

AHCCCS Formulary List of covered drugs 2012

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

Health
CHOICE

“Welcome to Our Family”

2011 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.

simvastatin

ZOCOR

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

Flagyl

metronidazole 0.75% vaginal gel

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

Boldface indicates generic availability - 5

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
6 – **Boldface** indicates generic availability

any one therapeutic class of drug products (e.g., NTI drugs) differently 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.”

Children's Rehabilitative Services (CRS)

Prescriptions for CRS member's qualifying conditions must be processed by CRS network pharmacies and billed to CRS.

Regional Behavioral Health Agency (RBHA)

Prescriptions for RBHA enrolled member's behavioral health conditions must be processed by RBHA network pharmacies and billed to the specific RBHA.

Off-label Prescribing Guidelines

Health Choice Medical Services does not and cannot 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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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
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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 10%, 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

DRUGS AFFECTING THE THROAT AND MOUTH

QLL docosanol

ABREVA

docosanol/ABREVA maximum quantity 2 gm every 30 days

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

kaolin-pectin

KAOPECTATE

loperamide

IMODIUM

bismuth subsalicylate

PEPTO BISMOL

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ANTIULCER DRUGS

cimetidine
ranitidine

TAGAMET
ZANTAC

PROTON PUMP INHIBITORS

PA,QLL lansoprazole
QLL omeprazole magnesium

Prevacid OTC
PRILOSEC OTC

Lansoprazole maximum quantity 60 tablets every 30 days
omeprazole magnesium/PRILOSEC maximum quantity 60 tablets every 30 days.
Omeprazole is the HCA Formulary 1st line choice, Prevacid is the 2nd line choice, see the HCA Formulary for the 3rd and 4th line choices.

LAXATIVES AND CATHARTICS

bisacodyl
docusate sodium
magnesium hydroxide

DULCOLAX
COLACE
MILK OF MAGNESIA

magnesium sulfate
phenolphthalein
polyethylene glycol
psyllium
senna/docusate sodium
sennosides a&b, calcium
sodium phosphate/NA biphos

EPSOM SALT

GLYCOLAX
METAMUCIL
SENOKOT
EX-LAX
ENEMA

OTHER GI DRUGS

simethicone

GAS-X

MUSCULOSKELETAL MEDICATIONS

SALICYLATES AND RELATED DRUGS

aspirin
aspirin/acetaminophen/caffeine

BAYER
EXCEDRIN

NUTRITION, BLOOD

VITAMINS & MINERALS & RELATED PRODUCTS

calcium carbonate tablet
ferrous gluconate
ferrous sulfate
folic acid/vit b complex with c
multivitamins

TUMS
FERGON
FERATAB
DAILYVITE
Daily generic vitamins

pyridoxine
vitamin b complex
vitamin e

NESTREX

THERAPEUTIC VITAMINS & MINERALS

folic acid
zinc acetate

BLOOD DETOXICANTS

lactulose

ENULOSE

ELECTROLYTES, IRRIGATING SOLUTIONS, ETC.

electrolyte solution

PEDIALYTE

OBSTETRICAL & GYNECOLOGICAL MEDICATIONS

PRENATAL VITAMINS

Iron: ferrous sulfate and ferrous gluconate

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

lanolin/mineral oil/petrolatum

naphazoline/pheniramine

petrolatum, white

polyvinyl alcohol

GENTEAL

PURALUBE

NAPHCON-A

PURALUBE

HYPOTEARs

RESPIRATORY MEDICATIONS

ANTI-HISTAMINES

QLL,OTC

cetirizine tabs,syrup

chlorpheniramine tabs and syrup

ZYRTEC

CHLOR-TRIMETON

QLL, OTC

loratadine tabs, syrup

clemastine tabs

diphenhydramine caps, tabs, elixir

CLARITIN

TAVIST-1

BENADRYL

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

loratadine/CLARITIN. 150ml every 30 days Limited to children up to the age of 9. maximum quantity 30units per fill

