$\$\$	ZETIA	QLL = 30 tabs/30 days			X	
\$\$\$\$	WELCHOL				X	
4.8.2 HMG-COA REDUCTASE INHIBITORS						
\$	lovastatin	QLL = 30 tabs/30 days	X			
\$	pravastatin	QLL = 30 tabs/30 days	X			
\$	simvastatin	QLL = 30 tabs/30 days	X			
\$\$	LESCOL	QLL = 30 caps or tabs/30 days, ST			X	generic HMGs
\$\$\$	CRESTOR	QLL = 30 tabs/30 days, ST			X	generic HMGs
\$\$\$	LESCOL XL	QLL = 30 caps or tabs/30 days,ST			X	generic HMGs
\$\$\$	MEVACOR	QLL = 30 tabs/30 days, ST			X	generic HMGs
\$\$\$\$	ALTOPREV	QLL= 30 tabs/30 days, ST			X	generic HMGs
\$\$\$\$	LIPITOR	QLL = 30 tabs/30 days, ST			X	generic HMGs
\$\$\$\$	ZOCOR	QLL = 30 tabs/30 days, ST			X	generic HMGs
!!!!	PRAVACHOL	QLL = 30 tabs/30 days, ST			X	generic HMGs
4.8.2.1 HMG-COA COMBINATIONS						

	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$\$	ADVICOR	QLL = 60 tabs per 30 days, ST			X	
\$\$\$\$	VYTORIN	QLL = 30 tabs/30 days, ST		X		
\$\$\$\$\$	CADUET	QLL = 30 tabs/30 days, ST			X	
4.9 OTHER CARDIOVASCULAR DRUGS						
\$	pentoxifylline		X			
CHAPTER 5: AUTONOMIC AND CNS MEDICATIONS						
5.1.1 ANALGESICS						
\$	tramadol hcl		X			
\$	tramadol hcl- acetaminophen		X			
5.1.1.1 CLASS II NARCOTICS						
\$	fentanyl	PA (lozenge)	X			
\$	meperidine hcl		X			
\$	morphine sulfate		X			
\$	oxycodone apap		X			
\$	oxycodone hcl		X			
\$	oxycodone w/acetaminophen		X			
\$	oxycodone hcl extended release	QLL = 120 tabs/30 days	X			
\$\$	OXYIR				X	
\$\$\$\$\$	MS CONTIN				X	morphine sr, MS CONTIN
!!!!	AVINZA				X	morphine sr, MS CONTIN
!!!!	KADIAN				X	morphine sr, MS CONTIN
!!!!	OXYCONTIN	QLL = 120 tabs/30 days			X	generics
5.1.1.2 CLASS III NARCOTICS						
\$	acetaminophen w/codeine		X			
\$	acetaminophen w/hydrocodone		X			
\$	hydrocodone bit- ibuprofen		X			
5.1.1.3 CLASS IV NARCOTICS						
\$	propoxyphene hcl		X			
\$	propoxyphene hcl w/acetaminophen		X			
\$	propoxyphene napsylate w/acetaminophen		X			
5.1.2 DRUGS TO PREVENT AND TREAT HEADACHES						
\$	butalbital compound		X			
\$	butalbital/acetaminophen/ caffeine		X			
\$\$\$\$	RELPAK	QLL = 12 tabs/30 days			X	IMITREX, ZOMIG/ZMT
\$\$\$\$	ZOMIG	QLL = 12 tabs/30 days		X		
\$\$\$\$	ZOMIG NASAL SPRAY	QLL = 6 units/30 days		X		
\$\$\$\$	ZOMIG ZMT	QLL = 12 tabs/30 days		X		
\$\$\$\$\$	AXERT	QLL = 12 tabs per fill			X	IMITREX,

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DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
		1	2	3	
					ZOMIG/ZMT
\$\$\$\$	FROVA	QLL = 12 tabs/30 days			X IMITREX, ZOMIG/ZMT
\$\$\$\$	IMITREX	QLL = tabs (12 tabs/30 days); nasal spray (6 units/30 days); syringe (1 kit-2 syr/30 days)		X	
\$\$\$\$	MAXALT	QLL = 12 tabs/30 days			X IMITREX, ZOMIG/ZMT
\$\$\$\$	MAXALT MLT	QLL = 12 tabs/30 days			X IMITREX, ZOMIG/ZMT
!!!!	AMERGE	QLL = 12 tabs/30 days			X IMITREX, ZOMIG/ZMT
5.2.1 ANXIOLYTICS					
\$	alprazolam		X		
\$	bupirone hcl		X		
\$	chlordiazepoxide hcl		X		
\$	clorazepate dipotassium		X		
\$	diazepam		X		
\$	lorazepam		X		
5.2.2 SEDATIVE/HYPNOTIC DRUGS					
\$	flurazepam hcl		X		
\$	temazepam		X		
\$	triazolam		X		
\$	zolpidem tartrate		X		
\$\$\$	ROZEREM	QLL= 30 tabs/30 days, ST			X
\$\$\$\$	AMBIEN	QLL = 30 tabs/30 days, ST			X zolpidem tartrate
\$\$\$\$	AMBIEN CR	QLL= 30 tabs/30 days, ST			X zolpidem tartrate
\$\$\$\$	LUNESTA	QLL= 30 tabs/ 30 days, ST			X zolpidem tartrate
\$\$\$\$	RESTORIL				X
\$\$\$\$	SONATA	QLL = 30 tabs/30 days, ST			X zolpidem tartrate
5.3 ANTIMANIA DRUGS					
\$	lithium carbonate		X		
\$	lithium citrate		X		
5.4.1 CARBAMAZEPINES					
\$	carbamazepine		X		
\$\$\$	TEGRETOL XR			X	
\$\$\$\$	CARBATROL				X
\$\$\$\$\$	TRILEPTAL				X
5.4.2 ANTICONVULSANT BENZODIAZEPINES					
\$	clonazepam		X		
5.4.3 HYDANTOINS					
\$	phenytoin		X		
\$	phenytoin sodium, extended		X		
\$\$	DILANTIN 50mg only			X	
\$\$	PHENYTEK				X
5.4.4 VALPROIC ACID AND DERIVATIVES					
\$\$\$\$\$	DEPAKOTE			X	
\$\$\$\$\$	DEPAKOTE ER			X	
5.4.6 ANTICONVULSANT BARBITURATES					

