



HEALTH CHOICE ARIZONA
2010 AHCCCS
Formulary

Questions?
Contact the Health
Choice Arizona
Pharmacy
Department at
1-800-322-8670

*Our Mission is to
improve the lives
of our members
by providing them
access to quality
healthcare,
protecting their
dignity, and
respecting their
individual needs.*



2010 AHCCCS Formulary

Introduction

Health Choice Arizona (HCA) is pleased to provide the Health Choice Formulary to be used when prescribing for patients covered by the pharmacy plan offered by Health Choice.

This is a closed formulary; therefore, the drugs listed in this formulary are the preferred medications which are covered by Health Choice. In the absence of substantial documented clinical support, HCA requires that formulary choices be utilized.

The drugs listed in the Health Choice Formulary have been reviewed and approved by the Health Choice Pharmacy and Therapeutics (P&T) Committee. The formulary has been developed to provide medications which are both clinically appropriate and cost-effective for patients who have their drug benefit administered through Health Choice. There may be occasions when an unlisted drug is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through the Prior Authorization process.

The information contained in the Health Choice Formulary and its appendices is provided by Health Choice, solely for the convenience of medical providers. Health Choice does not warrant or assure accuracy of such information, nor is it intended to be comprehensive in nature. The Health Choice Formulary is not intended to be a substitute for the knowledge, expertise, skill, and judgment of the medical provider in their choice of prescription drugs. Health Choice does not assume responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. **The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.**

Preface

The Health Choice Formulary is organized by sections. Each section includes therapeutic groups identified by either a drug class or disease state. Products are listed by generic name. Brand names of products are included only as a reference to assist in product recognition. Unless

exceptions are noted, generally all dosage forms and strengths of the drug cited are covered.

This formulary covers selected, cost-effective Over-The-Counter (OTC) products. You are encouraged to prescribe them when clinically appropriate.

Pharmacy and Therapeutics Committee

The actions of the Health Choice P&T Committee are communicated on the Health Choice web site and in the Health Choice *Provider Newsletter*, which is distributed to all network providers.

Product Selection Criteria

The Health Choice P&T Committee will consider all new-to-market drugs for inclusion to the formulary. The evaluation includes a literature review and expert external opinion may also be sought. Formal reviews are prepared that typically address the following information:

- Safety
- Efficacy
- Comparison studies
- Approved indications
- Adverse effects
- Contraindications/Warnings/Precautions
- Pharmacokinetics
- Patient administration/compliance considerations
- Cost effectiveness

When a new drug is considered for formulary inclusion, an attempt will be made to examine the drug relative to similar drugs currently on formulary. In addition, entire therapeutic classes are periodically reviewed. The class review process may result in deletion of one or more drugs in a particular therapeutic class in an effort to continually promote the most clinically useful and cost-effective agents.

All the information in the Health Choice formulary is provided as a reference for drug therapy selection. Specific drug selection for an individual patient rests solely with the prescriber.

Formulary Product Descriptions

To assist in understanding which specific strengths and dosage forms are on the formulary, examples are noted below. The general principles shown in the examples can then usually be extended to other entries in the book. Any exceptions are noted in the drug list. There may also be a statement associated with a drug list that gives additional information about which specific products or dosage forms are on formulary.

The brand name products shown are for reference only; a different brand or a generic version may be dispensed.

Products on formulary include all strengths and dosage forms of the cited brand name product.

ondansetron

Zofran

In addition to the tablets, the oral solution and orally disintegrating tablets are on formulary.

When a strength or dosage form is specified, only the specified strength and dosage form is on formulary. Other strengths/dosage forms of the reference product are not.

metronidazole tabs

metronidazole 0.75% vaginal gel

Flagyl

Metrogel

Tablets and vaginal gel are on formulary, but not the capsules.

Extended-release and delayed-release products require their own entry.

bupropion ext-rel

Wellbutrin XL

The long-acting products bupropion SR and bupropion XL are on formulary.

The brand name product Wellbutrin immediate or extended release is not on formulary.

Dosage forms on formulary will be consistent with the category and use where listed.

neomycin/polymyxin B/hydrocortisone

Cortisporin

As listed in the OTIC section, limited to the otic solution and suspension. From this entry the ophthalmic solution and ophthalmic ointment, and the topical cream cannot be assumed to be on formulary unless there are entries for these products in the OPHTHALMIC and DERMATOLOGY sections of the formulary.

Generic Availability

Boldface type of a generic drug name in this book indicates generic availability of that product. However, not all strengths or dosage forms of the generic name in boldface type may be generically available. In some cases, **the brand name listed is a generic drug**. Examples of the latter include Levoxyl and Trivora.

Generic Substitution

AHCCCS health plans are required to utilize a mandatory generic drug substitution policy. Generic substitution is a pharmacy action whereby a generic version is dispensed rather than a prescribed brand name product. An important consideration for generic substitution is the knowledge that all approvals of generic drugs by the FDA since 1984, and many generic approvals prior to 1984, have a showing of bioequivalence between the generic versions and the reference brand name product. To gain FDA approval:

1. The generic drug must contain the same active ingredient(s), be the same strength and the same dosage form as the brand name product.
2. The FDA has given the generic an "A" rating compared to the brand name product indicating bioequivalence, and has determined the generic is therapeutically equivalent to the reference brand name product. The ratings of generic drugs are available by referring to the FDA reference, *Approved Drug Products with Therapeutic Equivalence Evaluations* (Orange Book).

When the above two criteria are met, a generic can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product. Drug products that have a narrow therapeutic index (NTI) can also be guided by these principles. It is not necessary for the healthcare practitioner to approach any one therapeutic class of drug products (e.g., NTI drugs) differently

6 – **Boldface** indicates generic availability

from any other class, when there has been a determination of therapeutic equivalence by the FDA for the drug products under consideration. Also, additional clinical tests or examinations by the practitioner are not needed when a therapeutically equivalent generic drug product is substituted for the brand name product.

It is recommended that generic substitution not be exercised by the pharmacist with multisource products that appear in the Orange Book and carry a "B" rating, indicating that these products cannot be considered therapeutically equivalent to other products in the group. It is also recommended that generic substitution not be undertaken for any unrated multisource products that might be considered narrow therapeutic index, or maintenance drugs where it is known that unrated products from different labelers are not bioequivalent. State law or regulations may dictate the ability to practice generic substitution for selected products or categories of drugs.

Drug Efficacy Study Implementation Drugs

Drugs first marketed between 1938 and 1962 were approved as safe but required no showing of effectiveness for FDA approval. Beginning in 1962, all new drugs were required to be both safe and effective before they could be marketed. This legislation also applied retroactively to all drugs approved as safe from 1938-1962. The Drug Efficacy Study Implementation (DESI) program was established by the FDA to review the effectiveness of these pre-1962 drugs for their labeled indications, and a determination of fully effective was made for most of these products and they remain in the marketplace. A few DESI products remain classified as "less than fully effective" while awaiting final administrative disposition. Also, classified as DESI are many products listed as identical, similar, or related to actual DESI products.

AHCCCS and Health Choice will not pay for DESI "less than fully effective" drug products.

Request for Formulary Consideration

Health Choice providers may formally request the HCA P&T Committee consider a medication be considered for addition to the formulary. The instructions and required submission form(s) which indicate how to

submit a formulary medication consideration request are detailed in the Health Choice Provider Manual as well as on the Health Choice website.

Prior Authorization

Prior Authorization (PA) is required for two groups of medications and for two clinical formulary override conditions:

Medication Groups

1. Medications noted with a PA in the drug list.
2. All unlisted medications.

Clinical Override Conditions

1. To override a Step Therapy (ST) edit.
2. To override a Quantity Level Limit (QLL) edit.

It is anticipated that a request for an unlisted medication will be infrequent, and that physicians will be able to prescribe a formulary medication for the vast majority of therapeutic needs. Physicians are encouraged to use this formulary when prescribing medications for patients to avoid unnecessary delays in therapy.

A physician may request a formulary exception or clinical override by utilizing the pharmacy Prior Authorization form available from Health Choice. The completed form specified as either “Expedited” or “Standard” (see below for AHCCCS/HCA definitions) and supportive documentation should be faxed to Health Choice Prior Authorization at 1-888-291-4542. The request will be reviewed and a response will be received within 3 business days for Expedited requests and 14 calendar days for Standard requests. In those extenuating circumstances where the patient’s medical condition may be in jeopardy by waiting 24 hours, certain medications may be authorized by telephone at 480-968-6866, ext. 1800 or toll free 1-800-322-8670, ext. 1800.

For your reference, we have included key factors that will be considered in reviewing a prior authorization request. These precede the drug list in the formulary. [Please see the Health Choice Provider Manual for detailed information on medication Prior Authorization processes and requirements].

- ✓ **“Standard”**: **Up to 14 calendar days** - Standard means a request for which a Contractor must provide a decision as expeditiously as the member’s health condition requires, but not later than 14 calendar days following receipt of the authorization request, with a possible extension (see HCA Provider Manual or AHCCCS Medical

Policy Manual for extension details) of up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest. "

- ✓ **"Expedited": 3 business days** – Expedited means a request for which a provider indicates or a Contractor determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with possible extension of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest."

Off-label Prescribing Guidelines

Health Choice Medical Services does not and can not promote off-label use of currently available medications by granting approval for such use. Providers who wish to utilize medications for off-label diagnoses and conditions do so outside the realm of plan approval criteria.