DECONGESTANTS

Pseudoephedrine tabs, syrup

SUDAFED

ANTITUSSIVE AND EXPECTORANT DRUGS

guaifenesin/dextromethorphan syrup

guaifenesin/pseudoephedrine syrup & caps

GUAICON

SINUTAB LiquiCaps

guaifenesin syrup

ROBITUSSIN

SMOKING CESSATION PRODUCTS

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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	KETOCARE
	ketone testing products	CHEMSTRIP

MEDICAL (MISCELLANEOUS) SUPPLIES

DIABETIC SUPPLIES		
	glucose monitors, supplies	ACCU-CHEK AVIVA, COMPACT PLUS

HCA Formulary

ANTIINFECTIVES

CEPHALOSPORINS

QLL	cefaclor	CECLOR
	cefdinir	OMNICEF
	cefixime 400mg	SUPRAX
	cefprozil	CEFZIL
	cephalexin	KEFLEX

cefixime 400mg/SUPRAX maximum quantity 1 per month

CLINDAMYCINS

QLL	clindamycin hcl	CLEOCIN HCL
	clindamycin palmitate	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	ERY-TAB
erythromycin ethylsuccinate	E.E.S

OTHER MACROLIDES

QLL	azithromycin	ZITHROMAX
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azithromycin/ZITHROMAX maximum quantity 6 units per fill

PENICILLINS

*	amoxicillin	AMOXIL
	amoxicillin clavulanate	AUGMENTIN
	ampicillin	PRINCIPEN
	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
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levofloxacin
moxifloxacin

LEVAQUIN
AVELOX / ABC PACK

AMINOGLYCOSIDE

paromomycin

HUMATIN

TOPICAL ANTIBACTERIAL DRUGS

OTC bacitracin

OTC bacitracin zinc

OTC bacitracin/polymyxin

Polysporin

clindamycin hcl topical solution 1%

erythromycin top solution 2%

gentamicin sulfate

PA mupirocin oint

OTC neomycin/bacitracin/polymyxin

silver sulfadiazine

CLEOCIN HCL

A/T/S

GARAMYCIN

BACTROBAN

NEOSPORIN

SILVADENE

mupirocin/BACROBAN requires prior authorization

ORAL ANTIFUNGAL DRUGS

PA, QLL clotrimazole

fluconazole

PA, QLL griseofulvin ultramicrosize

itraconazole

ketoconazole

nystatin

PA, QLL terbinafine

MYCELEX

DIFLUCAN

GRIS-PEG

SPORANOX

NIZORAL

MYCOSTATIN

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

OTC clotrimazole

OTC miconazole nitrate

nystatin

FEMSTAT 3

MYCELEX

MONISTAT

MYCOSTATIN

OTHER TOPICAL ANTIFUNGALS

OTC clotrimazole

ketoconazole

OTC miconazole nitrate

LOTTRIMIN

NIZORAL

MICRO-GUARD

nystatin

OTC tolnaftate

MYCOSTATIN

TINACTIN

TOPICAL CORTICOSTEROIDS

nystatin/triamcinolone

MYCOLOG

ANTIRETROVIRALS & PROTEASE INHIBITORS

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

enfuvirtide/FUZEON use specialty pharmacy

OTHER ANTIVIRAL DRUGS

	acyclovir	ZOVIRAX
PA, SPBM	amantadine	SYMMETREL
	boceprevir	VICTRELIS
	ganciclovir	CYTOVENE
	lamivudine	EPIVIR
PA	lamivudine	EPIVIR HBV
	oseltamivir phosphate	TAMIFLU
PA, SPBM	ribavirin	COPEGUS
PA, SPBM	ribavirin	REBETOL
PA, SPBM	telaprevir	INCIVEK
PA, QLL	valacyclovir	VALTREX
	zanamivir	RELENZA

INCIVEK, ribavirin/COPEGUS, REBETOL, VICTRELIS are dispensed by the HCA specialty pharmacy
valacyclovir/VALTREX requires prior authorization, maximum quantity 30 units per fill