	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	phenobarbital		X			
\$	primidone		X			
5.4.7 OTHER ANTICONVULSANTS						
\$	gabapentin		X			
\$\$\$\$	NEURONTIN				X	gabapentin
\$\$\$\$\$	LYRICA	ST			X	gabapentin
\$\$\$\$\$	ZONEGRAN				X	
!!!!	KEPPRA				X	
!!!!	LAMICTAL			X		
!!!!	TOPAMAX			X		
5.5.1.1 TERTIARY AMINES						
\$	amitriptyline hcl		X			
\$	doxepin hcl		X			
\$	imipramine hcl		X			
!!!!	TOFRANIL-PM				X	
5.5.1.2 SECONDARY AMINES						
\$	desipramine hcl		X			
\$	nortriptyline hcl		X			
5.5.1.3 SELECTIVE SEROTONIN REUPTAKE INHIBITORS						
\$	citalopram	QLL = 45 tabs/30 days	X			
\$	fluoxetine hcl	QLL = 10mg & 20mg caps (90 tabs or caps/30 days); 40mg (60 tabs or caps /30 days)	X			
\$	fluvoxamine maleate	QLL = 100mg (90 tabs); 25mg (45 caps); 50mg (60 tabs)/30 days	X			
\$	paroxetine hcl	QLL = 10mg/40mg (45 tabs/30 days); 20mg/30mg (60 tabs/30 days)	X			
\$	sertraline	QLL = 25mg & 50mg (45 tabs/30 days); 100mg (60 tabs/30 days)	X			
\$\$	CELEXA	QLL = 45 tabs/30 days			X	citalopram
\$\$\$	LEXAPRO	QLL = 45 tabs/30 days; ST			X	citalopram or other generic
\$\$\$	PAXIL	QLL = 10mg & 40mg (45 tabs/30 days); 20mg & 30mg (60 tabs/30 days); ST			X	paroxetine hcl
\$\$\$\$	PAXIL CR	QLL = 12.5mg (30 tabs/30 days); 25mg & 37.5mg (60 tabs/30 days); ST			X	paroxetine hcl
\$\$\$\$	ZOLOFT	QLL = 25mg & 50mg (45 tabs/30 days); 100mg (60 tabs/30 days); ST			X	sertraline
\$\$\$\$\$	PROZAC WEEKLY	QLL= 4 caps/ 30 days; ST			X	fluoxetine hcl
5.5.1.4 OTHER ANTIDEPRESSANTS						
\$	budeprion sr (150 mg)		X			
\$	bupropion hcl		X			
\$	bupropion sr		X			
\$	bupropion hcl		X			
\$	mirtazapine		X			

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	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	nefazodone hcl		X			
\$	trazodone hcl		X			
\$	venlafaxine HCL	QLL = 60 tabs/30 days	X			
\$\$\$	REMERON (M tab)				X	bupropion sr, EFFEXOR/XR
\$\$\$\$	EFFEXOR	QLL = 60 tabs/30 days; ST			X	venlafaxine
\$\$\$\$\$	CYMBALTA	QLL = 20mg (60 caps/30 days); 30,60mg (30 caps/30 days); ST			X	generic SSRI first
\$\$\$\$\$	EFFEXOR XR	QLL = 37.5mg (30 caps/30 days); 75mg (90 caps/30 days); 150mg (60 caps/30 days); ST		X		venlafaxine
\$\$\$\$\$	WELLBUTRIN XL	ST			X	bupropion sr
5.6 ANTIVERTIGO AND ANTIEMETIC DRUGS						
\$	ondansetron hcl, -odt	QLL = solution 1 days supply/30 days; 4mg & 8mg tabs 12/fill; 24mg 1 tab/30 days	X			
\$	prochlorperazine maleate		X			
\$	trimethobenzamide hcl		X			
\$\$\$\$	EMEND	QLL = 125mg (1 cap/30 days); 40 & 80mg (2 caps/30 days); trifold pack (1 pk/30 days); ST			X	
\$\$\$\$\$	KYTRIL	QLL = tabs (6 tabs/30 days); solution (1 btl/30 days)			X	
\$\$\$\$\$	ZOFRAN	QLL = 4mg & 8mg (12 tabs/fill); 24mg (1 tab/30 days); solution (1 day supply/30 days)			X	ondansetron hcl
\$\$\$\$\$	ZOFRAN IN DEXTROSE			X		
\$\$\$\$\$	ZOFRAN ODT				X	ondansetron odt
!!!!	ANZEMET	QLL = 2 tabs/30 days			X	
5.7.1 ANTIPARKINSON ANTICHOLINERGIC DRUGS						
\$	benztropine mesylate		X			
5.7.2 OTHER ANTIPARKINSON DRUGS						
\$	bromocriptine mesylate		X			
\$	carbidopa/levodopa		X			
\$\$\$\$\$	MIRAPEX			X		
\$\$\$\$\$	REQUIP				X	
\$\$\$\$\$	ZELAPAR ODT				X	
!!!!	STALEVO			X		
5.8 ANTIPSYCHOTIC DRUGS						
\$	clozapine	QLL = 14 day supply per fill first year, then 30 days supply per fill	X			
\$	haloperidol		X			
\$	thioridazine hcl		X			
\$\$\$	RISPERDAL			X		
\$\$\$	RISPERDAL- M			X		

	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$	SEROQUEL, -XR			X		
\$\$\$\$	RISPERDAL CONSTA				X	
\$\$\$\$\$	GEODON				X	RISPERDAL, SEROQUEL, ZYPREXA
\$\$\$\$\$	ZYPREXA			X		
!!!!	ABILIFY				X	RISPERDAL, SEROQUEL, ZYPREXA
!!!!	ZYPREXA ZYDIS				X	ZYPREXA
5.9.1 CNS STIMULANT DRUGS						
\$	amphetamine salt combo		X			
\$	methamphetamine hcl		X			
\$	methylin		X			
\$	methylin er		X			
\$	methylphenidate er		X			
\$	methylphenidate hcl		X			
\$\$	FOCALIN				X	methylphenidate hcl
\$\$	METADATE ER				X	methylphenidate hcl
\$\$\$\$	METADATE CD				X	
\$\$\$\$	RITALIN LA				X	methylphenidate sr
\$\$\$\$\$	ADDERALL XR	QLL = 5mg, 10mg, 15mg, 25mg, 30mg (30 caps/30 days); 20mg (60 caps/30 days)		X		
\$\$\$\$\$	CONCERTA	QLL = 18mg, 27mg, 54mg (30 tabs/30 days); 36 mg (60 tabs/30 days)		X		
\$\$\$\$\$	DAYTRANA	QLL = 30 patches/30 days			X	methylphenidate hcl
\$\$\$\$\$	FOCALIN XR	QLL = 30 caps/30 days			X	
!!!!	PROVIGIL	PA			X	
5.9.3 ANTIDEMENTIA DRUGS						
\$\$\$\$\$	ARICEPT			X		
\$\$\$\$\$	EXELON				X	
\$\$\$\$\$	NAMENDA			X		
\$\$\$\$\$	RAZADYNE				X	
5.9.4 DRUGS TO TREAT MULTIPLE SCLEROSIS						
!!!!	COPAXONE			X		
	see also interferons					
CHAPTER 6: DERMATOLOGICAL MEDICATIONS						
6.1 TOPICAL CORTICOSTEROID DRUGS						
\$	alclometasone dipropionate		X			
\$	betamethasone dipropionate		X			
\$	clobetasol propionate		X			
\$	desonide		X			
\$	desoximetasone		X			