In cases where off-label use of a medication has become the accepted community standard of care as definitively reported in the medical literature, HCA will review such requests on a case-by-case basis.

Editor

Your comments and suggestions regarding the Health Choice Formulary are encouraged. Your input is vital to this clinical formulary's continued success. All responses will be reviewed and considered. Please send your comments to:

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Health Choice Arizona
410 North 44th Street, Suite 405
Phoenix, AZ 85008

Notice

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LEGEND

boldface	Indicates generic availability
OTC	Over-the-Counter
PA	Prior Authorization Required
QLL	Quantity Level Limit
SPBM	Specialty Drug, Fill at CuraScript-PA Required
ST	Step Therapy through prerequisite drug required

OTC (Over-the-Counter) Formulary

The OTC products included on this list are covered for Health Choice AHCCCS patients. **A written prescription from a Health Choice provider is required.**

- Generic availability is indicated by **boldface** type
- The brand name products noted are for reference only; generics should be dispensed whenever possible
- The list suggests dosage forms for some products. Generally, the commonly available products associated with each line item are covered

ANTIINFECTIVES

TOPICAL ANTIBACTERIAL DRUGS

bacitracin
bacitracin/polymyxin POLYSPORIN

bacitracin zinc
neomycin/bacitracin/polymyxin NEOSPORIN

VAGINAL ANTIFUNGALS

clotrimazole MYCELEX
miconazole nitrate MONISTAT

OTHER TOPICAL ANTIFUNGALS

clotrimazole LOTRIMIN
miconazole nitrate MICRO-GUARD

tolnaftate TINACTIN

AUTONOMIC AND CNS MEDICATIONS

ANALGESICS

acetaminophen TYLENOL
aspirin/buffers BAYER

AUTONOMIC AND CNS MEDICATIONS

ANTIVERTIGO AND ANTIEMETIC DRUGS

dimenhydrinate DRAMAMINE

DERMATOLOGICAL MEDICATIONS

TOPICAL CORTICOSTEROID DRUGS

Boldface indicates generic availability - 11

hydrocortisone

CORTAID

ANTIACNE DRUGS

OTC benzoyl peroxide

BREVOXYL

KERATOLYTIC DRUGS

salicylic acid

COMPOUND W

ANTIPSORIASIS AND ANTIECZEMA DRUGS

coal tar

NEUTROGENA T/GEL

selenium sulfide

SELSUN BLUE

TOPICAL DERMATOLOGICAL DRUGS

calamine

hydrogen peroxide

mineral oil/petrolatum

permethrin 1%

piperonyl butoxide/pyrethrins

urea 20%

AQUAPHOR

NIX

RID

Carmol

EAR-NOSE-THROAT MEDICATIONS

DRUGS AFFECTING THE EAR

antipyrine/benzocaine

BENZOTIC

carbamide peroxide

DEBROX

DRUGS AFFECTING THE NOSE

cromolyn

NASALCROM

GASTROINTESTINAL MEDICATIONS

ANTACIDS

aluminum hydroxide

AMPHOJEL

calcium carbonate

MYLANTA

dihydroxyaluminum sodium carbonate

ROLAIDS

magnesium hydroxide/al hydrox

MAALOX

mag hydrox/al hydrox/simeth

MYLANTA

sodium bicarbonate

GENATON

ANTIDIARRHEAL DRUGS

attapulgite

KA-PEC

bismuth subsalicylate

KAOPECTATE

loperamide

IMODIUM

ANTIULCER DRUGS

cimetidine

TAGAMET

ranitidine

ZANTAC

PROTON PUMP INHIBITORS

QLL omeprazole magnesium PRILOSEC OTC

omeprazole magnesium/PRILOSEC maximum quantity 60 tablets every 30 days

LAXATIVES AND CATHARTICS

bisacodyl	DULCOLAX
docusate sodium	COLACE
magnesium hydroxide	MILK OF MAGNESIA
magnesium sulfate	EPSOM SALT
phenolphthalein	
polyethylene glycol	GLYCOLAX
psyllium	METAMUCIL
senna/docusate sodium	SENOKOT
sennosides a&b, calcium	EX-LAX
sodium phosphate/NA biphos	ENEMA

OTHER GI DRUGS

simethicone GAS-X

MUSCULOSKELETAL MEDICATIONS

SALICYLATES AND RELATED DRUGS

aspirin	BAYER
aspirin/acetaminophen/caffeine	EXCEDRIN

NUTRITION, BLOOD

VITAMINS & MINERALS & RELATED PRODUCTS

calcium carbonate tablet	TUMS
ferrous gluconate	FERGON
ferrous sulfate	FERATAB
folic acid/vit b complex with c	DAILYVITE
multivitamins	Daily generic vitamins
pyridoxine	NESTREX
vitamin b complex	
vitamin e	

THERAPEUTIC VITAMINS & MINERALS

folic acid
zinc acetate

BLOOD DETOXICANTS

lactulose ENULOSE

ELECTROLYTES, IRRIGATING SOLUTIONS, ETC.

electrolyte solution PEDIALYTE

OBSTETRICAL & GYNECOLOGICAL MEDICATIONS

PRENATAL VITAMINS

iron

OTC, RX generic oral prenatal vitamins w/ or w/o folic acid

Prenatal vitamins generics only covered for women age 14 to 45.

OPHTHALMIC MEDICATIONS

OTHER OPHTHALMIC DRUGS

carboxymethylcellulose, sodium	THERA TEARS
dextran 70/he-cell	TEARS NATURALE
hydroxypropyl methylcellulose	GENTEAL
lanolin/mineral oil/petrolatum	PURALUBE
naphazoline/pheniramine	NAPHCON-A
petrolatum, white	PURALUBE
polyvinyl alcohol	HYPOTEARs

RESPIRATORY MEDICATIONS

ANTI-HISTAMINES

QLL,OTC	cetirizine tabs	ZYRTEC
QLL,OTC	cetirizine syrup	ZYRTEC
	chlorpheniramine	CHLOR-TRIMETON
QLL, OTC	loratadine tabs, syrup	CLARITIN
	clemastine tabs	TAVIST-1
	diphenhydramine caps, tabs, elixir	BENADRYL

cetirizine/ZYRTEC, maximum quantity 150mL every 30 days. Limited to children up to the age of 9

loratadine/CLARITIN maximum quantity 34 units per fill. Limited to children up to the age of 9

DECONGESTANTS

pseudoephedrine	SUDAFED
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ANTITUSSIVE AND EXPECTORANT DRUGS

guaifenesin/dextromethorphan	GUAICON
guaifenesin/pseudoephedrine	SINUTAB LiquiCaps
guaifenesin syrup	ROBITUSSIN

SMOKING CESSATION PRODUCTS

QLL, OTC	nicotine polacrilex gum	
QLL, OTC	nicotine lozenge	NICODERM
QLL, OTC	nicotine patch	

nicotine gum/NICORETTE maximum quantity 108 per fill, 324 in 6 months

nicotine patch/NICODERM CQ maximum quantity 30 per fill, 90 in 6 months

UROLOGICAL MEDICATIONS

URINARY ANESTHETICS

phenazopyridine

URISTAT

DIAGNOSTIC & MISCELLANEOUS MEDICATIONS

DIAGNOSTIC PRODUCTS

ketone testing products
ketone testing products

KETOCARE
CHEMSTRIP

MEDICAL (MISCELLANEOUS) SUPPLIES

DIABETIC SUPPLIES

glucose monitors, supplies

ACCU-CHEK AVIVA,
COMPACT PLUS

HCA Formulary

ANTIINFECTIVES

CEPHALOSPORINS

QLL cefaclor
 cefdinir
 cefixime 400mg
 cefprozil
 cephalixin

CECLOR
OMNICEF
SUPRAX
CEFZIL
KEFLEX

cefixime 400mg/SUPRAX maximum quantity 1 per month

CLINDAMYCINS

QLL clindamycin hcl
 clindamycin palmitate

CLEOCIN HCL
CLEOCIN GRANULES

clindamycin palmitate/CLEOCIN GRANULES covered up to age 10 without prior authorization, maximum of 300ml per rx. PA needed for either exception.

ERYTHROMYCINS

erythromycin
erythromycin ethylsuccinate

ERY-TAB
E.E.S

OTHER MACROLIDES

QLL azithromycin

ZITHROMAX

azithromycin/ZITHROMAX maximum quantity 6 units per fill

PENICILLINS

amoxicillin
amoxicillin clavulanate
ampicillin

AMOXIL
AUGMENTIN
PRINCIPEN

Boldface indicates generic availability - 15

	dicloxacillin	DYNAPEN
	penicillin	VEETIDS
*	amox/clavulanate	AUGMENTIN ES-600
*Limited to children under age of 6.		