TOPICAL ANTIVIRAL DRUGS

PA	acyclovir cream, oint	ZOVIRAX CREAM, OINT
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docosanol cream

Abreva

ANTITUBERCULOSIS DRUGS

ethambutol
isoniazid
pyrazinamide
rifampin

MYAMBUTOL
NYDRAZID

RIFADIN

PLASMODICIDES

hydroxychloroquine
mefloquine
primaquine

PLAQUENIL
LARIAM

SULFONES

dapsone

TRICHOMONOCIDES

metronidazole

FLAGYL

ANTHELMINTICS

mebendazole
pyrantel

VERMOX
PIN-X

OTHER ANTIINFECTIVE DRUGS

PA atovaquone
vancomycin

MEPRON
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

flutamide

EULEXIN

hydroxyurea

HYDREA

PA, SPBM infliximab

REMICADE

letrozole

FEMARA

lomustine

CEENU

megestrol

MEGACE

PA, SPBM melphalan

ALKERAN

mercaptopurine

PURINETHOL

methotrexate

RHEUMATREX

	mitotane	LYSODREN
tacrolimus	mycophenolate mofetil	CELLCEPT
	procarbazine	MATULANE
	sirolimus	RAPAMUNE
	PROGRAF	
	tamoxifen	NOLVADEX
	thioguanine	
	toremifene	FARESTON

abatacept/maltose/ORENCIA requires prior authorization, use specialty pharmacy
adalimumab/HUMIRA requires prior authorization, use specialty pharmacy, maximum quantity 3 units per fill

anagrelide/AGRYLIN requires prior authorization, requires prior authorization

cyclophosphamide/CYTOXAN requires prior authorization, use specialty pharmacy

cyclosporine/SANDIMMUNE requires prior authorization, use specialty pharmacy

etanercept/ENBREL requires prior authorization, use specialty pharmacy, maximum quantity 8 units per dispensing

etoposide/TOPOSAR requires prior authorization, use specialty pharmacy

infliximab/REMICADE requires prior authorization, use specialty pharmacy

melfalan/ALKERAN requires prior authorization, use specialty pharmacy

mycophenolate mofetil/CELLCEPT Injectable requires prior authorization, use specialty pharmacy

tacrolimus/PROGRAF Requires prior authorization, 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
indapamide	LOZOL
metolazone	ZAROXOLYN

POTASSIUM SPARING DIURETICS

spironolactone	ALDACTONE
spironolactone/hctz	ALDACTAZIDE

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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

ST losartan

AVAPRO

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 /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
isosorbide mononitrate

SORBITRATE
MONOKET

Boldface indicates generic availability - 21

isosorbide mononitrate	IMDUR
nitroglycerin sublingual	NITROSTAT
nitroglycerin transdermal ointment	NITRO-BID

CLASS 1A

procainamide	PRONESTYL
quinidine gluconate	QUINAGLUTE
quinidine sulfate	QUINIDEX

CLASS 1C

propafenone	RHYTHMOL
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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	NIASPAN (500mg ER)

HMG-COA REDUCTASE INHIBITORS

QLL	atorvastatin calcium 80 mg ONLY	LIPITOR 80 mg ONLY
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QLL	lovastatin	MEVACOR
QLL	pravastatin	PRAVACHOL
QLL	simvastatin	ZOCOR

atorvastatin calcium/LIPITOR 80 mg only 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

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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 120 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
	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

DRUGS TO PREVENT AND TREAT HEADACHES

	apap/butalbital/caffeine	FIORICET
	aspirin/butalbital/caffeine	FIORINAL
	codeine/apap/butalbital/caffeine	FIORICET
	codeine/asa/butalbital/caffeine	FIORINAL
QLL	ergotamine tartrate/caffeine	CAFERGOT
	naratriptan hcl	AMERGE
QLL	sumatriptan	IMITREX

Naratriptan/AMERGE maximum quantity 9 tablets every 30 days
 sumatriptan/IMITREX maximum quantity 9 tablets every 30 days; nasal spray & injection maximum quantity 6 units every 30 days

ANXIOLYTICS

QLL	alprazolam	XANAX
	buspirone	BUSPAR

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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
maximum quantity 120 units collectively every 30 days
RBHA members must obtain through the RBHA program.