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	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	diflorasone diacetate		X			
\$	fluocinonide		X			
\$	fluticasone propionate (oint)		X			
\$	hydrocortisone		X			
\$	mometasone furoate		X			
\$	triamcinolone acetonide		X			
\$\$	LOCOID				X	
\$\$\$	PRAMOSONE				X	
\$\$\$\$	HALOG				X	
6.2 ANTIPRURITIC DRUGS						
\$	hydroxyzine hcl		X			
\$	hydroxyzine pamoate		X			
6.3 ANTIACNE DRUGS						
\$	clindamycin phosphate		X			
\$	erythromycin base		X			
\$	metronidazole (0.75%)		X			
\$	sod.sulfacetamide/ sulfur tf		X			
\$	tretinoin	PA if under 13 or over 29	X			
\$\$\$\$	AVITA	PA if under 13 or over 29			X	tretinoin
\$\$\$\$	AZELEX			X		
\$\$\$\$	BENZAMYCIN				X	
\$\$\$\$	DIFFERIN	PA if under 13 or over 29			X	tretinoin
\$\$\$\$	FINACEA				X	
\$\$\$\$	METROGEL			X		
\$\$\$\$	METROLOTION				X	
\$\$\$\$	NORITATE			X		
\$\$\$\$	PLEXION SCT				X	
\$\$\$\$	PLEXION TS				X	
\$\$\$\$	RETIN-A MICRO	PA if under 13 or over 29			X	
\$\$\$\$\$	BENZAACLIN				X	
\$\$\$\$\$	DUAC				X	
\$\$\$\$\$	PLEXION				X	
6.7 KERATOLYTIC DRUGS						
!!!!	CONDYLOX			X		
6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS						
\$	selenium sulfide		X			
\$\$\$\$\$	KLARON				X	
\$\$\$\$\$	TAZORAC	PA if under 13 or over 29			X	
!!!!	DOVONEX			X		
6.9.2 TOPICAL DERMATOLOGICAL DRUGS						
\$\$\$\$\$	ELIDEL				X	PROTOPIC
\$\$\$\$\$	PROTOPIC			X		
!!!!	ALDARA				X	
6.9.3 SCABICIDES						
!!!!	LINDANE Shampoo			X		
CHAPTER 7: EAR-NOSE-THROAT MEDICATIONS						
7.1 DRUGS AFFECTING THE EAR						
\$	a/b otic		X			

DRUG NAME		PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$	FLOXIN (OPHTH DROPS)			X		
\$\$\$\$	CIPRO HC				X	
\$\$\$\$	CIPRODEX OTIC			X		
7.2 DRUGS AFFECTING THE NOSE						
\$	flunisolide		X			
\$	ipratropium bromide		X			
\$	fluticasone propionate nasal		X			
\$\$\$	NASAREL				X	fluticasone propionate nasal
\$\$\$	NASONEX			X		
\$\$\$\$	BECONASE AQ				X	fluticasone propionate nasal
\$\$\$\$	FLONASE				X	fluticasone propionate nasal
\$\$\$\$	NASACORT AQ				X	fluticasone propionate nasal
\$\$\$\$	RHINOCORT AQUA			X		
7.3 DRUGS AFFECTING THE THROAT AND MOUTH						
\$	chlorhexidine gluconate		X			
CHAPTER 8: ENDOCRINE MEDICATIONS						
8.1.1 INSULIN						
\$\$	HUMULIN 50/50			X		
\$\$	HUMULIN 70/30			X		
\$\$	HUMULIN L			X		
\$\$	HUMULIN N			X		
\$\$	HUMULIN R			X		
\$\$	HUMULIN U			X		
\$\$	NOVOLIN 70/30			X		
\$\$	NOVOLIN N			X		
\$\$	NOVOLIN R			X		
\$\$\$\$	LANTUS			X		
\$\$\$\$	APIDRA			X		
\$\$\$\$	HUMALOG			X		
\$\$\$\$	HUMALOG MIX 75/25			X		
\$\$\$\$	LEVEMIR			X		
\$\$\$\$	NOVOLOG			X		
\$\$\$\$	NOVOLOG MIX 70/30			X		
8.1.2 ORAL HYPOGLYCEMIC DRUGS						
\$	glimepiride		X			
\$	glipizide		X			
\$	glipizide er		X			
\$	glyburide		X			
\$	glyburide-metformin		X			
\$	metformin er		X			
\$	metformin hcl		X			
\$\$	AMARYL				X	glimepiride
\$\$	GLUCOPHAGE XR				X	
\$\$\$	GLYSET				X	PRECOSE
\$\$\$	METAGLIP				X	

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DRUG NAME		PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$	PRECOSE			X		
\$\$\$\$	PRANDIN				X	
\$\$\$\$	STARLIX				X	
8.1.3 INSULIN SENSITIZERS						
\$\$\$\$	AVANDAMET				X	AVANDIA, and metformin
\$\$\$\$	AVANDARYL				X	
\$\$\$\$	AVANDIA			X		
\$\$\$\$\$	ACTOS			X		
\$\$\$\$\$	ACTOPLUS MET				X	ACTOS and metformin
8.1.5.2 DIPEPTIDYL PEPTIDASE-IV INHIB						
	JANUVIA			X		
8.3.1 GLUCOCORTICOID DRUGS						
\$	dexamethasone			X		
\$	hydrocortisone			X		
\$	methylprednisolone			X		
\$	prednisolone			X		
\$	prednisone			X		
\$	ORAPRED				X	
8.3.2 MINERALOCORTICOID DRUGS						
\$	fludrocortisone acetate			X		
8.4.1 THYROID SUPPLEMENTS						
\$	levothroid			X		
\$	levothyroxine sodium			X		
\$	levoxyl			X		
\$	thyroid			X		
\$	ARMOUR THYROID				X	
\$	SYNTHROID				X	
\$\$	CYTOMEL				X	
8.4.2 ANTITHYROID DRUGS						
\$	methimazole			X		
\$	propylthiouracil			X		
8.6 OTHER ENDOCRINE DRUGS						
\$\$\$	ACTONEL				X	
\$\$\$	BONIVA				X	
\$\$\$	FOSAMAX			X		
\$\$\$	FOSAMAX PLUS D			X		
\$\$\$	MIACALCIN				X	FOSAMAX
\$\$\$\$	DIDRONEL				X	FOSAMAX
\$\$\$\$	MIACALCIN (inj)				X	FOSAMAX
!!!!	FORTEO				X	
!!!!	SENSIPAR				X	
!!!!	SKELID				X	FOSAMAX
CHAPTER 9: GASTROINTESTINAL MEDICATIONS						
9.2 ANTIDIARRHEAL DRUGS						
\$	diphenoxylate w/atropine			X		
9.3 ANTISPASMODICS/DRUGS AFFECT GI MOTILITY						