SULFONAMIDES

	erythromycin/sulfisoxazole	PEDIAZOLE
	sulfamethoxazole/trimethoprim	SEPTRA

TETRACYCLINES

	doxycycline hyclate	DORYX
	tetracycline	SUMYCIN

URINARY ANTIINFECTIVES

	nitrofurantoin macrocrystal	MACROBID
	trimethoprim	PRIMSOL

QUINOLONES

	ciprofloxacin	CIPRO
	levofloxacin	LEVAQUIN
	moxifloxacin	AVELOX / ABC PACK

TOPICAL ANTIBACTERIAL DRUGS

OTC	bacitracin	
OTC	bacitracin zinc	
*	clindamycin hcl topical solution 1%	CLEOCIN HCL
	erythromycin top solution 2%	A/T/S
	gentamicin sulfate	GARAMYCIN
PA	mupirocin oint	BACTROBAN
OTC	neomycin/bacitracin/polymyxin	NEOSPORIN
	silver sulfadiazine	SILVADENE

mupirocin/BACROBAN requires prior authorization
 *clindamycin is 2nd line after erythromycin

ORAL ANTIFUNGAL DRUGS

	clotrimazole	MYCELEX
PA, QLL	fluconazole	DIFLUCAN
	griseofulvin ultramicrosize	GRIS-PEG
PA, QLL	itraconazole	SPORANOX
	ketoconazole	NIZORAL
	nystatin	MYCOSTATIN
PA, QLL	terbinafine	LAMISIL

fluconazole/DIFLUCAN requires prior authorization, maximum quantity 2 units per fill, without PA for 150mg only
 itraconazole/SPORANOX maximum quantity 34 units per fill
 itraconazole/SPORANOX capsules requires prior authorization
 terbinafine/LAMISIL tablets require prior authorization, maximum quantity 84 units per lifetime

VAGINAL ANTIFUNGALS

OTC	butoconazole	FEMSTAT 3
OTC	clotrimazole	MYCELEX

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OTC	miconazole nitrate nystatin	MONISTAT MYCOSTATIN
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OTHER TOPICAL ANTIFUNGALS

OTC	clotrimazole ketoconazole	LOTRIMIN NIZORAL
OTC	miconazole nitrate	MICRO-GUARD
OTC	nystatin tolnaftate	MYCOSTATIN TINACTIN

TOPICAL CORTICOSTEROIDS

nystatin/triamcinolone	MYCOLOG
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ANTIRETROVIRALS & PROTEASE INHIBITORS

PA, SPBM	abacavir sulfate abacavir sulfate/lamivudine amprenavir atazanavir sulfate darunavir ethanolate delavirdine mesylate didanosine efavirenz emtricitabine emtricitabine/tenofovir emtricitabine/tenofovir/efavir enfuvirtide etravirine fosamprenavir calcium indinavir lamivudine lamivudine/zidovudine maraviroc nelfinavir mesylate nevirapine raltegravir ritonavir ritonavir/lopinavir saquinavir saquinavir mesylate stavudine tenofovir disproxil fumarate tipranavir zalcitabine zidovudine zidovudine/lamivudine/abacavir	ZIAGEN EPZICOM AGENERASE REYATAZ PREZISTA RESCRIPTOR VIDEX SUSTIVA EMTRIVA TRUVADA ATRIPLA FUZEON INTELENCE LEXIVA CRIXIVAN EPIVIR COMBIVIR SELZENTRY VIRACEPT VIRAMUNE INSENTRESS NORVIR KALETRA FORTOVASE INVIRASE ZERIT VIREAD APTIVUS HIVID RETROVIR TRIZIVIR
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enfuvirtide/FUZEON use specialty pharmacy

OTHER ANTIVIRAL DRUGS

PA, SPBM PA, SPBM	acyclovir amantadine ganciclovir lamivudine ribavirin ribavirin	ZOVIRAX SYMMETREL CYTOVENE EPIVIR COPEGUS REBETOL
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PA, QLL valacyclovir VALTREX

ribavirin/COPEGUS, REBETOL use specialty pharmacy
valacyclovir/VALTREX requires prior authorization, maximum quantity 30 units per fill

TOPICAL ANTIVIRAL DRUGS

PA **acyclovir** ZOVIRAX
acyclovir cream, oint ZOVIRAX CREAM, OINT

paromomycin HUMATIN

ANTITUBERCULOSIS DRUGS

ethambutol MYAMBUTOL
isoniazid NYDRAZID
pyrazinamide
rifampin RIFADIN

PLASMOCIDICIDES

hydroxychloroquine PLAQUENIL
mefloquine LARIAM
primaquine

SULFONES

dapsone

TRICHOMONOCIDES

metronidazole FLAGYL

ANTHELMINTICS

mebendazole VERMOX
pyrantel PIN-X

OTHER ANTIINFECTIVE DRUGS

PA **atovaquone** MEPRON
vancomycin vancocin

ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS

ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS

PA,SPBM abatacept/maltose ORENCIA
PA,SPBM, QLL adalimumab HUMIRA
altretamine HEXALEN
PA **anagrelide** AGRYLIN
anastrozole ARIMIDEX
azathioprine AZASAN
bexarotene TARGRETIN
busulfan MYLERAN
chlorambucil LEUKERAN
PA,SPBM **cyclophosphamide** CYTOXAN
cyclosporine NEORAL
PA,SPBM **cyclosporine** SANDIMMUNE
PA,SPBM, QLL etanercept ENBREL
PA, SPBM **etoposide** TOPOSAR
exemestane AROMASIN

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	flutamide	EULEXIN
	hydroxyurea	HYDREA
PA, SPBM	infliximab	REMICADE
	letrozole	FEMARA
	lomustine	CEENU
	megestrol	MEGACE
PA, SPBM	melphalan	ALKERAN
	mercaptopurine	PURINETHOL
	methotrexate	RHEUMATREX
	mitotane	LYSODREN
PA, SPBM	mycophenolate mofetil	CELLCEPT
	procarbazine	MATULANE
	sirolimus	RAPAMUNE
PA, SPBM	tacrolimus	PROGRAF
	tamoxifen	NOLVADEX
	thioguanine	
	toremifene	FARESTON

abatacept/maltose/ORENCIA use specialty pharmacy
adalimumab/HUMIRA use specialty pharmacy, maximum quantity 3 units per fill
anagrelide/AGRYLIN requires prior authorization
cyclophosphamide/CYTOXAN use specialty pharmacy
cyclosporine/SANDIMMUNE use specialty pharmacy
etanercept/ENBREL use specialty pharmacy, maximum quantity 5 units per dispensing
etoposide/TOPOSAR use specialty pharmacy
infliximab/REMICADE use specialty pharmacy
melphalan/ALKERAN use specialty pharmacy
mycophenolate mofetil/CELLCEPT injectable use specialty pharmacy
tacrolimus/PROGRAF injectable use specialty pharmacy

CARDIOVASCULAR MEDICATIONS

CARDIAC GLYCOSIDES

digitek	LANOXIN
digoxin	LANOXIN

CALCIUM ANTAGONISTS

amlodipine	NORVASC
diltiazem	CARDIZEM CD
diltiazem	TIAZAC
nifedipine	ADALAT CC
nifedipine	PROCARDIA XL
verapamil	CALAN SR
verapamil	COVERA-HS
verapamil	VERELAN

LOOP DIURETICS

furosemide	LASIX
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THIAZIDE AND RELATED DRUGS

chlorthalidone	HYDONE
hydrochlorothiazide	MICROZIDE

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indapamide
metolazone

LOZOL
ZAROXOLYN

POTASSIUM SPARING DIURETICS

spironolactone
spironolactone/hctz

ALDACTONE
ALDACTAZIDE

hctz/triamterene

MAXZIDE-25MG

hctz/triamterene

DYAZIDE

BETA-ADRENERGIC ANTAGONIST DRUGS

atenolol
carvedilol
labetalol
metoprolol succinate
metoprolol tartrate
pindolol
propranolol

TENORMIN
COREG
TRANDATE
TOPROL XL
LOPRESSOR
VISKEN
INDERAL

VASODILATOR ANTIHYPERTENSIVES

doxazosin
hydralazine
prazosin
terazosin

CARDURA
APRESOLINE
MINIPRESS
HYTRIN

CENTRALLY ACTING ANTIHYPERTENSIVES

clonidine tabs
methyldopa

CATAPRES
ALDOMET

ANGIOTENSIN CONVERTING ENZYME INHIBITORS

benazepril
captopril
enalapril
lisinopril
lisinopril
quinapril

LOTENSIN
CAPOTEN
VASOTEC
PRINIVIL
ZESTRIL
ACCUPRIL

ANGIOTENSIN II RECEPTOR ANTAGONISTS

ST irbesartan

AVAPRO

ST losartan

COZAAR

irbesartan/AVAPRO requires trial of generic ACEI first.

losartan/COZAAR requires trial of generic ACEI first.

OTHER ANTIHYPERTENSIVES

benazepril/hctz

LOTENSIN HCT

captopril/hctz
hctz/bisoprolol fumarate

CAPOZIDE
ZIAC

ST irbesartan/hctz

AVALIDE

lisinopril/hctz

PRINZIDE

ST losartan /hctz

HYZAAR

trandolapril/verapamil

TARKA

irbesartan/hctz/AVALIDE requires trial of generic ACEI/HCTZ first.
 losartan/hctz/HYZAAR requires trial of generic ACEI/HCTZ first.