SEDATIVE/HYPNOTIC DRUGS

	chloral hydrate	SOMNOTE
QLL	temazepam	RESTORIL
ST, QLL	zolpidem	AMBIEN

temazepam/RESTORIL maximum quantity 14 capsules every 30 days
zolpidem/AMBIEN requires trial of temazepam first, maximum quantity 14 tablets every 30 days

CARBAMAZEPINES

	carbamazepine	CARBATROL
	carbamazepine	TEGRETOL
PA	oxcarbazepine	TRILEPTAL

oxcarbazepine/TRILEPTAL requires prior authorization; maximum quantity 120 units every 30 days

ANTICONSULSANT BENZODIAZEPINES

	clonazepam	KLONOPIN
QLL	diazepam	DIASTAT

diazepam/DIASTAT maximum quantity 1 twinpak per fill

HYDANTOINS

	phenytoin	DILANTIN
	phenytoin sodium	DILANTIN

VALPROIC ACID AND DERIVATIVES

	divalproex	DEPAKOTE
	valproic acid	DEPAKENE

SUCCINIMIDES

	ethosuximide	ZARONTIN
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ethosuximide/ZARONTIN maximum quantity 120 units every 30 days

ANTICONSULSANT BARBITURATES

	phenobarbital	
	primidone	MYSOLINE

OTHER ANTICONSULSANTS

PA	felbamate	FELBATOL
QLL	gabapentin	NEURONTIN

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PA	lamotrigine	LAMICTAL
QLL	levetiracetam	KEPPRA
QLL	topiramate	TOPAMAX

felbamate/FELBATOL requires prior authorization
gabapentin/NEURONTIN requires maximum quantity 90 units per fill, all strengths combined
lamotrigine/LAMICTAL requires prior authorization. RBHA members must obtain through the RBHA program.

levetiracetam/Keppra maximum quantity up to 120 tablets every 30 days
topiramate/TOPAMAX maximum quantity 60 tabs per 30 days
Valproic acid – RBHA members must obtain through the RBHA program.

TERTIARY AMINES

amitriptyline	ELAVIL
doxepin	ADAPIN
imipramine hcl	TOFRANIL
imipramine pamoate	TOFRANIL PM

RBHA members must obtain through the RBHA program.

SECONDARY AMINES

desipramine	NORPRAMIN
nortriptyline	AVENTYL

RBHA members must obtain through the RBHA program.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS

citalopram	CELEXA
fluoxetine	PROZAC
paroxetine	PAXIL
PA	PAXIL CR
sertraline	ZOLOFT

RBHApoxetine/PAXIL CR PAXILCR requires prior authorization, use RBHA program

RBHA members must obtain SSRI's through the RBHA program.

OTHER ANTIDEPRESSANTS

	bupropion	WELLBUTRIN
PA, QLL	bupropion	WELLBUTRIN, SR
PA, QLL	bupropion	WELLBUTRIN XL
QLL	milnacipran	SAVELLA
	mirtazapine	REMERON
	trazodone	DESYREL

mirtazapine/REMERON requires prior authorization
milnacipran/Savella maximum quantity 60 units per 30 days
bupropion/WELLBUTRIN SR/XL requires prior authorization
RBHA members must obtain through the RBHA program.

MAO INHIBITORS

tranylcypromine	PARNATE
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RBHA members must obtain through the RBHA program.