	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	dicyclomine hcl		X			
\$	hyoscyamine sulfate		X			
\$	metoclopramide hcl		X			
\$\$	NULEV				X	
9.4 ANTIULCER DRUGS						
\$	cimetidine		X			
\$	famotidine		X			
\$	nizatidine		X			
\$	ranitidine hcl		X			
9.4.1 OTHER ANTIULCER DRUGS						
\$	misoprostol		X			
\$	sucralfate		X			
9.4.2 PROTON PUMP INHIBITORS						
\$	omeprazole	QLL = 10mg (30 tabs or caps/30 days) 20 mg (60 tabs or caps/30 days)	X			
\$	Prilosec OTC	QLL= 42 tabs/42 days	X			
\$\$\$	PROTONIX	QLL = 30 tabs/30 days, ST		X		omeprazole, Prilosec OTC
\$\$\$\$	NEXIUM	QLL = 30 tabs/30 days, ST			X	omeprazole, Prilosec OTC
\$\$\$\$	PREVACID	QLL = 30 tabs/30 days, ST			X	omeprazole, Prilosec OTC
\$\$\$\$\$	ACIPHEX	QLL = 30 tabs/30 days, ST			X	omeprazole, Prilosec OTC
\$\$\$\$\$	ZEGERID	QLL= 30 caps/30 days, ST			X	omeprazole, Prilosec OTC
!!!!	PRILOSEC	QLL = 10mg, 40mg (30 caps/30 days); 20mg (60 caps/30 days), ST			X	omeprazole, Prilosec OTC
9.4.3 HELICOBACTER PYLORI DRUGS						
!!!!	HELIDAC				X	PREVPAC
!!!!	PREVPAC			X		
9.5 LAXATIVES AND CATHARTICS						
\$	glycolax		X			
9.6 OTHER GI DRUGS						
\$	hydrocortisone		X			
\$	PEG		X			
\$	sulfasalazine		X			
\$	GOLYTELY				X	
\$	NULYTELY				X	
\$	NULYTELY WITH FLAVOR PACKS				X	
\$\$	ANALPRAM-HC				X	
\$\$\$\$	DIPENTUM				X	ASACOL, PENTASA
\$\$\$\$\$	ASACOL			X		
\$\$\$\$\$	CANASA			X		
\$\$\$\$\$	PENTASA			X		
\$\$\$\$\$	ULTRASE				X	
!!!!	COLAZAL				X	ASACOL, PENTASA
!!!!	CREON			X		
!!!!	ULTRASE MT				X	

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DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
		1	2	3	
!!!!	URSO			X	
!!!!	URSO FORTE			X	
CHAPTER 10: IMMUNOLOGICALS AND VACCINES					
10.0 IMMUNOLOGICALS AND VACCINES					
\$	BAYHEP B			X	
\$	BAYRHO-D			X	
\$	MICRHOGAM			X	
\$	RHOGAM			X	
\$	RHOPHYLAC			X	
\$\$\$\$	IVEEGAM EN			X	
\$\$\$\$	NABI-HB			X	
\$\$\$\$	WINRHO SDF		X		
\$\$\$\$\$	GAMIMUNE N			X	
\$\$\$\$\$	GAMMAGARD S/D			X	
\$\$\$\$\$	GAMUNEX			X	
\$\$\$\$\$	PANGLOBULIN NF			X	
\$\$\$\$\$	POLYGAM S/D			X	
!!!!	CARIMUNE			X	
!!!!	CARIMUNE NF NANOFILTERED			X	
!!!!	FLEBOGAMMA			X	
!!!!	GAMMAR-P I.V.			X	
	GARDASIL	female, age 9-26		X	or medical with no co-payment
	ZOSTAVAX	over age 60		X	or medical with no co-payment
10.2.1 MYELOID STIMULANTS					
\$\$\$	NEULASTA	QLL=2 syringes/ 30 days			X
\$\$\$	NEUPOGEN	QLL=10 vials/syringes/30 days			X
10.2.2 ERYTHROID STIMULANTS					
\$\$	ARANESP	PA			X
\$\$	EPOGEN	PA		X	
\$\$	PROCRIT	PA		X	
10.2.3 INTERFERONS					
\$\$	AVONEX			X	
\$\$	AVONEX ADMINISTRATION PACK			X	
\$\$	BETASERON			X	
\$\$	INTRON A			X	
\$\$\$	INFERGEN				X
\$\$\$	REBIF			X	
\$\$\$\$\$	PEGASYS				X
\$\$\$\$\$	PEG-INTRON				X
\$\$\$\$\$	PEG-INTRON REDIPEN				X
10.2.4 GROWTH HORMONES AND RELATED DRUGS					
\$	TEV-TROPIN	PA			X
	INCRELEX	PA			X
	IPLIX	PA			X
\$\$\$	GENOTROPIN	PA			X

DRUG NAME		PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$	HUMATROPE	PA			X	
\$\$\$\$	NORDITROPIN	PA			X	
\$\$\$\$	NORDITROPIN NORDIFLEX	PA			X	
\$\$\$\$	SAIZEN	PA			X	
\$\$\$\$\$	NUTROPIN	PA		X		
\$\$\$\$\$	NUTROPIN AQ	PA		X		
10.2.5 INTERLEUKINS						
	NEUMEGA				X	
CHAPTER 11: MUSCULOSKELETAL MEDICATIONS						
11.1.1 SALICYLATES AND RELATED DRUGS						
\$	diflunisal		X			
\$	salsalate		X			
11.1.2 NON-STEROIDAL ANTIINFLAMMATORY AGENTS						
\$	diclofenac sodium		X			
\$	etodolac		X			
\$	ibuprofen		X			
\$	indomethacin		X			
\$	ketoprofen		X			
\$	meloxicam	PA;QLL = 30 tabs/30 days; ST	X			
\$	nabumetone		X			
\$	naproxen		X			
\$	oxaprozin		X			
\$	piroxicam		X			
\$	sulindac		X			
\$\$\$\$\$	PREVACID NAPRAPAC				X	
!!!!	CELEBREX	PA;QLL = 60 tabs/30 days; ST		X		
!!!!	MOBIC	PA;QLL = 30 tabs/30 days; ST			X	
11.1.4 OTHER DRUGS FOR ARTHRITIS						
	EUFLEXXA				X	
!!!!	HYALGAN				X	
!!!!	ORTHOVISC				X	
!!!!	SYNVISC				X	
11.2 DRUGS TO PREVENT AND TREAT GOUT						
\$	allopurinol		X			
\$	colchicine		X			
\$	probenecid		X			
11.3.1 DIRECT MUSCLE RELAXANTS						
\$	baclofen		X			
\$	tizanidine hcl		X			
11.3.2 CNS MUSCLE RELAXANTS						
\$	carisoprodol		X			
\$	cyclobenzaprine hcl		X			
\$	methocarbamol		X			
\$	orphenadrine citrate		X			
\$\$\$\$\$	SKELAXIN				X	
CHAPTER 12: NUTRITION, BLOOD						

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DRUG NAME		PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
12.1.2 VITAMINS & MINERALS & RELATED PRODUCTS						
\$\$	FOLTX				X	
\$\$	METANX				X	
\$\$\$	CEREFOLIN				X	
12.1.3 THERAPEUTIC VITAMINS & MINERALS						
\$	calcitriol		X			
\$	folic acid		X			
\$\$\$	PHOSLO				X	
12.2 POTASSIUM SUPPLEMENTS						
\$	klor-con		X			
\$	potassium chloride		X			
\$\$	POTASSIUM CHLORIDE (inj)				X	
12.3.1 ORAL ANTICOAGULANTS, VITAMIN K						
\$	warfarin sodium		X			
\$\$	COUMADIN				X	
12.3.2 HEPARIN AND HEPARIN ANTAGONISTS						
!!!!	ARIXTRA	QLL=14 day supply/fill			X	
!!!!	FRAGMIN	QLL=14 day supply/fill			X	
!!!!	INNOHEP	QLL=14 day supply/fill			X	
!!!!	LOVENOX	QLL=14 day supply/fill		X		
12.4 ANTIPLATELET DRUGS						
\$	cilostazol		X			
\$	dipyridamole		X			
\$	ticlopidine hcl		X			
!!!!	AGGRENOX				X	
!!!!	PLAVIX			X		
12.5 HEMOSTATICS						
!!!!	BEBULIN VH IMMUNO				X	
!!!!	PROFILNINE SD				X	
!!!!	PROPLEX T				X	
!!!!	ADVATE				X	
!!!!	ALPHANATE				X	
!!!!	ALPHANINE SD				X	
!!!!	BENEFIX				X	
!!!!	HELIXATE FS				X	
!!!!	HEMOFIL-M				X	
!!!!	HUMATE-P				X	
!!!!	KOATE-DVI				X	
!!!!	KOGENATE FS				X	
!!!!	MONARC-M				X	
!!!!	MONOCLATE-P				X	
!!!!	MONONINE				X	
!!!!	RECOMBINATE				X	
!!!!	REFACTO				X	
12.7 BLOOD DETOXICANTS						
\$	lactulose		X			
\$\$\$	KRISTALOSE				X	
!!!!	FOSRENOL				X	
!!!!	RENAGEL			X		

DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
		1	2	3	
CHAPTER 13: OBSTETRICAL & GYNECOLOGICAL MEDICATIONS					
13.1.1 PRENATAL VITAMINS					
\$	natacare plus		X		
\$	prenatal rx		X		
\$\$	PRENATE ELITE			X	
13.1.2 SPECIALIZED OB/GYN DRUGS					
\$\$\$	PREGNYL			X	
\$\$\$\$	OVIDREL			X	
!!!!	CETROTIDE	PA		X	
!!!!	GANIRELIX ACETATE	PA		X	
!!!!	LUPRON			X	
!!!!	LUPRON DEPOT			X	
13.2 OVULATORY STIMULANTS					
\$	clomiphene citrate		X		
\$\$\$\$	BRAVELLE	PA		X	
\$\$\$\$	FOLLISTIM AQ	PA		X	
\$\$\$\$	GONAL-F	PA		X	
\$\$\$\$	GONAL-F RFF	PA		X	
!!!!	REPRONEX	PA		X	
13.3 ANDROGEN DRUGS					
\$\$\$\$	ANDRODERM			X	
\$\$\$\$	ANDROGEL			X	ANDRODERM
\$\$\$\$	TESTIM			X	ANDRODERM
13.4 ESTROGEN DRUGS					
\$	estradiol		X		
\$	estradiol tds		X		
\$	estradiol transdermal patch		X		
\$	estropipate		X		
\$	MENEST			X	
\$\$	ALORA			X	
\$\$	CENESTIN			X	MENEST, PREMARIN
\$\$	VIVELLE			X	
\$\$	VIVELLE-DOT			X	
\$\$\$	CLIMARA			X	
\$\$\$	ESTRADERM			X	
\$\$\$	ESTRASORB			X	
\$\$\$	MENOSTAR			X	
\$\$\$	PREMARIN			X	
\$\$\$	VAGIFEM			X	
\$\$\$\$	ESTRATEST			X	
\$\$\$\$	ESTRATEST H.S.			X	
\$\$\$\$	ESTROGEL			X	
13.4.1 ESTROGEN/PROGESTIN COMBINATIONS					
\$\$	ACTIVELLA			X	PREMPRO/PHASE, FEMHRT
\$\$	CLIMARA PRO			X	
\$\$\$	COMBIPATCH			X	
\$\$\$	FEMHRT			X	

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DRUG NAME		PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$	PREFEST				X	
\$\$\$	PREMPHASE			X		
\$\$\$	PREMPRO			X		
13.4.3 SELECTIVE ESTROGEN RECEPTOR MODULATOR						
\$\$\$\$	EVISTA			X		
13.5 PROGESTIN DRUGS						
\$	camila		X			
\$	errin		X			
\$	jolivette		X			
\$	medroxyprogesterone acetate		X			
\$	nora-be		X			
\$	norethindrone acetate		X			
\$\$	NOR-Q-D				X	
\$\$	ORTHO MICRONOR				X	camila
\$\$\$	DEPO-PROVERA (INJ)			X		
\$\$\$	PROMETRIUM				X	
13.7 CONTRACEPTIVES						
\$	apri		X			
\$	aranelle		X			
\$	aviane		X			
\$	cesia		X			
\$	cryselle		X			
\$	enpresse		X			
\$	junel fe		X			
\$	kariva		X			
\$	kelnor 1/35		X			
\$	lessina		X			
\$	levora-28		X			
\$	low-ogestrel		X			
\$	microgestin		X			
\$	microgestin fe		X			
\$	mononessa		X			
\$	necon		X			
\$	nortrel		X			
\$	previfem		X			
\$	solia		X			
\$	sprintec		X			
\$	trinessa		X			
\$	tri-previfem		X			
\$	tri-sprintec tablet		X			
\$	trivora-28		X			
\$	velivet 28 day		X			
\$	zovia 1/35e		X			
\$\$	ALESSE				X	
\$\$	BREVICON			X		
\$\$	CYCLESSA				X	generic
\$\$	DEMULEN 1/35				X	
\$\$	DEMULEN 1/50				X	
\$\$	DESOGEN				X	

	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$	LEVLEN				X	
\$\$	LEVLITE				X	
\$\$	LO/OVRAL				X	
\$\$	LOESTRIN				X	
\$\$	LOESTRIN FE				X	
\$\$	MODICON				X	necon, nortrel
\$\$	NORDETTE				X	
\$\$	NORINYL 1/35				X	necon, nortrel
\$\$	NORINYL 1/50				X	necon, nortrel
\$\$	NUVARING				X	
\$\$	ORTHO TRI-CYCLEN				X	tri-sprintec tablet
\$\$	ORTHO-CEPT				X	apri
\$\$	ORTHO-CYCLEN				X	sprintec, mononessa
\$\$	ORTHO-NOVUM				X	necon, nortrel
\$\$	TRI-LEVLEN				X	
\$\$	TRIPHASIL				X	
\$\$	YAZ				X	
\$\$	YASMIN				X	
\$\$\$	ESTROSTEP FE			X		
\$\$\$	MIRCETTE				X	
\$\$\$	ORTHO EVRA	QLL = 3 patches/30 days			X	
\$\$\$	ORTHO TRI-CYCLEN LO				X	
\$\$\$	OVCON				X	
\$\$\$	TRI-NORINYL			X		
	SEASONIQUE				X	
\$\$\$\$	SEASONALE				X	
CHAPTER 14: OPHTHALMIC MEDICATIONS						
14.1.1 OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS						
\$	ciprofloxacin hcl (ophth drops)			X		
\$	erythromycin			X		
\$	gentamicin sulfate			X		
\$	ofloxacin (eye drops)			X		
\$	polymyxin b sul/trimethoprim			X		
\$	sulfacetamide sodium			X		
\$	tobramycin sulfate			X		
\$\$\$	QUIXIN				X	CILOXAN, OCUFLOX
\$\$\$\$	CILOXAN				X	
\$\$\$\$	VIGAMOX				X	CILOXAN, OCUFLOX
\$\$\$\$	ZYMAR				X	CILOXAN, OCUFLOX
14.2 OPHTHALMIC CORTICOSTEROID DRUGS						
\$	prednisolone acetate			X		
\$\$	FML FORTE				X	prednisolone acetate
\$\$\$	LOTEMAX				X	prednisolone acetate