NITRATES

isosorbide dinitrate	SORBITRATE
isosorbide mononitrate	MONOKET
isosorbide mononitrate	IMDUR
nitroglycerin capsule	NITRO-TIME
nitroglycerin sublingual	NITROSTAT
nitroglycerin transdermal ointment	NITRO-BID

CLASS 1A

procainamide	PRONESTYL
quinidine gluconate	QUINAGLUTE
quinidine sulfate	QUINIDEX

CLASS 1C

propafenone	RYTHMOL
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AMIODARONES

amiodarone	PACERONE
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OTHER ANTIARRHYTHMICS

sotalol	BETAPACE
sotalol	BETAPACE AF

HYPOLIPOPROTEINEMICS

cholestyramine/aspartame	QUESTRAN
cholestyramine/sucrose	QUESTRAN
fenofibrate	
gemfibrozil	LOPID
niacin, niacin er	

HMG-COA REDUCTASE INHIBITORS

QLL	atorvastatin calcium	LIPITOR
QLL	lovastatin	MEVACOR
QLL	pravastatin	PRAVACHOL
QLL	simvastatin	ZOCOR

atorvastatin calcium/LIPITOR maximum quantity 30 tablets every 30 days

lovastatin/MEVACOR maximum quantity 30 tablets every 30 days

pravastatin/PRAVACHOL maximum quantity 30 tablets every 30 days

simvastatin/ZOCOR maximum quantity of 30 tablets every 30 days

OTHER CARDIOVASCULAR DRUGS

midodrine	PROAMATINE
pentoxifylline	TRENTAL

AUTONOMIC AND CNS MEDICATIONS

ANALGESICS

OTC	acetaminophen	TYLENOL
OTC	aspirin/buffers	BAYER
QLL	tramadol tab 50mg	ULTRAM

CLASS II NARCOTICS

PA, QLL	fentanyl	DURAGESIC
QLL	hydromorphone	DILAUDID
QLL	meperidine	DEMEROL
QLL	methadone	METHADOSE
PA, QLL	morphine ext release	AVINZA
PA, QLL	oxycodone	OXYCONTIN,
ROXICODONE		
QLL	oxycodone/acetaminophen 5/325	PERCOCET
	oxycodone/aspirin	PERCODAN
QLL	morphine sulfate ir, er tabs, soln	MS IR, MS CONTIN

hydromorphone/DILAUDID, maximum quantity 180 tablets every 30 days.

meperidine/DEMEROL, maximum quantity 120 tablets every 30 days.

methadone/METHADOSE maximum quantity 240 tablets every 30 days.

morphine sulfate IR and ER are 1st line opiate therapy; oxycodone IR and ER are 2nd line therapy; fentanyl is 3rd line ER therapy. Prior authorization is required for multiple dose/strength orders.

morphine ext release/AVINZA requires prior authorization, maximum quantity 30 capsules every 30 days

morphine ir/MSIR maximum quantity 240 tablets every 30 days

morphine er/MS CONTIN maximum quantity 90 tablets every 30 days

oxycodone/OXYCONTIN/ROXICODONE maximum quantity 90 tablets or capsules every 30 days

oxycodone/apap/PERCOCET maximum quantity 240 tablets every 30 days

tramadol maximum quantity 120 tablets every 30 days

CLASS III NARCOTICS

QLL	codeine phosphate/apap	PHENAPHEN
QLL	hydrocodone bitartrate/apap 10/650	LORCET 10/650
QLL	hydrocodone bitartrate/apap 2.5/500	LORTAB 2.5/500
QLL	hydrocodone bitartrate/apap 5/500	VICODIN 5/500
QLL	hydrocodone bitartrate/apap 7.5/750	VICODIN ES 7.5/750

hydrocodone/apap combined maximum of 120 tablets/capsules every 30 days

CLASS IV NARCOTICS

	propoxyphene	DARVON
	propoxyphene napsylate/apap	DARVOCET-N 100

sumatriptan/Imitrex maximum quantity 6 intranasal solution & 6 subcutaneous injection solution vials - only one dosage form quantity per 30 days.

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DRUGS TO PREVENT AND TREAT HEADACHES

	apap/butalbital/caffeine	FIORICET
	aspirin/butalbital/caffeine	FIORINAL
	codeine/apap/butalbital/caffeine	FIORICET
	codeine/asa/butalbital/caffeine	FIORINAL
	ergotamine tartrate/caffeine	CAFERGOT
QLL	eletriptan	RELPAK
QLL	sumatriptan	IMITREX
QLL	zolmitriptan	ZOMIG / ZMT

eletriptan/RELPAK maximum quantity 9 tablets every 30 days

sumatriptan/IMITREX maximum quantity 9 tablets every 30 days

zolmitriptan/ZOMIG/ZOMIG ZMT maximum quantity 6 tablets every 30 days

ANXIOLYTICS

QLL	alprazolam	XANAX
	buspirone	BUSPAR
QLL	chlordiazepoxide hcl	LIBRIUM
QLL	diazepam	VALIUM
QLL	lorazepam	ATIVAN
QLL	oxazepam	SERAX

alprazolam/XANAX maximum quantity 120 tablets every 30 days

chlordiazepoxide/LIBRIUM maximum quantity 120 capsules every 30 days

diazepam/VALIUM maximum quantity 120 tablets every 30 days

lorazepam/ATIVAN maximum quantity 120 tablets every 30 days

oxazepam/SERAX maximum quantity 120 capsules every 30 days

RHBA members must obtain through the RHBA program.

SEDATIVE/HYPNOTIC DRUGS

	chloral hydrate	SOMNOTE
QLL	temazepam	RESTORIL
PA, QLL	zolpidem	AMBIEN

temazepam/RESTORIL maximum quantity 14 capsules every 30 days

zolpidem/AMBIEN requires prior authorization (temazepam is 1st line therapy); maximum quantity 14 tablets every 30 days

CARBAMAZEPINES

	carbamazepine	CARBATROL
	carbamazepine	TEGRETOL
PA	oxcarbazepine	TRILEPTAL

oxcarbazepine/TRILEPTAL requires prior authorization

ANTICONSULSANT BENZODIAZEPINES

	clonazepam	KLONOPIN
QLL	diazepam	DIASTAT

diazepam/DIASTAT maximum quantity 1 twinpak per fill

sumatriptan/Imitrex maximum quantity 6 intranasal solution & 6 subcutaneous injection solution vials - only one dosage form quantity per 30 days.

HYDANTOINS

phenytoin	DILANTIN
phenytoin sodium	DILANTIN

VALPROIC ACID AND DERIVATIVES

divalproex	DEPAKOTE
valproic acid	DEPAKENE

SUCCINIMIDES

ethosuximide	ZARONTIN
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ANTICONVULSANT BARBITURATES

phenobarbital	
primidone	MYSOLINE

OTHER ANTICONVULSANTS

PA	felbamate	FELBATOL
QLL	gabapentin	NEURONTIN
PA	lamotrigine	LAMICTAL
PA, QLL	levetiracetam	KEPPRA
PA, QLL	topiramate	TOPAMAX
	milnacipran	SAVELLA

felbamate/FELBATOL requires prior authorization

gabapentin/NEURONTIN requires maximum quantity 90 units per fill

lamotrigine/LAMICTAL requires prior authorization. RHBA members must obtain through the RHBA program.

levetiracetam /Keppra requires prior authorization, maximum quantity 60 tablets every 30 days

pregabalin/LYRICA requires prior authorization, maximum quantity 90 capsules every 30 days

topiramate/TOPAMAX requires prior authorization, maximum quantity 60 tabs per 30 days
Valproic acid – RHBA members must obtain through the RHBA program.

TERTIARY AMINES

amitriptyline	ELAVIL
doxepin	ADAPIN
imipramine hcl	TOFRANIL
imipramine pamoate	TOFRANIL PM

RHBA members must obtain through the RHBA program.

SECONDARY AMINES

desipramine	NORPRAMIN
nortriptyline	AVENTYL

RHBA members must obtain through the RHBA program.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS

PA	citalopram	CELEXA
	escitalopram oxalate	LEXAPRO
	fluoxetine	PROZAC
	paroxetine	PAXIL
PA	paroxetine	PAXIL CR

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sertraline

ZOLOFT

escitalopram oxalate/LEXAPRO requires prior authorization, use RHBA program
paroxetine/PAXIL CR requires prior authorization, use RHBA program
RHBA members must obtain SSRI's through the RHBA program.

OTHER ANTIDEPRESSANTS

PA, QLL bupropion
PA, QLL **bupropion**
PA **bupropion**
 mirtazapine
 trazodone

WELLBUTRIN
WELLBUTRIN, SR
WELLBUTRIN XL
REMERON
DESYREL

mirtazapine/REMERON requires prior authorization
bupropion/WELLBUTRIN SR/XL requires prior authorization
RHBA members must obtain through the RHBA program.

MAO INHIBITORS

tranylcypromine

PARNATE

RHBA members must obtain through the RHBA program.