SMOKING CESSATION PRODUCTS

QLL	bupropion 150mg SR	ZYBAN
QLL,OTC	nicotine polacrilex gum	NICORETTE
QLL	nicotine inhaler	NICOTROL
QLL	nicotine nasal spray	NICOTROL
QLL,OTC	nicotine patch	NICODERM CQ
QLL	varenicline tartrate	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	DRAMAMINE
PA, QLL	granisetron	KYTRIL
	meclizine hcl	MEDIVERT
PA, QLL	ondansetron	ZOFRAN / ODT
	prochlorperazine maleate	COMPazine
	promethazine	PHENERGAN
	trimethobenzamide	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 24mgtab, 12 units per fill for 4 and 8mg tabs, 50ml per fill for liquid

ANTIPARKINSON ANTICHOLINERGIC DRUGS

benztropine	COGENTIN
trihexyphenidyl	ARTANE

OTHER ANTIPARKINSON DRUGS

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

bromocriptine mesylate/PARLODEL maximum quantity 30 tablets or capsules
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

RBHA members must obtain through the RBHA program.

CNS STIMULANTS*

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

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 RBHA 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

DRUGS TO TREAT MULTIPLE SCLEROSIS

SPBM, QLL, PA	glatiramer acetate	COPAXONE
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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 .5, 1, & 2.5% Cr & Oint	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

ANTIPRURITIC DRUGS

hydroxyzine hcl	ATARAX
hydroxyzine pamoate	VISTARIL

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ANTIACNE DRUGS

OTC	benzoyl peroxide gel, lotion, liquid (generics)	BREVOXYL
QLL	clindamycin phosphate 1% top solution/gel	CLEOCIN
	erythromycin 2% top soln, gel	A/T/S
QLL	metronidazole top gel 0.075%	METROGEL
PA	tretinoin	RETIN-A

clindamycin phosphate soln maximum quantity 60cc every 30 days, gel maximum quantity 30 gm every 30 days

metronidazole /Metrogel maximum quantity 45gm every 30 days

tretinoin/RETIN-A requires prior authorization;maximum quantity of 45 grams every 30 days

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; maximum quantity 100 grams every 30 days

tazarotene/TAZORAC requires prior authorization;maximum quantity 60 grams every 30 days

TOPICAL DERMATOLOGICAL DRUGS

OTC	calamine	
	fluorouracil 1% cream	FLUOROPLEX
OTC	hydrogen peroxide	
QLL	lidocaine 5% ointment	
OTC	mineral oil/petrolatum	AQUAPHOR
	permethrin	ACTICIN
OTC	piperonyl butoxide/pyrethrins	RID
	podofilox solution	CONDYLOX
OTC	urea 10%, 20% cream	Carmol

lidocaine 5% ointment maximum quantity 35.44 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

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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
QLL	docosanol	ABREVA
	triamcinolone acetonide	KENALOG
	lidocaine viscous	XYLOCAINE VISCOUS

docosanol/ABREVA maximum quantity 2 gm every 30 days

ENDOCRINE MEDICATIONS

INSULIN

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

Use with caution in geriatric patients

DIPEPTIDYL PEPTIDASE – IV INHIB

QLL	sitagliptin phosphate	JANUVIA
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sitagliptin/JANUVIA maximum quantity 30 tablets every 30 days

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
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THYROID SUPPLEMENTS

levothyroxine	LEVOXYL
levothyroxine	LEVOTHROID
levothyroxine	L-THYROXINE MYLAN
thyroid	

ANTITHYROID DRUGS

	methimazole	TAPAZOLE
	propylthiouracil	

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

ANTI-DIARRHEAL DRUGS

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

ANTI-SPASMODICS/DRUGS AFFECT GI MOTILITY

	dicyclomine	BENTYL
	hyoscyamine	CYSTOSPAZ
	metoclopramide	REGLAN
PA	propantheline	

ANTI-ULCER DRUGS

OTC	cimetidine	TAGAMET
OTC	ranitidine	ZANTAC

OTHER ANTI-ULCER DRUGS

	misoprostol	CYTOTEC
	sucralfate tabs	CARAFATE

PROTON PUMP INHIBITORS

PA, QLL, OTC	lansoprazole	PREVACID 15mg OTC
QLL, OTC	omeprazole magnesium	PRIOSECC OTC
PA, QLL	pantoprazole 40mg	PROTONIX

lansoprazole/PREVACID 15mg OTC maximum quantity 60 units ever 30 days.
omeprazole magnesium/PRIOSECC OTC maximum quantity 60 tablets every 30 days without PA.