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	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$\$\$	VEXOL				X	prednisolone acetate
\$\$\$\$	ALREX				X	ACULAR, OPTIVAR, ZADITOR
14.3 OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS						
\$	neomycin/polymyxin/de xameth		X			
\$\$\$\$	ZYLET				X	
\$\$\$\$\$	TOBRADEX			X		
14.5 ANTIGLAUCOMA DRUGS						
\$	brimonidine tartrate		X			
\$	levobunolol hcl		X			
\$	pilocarpine hcl		X			
\$	timolol maleate		X			
\$\$\$	BETIMOL				X	ALPHAGAN-P, AZOPT, TRUSOPT, COSOPT
\$\$\$	ISTALOL				X	
\$\$\$\$	AZOPT			X		
\$\$\$\$	TRUSOPT			X		
\$\$\$\$	XALATAN			X		
\$\$\$\$\$	ALPHAGAN P			X		
\$\$\$\$\$	COSOPT			X		
\$\$\$\$\$	IOPIDINE				X	ALPHAGAN-P, AZOPT, TRUSOPT, COSOPT
\$\$\$\$\$	LUMIGAN			X		
\$\$\$\$\$	TRAVATAN				X	LUMIGAN, XALATAN
14.6 OTHER OPHTHALMIC DRUGS						
\$	cromolyn sodium		X			
\$	diclofenac		X			
\$	ketotifen		X			
\$\$\$\$	VOLTAREN				X	cromolyn sodium
\$\$\$\$	ZADITOR				X	OPTIVAR; ketotifen
\$\$\$\$\$	ACULAR			X		
\$\$\$\$\$	ACULAR LS			X		
\$\$\$\$\$	ACULAR PF			X		
\$\$\$\$\$	ALAMAST				X	ACULAR, OPTIVAR
\$\$\$\$\$	ALOCRIAL				X	ACULAR, OPTIVAR
\$\$\$\$\$	ALOMIDE				X	ACULAR, OPTIVAR
\$\$\$\$\$	ELESTAT				X	
\$\$\$\$\$	EMADINE				X	ACULAR, OPTIVAR
\$\$\$\$\$	NEVANAC				X	
\$\$\$\$\$	OPTIVAR			X		
\$\$\$\$\$	PATANOL				X	ACULAR, OPTIVAR
\$\$\$\$\$	XIBROM				X	
!!!!	RESTASIS				X	
CHAPTER 15: RESPIRATORY MEDICATIONS						
15.1.1 BETA-2 ADRENERGIC DRUGS						
\$	albuterol		X			

	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	albuterol sulfate		X			
\$\$	PROAIR HFA			X		
\$\$\$	PROVENTIL HFA				X	
\$\$\$	VENTOLIN HFA				X	PROAIR HFA
\$\$\$\$	FORADIL	QLL= 60 blisters per 30 days		X		
\$\$\$\$	MAXAIR AUTOHALER			X		
!!!!	SEREVENT DISKUS	QLL= 60 tabs/30 days		X		
!!!!	XOPENEX				X	
!!!!	XOPENEX HFA				X	
15.1.2 METHYL XANTHINE DRUGS						
\$	theophylline, - er		X			
\$	theophylline anhydrous		X			
\$\$\$	UNIPHYL			X		
15.1.3 OTHER DRUGS FOR ASTHMA						
\$	ipratropium bromide		X			
\$\$	QVAR			X		
\$\$\$	AEROBID				X	
\$\$\$	AEROBID-M				X	
\$\$\$	AZMACORT				X	
\$\$\$\$	ATROVENT HFA			X		
\$\$\$\$	FLOVENT HFA			X		
\$\$\$\$	COMBIVENT			X		
\$\$\$\$	EPIPEN	QLL = 1 kit/fill		X		
\$\$\$\$	EPIPEN JR.	QLL = 1 kit/fill		X		
\$\$\$\$	PULMICORT			X		
\$\$\$\$	TILADE			X		
\$\$\$\$	ADVAIR HFA	QLL= 1 inhaler per 30 days		X		
!!!!	ADVAIR DISKUS	QLL= 60 metered doses (1 diskus) per 30 days		X		
!!!!	ASMANEX			X		
!!!!	DUONEB				X	
!!!!	INTAL			X		
!!!!	SPIRIVA			X		
!!!!	TWINJECT				X	
15.1.4 LEUKOTRIENE MODIFIERS						
\$\$\$\$	ACCOLATE				X	SINGULAIR
\$\$\$\$	ZYFLO				X	
!!!!	SINGULAIR	PA, ST		X		for asthma only
15.2.1 ANTIHISTAMINES						
\$	cyproheptadine hcl		X			
\$	promethazine hcl		X			
\$	fexofenadine	QLL = 30,60mg (60 tabs/30 days); 180mg (30 tabs/30 days)	X			
\$\$\$\$	ALLEGRA	QLL = 30,60mg (60 tabs/30 days); 180mg (30 tabs/30 days)			X	fexofenadine
\$\$\$\$	CLARINEX	QLL = 30 tabs/30 days			X	
\$\$\$\$	ZYRTEC	QLL = 30 tabs/30 days			X	
15.2.3 ANTIHISTAMINE/DECONGESTANT COMBINATIONS						

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	DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
			1	2	3	
\$	promethazine vc			X		
\$\$\$	SEMPREX-D			X		
\$\$\$	ZYRTEC-D	QLL = 60 tabs/30 days			X	
\$\$\$\$	ALLEGRA-D	QLL= 60 tabs/30 days			X	
\$\$\$\$	CLARINEX-D	QLL = 30 tabs/30days			X	
\$\$\$\$	RYNATAN				X	
15.3 ANTITUSSIVE AND EXPECTORANT DRUGS						
\$	benzonatate		X			
\$	guaifenesin w/codeine		X			
\$	guaifenex pse		X			
\$	hydrocodone w/guaifenesin		X			
\$	promethazine vc w/codeine			X		
\$	promethazine w/codeine		X			
\$	promethazine w/dm		X			
\$\$\$\$	TUSSIONEX			X		
CHAPTER 16: UROLOGICAL MEDICATIONS						
16.1.1 ANTICHOLINERGIC ANTISPASMODICS						
\$	oxybutynin chloride		X			
\$	oxybutynin cl er		X			
\$\$\$	ENABLEX	ST			X	
\$\$\$	SANCTURA	ST			X	
\$\$\$	VESICARE	ST			X	
\$\$\$\$	DETROL	ST			X	
\$\$\$\$	DETROL LA	ST			X	
\$\$\$\$	DITROPAN XL	ST			X	oxybutynin cl er
\$\$\$\$	OXYTROL				X	
16.1.3 URINARY ANESTHETICS						
\$	phenazopyridine hcl		X			
16.1.4 OTHER GENITOURINARY PRODUCTS						
\$	finasteride		X			
\$\$	UROXATRAL				X	FLOMAX
\$\$\$	FLOMAX			X		
\$\$\$	LEVITRA	QLL = 4 tabs/30 days			X	VIAGRA
\$\$\$\$	AVODART				X	generic beta-blocker, FLOMAX
\$\$\$\$	CIALIS	QLL = 4 tabs/30 days			X	VIAGRA
\$\$\$\$	PROSCAR				X	finasteride
\$\$\$\$	VIAGRA	QLL = 4 tabs/30 days		X		
\$\$\$\$\$	CAVERJECT	QLL= 4 doses/30 days		X		
\$\$\$\$\$	MUSE	QLL= 4 doses/30 days		X		
!!!!	EDEX	QLL= 4 doses/30 days		X		
CHAPTER 17: DIAGNOSTIC & MISCELLANEOUS MEDICATIONS						
17.1 DIAGNOSTIC PRODUCTS						
\$\$\$\$	PRECISION XTRA				X	
17.3.1 APPETITE SUPPRESSANTS						
\$\$\$\$\$	MERIDIA	PA			X	
17.3.2 OTHER WEIGHT LOSS PRODUCTS						
\$\$\$\$\$	XENICAL	PA			X	

DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
		1	2	3	
CHAPTER 18: MEDICAL (MISCELLANEOUS) SUPPLIES					
18.1 DIABETIC SUPPLIES					
\$	PRECISION		X		
\$\$	NOVOFINE 30		X		
\$\$\$	ASCENSIA AUTODISC TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$	ASCENSIA AUTODISC (SOLN)			X	NOT COVERED
\$\$\$	ASCENSIA BREEZE 10 DISC TEST STRIPS			X	
\$\$\$	ASCENSIA CONTOUR SYSTEM			X	NOT COVERED
\$\$\$	ASCENSIA CONTOUR TEST STRIPS			X	
\$\$\$	ASCENSIA DEX2 MONITOR			X	NOT COVERED
\$\$\$	ASCENSIA ELITE TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$	ASCENSIA ELITE (SOLN)			X	NOT COVERED
\$\$\$	ASCENSIA ELITE XL KIT MONITOR				
\$\$\$\$	ACCU-CHEK COMFORT CURVE TEST STRIPS		X		
\$\$\$\$	ACCU-CHEK COMFORT MONITOR			X	NOT COVERED
\$\$\$\$	ACCU-CHEK ACTIVE TEST STRIPS		X		
\$\$\$\$	ACCU-CHEK ADVANTAGE TEST STRIPS		X		
\$\$\$\$	ACCU-CHEK ADVANTAGE KIT MONITOR			X	NOT COVERED
\$\$\$\$	ACCU-CHEK AVIVA TEST STRIPS		X		
\$\$\$\$	ACCU-CHEK INSTANT PLUS TEST STRIPS		X		
\$\$\$\$	ACCU-CHEK III MONITOR			X	NOT COVERED
\$\$\$\$	CHEMSTRIP BG		X		
\$\$\$\$	FAST TAKE TEST STRIPS		X		
\$\$\$\$	FREESTYLE LITE			X	NOT COVERED
\$\$\$\$	FREESTYLE LITE TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$\$	FREESTYLE FLASH SYSTEM KIT			X	NOT COVERED
\$\$\$\$	FREESTYLE FREEDOM KIT			X	NOT COVERED
\$\$\$\$	FREESTYLE SIDEKICK II MONITOR			X	NOT COVERED
\$\$\$\$	FREESTYLE SYSTEM KIT			X	NOT COVERED
\$\$\$\$	FREESTYLE TEST			X	ACCU-CHEK, ONE

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DRUG NAME	PA/QLL/ST	TIER			SUGGESTED PREFERRED ALTERNATIVES
		1	2	3	
	STRIPS				TOUCH
\$\$\$\$	GLUCOMETER DEX TEST STRIPS			X	
\$\$\$\$	GLUCOMETER ELITE SYSTEM			X	NOT COVERED
\$\$\$\$	GLUCOMETER ELITE TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$\$	ONE TOUCH BASIC SYSTEM			X	NOT COVERED
\$\$\$\$	ONE TOUCH TEST STRIPS		X		
\$\$\$\$	ONE TOUCH ULTRAMINI			X	NOT COVERED
\$\$\$\$	ONE TOUCH ULTRA SMART SYSTEM			X	NOT COVERED
\$\$\$\$	ONE TOUCH ULTRA SYSTEM			X	NOT COVERED
\$\$\$\$	ONE TOUCH ULTRA TEST STRIPS		X		
\$\$\$\$	PRECISION XTRA TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$\$	SURESTEP TEST STRIPS		X		
\$\$\$\$	SURESTEP PRO TEST STRIPS		X		
\$\$\$\$	SURESTEP SYSTEM			X	NOT COVERED
\$\$\$\$\$	PRECISION PCX TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$\$\$	PRECISION PCX PLUS TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$\$\$	PRECISION Q-I-D MONITOR			X	NOT COVERED
	PRECISION Q-I-D TEST STRIPS			X	ACCU-CHEK, ONE TOUCH
\$\$\$\$\$	PRECISION SOF-TACT			X	ACCU-CHEK, ONE TOUCH
	PRECISION SOF-TACT MONITOR			X	NOT COVERED
\$\$\$\$\$	SOF-TACT TEST STRIPS			X	ACCU-CHEK, ONE TOUCH