SMOKING CESSATION PRODUCTS

QLL **bupropion 150mg SR**
QLL,OTC **nicotine polacrilex gum**
QLL nicotine inhaler
QLL nicotine nasal spray
QLL,OTC **nicotine patch**
QLL varenicline tartrate

ZYBAN
NICORETTE
NICOTROL
NICOTROL
NICODERM CQ
CHANTIX

bupropion/ZYBAN maximum quantity 60 per fill, 180 in 6 months
nicotine gum/NICORETTE maximum quantity 108 per fill, 324 in 6 months
nicotine patch/NICODERM CQ maximum quantity 30 per fill, 90 in 6 months
nicotine inhaler/NICOTROL maximum quantity 168 per fill, 504 in 6 months
nicotine nasal spray/NICOTROL maximum quantity 2 packages per fill, 6 in 6 months
varenicline tartrate/CHANTIX maximum quantity 1 kit per fill, 3 kits in 6 months

AUTONOMIC AND CNS MEDICATIONS

ANTIVERTIGO AND ANTIEMETIC DRUGS

OTC **dimenhydrinate**
PA, QLL **granisetron**
 meclizine hcl
PA, QLL **ondansetron**
 prochlorperazine maleate
 promethazine
 trimethobenzamide

DRAMAMINE
KYTRIL
MEDIVERT
ZOFRAN / ODT
COMPazine
PHERGAN
TIGAN

granisetron/KYTRIL requires prior authorization, maximum quantity 2 units per fill for tabs,
30ml per fill for liquid

ondansetron/ZOFRAN/ZOFRAN ODT requires prior authorization, maximum quantity 1 unit per fill for 24mg tab, 12 units per fill for 4 and 8mg tabs, 50ml per fill for liquid

ANTIPARKINSON ANTICHOLINERGIC DRUGS

	benztropine	COGENTIN
	trihexyphenidyl	ARTANE

OTHER ANTIPARKINSON DRUGS

PA	bromocriptine mesylate	PARLODEL
	carbidopa/levodopa	SINEMET
PA	entacapone	COMTAN
PA,QLL	ropinirole	REQUIP
	selegiline	ELDEPRYL

bromocriptine mesylate/PARLODEL requires prior authorization
entacapone/COMTAN requires prior authorization
ropinirole/REQUIP requires prior authorization, Maximum quantity is #30

ANTIPSYCHOTIC DRUGS

	fluphenazine hcl	PERMITIL
	haloperidol 0.5mg, 1mg, 2mg, 5mg	HALDOL

RHBA members must obtain through the RHBA program.

CNS STIMULANTS*

QLL	amphetamine/dextroamphetamine	ADDERALL
QLL	dextroamphetamine	DEXEDRINE
PA, QLL	methylphenidate	CONCERTA
PA, QLL	methylphenidate	METADATE
QLL	methylphenidate	RITALIN
PA, QLL	atomoxetine	STRATTERA

* Limited to children ages 5 years to 20 years of age.

Amphetamine/dextroamphetamine/methylphenidate requires prior authorization for Brand products.

Generic: immediate release maximum quantity 60 per month; extended release maximum quantity 30 per month.

DEXEDRINE requires prior authorization; immediate release maximum quantity 60 per month; extended release maximum quantity 30 per month

CONCERTA requires prior authorization; maximum quantity 30 per month, maximum quantity 30 per month

RITALIN requires prior authorization (unless generic); immediate release maximum quantity 60 per month; extended release maximum quantity 30 per month

STRATTERA requires prior authorization, maximum quantity 30 capsules per month.

RBHA members must obtain ADHD medications through the RHBA program.

OTHER CNS/AUTONOMIC DRUGS

	pyridostigmine	MESTINON
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ANTIDEMENTIA DRUGS

PA	donepezil	ARICEPT/ODT
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donepezil/ARICEPT requires prior authorization, with current MMSE

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DRUGS TO TREAT MULTIPLE SCLEROSIS

SPBM, QLL, PA glatiramer acetate

COPAXONE

glatiramer acetate/COPAXONE use specialty pharmacy, maximum quantity 1 unit per fill, requires prior authorization

DERMATOLOGICAL MEDICATIONS

TOPICAL CORTICOSTEROID DRUGS

VHP	betamethasone/propylene glycol	DIPROLENE AF
HP	betamethasone dipropionate	ALPHATREX
MP	betamethasone valerate	BETATREX
VHP	clobetasol propionate	
HP	fluocinonide	LIDEX
LP, OTC	hydrocortisone	CORTAID
MP, MP, HP	triamcinolone acetonide 0.025%, 0.1%, 0.5%	KENALOG

VHP = Very High Potency; **HP** = High Potency; **MP** = Medium Potency; **LP** = Low Potency

ANTI PRURITIC DRUGS

	hydroxyzine	ATARAX
	hydroxyzine pamoate	VISTARIL

ANTIACNE DRUGS

OTC	benzoyl peroxide gel, lotion, liquid (generics)	BREVOXYL
QLL	clindamycin phosphate 1% top solution	CLEOCIN
	erythromycin 2% top soln, gel	A/T/S
PA	tretinoin	RETIN-A

tretinoin/RETIN-A requires prior authorization

KERATOLYTIC DRUGS

OTC	salicylic acid liquid	COMPOUND W
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ANTIPSORIASIS AND ANTIECZEMA DRUGS

PA	calcipotriene	DOVONEX
OTC	coal tar	NEUTROGENA T/GEL
OTC	selenium sulfide	SELSUN BLUE
PA	tazarotene	TAZORAC

calcipotriene/DOVONEX requires prior authorization

tazarotene/TAZORAC requires prior authorization

TOPICAL DERMATOLOGICAL DRUGS

OTC	calamine	
	fluorouracil 1% cream	FLUOROPLEX
OTC	hydrogen peroxide	

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QLL	lidocaine 5% ointment	
OTC	mineral oil/petrolatum	AQUAPHOR
	permethrin	ACTICIN
OTC	piperonyl butoxide/pyrethrins	RID
	podofilox solution	CONDYLOX
OTC	capsaisin topical cream	Zostrix
	Metronidazole 0.75% topical gel	MetroGel

lidocaine 5% ointment maximum quantity 35 gm per fill

EAR-NOSE-THROAT MEDICATIONS

DRUGS AFFECTING THE EAR

	acetic acid	VOSOL
	acetic acid/hydrocortisone	VOSOL HC
OTC	antipyrine/benzocaine	BENZOTIC
OTC	carbamide peroxide	DEBROX
ST	ciprofloxacin/dexameth	CIPRODEX
	neomycin sulfate/polymyxin/hc	CORTISPORIN
	ofloxacin	FLOXIN

ciprofloxacin/dexameth/CIPRODEX requires PA or CIPRODEX Otic can be accessed via Step Therapy after 5 days use/failure on formulary 1st line otic medications.

DRUGS AFFECTING THE NOSE

QLL	azelastine hcl	ASTELIN
ST, QLL	budesonide	RHINOCORT AQUA
OTC, QLL	cromolyn	NASALCROM
QLL	fluticasone propionate	FLONASE
QLL	ipratropium	ATROVENT
ST, QLL	mometasone	NASONEX

azelastine hcl/ASTELIN maximum quantity 30 units per fill

budesonide/RHINOCORT AQUA requires fluticasone first , maximum quantity 8.6 units per month

cromolyn/NASALCROM maximum quantity 13 units per dispensing

fluticasone propionate/FLONASE maximum quantity 16 units per month

ipratropium/ATROVENT maximum quantity 15 units per dispensing

mometasone/NASONEX requires fluticasone first, maximum quantity 17 units per month

Fluticasone is the 1st line nasal steroid spray. Rhinocort Aqua & Nasonex are 2nd line.

DRUGS AFFECTING THE THROAT AND MOUTH

OTC	carbamide peroxide	GLY-OXIDE
	chlorhexedine	PERIDEX
	triamcinolone acetonide	KENALOG
	lidocaine viscous	XYLOCAINE VISCOUS

ENDOCRINE MEDICATIONS

INSULIN

QLL	insulin aspart	NOVOLOG
QLL	insulin glargine	LANTUS
QLL	insulin human regular	HUMULIN

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QLL	insulin human regular	NOVOLIN
QLL	insulin lispro	HUMALOG
QLL	insulin NPH	HUMULIN N
QLL	insulin NPH	NOVOLIN N
QLL	insulin regular	HUMULIN R
QLL	insulin regular	NOVOLIN R

insulin aspart/NOVOLOG vials maximum quantity 30ml per month, pens maximum quantity 15ml per month

insulin glargine/LANTUS vials maximum quantity 30ml per month

insulin lispro/HUMALOG vials maximum quantity 30ml per month, pens maximum quantity 15ml per month

insulin human vials maximum quantity 30ml per month

all insulin pens require Prior Authorization

ORAL HYPOGLYCEMIC DRUGS

QLL	acarbose	PRECOSE
QLL	glimepiride	AMARYL
	glipizide	GLUCOTROL
	glyburide	GLYNASE
	glyburide	MICRONASE
	glyburide/metformin	GLUCOVANCE
	metformin	GLUCOPHAGE
QLL	repaglinide	PRANDIN

acarbose/PRECOSE maximum quantity 90 units per fill

glimepiride/AMARYL maximum quantity 60 units per 30 days

repaglinide/PRANDIN maximum quantity 90 units per fill

INSULIN SENSITIZERS

QLL	pioglitazone	ACTOS
QLL	pioglitazone/metformin	ACTOPLUS MET
QLL	rosiglitazone	AVANDIA
QLL	rosiglitazone/metformin	AVANDAMET

pioglitazone/ACTOS maximum quantity 30 units per fill

pioglitazone/metformin/ACTOPLUS MET maximum quantity 90 units per fill

rosiglitazone/AVANDIA maximum quantity 30 units per fill

rosiglitazone/metformin/AVANDAMET maximum quantity 60 units per fill

DIPEPTIDYL PEPTIDASE – IV INHIB

sitagliptin phosphate	JANUVIA
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GLUCOSE ELEVATING DRUGS

glucagon, human recombinant	GLUCAGON
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GLUCOCORTICOID DRUGS

dexamethasone	DECADRON
hydrocortisone	CORTEF
methylprednisolone	MEDROL
prednisolone	PRELONE
prednisone	DELTASONE

MINERALOCORTICOID DRUGS

fludrocortisone

FLORINEF

THYROID SUPPLEMENTS

levothyroxine
levothyroxine
levothyroxine

LEVOXYL
LEVOTHROID
LEVOTHYROXINE -

MYLAN

thyroid

ANTITHYROID DRUGS

methimazole
propylthiouracil

TAPAZOLE

OTHER ENDOCRINE DRUGS

QLL	alendronate	FOSAMAX
PA	cinacalcet	SENSIPAR
PA	desmopressin acetate nasal	DDAVP NASAL
PA, SPBM	desmopressin acetate inj	DDAVP INJ
ST, QLL	risedronate	ACTONEL
PA, SPBM	teriparatide	FORTEO
PA, SPBM	cinacalcet	SENSIPAR

alendronate/FOSAMAX, 10mg, 40mg maximum quantity 30 units per month; 35mg, 70mg maximum quantity 4 units per month. Alendronate is the formulary's 1st line bisphosphonate.

cinacalcet/SENSIPAR requires prior authorization

desmopressin acetate/DDAVP injectable use specialty pharmacy

risedronate/ACTONEL requires generic alendronate first; 5mg, 30mg maximum quantity 30 units per month; 35mg maximum quantity 4 units per month; 75mg maximum quantity 2 units per month; 150mg maximum quantity 1 unit per month

teriparatide/FORTEO use specialty pharmacy

Prior authorization requires DEXA-SCAN every 2 years.