PRIOSECC OTC is formulary 1st line therapy

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

Omeprazole OTC is 1st line PPI therapy; Prevacid OTC is 2nd line; Pantoprazole is 3rd line.

LAXATIVES AND CATHARTICS

OTC	bisacodyl	DULCOLAX
OTC	docusate sodium	COLACE
OTC	magnesium hydroxide	MILK OF MAGNESIA
OTC	magnesium sulfate	EPSOM SALT
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
	electrolyte solution/PEG'S	GOLYTELY
	electrolyte solution/PEG'S	NULYTELY
	hydrocortisone 2.5% rectal cream	
	hydrocortisone acetate	CORTIFOAM
	balsalazide	COLAZAL
	mesalamine	ASACOL/HD
	mesalamine	CANASA
	simethicone	MYLANTA
	sulfasalazine	AZULFIDINE
	ursodiol	URSO

amylase/lipase/protease /CREON / maximum quantity 270 units per 30 days

IMMUNOLOGICALS AND VACCINES

IMMUNOLOGICALS AND VACCINES

PA, SPBM	palivizumab	SYNAGIS
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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

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ERYTHROID STIMULANTS

PA	darbepoetin alfa	ARANESP
PA	epoetin alfa	PROCRIT

darbepoetin alfa/ARANESP use specialty pharmacy

epoetin alfa/PROCRIT 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

QLL	diclofenac potassium	CATAFLAM
	diclofenac sodium	VOLTAREN
	etodolac regular release	LODINE
	fenoprofen calcium	NALFON
	ibuprofen	ADVIL
QLL	ibuprofen	MOTRIN
	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

OTC	auranofin	RIDAURA
	capsaisin topical cream 0.025%	
PA	penicillamine	CUPRIMINE
	lefunomide	ARAVA

capsaicin 0.025% cream maximum quantity 60 gm per 30 days

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	calcitriol	ROCALTROL
	calcium acetate	PHOSLO
QLL	cyanocobalamin 1000mcg injectable	
PA	doxercalciferol	HECTOROL
QLL	ergocalciferol/vitamin d 50,000 units	
OTC	folic acid	
OTC	zinc acetate	

calcitriol/ROCALTROL maximum quantity 30 units every 30 days
cyanocobalamin maximum quantity 10ml
ergocalciferol 50,000 units maximum quantity 8 units per 28 days
doxercalciferol/HECTOROL requires prior authorization

FLUORIDE PRODUCTS

	sodium fluoride	ETHEDENT
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POTASSIUM SUPPLEMENTS

	potassium chloride	
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POTASSIUM REMOVING RESINS

34 – **Boldface** indicates generic availability

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% Vaginal gel**
Metronidazole, maximum quantity is 70 Grams

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, is 1st line

ESTROGEN DRUGS

QLL **estradiol patch**
estradiol tab
QLL **estradiol 1% vaginal cream**

CLIMARA
ESTRACE
ESTRACE vaginal cream

PA	estrogens, conjugated vaginal cream estrogens,conjugated	PREMARIN vag cream ENJUVA
	estropipate	ORTHO-EST

estradiol/CLIMARA maximum quantity 4 units per fill
estradiol 1% vaginal cream QLL 42.5 gm

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, note AHCCCS allowable pricing is in place.