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PAXIL CR	5.5.1.3	propafenone hcl	4.7.1.3
PCE	2.1.4	PROPLEX T	12.5
PEG	9.6	propoxyphene hcl	5.1.1.3
PEGASYS	10.2.3	propoxyphene hcl w/acetaminophen	5.1.1.3
PEG-INTRON	10.2.3	propoxyphene napsylate	5.1.1.3
PEG-INTRON REDIPEN	10.2.3	propranolol hcl	4.4
penicillin v potassium	2.1.5	propylthiouracil	8.4.2
PENLAC	2.4.2	PROSCAR	16.1.4
PENTASA	9.6	PROTONIX	9.4.2
pentoxifylline	4.9	PROTOPIC	6.9.2
phenazopyridine hcl	16.1.3	PROVENTIL HFA	15.1.1
phenobarbital	5.4.6	PROVIGIL	5.9.1
PHENYTEK	5.4.3	PROZAC WEEKLY	5.5.1.3
phenytoin	5.4.3	PULMICORT	15.1.3
phenytoin sodium, extended	5.4.3	quinapril hcl	4.5.4.1
PHOSLO	12.1.3	quinaretic	4.5.6
pilocarpine hcl	14.5	quinidine gluconate	4.7.1.1
piroxicam	11.1.2	quinine sulfate	2.7.3
PLAVIX	12.4	QUIXIN	14.1.1
PLEXION	6.3	QVAR	15.1.3
PLEXION SCT	6.3	RANEXA	4.7.5
PLEXION TS	6.3	ranitidine hcl	9.4
POLYGAM S/D	10	RAZADYNE	5.9.3
polymyxin b sul/trimethoprim	14.1.1	REBIF	10.2.3
potassium chloride	12.2	RECOMBINATE	12.5
POTASSIUM CHLORIDE (inj)	12.2	REFACTO	12.5
PRAMOSONE	6.1	RELENZA	2.5.2
PRANDIN	8.1.2	RELPAK	5.1.2
PRAVACHOL	4.8.2	REMERON (M tab)	5.5.1.4
pravastatin	4.8.2	RENAGEL	12.7
prazosin hcl	4.5.1	REPRONEX	13.2
PRECISION	18.1	REQUIP	5.7.2
PRECISION PCX PLUS TEST STRIPS	18.1	RESTASIS	14.6
PRECISION PCX TEST STRIPS	18.1	RESTORIL	5.2.2
PRECISION Q-I-D MONITOR	18.1	RETIN-A MICRO	6.3
PRECISION Q-I-D TEST STRIPS	18.1	REVLIMID	3
PRECISION SOF-TACT	18.1	REYATAZ	2.5.1
PRECISION SOF-TACT MONITOR	18.1	RHINOCORT AQUA	7.2
PRECISION XTRA	17.1	RHOGAM	10
PRECISION XTRA TEST STRIPS	18.1	RHOPHYLAC	10
PRECOSE	8.1.2	RIBATAB	2.5.2
prednisolone	8.3.1	rifampin	2.7.2
prednisolone acetate	14.2	RISPERDAL	5.8
prednisone	8.3.1	RISPERDAL CONSTA	5.8
PREFEST	13.4.1	RISPERDAL- M	5.8
PREGNYL	13.1.2	RITALIN LA	5.9.1
PREMARIN	13.4	ROZEREM	5.2.2
PREMPHASE	13.4.1	RYNATAN	15.2.3
PREMPRO	13.4.1	SAIZEN	10.2.4
prenatal rx	13.1.1	salsalate	11.1.1
PRENATE ELITE	13.1.1	SANCTURA	16.1.1
PREVACID	9.4.2	SEASONALE	13.7
PREVACID NAPRAPAC	11.1.2	SEASONIQUE	13.7
previfem	13.7	see also interferons	5.9.4
PREVPAC	9.4.3	selenium sulfide	6.8
PRILOSEC	9.4.2	SEMPREX-D	15.2.3
Prilosec OTC	9.4.2	SENSIPAR	8.6
primidone	5.4.6	SEREVENT DISKUS	15.1.1
PROAIR HFA	15.1.1	SEROQUEL, -XR	5.8
probenecid	11.2	sertraline	5.5.1.3
prochlorperazine maleate	5.6	silver sulfadiazine	2.2
PROCRIT	10.2.2	simvastatin	4.8.2
PROFILNINE SD	12.5	SINGULAIR	15.1.4
promethazine hcl	15.2.1	SKELAXIN	11.3.2
promethazine vc	15.2.3	SKELID	8.6
promethazine vc w/codeine	15.3	sod.sulfacetamide/ sulfur tf	6.3
promethazine w/codeine	15.3	SOF-TACT TEST STRIPS	18.1
promethazine w/dm	15.3	solia	13.7

SONATA	5.2.2	TRIMOX	2.1.5
sotalol	4.7.5	trinessa	13.7
SPECTRACEF	2.1.1	TRI-NORINYL	13.7
SPIRIVA	15.1.3	TRIPHASIL	13.7
spironolactone	4.3.3	tri-previfem	13.7
spironolactone w/hctz	4.3.3	tri-sprintec tablet	13.7
SPORANOX	2.3	trivora-28	13.7
sprintec	13.7	TRUSOPT	14.5
SPRYCEL	3	TRUVADA	2.5.1
STALEVO	5.7.2	TUSSIONEX	15.3
STARLIX	8.1.2	TWINJECT	15.1.3
sucrafate	9.4.1	ULTRASE	9.6
SULAR	4.2	ULTRASE MT	9.6
sulfacetamide sodium	14.1.1	UNIPHYL	15.1.2
sulfamethoxazole/ trimethoprim	2.1.6	UNIRETIC	4.5.6
sulfasalazine	9.6	UNIVASC	4.5.4.1
sulindac	11.1.2	UROXATRAL	16.1.4
SUPRAX (SUSP)	2.1.1	URSO	9.6
SURESTEP PRO TEST STRIPS	18.1	URSO FORTE	9.6
SURESTEP SYSTEM	18.1	VAGIFEM	13.4
SURESTEP TEST STRIPS	18.1	VALTREX	2.5.2
SUTENT	3	VANTIN	2.1.1
SYNTHROID	8.4.1	velivet 28 day	13.7
SYNVISC	11.1.4	venlafaxine HCL	5.5.1.4
TAMIFLU capsules, oral suspension	2.5.2	VENTOLIN HFA	15.1.1
tamoxifen citrate	3	verapamil hcl	4.2
TARKA	4.5.6	VERELAN PM	4.2
TAZORAC	6.8	VESICARE	16.1.1
TEGRETOL XR	5.4.1	VEXOL	14.2
temazepam	5.2.2	VIAGRA	16.1.4
TEQUIN	2.1.9	VIGAMOX	14.1.1
terazosin hcl	4.5.1	VIVELLE	13.4
terbinafine hcl	2.3	VIVELLE-DOT	13.4
terconazole	2.4.1	VOLTAREN	14.6
TESTIM	13.3	VYTORIN	4.8.2.1
tetracycline hcl	2.1.7	warfarin sodium	12.3.1
TEVETEN	4.5.4.2	WELCHOL	4.8.1
TEVETEN HCT	4.5.6	WELLBUTRIN XL	5.5.1.4
TEV-TROPIN	10.2.4	WINRHO SDF	10
theophylline anhydrous	15.1.2	XALATAN	14.5
theophylline, - er	15.1.2	XENICAL	17.3.2
thioridazine hcl	5.8	XIBROM	14.6
thyroid	8.4.1	XOPENEX	15.1.1
ticlopidine hcl	12.4	XOPENEX HFA	15.1.1
TILADE	15.1.3	YASMIN	13.7
timolol maleate	14.5	YAZ	13.7
tizanidine hcl	11.3.1	ZADITOR	14.6
TOBRADEX	14.3	ZEGERID	9.4.2
tobramycin sulfate	14.1.1	ZELAPAR ODT	5.7.2
TOFRANIL-PM	5.5.1.1	ZETIA	4.8.1
TOPAMAX	5.4.7	ZITHROMAX	2.1.4.1
TOPROL XL	4.4	ZITHROMAX TRI-PAK	2.1.4.1
torse mide	4.3.1	ZOCOR	4.8.2
tramadol hcl	5.1.1	ZOFRAN	5.6
tramadol hcl-acetaminophen	5.1.1	ZOFRAN IN DEXTROSE	5.6
trandolapril	4.5.4.1	ZOFRAN ODT	5.6
TRAVATAN	14.5	ZOLINZA	3
trazodone hcl	5.5.1.4	ZOLOFT	5.5.1.3
TRELSTAR DEPOT	3	zolpidem tartrate	5.2.2
TRELSTAR LA	3	ZOMIG	5.1.2
tretinoin	6.3	ZOMIG NASAL SPRAY	5.1.2
triamcinolone acetonide	6.1	ZOMIG ZMT	5.1.2
triamterene w/hctz	4.3.3	ZONEGRAN	5.4.7
triazolam	5.2.2	ZOSTAVAX	10
TRIGLIDE	4.8.1	zovia 1/35e	13.7
TRILEPTAL	5.4.1	ZYFLO	15.1.4
TRI-LEVLEN	13.7	ZYLET	14.3
trimethobenzamide hcl	5.6	ZYMAR	14.1.1

ZYPREXA
ZYPREXA ZYDIS

5.8

ZYRTEC
ZYRTEC-D

15.2.1

5.8

15.2.3

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