GASTROINTESTINAL MEDICATIONS

ANTACIDS

OTC	aluminum hydroxide	AMPHOJEL
OTC	calcium carbonate	MYLANTA
OTC	dihydroxyaluminum sodium carbonate	ROLAIDS
OTC	magnesium hydroxide/al hydrox	MAALOX
OTC	mag hydrox/al hydrox/simeth	MYLANTA
OTC	sodium bicarbonate	GENATON

ANTIDIARRHEAL DRUGS

OTC	bismuth subsalicylate	KAOPECTATE
	diphenoxylate/atropine sulfate	LOMOTIL
OTC	loperamide	IMODIUM

ANTISPASMODICS/DRUGS AFFECT GI MOTILITY

	dicyclomine	BENTYL
	hyoscyamine	CYSTOSPAZ

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PA	metoclopramide	REGLAN
	propantheline	

ANTIULCER DRUGS

OTC	cimetidine	TAGAMET
OTC	ranitidine	ZANTAC

OTHER ANTIULCER DRUGS

misoprostol	CYTOTEC
sucralfate tabs	CARAFATE

PROTON PUMP INHIBITORS

PA, QLL	esomeprazole mag trihyd	NEXIUM
PA, QLL, OTC	lansoprazole	PREVACID 15mg OTC
QLL, OTC	omeprazole magnesium	PRIOSEC OTC
PA, QLL	pantoprazole 40mg	PROTONIX

esomeprazole mag trihyd/NEXIUM requires prior authorization, maximum quantity 30 units per fill, 90 capsules per year

lansoprazole/PREVACID 15mg OTC maximum quantity 60 units ever 30 days.

omeprazole magnesium/PRIOSEC OTC maximum quantity 60 tablets every 30 days without PA.

PRIOSEC OTC is formulary 1st line therapy

pantoprazole/PROTONIX requires prior authorization, 2nd line therapy, maximum quantity 30 tablets every 30 days

LAXATIVES AND CATHARTICS

OTC	bisacodyl	DULCOLAX
OTC	docusate sodium	COLACE
OTC	magnesium hydroxide	MILK OF MAGNESIA

OTC	magnesium sulfate	EPSOM SALT
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OTC	polyethylene glycol 3350	GLYCOLAX, MIRALAX
OTC	psyllium	METAMUCIL
OTC	senna/docusate sodium	SENOKOT
OTC	sennosides a&b, calcium	EX-LAX
OTC	sodium phosphate/NA biphos	OSMOPREP

OTHER GI DRUGS

QLL	amylase/lipase/protease	CREON
QLL	amylase/lipase/protease electrolyte solution/PEG'S	PANGESTYME
	electrolyte solution/PEG'S	GOLYTELY
	hydrocortisone 2.5% cream	NULYTELY
	hydrocortisone acetate	
	basalazide	CORTIFOAM
	mesalamine	COLAZAL
	mesalamine	ASACOL/HD
	simethicone	CANASA
	sulfasalazine	MYLANTA
	ursodiol	AZULFIDINE
		URSO

amylase/lipase/protease /CREON/PANGESTYME/ULTRASE/MT/VIOKASE maximum quantity 270 units per 30 days

IMMUNOLOGICALS AND VACCINES

IMMUNOLOGICALS AND VACCINES

PA, SPBM palivizumab SYNAGIS

palivizumab/SYNAGIS use specialty pharmacy

MYELOID STIMULANTS

PA, SPBM filgrastim NEUPOGEN

PA, SPBM sargramostim LEUKINE

filgrastim/NEUPOGEN use specialty pharmacy

sargramostim/LEUKINE use specialty pharmacy

ERYTHROID STIMULANTS

PA darbepoetin alfa ARANESP

PA epoetin alfa PROCRT

darbepoetin alfa/ARANESP use specialty pharmacy

epoetin alfa/PROCRT use specialty pharmacy

INTERFERONS

PA, SPBM interferon alfa-2B, recombinant

INTRON A

PA, SPBM, QLL interferon beta-1A

AVONEX / ADMIN PACK

PA, SPBM, QLL peginterferon alfa-2A

PEGASYS

interferon alfa-2B recombinant/INTRON A use specialty pharmacy

interferon beta-1A/AVONEX/AVONEX ADMINISTRATION PACK use specialty pharmacy,

maximum quantity 4 units per fill

peginterferon alfa-2A/PEGASYS use specialty pharmacy, maximum quantity 1 unit per fill

GROWTH HORMONES AND RELATED DRUGS

PA, SPBM somatropin TEV TROPIN

PA, SPBM somatropin SEROSTIM

somatropin/TEV TROPIN requires prior authorization, use specialty pharmacy

somatropin/SEROSTIM use specialty pharmacy

MUSCULOSKELETAL MEDICATIONS

SALICYLATES AND RELATED DRUGS

OTC aspirin BAYER

OTC aspirin/acetaminophen/caffeine EXCEDRIN

salsalate DISALCID

NON-STEROIDAL ANTIINFLAMMATORY AGENTS

diclofenac potassium CATAFLAM

diclofenac sodium VOLTAREN

QLL **etodolac regular release** LODINE

fenoprofen calcium NALFON

ibuprofen ADVIL

ibuprofen MOTRIN

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QLL	indomethacin	INDOCIN
	meloxicam	MOBIC
	naproxen	NAPROSYN
	piroxicam	FELDENE
	sulindac	CLINORIL

etodolac/LODINE maximum quantity 90 units per month
meloxicam/MOBIC maximum quantity 30 units per month

OTHER DRUGS FOR ARTHRITIS

auranofin	RIDAURA
penicillamine	CUPRIMINE
lefunomide	ARAVA

DRUGS TO PREVENT AND TREAT GOUT

allopurinol	ZYLOPRIM
colchicine	
probenecid	

DIRECT MUSCLE RELAXANTS

QLL	baclofen	LIORESAL
QLL	dantrolene sodium	DANTRIUM

baclofen/LIORESAL maximum quantity 90 per fill
dantrolene sodium/DANTRIUM maximum quantity 120 per fill

CNS MUSCLE RELAXANTS

cyclobenzaprine	FLEXERIL
methocarbamol	ROBAXIN

NUTRITION, BLOOD

VITAMINS & MINERALS & RELATED PRODUCTS

OTC	calcium carbonate tablet	TUMS
OTC	ferrous gluconate	FERGON
OTC	ferrous sulfate	FERATAB
OTC	folic acid/vit b complex with c	DAILYVITE
OTC	multivitamins	
OTC	pyridoxine	NESTREX
OTC	vitamin b complex	
OTC	vitamin e	

THERAPEUTIC VITAMINS & MINERALS

QLL	calcium acetate	PHOSLO
PA	cyanocobalamin 1000mcg injectable	
OTC	doxercalciferol	HECTOROL
OTC	folic acid	
OTC	zinc acetate	

cyanocobalamin maximum quantity 10ml
doxercalciferol/HECTOROL requires prior authorization

FLUORIDE PRODUCTS

sodium fluoride

ETHEDENT

POTASSIUM SUPPLEMENTS

potassium chloride

POTASSIUM REMOVING RESINS

sodium polystyrene sulfonate
sodium polystyrene sulfonate

KIONEX
SPS

ORAL ANTICOAGULANTS, VITAMIN K

warfarin sodium

COUMADIN

HEPARIN AND HEPARIN ANTAGONISTS

PA-SPBM QLL enoxaparin

LOVENOX

enoxaparin/LOVENOX use specialty pharmacy for chronic treatment use only
enoxaparin/LOVENOX maximum quantity 20 syringes or 10 days therapy whichever is
greater; prior authorization required for greater quantities or longer duration of therapy.

ANTIPLATELET DRUGS

clopidogrel
dipyridamole
ticlopidine

PLAVIX
PERSANTINE
TICLID

BLOOD DETOXICANTS

OTC lactulose
PA lanthanum carbonate

ENULOSE
FOSRENOL

lanthanum carbonate/FOSRENOL requires 30 day trial of PHOSLO for prior authorization

ELECTROLYTES, IRRIGATING SOLUTIONS, ETC.