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-ethilyn estradiol	APRI
QLL	desogestrel-ethilyn 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

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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

OPHTHALMIC CORTICOSTEROID DRUGS

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

prednisolone acetate/ECONOPRED maximum quantity 10cc every 30 days
rimexolone/VEXOL 1% eye drops require prior authorization; maximum quantity 10cc every 30 days

OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS

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

ANTIGLAUCOMA DRUGS

	acetazolamide	DIAMOX
QLL, ST	imatoprost	LUMIGAN

	brimonidine tartrate	ALPHAGAN / P
QLL	brinzolamide dipivefrin latanoprost levobunolol methazolamide pilocarpine timolol	AZOPT PROPINE XALATAN BETAGAN NEPTAZANE PILOPINE BETIMOL

bimatoprost/LUMIGAN maximum quantity 2.5cc every 30 days
latanoprost/XALATAN maximum quantity 2.5cc every 30 days

OTHER OPHTHALMIC DRUGS

OTC	atropine sulfate carboxymethylcellulose, sodium	ATROPISOL THERA TEARS
QLL	cromolyn	OPTICROM
OTC	dextran 70/he-cell	TEARS NATURALE
QLL	diclofenac sodium 0.1%	VOLTAREN
OTC	hydroxypropyl methylcellulose	GENTEAL
PA	ketorolac	ACULAR
OTC	lanolin/mineral oil/petrolatum	
OTC	naphazoline/pheniramine	NAPHCON-A
OTC	petrolatum, white	PURALUBE
OTC	polyvinyl alcohol	HYPOTEARs

cromolyn/OPTICROM maximum quantity 10cc every 30 days
diclofenac /VOLTAREN maximum quantity 2.5cc per 30 days

RESPIRATORY MEDICATIONS

BETA-2 ADRENERGIC DRUGS

QLL	albuterol HFA	PROAIR HFA
QLL	albuterol SVN 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
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OTHER DRUGS FOR ASTHMA

QLL	albuterol sulfate/ipratropium	COMBIVENT
QLL	beclomethasone dipropionate	QVAR
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

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QLL	salmeterol/fluticasone sodium chloride	ADVAIR HFA / DISKUS BRONCHO SALINE
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albuterol sulfate/ipratropium/COMBIVENT maximum quantity 3 inhalers per fill
 beclomethasone/QVAR maximum quantity 1 inhaler per 25 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
 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
QLL,OTC	cetirizine syrup	ZYRTEC
OTC	chlorpheniramine tabs, syrup	CHLOR-TRIMETON
	clemastine fumarate	TAVIST
	cyproheptadine	PERIACTIN
	diphenhydramine tablet, capsule	BENADRYL
PA, QLL	fexofenadine tabs, syrup	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 tabs, syrup	SUDAFED
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ANTI-HISTAMINE/DECONGESTANT COMBINATIONS

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

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OTC	pseudoephedrine/chlorpheniramine	SYR 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/	TRIAMINIC
COLD/COUGH	chlorpheniramine	
OTC	guaifenesin/codeine	GUIATUSS AC
OTC	guaifenesin/dextromethorphan	GUAICON
OTC	guaifenesin/pseudoephedrine	ROBITUSSIN PE
OTC	guaifenesin syrup	MUCINEX
	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	PROLASTIN
	spacers	AERO-CHAMBER, OPTICHAMBER, RITEFLO

alpha-1-proteinase inhibitor/ARALAST requires prior authorization
alpha-1-proteinase inhibitor/PROLASTIN requires prior authorization

SPECIALTY MEDICATIONS

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

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GenoTropin*	Thalomid*
Humira*	Tobi*
Hyalgan*	Tracleer*
Immune Globulin IM*	Tykerb*
Immune Globulin IV*	Tysabi*
Implanon*	Vectibix
Kineret*	Vimpat*
Letairis*	Vivaglobin*
Lovenox – Extended use*	Xeloda*
Lupron, Lupron Depot*	Xolair*

Neulasta*

*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

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KETOROLAC TROMETHAMINE, 15 MG	J1885
LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 3.75 MG	J1950
LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG	J9217
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 (requires J codes shown above).

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
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 insulin syringes/needles	PRECISION PRODIGY INSULIN SYRINGE
	Insulin syringes/needles	PRODIGY PEN NEEDLE
	lancets	SOFT TOUCH
	lancets	SOFTCLIX

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