OTC electrolyte solution

PEDIALYTE

OBSTETRICAL & GYNECOLOGICAL MEDICATIONS

PRENATAL VITAMINS

OTC iron
OTC, RX prenatal vitamins, generic

Prenatal vitamins generics only covered for women age 14 – 45.

OB/GYN TOPICAL ANTIINFECTIVES

QLL metronidazole 0.75% gel

METROGEL

ANDROGEN DRUGS

PA testosterone
PA testosterone
PA testosterone cypionate IM

ANDRODERM
ANDROGEL

testosterone/ANDRODERM requires prior authorization; testosterone Injectable is 1st line
testosterone/ANDROGEL requires prior authorization; testosterone Injectable is 1st line
testosterone cypionate or enanthate requires prior authorization

ESTROGEN DRUGS

QLL	estradiol patch estradiol tab	CLIMARA ESTRACE
	estrogens, conjugated estropipate	PREMARIN ORTHO-EST

estradiol/CLIMARA maximum quantity 4 units per fill

ESTROGEN/PROGESTIN COMBINATIONS

estrogen/medroxyprogesterone	PREMPRO
estrogen/medroxyprogesterone	PREMPHASE
norethindrone A-E estradiol	FEMHRT

SELECTIVE ESTROGEN RECEPTOR MODULATORS

raloxifene	EVISTA
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PROGESTIN DRUGS

PA	levonorgestrel	MIRENA IUD
QLL	medroxyprogesterone	PROVERA
QLL	norethindrone	ERRIN
QLL	norethindrone	CAMILA
QLL	norethindrone	JOLIVETTE
QLL	norethindrone	NORA-BE
	norethindrone acetate	AYGESTINE

levonorgestrel/MIRENA requires prior authorization
medroxyprogesterone/PROVERA maximum quantity 1 unit per fill
norethindrone/ERRIN maximum quantity 3 units per fill
norethindrone/CAMILA maximum quantity 3 units per fill
norethindrone/JOLIVETTE maximum quantity 3 units per fill
norethindrone/NORA-BE maximum quantity 3 units per fill

CONTRACEPTIVES

QLL	desogestrel-ethinyl estradiol	APRI
QLL	desogestrel-ethinyl estradiol / ethynodiol	KARIVA
QLL	ethinyl estradiol/drospirenone	YASMIN / 28
QLL	ethinyl estradiol/norelgest	ORTHO EVRA
QLL	ethynodiol diace-eth estradiol	ZOVIA
QLL	etonogestrel/ethin estradiol	NUVARING
	levonorgestrel	PLAN B
QLL	levonorgestrel-ethin estradiol	TRIVORA
QLL	levonorgestrel-ethin estradiol	LEVORA
QLL	levonorgestrel-ethin estradiol	AVIANE
QLL	levonorgestrel-ethin estradiol	ENPRESSE
QLL	levonorgestrel-ethin estradiol	PORTIA
QLL	levonorgestrel-ethin estradiol	LESSINA
QLL	levonorgestrel-ethin estradiol	LEVORA
QLL	noreth A-ET estra/fe fumarate	MICROGESTIN
QLL	noreth A-ET estra/fe fumarate	ESTROSTEP FE
QLL	noreth A-ET estra/fe fumarate	JUNEL FE
QLL	norethindrone-ethin estradiol	NECON
QLL	norethindrone-ethin estradiol	NORTREL
QLL	norethindrone-ethin estradiol	BREVICON
QLL	norethindrone-ethin estradiol	NELOVA

Boldface indicates generic availability - 35

QLL	norethindrone-mestranol	NECON
QLL	norethindrone-mestranol	NELOVA
QLL	norgestimate-ethinyl estradiol	ORTHO TRI-CYCLEN
LO		
QLL	norgestimate-ethinyl estradiol	TRINESSA
QLL	norgestimate-ethinyl estradiol	SPRINTEC
QLL	norgestimate-ethinyl estradiol	TRI-SPRINTEC
QLL	norgestimate-ethinyl estradiol	MONONESSA
QLL	norgestimate-ethinyl estradiol	PREVIFEM
QLL	norgestrel-ethinyl estradiol	LOW-OGESTREL
QLL	norgestrel-ethinyl estradiol	CRYSSELLE
QLL	norgestrel-ethinyl estradiol	OGESTREL

etonogestrel/ethin estradiol/NUVARING maximum quantity one (1) cycle per fill
All quantity level limits are maximum one (1) cycle per fill

OXYTOCICS

methylergonovine	METHERGINE
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OPHTHALMIC MEDICATIONS

OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS

	bacitracin	ILOTYCIN
	erythromycin	GENTAK
	gentamicin	VIGAMOX
PA	moxifloxacin	NEOSPORIN
	neomycin/bacitracin/polymyxin	OCUFLOX
	ofloxacin	POLYTRIM
	polymyxin B sulfate	CETAMIDE
	sulfacetamide	TOBEX
	tobramycin	VIROPTIC
	trifluridine	

moxifloxacin/VIGAMOX eye drops require prior authorization
ofloxacin/OCUFLOX eye drops require prior authorization

OPHTHALMIC CORTICOSTEROID DRUGS

	dexamethasone sodium phosp	DECADRON
	loteprednol etabonate	LOTEMAX
	prednisolone acetate	ECONOPRED
	prednisolone sodium phosphate	PREDNISOL
PA	rimexolone	VEXOL

rimexolone/VEXOL 1% eye drops require prior authorization

OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS

	neomycin/polymyxin/dexameth	DEXACINE
	sulfacetamide/prednisolone SP	VASOCIDIN
	sulfacetamide/prednisolone AC	BLEPHAMIDE
	tobramycin sulfate/dexameth	TOBRADEX

ANTIGLAUCOMA DRUGS

	acetazolamide	DIAMOX
	bimatoprost	LUMIGAN
	brimonidine tartrate	ALPHAGAN / P

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brinzolamide
dipivefrin
 latanoprost
levobunolol
methazolamide
pilocarpine
 timolol

AZOPT
 PROPINE
 XALATAN
 BETAGAN
 NEPTAZANE
 PILOPINE
 BETIMOL

OTHER OPHTHALMIC DRUGS

OTC	atropine sulfate carboxymethylcellulose, sodium	ATROPISOL THERA TEARS
OTC	cromolyn dextran 70/he-cell	OPTICROM TEARS NATURALE
OTC PA PA	hydroxypropyl methylcellulose ketorolac diclofenac 0.5%	GENTEAL ACULAR Voltaren
OTC	lanolin/mineral oil/petrolatum	
OTC	naphazoline/pheniramine	NAPHCON-A
OTC	petrolatum, white	PURALUBE
OTC	polyvinyl alcohol	HYPOTEARs

RESPIRATORY MEDICATIONS

BETA-2 ADRENERGIC DRUGS

QLL	albuterol HFA	PROAIR HFA
QLL	albuterol soln, tabs	PROVENTIL
QLL	formoterol fumarate	FORADIL
QLL	salmeterol	SEREVENT DISKUS
	terbutaline sulfate	BRETHAIRE

albuterol/PROAIR HFA maximum quantity 2 inhalers every 30 days
 formoterol fumarate/FORADIL maximum quantity 60 capsules every 30 days
 salmeterol/SEREVENT DISKUS maximum quantity 1 inhaler every 30 days

METHYL XANTHINE DRUGS

theophylline AEROLATE

OTHER DRUGS FOR ASTHMA

QLL	albuterol sulfate/ipratropium	COMBIVENT
QLL	budesonide	PULMICORT
FLEXHALER		
QLL	budesonide	PULMICORT
RESPULES		
QLL	cromolyn	INTAL
QLL	epinephrine	EPIPEN / JR
QLL	fluticasone propionate	FLOVENT HFA /
DISKUS		
QLL	formoterol/budesonide	SYMBICORT
QLL	ipratropium	ATROVENT HFA
QLL	mometasone	ASMANEX
QLL	salmeterol/fluticasone	ADVAIR HFA / DISKUS
	sodium chloride	BRONCHO SALINE

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albuterol sulfate/ipratropium/COMBIVENT maximum quantity 3 inhalers per fill
 budesonide/PULMICORT Flexhaler maximum quantity 1 inhaler every 30 days
 budesonide/PULMICORT Respules maximum quantity 60 units every 30 days for members up to 6 years of age
 cromolyn/INTAL maximum quantity 2 inhalers per fill
 epinephrine/EPIPEN/EPIPEN JR maximum quantity 2 units per year
 fluticasone propionate/FLOVENT maximum quantity 1 inhaler every 30 days
 formoterol/budesonide/SYMBICORT maximum quantity 1 inhaler every 30 days
 ipratropium/ATROVENT HFA maximum quantity 1 inhaler every 30 days
 mometasone/ASMANEX maximum quantity 1 in haler every 30 days
 salmeterol/fluticasone/ADVAIR HFA/ADVAIR DISKUS maximum quantity 1 inhaler every 30 days

LEUKOTRIENE MODIFIERS

ST	montelukast sodium	SINGULAIR
ST	zafirlukast	ACCOLATE

montelukast sodium/SINGULAIR for non-asthma use requires trial of generic non-sedating antihistamine plus nasal steroid; for asthma use requires trial of beta-agonist and steroid inhaler for at least 30 days
 zafirlukast/ACCOLATE for non-asthma use requires trial of generic non-sedating antihistamine plus nasal steroid; for asthma use requires trial of beta-agonist and steroid inhaler for at least 30 days

ANTI HISTAMINES

QLL, OTC	cetirizine tabs	ZYRTEC
ST, QLL, OTC	cetirizine syrup	ZYRTEC
OTC	chlorpheniramine	CHLOR-TRIMETON
	clemastine fumarate	TAVIST
	cyproheptadine	PERIACTIN
	diphenhydramine tablet, capsule	BENADRYL
PA, QLL	fexofenadine	ALLEGRA
QLL, OTC	loratadine tablet, syrup	CLARITIN
	promethazine	PHENERGAN

cetirizine/ZYRTEC syrup, maximum quantity 150mL every 30 days Limited to children up to the age of 9
 cetirizine/ZYRTEC tabs maximum quantity 30 units per fill
 fexofenadine/ALLEGRA requires prior authorization, maximum quantity 30 units per fill
 loratadine/CLARITIN maximum quantity 30 units per fill
 loratadine/CLARITIN syrup maximum quantity 150ml every 30 days. Limited to children up to the age of 9.

DECONGESTANTS

OTC	pseudoephedrine	SUDAFED
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ANTI HISTAMINE/DECONGESTANT COMBINATIONS

	phenylephrine/brompheniramine	BROMFED CAP
OTC	pseudoephedrine/brompheniramine	BROMFED CAP SA,
	DRIXORAL	SYR

OTC	pseudoephedrine/chlorpheniramine	CHLOR-TRIMETON D, DECONAMINE SR CAP
OTC TABS	pseudoephedrine/triprolidine	HISTAFED SYR, HISTA-

RESPIRATORY MEDICATIONS

ANTITUSSIVE AND EXPECTORANT DRUGS

	benzonatate	TESSALON
	codeine/promethazine	PHENERGAN
W/CODEINE	dextromethorphan/promethazine	PROMETHAZINE
	dextromethorphan/pseudoephedrine/ chlorpheniramine	TRIAMINIC
COLD/COUGH		
OTC	guaifenesin/codeine	GUIATUSS AC
OTC	guaifenesin/dextromethorphan	GUAICON
OTC	guaifenesin/pseudoephedrine	ROBITUSSIN PE
	guaifenesin syrup	MUCINEX
OTC	hydrocodone/homatropine	HYCODAN
	phenylephrine/codeine/promethazine	PHENERGAN
	phenylephrine/hydrocodone/chlorpheniramine	H-C TUSSIVE

OTHER RESPIRATORY DRUGS AND DEVICES

PA	alpha-1-proteinase inhibitor	ARALAST
PA	alpha-1-proteinase inhibitor spacer	PROLASTIN AERO-CHAMBER

alpha-1-proteinase inhibitor/ARALAST requires prior authorization

alpha-1-proteinase inhibitor/PROLASTIN requires prior authorization

SPECIALTY MEDICATIONS

Aralast*	Neulasta*
Aranesp*	Neupogen*
Aredia*	Orencia*
Avastin*	Orthovisc*
Avonex*	Pamidronate Disodium*
Betaseron*	Pegasys*
Boniva Injection*	Procrit*
CellCept Injection*	Prograf Injection*
Copaxone*	Provisc*
Cyclospine*	Pulmozyme*
DDAVP Injection*	Remodulin*
Desferal*	Revatio*
Eligard *	Ribavirin*
Enbrel	Rituxin*
Epogen*	Sandimmune
Erbitux*	Sandostatin
Exjade*	Supartz*
Flolan* - generic available	Synagis*
Forteo*	Tarceva*
Fuzeon*	Temodar*
GenoTropin*	Tev-Tropin*
Humira*	Thalomid*

Boldface indicates generic availability - 39

Hyalgan*	Tobi*
Immune Globulin IM*	Tracleer*
Immune Globulin IV*	Tykerb*
Implanon*	Tysabi*
Kineret*	Vectibix
Letairus*	Vivaglobin*
Lovenox – Extended use*	Xeloda*
Lupron, Lupron Depot*	Xolair*
Methotrexate Injection*	Zemaira*

*Note: All Specialty medications that are dispensed to the member require HCA prior authorization and are distributed by Health Choice's Designated Specialty Pharmacy.

Specialty Drug Medication description	J Code
17 ALPHA-HYDROXYPROGESTERONE CAPROATE	J3490
ALPHA 1 - PROTEINASE INHIBITOR - HUMAN, 10 MG	J0256
APREPITANT 5 MG	J8501
BORTEZOMIB, 0.1 MG	J9041
CETUXIMAB, 10 MG	J9055
BEVACIZUMAB, 10 MG	J9035
BORTEZOMIB, 0.1MG	J9041
DAPTOMYCIN, 1 MG	J0878
DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE)	J0881
DARBEPOETIN ALFA, 1 MICROGRAM (FOR ESRD ON DIALYSIS)	J0882
DEFEROXAMINE MESYLATE, 500 MG	J0895
DOLASETRON MESYLATE, 10 MG	J1260
ENOXAPARIN SODIUM, 10 MG	J1650
EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS)	J0886
EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS	J0885
EPOPROSTENOL, 0.5 MG	J1325
ETANERCEPT, 25 MG	J1438
ETONOGESTREL IMPLANT, 68 MG	J7307
FILGRASTIM (G-CSF), 300 MCG	J1440
FILGRASTIM (G-CSF), 480 MCG	J1441
GAMMA GLOBULIN, INTRAMUSCULAR, OVER 10 CC	J1560
GEMCITABINE, 200 MG	J9201
GANCICLOVIR SODIUM, 500 MG	J1570
GRANISETRON HYDROCHLORIDE, 100 MCG	J1626
HISTRELIN IMPL ANT, 50 MG	J9225
	J9226
HYALURONIAN (SODIUM HYALURONATE) FOR G F 20, HYALGAN, HYLAN, PROVISC, EUFLEXXA, & SUPARTZ PRODUCTS	J7321
	J7322
	J7323
	J7324
IMIGLUCERASE, PER UNIT	J1785
IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG	J1566
IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID),500MG	J1567
INFLIXIMAB, 10 MG	J1745
KETOROLAC TROMETHAMINE, 15 MG	J1885
LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 3.75 MG	J1950
LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG	J9217

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LINEZOLID, 200MG	J2020
NATALIZUMAB, 1 MG	J2323
OCTREOTIDE, NON-DEPOT FORM FOR INTRAMUSCULAR INJECTION, 25mcg	J2354
OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	J2353
ONDANSETRON HYDROCHLORIDE, PER 1 MG	J2405
PAMIDRONATE DISODIUM, PER 30 MG	J2430
PALONOSETRON HCL, 25 MCG	J2469
PANITUMUMAB 10 mg	J9303
PEGFILGRASTIM, 6 MG	J2505
RENIBIZUMAB, 0.5MG	J2778
RITUXIMAB, 100 MG	J9310
SARGRAMOSTIM (GM-CSF), 50 MCG	J2820
TESTOSTERONE CYPIONATE, 1 CC, 200 MG	J1080
TESTOSTERONE SUSPENSION, UP TO 50 MG	J3140
TESTOSTERONE CYPIONATE, UP TO 100 MG	J1070
TESTOSTERONE CYPIONATE AND ESTRADIOL CYPIONATE, UP TO 1 ML	J1060
TESTOSTERONE ENANTHATE, UP TO 100 MG	J3120
TESTOSTERONE ENANTHATE, UP TO 200 MG	J3130
TOBRAMYCIN, INHALATION SOLUTION, 300MG	J7682
TRASTUZUMAB, 10 MG	J9355
TREPROSTINIL, 1 MG	J3285
TRIAMCINOLONE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME	J7683
ZOLEDRONIC ACID, 1 MG	J3487
UNCLASSIFIED DRUGS	J3490
UNCLASSIFIED BIOLOGICS	J3590
UNCLASSIFIED ANTINEOPLASTIC DRUGS	J9999

* HCA PA required if administered in provider office

UROLOGICAL MEDICATIONS

ANTICHOLINERGIC ANTISPASMODICS

QLL	oxybutynin, ER	DITROPAN, XL
	tolterodine tartrate	DETROL
	tolterodine tartrate	DETROL LA
	oxybutynin ER/DITROPAN XL maximum quantity 30 units per fill	

CHOLINERGIC STIMULANTS

QLL	bethanechol	MYOTONACHOL
	bethanechol/MYOTONACHOL maximum quantity 120 per fill	

URINARY ANESTHETICS

OTC	phenazopyridine	URISTAT
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OTHER GENITOURINARY PRODUCTS

PA	dutasteride	AVODART
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Boldface indicates generic availability - 41

PA	finasteride	PROSCAR
PA	tamsulosin	FLOMAX

dutasteride/AVODART requires prior authorization after trial of doxazosin or terazosin
 finasteride/PROSCAR 5mg tablets requires prior authorization after trial of doxazosin or terazosin
 tamsulosin/FLOMAX requires prior authorization after trial of doxazosin or terazosin

DIAGNOSTIC & MISCELLANEOUS MEDICATIONS

DIAGNOSTIC PRODUCTS

OTC	ketone testing products	KETOCARE
OTC	ketone testing products	CHEMSTRIP

MEDICAL (MISCELLANEOUS) SUPPLIES

DIABETIC SUPPLIES

OTC	glucose monitors, supplies ADVANTAGE,	ACCU-CHEK AVIVA,
	insulin syringes/needles	COMPACT PLUS NOVOFINE / 30
	insulin syringes/needles	PRECISION

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